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## Abstracts

British Association for Behavioural and Cognitive Psychotherapies

# BABCP Warwick 2015 Abstract Book

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## Keynote Addresses

### Adapting CBT for people with Autism Spectrum Disorders: the known and the unknown

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#### **Ailsa Russell, Dept. of Psychology, University of Bath**

There is increasing evidence that mental health problems such as anxiety and depression commonly occur in people with Autism Spectrum Disorders (ASD). Clinical and empirical studies considering the usefulness of cognitive behavioural interventions have highlighted adaptations to CBT which may be of particular help for therapists when working with people with ASD. The nature of and evidence supporting these adaptations will be discussed.

### Four decades of outcome research on psychotherapies for adult depression: What's next?

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#### **Professor Pim Cuijpers, VU University Amsterdam, the Netherlands**

In the past four decades more than 400 randomized have examined the effects of psychotherapies for adults depression. These trials have focused on different types of psychotherapy, including cognitive behaviour therapy, interpersonal psychotherapy, behavioural activation and several other types. These studies have compared psychotherapies with control groups, with each other, with pharmacotherapy and with combined treatments, and have applied different treatment formats, in varying populations and at different time points. In this presentation an overview will be given of a series of meta-analyses in which the outcomes of this large body of research has been summarized, as well as the strong and weak points of this research and what has to be done next to improve the outcomes of psychotherapies.

### Mirrors of the mind: how imagery reveals the self

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#### **Lusia Stopa, University of Southampton**

Distorted views of self are at the heart of many clinical disorders. These self-views are often encapsulated by a mental image that both represents the individual's view of self and is associated with a set of autobiographical memories that reinforce those views. Although traditionally cognitive therapy has discussed these negative self-views in terms of core beliefs or schema, the focus of this keynote address is on how more dynamic models of the self, namely, the self-memory system (Conway & Pleydell-Pearce, 2000), self-organisation (Showers & Zeigler-Hill, 2006), and retrieval competition (Brewin, 2006) may offer a better way to explain the image-self relationship. The talk will examine experimental research into self-images in social anxiety, where negative self-images increase anxiety and impair performance in social situations, reduce implicit and explicit self-esteem and self-concept clarity, and reduce access to positive autobiographical memories. This experimental work tested the hypothesis that images represent an individuals' 'working self', which describes a current 'on-line' self that is only one of many possible self-representations. Subsequent experimental tests of this hypothesis have looked at the role of imagery and the self in eating disorders and in paranoia. The final part of the talk will focus on using imagery in treatment and will consider the importance of dynamic models of imagery and self for understanding the mechanisms behind the success of imagery rescripting as well as suggesting further potential ways in which imagery techniques can be used in treatment to target negative self-views.

"Becoming a virtuoso in CBT: Learning and interpreting the 'score,' combining fidelity with artistry, and knowing and connecting with your 'audience.'"

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**Cory F. Newman, Ph.D., Center for Cognitive Therapy, University of Pennsylvania, Perelman School of Medicine, Philadelphia, PA, USA**

In the performing arts, actors must know the script and musicians must be faithful to the score, but attaining levels of virtuosity requires more than simply reproducing what is written on the page. In order to produce memorable performances, actors and musicians are very attentive to pacing, timing, volume, emotions, and other subtleties of effect that can move an audience. Similarly, when CBT is performed at virtuoso levels, treatment manuals and principles serve as important frameworks, but they are also imbued with the best personal qualities of the therapist, such that the treatment is moving and memorable. Further, formulating fluid, data-supported case conceptualizations enables expert cognitive-behavioral therapists to "know their audience," thus guiding them to craft their interpersonal style and methods to the specific needs of each client. The result is the delivery of CBT that has the best chance of making maximal positive impact, inspiring the clients to learn, grow, "quote the lines," and "hum the tunes" of CBT on their own for the long term.

## Unravelling the Enigma of Anorexia Nervosa: Novel Developments in Understanding and Treatment

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**Ulrike Schmidt, Section of Eating Disorders, Institute of Psychiatry, Psychology and Neurosciences, King's College London.**

Treatment of adults with anorexia nervosa (AN) remains a major challenge. Existing psychological treatments for adults with anorexia nervosa have poor outcomes and high drop-out rates. To address these problems, we have developed a novel cognitive-interpersonal maintenance model, drawing on our group's findings of the neurobiology of anorexia nervosa. This model is aetiologically based, includes both individual and interpersonal maintaining factors, and targets cognitive and emotional *processes* and traits, rather than focusing only on the content of experiences and beliefs. Based on this model, we have developed a modularised and manualised treatment, called the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA). In this talk I will summarise the evidence underpinning the model, describe the iterative treatment development process, and will present findings from our own group and others regarding the efficacy of MANTRA. Specifically, I will present new data from a large scale randomised controlled trial comparing MANTRA with Specialist Supportive Clinical Management in adult outpatients with broadly defined AN. At 12 months, both treatments resulted in significant improvements in body mass index (primary outcome) and on most secondary outcomes (eating disorders symptomatology, distress levels, clinical impairment) with no difference between groups. However, MANTRA patients rated their treatment as significantly more acceptable and credible than SSCM patients. In a subgroup analysis of full-syndrome AN cases, patients offered MANTRA tended to have better BMI outcomes than those in the comparison group. This suggests that a novel theory-based treatment has advantages over a comparison therapy, widely perceived to be a gold standard. We have now also conducted a 24-month follow-up of clinical outcomes and service utilisation and these data will also be presented.

## Does CBT for psychosis have a future?

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**Max Birchwood, University of Warwick**

CBT for psychosis developed over 15 years ago initially by changing the coping strategies used by patients to deal with their symptoms; and then introducing the assumptions and techniques which have been so successful in cognitive approach to affective disorders. Meta-analyses of this 'first generation' of CBT for psychosis shows that the effect size is much less than we initially thought, and their impact on delusions and hallucinations is unclear; and the effects do not always endure. Since these pioneering efforts, there has been sea change in our understanding of the nature and origins of psychotic symptoms, including the notion that these experiences run on a continuum; and that the metamorphosis into troubling psychosis takes place in adolescence and involves affective processes. This is why there is so much 'affective co-morbidity' in psychosis—I will argue that it provides the engine of psychosis development. I have previously argued that the first generation of CBT trials (including my own) used a 'quasi-neuroleptic model' in their focus on symptoms rather than on distress and behaviour. I will argue that recent evidence on the role of affect

dysregulation in the genesis of psychosis has critical implications for the future development of CBT approaches which I will illustrate by reference to i) our recent MRC COMMAND on commanding hallucinations which has shown a 50% reduction in harmful compliance while not changing the level of psychotic symptoms including voices. ii) the application of differential activation theory to suicidal thinking using ESM methodology. I will outline what I believe should be the 'next generation' of CBT in psychosis.

## Rumination and Memory in Depression

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**Michelle Moulds, The University of New South Wales**

A now extensive body of literature demonstrates that rumination plays a key role in the onset and maintenance of depression, and contributes to the persistence of a range of cognitive deficits that are characteristic of individuals with depressive disorders. Amongst such cognitive deficits are problems with memory; for example, depressed individuals are plagued by recurrent intrusive memories of negative events, and do not report mood-bolstering effects as a result of recalling positive memories. In this talk I will discuss work conducted by my group that has examined the interplay of rumination and memory in depression, and has demonstrated that engaging in repetitive ruminative thought has implications for the qualities and emotional impact of memories in depressed and formerly depressed individuals. The outcomes suggest that treatments that teach depressed individuals to shift out of unhelpful rumination will in turn ameliorate memory disturbances.

**"Keep taking the pills" - intervening to improve adherence to medication.**

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**Ronan O'Carroll, Psychology Division, University of Stirling, Scotland, U.K.**

Prescribing medication is one of the most common interventions in medicine, however the World Health Organisation estimate that approximately 50% of people with long-term conditions fail to take their medication as prescribed. This can be for a variety of reasons, including non-intentional reasons (e.g. forgetting) and intentional reasons (not taking them due concerns about toxicity, dependence etc). In this talk I will present work aimed at eliciting reasons for poor adherence in stroke patients, and the development and evaluation of a brief intervention aimed at improving adherence to blood pressure medication.

**Can psychological therapies really help people living with bipolar disorder? A consideration of progress in research and challenges in implementation**

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**Steven H Jones, Spectrum Centre for Mental Health Research, Faculty of Health and Medicine, Lancaster University**

There has been an upsurge in the development and evaluation of psychological therapies for bipolar disorder over the last decade. This is reflected in the recent NICE Guideline update which reviewed over 50 therapy trials. Despite this progress there are still clear gaps in the evidence base, in particular how to improve functional outcomes and personal recovery in bipolar disorder. This talk will review recent research into individual, group and web interventions for bipolar disorder and the implications of this work for provision of care in clinical practice. This will include consideration of the potential role of the Improving Access to Psychological Therapies SMI programme to aid implementation.

**Developments in the treatment of Obsessive Compulsive Disorder:  
From the internet to the Self.**

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**Michael Kyrios, Research School of Psychology, College of Medicine, Biology and Environment, The Australian National University**

Cognitive-behavioural conceptualizations of Obsessive Compulsive Disorder (OCD) have led to effective psychological treatments. Despite the effectiveness of cognitive-behaviour therapy (CBT), outcomes vary with recovery rates of only around 40% - 50%. Furthermore,

the dissemination of CBT is hampered by the paucity of specialist clinicians, geographic remoteness from services and consumer reticence to present for treatment. In response, researchers have sought to identify factors predictive of poorer outcomes in order to develop novel treatments based on new theoretical approaches and to use digital technologies to disseminate treatments. This talk outlines findings from our group's OCD treatment evaluations, including a group-based CBT manual and an online therapist-assisted program. Furthermore, the talk overviews research focusing on the association between OCD phenomena and self-construals. A conceptual model of OCD incorporating cognitive and self-factors is presented, and recommendations made regarding future developments in the treatment of OCD.

### “Getting the most out of investigations of therapeutic processes and outcomes: Implications for clinical guidelines and evidence-based personalized clinical practice”

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**Robert J. DeRubeis, Samuel H. Preston Term Professor in the Social Sciences and Professor of Psychology, School of Arts and Sciences, University of Pennsylvania, Philadelphia, PA USA**

Studies of the effects of treatments are moving beyond a one-size-fits all approach, with a greater focus on features of individual patients, or subgroups of patients, that can be used to inform treatment decisions. The speaker will describe an approach to the use of pre-treatment assessments that differs from previous attempts to guide treatment matching hypotheses. He will also describe and propose solutions to a problem that vexes all treatment studies: variability among patients in the degree to which the quality of therapy they receive will have an effect on their outcome. It is safe to assume that some patients will improve irrespective of the quality or strength of the therapy they receive and others will show little or no improvement in a given period of time even if they are provided with the strongest, best treatment for them. However, the implications of this have received little attention from treatment researchers. The speaker will describe a method that uses prognostic information to distinguish, *a priori*, patients whose outcomes are unlikely to be contingent on the strength of the treatment they are exposed to versus those whose outcomes are likely to be affected by the strength of the treatment they receive. The implications for the interpretation of data from comparative trials and investigations of therapist effects will be illustrated with actual data as well as with Monte Carlo simulations.

### Preventing Depression in Adolescents: Challenges and Successes

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**Susan H Spence, School of Psychology and Australian Institute of Suicide Research and Prevention, Griffith University, Brisbane, Australia**

Depression is a relatively prevalent mental health problem among adolescents, and is associated with a large number of adverse consequences and correlates. Although effective treatments are available, a significant proportion of young people do not respond to current treatments or relapse, showing a repeated pattern of depression that may persist into adulthood. Given the high financial cost to the community and significant personal distress associated with depression, it would be far better to prevent its development in the first place. Despite an increasing body of research into the prevention of depression in young people, we are still a long way from having developed interventions that are consistently effective in achieving their goal. This presentation will present recent findings in the area and will draw on the presenter's recent research evaluating a long-term, school-based intervention with adolescents. In particular, it will examine some of the factors associated with outcome in the prevention of adolescent depression, and will propose strategies that should be explored in future research. It is clear that not all young people benefit from preventive interventions and it is important that we are able to identify those who are more likely to respond positively. The research also suggests that particular approaches to prevention are more likely to produce successful outcomes. For example, programs that are targeted to specific groups of young people who are at increased risk of developing depression appear to be more effective than universal programs administered to whole

school groups. Finally, the paper will examine the implications for clinicians and will explore ways in which they can lead or contribute to preventive programs through partnerships with schools, youth clubs, and other youth contexts. Recent developments with online CBT programs for youth depression may also offer promise in a preventive capacity.

### How can we improve the GP management of mental health problems?

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**Tony Kendrick MD FRCGP FRCPsych, Professor of Primary Care, Faculty of Medicine, University of Southampton**

GPs have been accused of missing treatable anxiety and depression on the one hand, and of medicalising unhappiness on the other, by treating people with mild psychological distress with unnecessary antidepressants. More than 10% of the population are now taking them, including more than 20% of women in deprived areas. This presentation will include primary research conducted by the speaker on the causes of the ever-increasing prevalence of antidepressant prescribing; the effects of NICE guidelines and the quality and outcomes framework on the GP management of depression; and an evaluation of the potential role of IAPT in reducing antidepressant prescribing. He will draw out the implications for practice and policy to help improve the primary care management of common mental health problems.

### The status of prevention programmes for psychopathology

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**Tracey Wade, School of Psychology, Flinders University, Australia**

Prevention of mental health problems in youth (up to age 25) has been the subject of much research, but what do we really know about how to prevent mental health problems from developing? The keynote addresses this issue across depression, anxiety and eating disorders, in terms of both reducing current levels of psychopathology and preventing the growth of psychopathology. Showing effects in universal, school-based prevention studies is the most challenging area of prevention, with less than a quarter of interventions evaluated showing an ability to prevent growth of psychopathology. Prevention in high risk (selective) populations shows more promise with respect to decreasing psychopathology and preventing onset of disorders. Given the range of mental health and health challenges presenting to youth, the potential application of transdiagnostic prevention strategies will be important in future work. Implications for the use of prevention strategies in both universal and selective populations will be discussed, along with future directions for research.

## Symposia

### New advances in understanding and addressing perfectionism, self-criticism and related constructs

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**Perfectionism: evidence for successfully targeting in treatment and novel performance based evidence in Anorexia Nervosa**

**Samantha Lloyd, King's College London; Jenny Yiend, Mizan Khondoker, Ulrike Schmidt & Kate Tchanturia**

Perfectionism is implicated in a range of psychiatric disorders, with some studies suggesting that it may impede treatment and is associated with poorer outcomes. As a result perfectionism has been identified as an important target for treatment. A systematic review and meta-analysis was carried out in order to summarise the existing evidence for psychological interventions targeting perfectionism in individuals with psychiatric disorders associated with perfectionism and / or clinical levels of perfectionism. The review identified eleven eligible studies of cognitive behavioural interventions, with the meta-analyses showing large pooled effect sizes for change in a number of aspects of perfectionism

following treatment. The study supports the effectiveness of cognitive behavioural interventions to reduce perfectionism in individuals with clinical disorders or clinical levels of perfectionism. The study also highlighted the limited evidence for certain conditions and formats of intervention, which will be discussed. The second part of the talk will focus upon a study addressing the lack of behavioural evidence for perfectionism in Anorexia Nervosa. This study used novel performance based measures to investigate whether there is behavioural evidence for elevated perfectionism in AN. 81 participants with AN and 72 healthy controls (HCs) completed two performance-based perfectionism tasks – a text replication task and a bead sorting task. Significant group differences were observed on the tasks. This study provides empirically tested evidence of elevated performance-based perfectionism in AN compared with a healthy control group. The research and clinical implications of these findings will be discussed, along with consideration of how these findings can be translated into interventions such as those identified by the systematic review.

### **Piloting a perfectionism intervention tailored for pre-adolescent children**

Kate Fairweather-Schmidt, & Tracey D. Wade, Flinders University

Reducing unhelpful perfectionism has been shown to produce transdiagnostic outcomes in adults, reducing depression, anxiety and weight concerns. There is limited evaluation of the impact of reducing unhelpful perfectionism in adolescents and none in children. The aim of the current pilot study was to pilot a 2-lesson perfectionism intervention for children. Classes of school students (N=125, 47.2% girls; mean age 11.60 years, SD=0.82; range 9.91-13.91) were randomly assigned to one of two conditions: perfectionism or assessment only-control. Assessment occurred on three occasions: baseline, post-intervention, and 2-week follow-up. At both post-intervention and 2-week follow-up, children receiving the intervention had significantly lower self-oriented perfectionism-striving than controls, with a between group effect size ranging from 0.40-0.47. This study offers proof of principle that unhelpful perfectionism can be reduced in young children and future research should investigate the potential of such an intervention to decrease perfectionism and increase resilience over the long term.

### **An experimental investigation of standard setting, negative affect, and self-criticism after failure in clinical perfectionism: The impact of manipulating the dependence of self-evaluation on standards**

Osamu Kobori & Bosco G. Chan

Previous studies have demonstrated that perfectionists have shown stronger negative affective reactions to failure and repeated failure than non-perfectionists. The aim of the present study is to investigate whether individuals with clinical perfectionism demonstrate negative affective reactions to failures and try to maintain their high standards, only when they perceive that their self-evaluation depends on striving to meet personally demanding standards. Student participants measured their level of perfectionism were asked to perform a difficult experimental task twice. After each task, they received a negative feedback, independent of their actual level of performance. Participants in the experimental condition were told that the task is very important for their self-evaluation, while participants in the control condition were told that the task has nothing to do with their self-evaluation. On the day of the symposium, we will present our preliminary findings regarding the effect of trait perfectionism and experimental manipulation on their cognitions about the task and their negative affect.

### **Self-critical thinking and overgeneralisation in depression and eating disorders: An experimental study**

Graham Thew, James Gregory, Kate Roberts & Katherine Rimes

Self-critical thinking is common across psychological disorders, yet it is rarely studied empirically. It is often considered an important part of perfectionism, but little is known about if and how it may contribute to clinical problems. This study hypothesised that it may play an important role in 'overgeneralisation', the process where specific negative

experiences activate more global negative self-views. Experimental tasks were used to elicit self-critical thoughts in participants with depression, eating disorders, and nonclinical controls. Following a failure experience, both clinical groups showed greater global negative self-views, controlling for baseline scores, compared to controls, indicating overgeneralisation. Both habitual and increases in state self-critical thinking were associated with overgeneralisation while negative perfectionism was not. As predicted from Barnard and Teasdale's (1991) Interacting Cognitive Subsystems model, increased global negative self-views were more strongly associated with post-task reduced mood than self-criticism. Self-critical thinking may be an important factor in the overgeneralisation process, and this activation of global negative self-beliefs may be particularly crucial for lowering of mood.

## Cognitive Biases and Intolerance of Uncertainty

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### **Intolerance of Uncertainty as a predictor of performance anxiety and sport-confidence in professional and semi-professional rugby players.**

**Gary Robinson, Newcastle University**

Intolerance of Uncertainty (IU) has been identified as an important transdiagnostic construct. No studies have yet examined IU in performance anxiety in competitive sport, although it is possible that IU plays a role in anxiety responses that can be experienced in competitive sport situations. Performance anxiety is now specified as a sub-type of social anxiety disorder (APA, 2013). The purpose of the present investigation was to investigate the relationship between IU and performance anxiety in competitive sport.

A total of 95 male professional and semi-professional rugby league and union players were included in the study. Participants completed measures of IU, performance anxiety, and sport-confidence.

Regression analyses revealed that the inhibitory dimension of IU, but not the prospective dimension of IU, was a significant predictor of performance anxiety. A simple mediation model was also tested and results suggested indirect and direct effects of inhibitory IU on performance anxiety through sport-confidence.

Results from the current study provide further support for the proposition that IU is a transdiagnostic maintaining factor across a range of anxiety disorders, including performance anxiety in competitive sport. Results also suggest that the ability to tolerate the uncertainty associated with competitive sport situations may be a critical element in the development and maintenance of performance anxiety. Interventions which focus on increasing tolerance of uncertainty may, therefore, prove effective in reducing the severity and intensity of performance anxiety symptoms.

CBT practitioners working with athletes suffering from performance anxiety should consider explicitly addressing IU with the goal of relieving performance anxiety symptoms and improving performance.

### **The Efficacy Of Cognitive Bias Modification Interventions For Mental Health Problems: A Meta-Analysis**

**Ioana Cristea, Babes Bolyai University**

Cognitive bias modification (CBM) interventions are strongly advocated in research and clinical practice. We aimed to examine the efficiency of CBM for clinically relevant outcomes, along with study quality, publication bias and potential moderators.

We conducted two meta-analyses of randomized controlled trials of CBM interventions for clinically relevant outcomes, one for patients with mental health problems and one for all populations. We included randomized controlled trials of CBM interventions, which reported clinically relevant outcomes assessed with standardized instruments. We examined the quality of the trials, as well as possible publication bias and possible moderators.

We identified 49 trials and grouped outcomes into anxiety and depression. ESs were small considering all the samples, and mostly non-significant for patient samples. ESs became non-significant when outliers were excluded and after adjustment for publication bias. The quality of the RCTs was sub-optimal. Publication year was consistently negatively associated

with ESs. More sessions were associated with smaller ES, as were the absence of participant compensation and, respectively, the non-exclusively laboratory based delivery of the intervention. The quality of the RCTs was not optimal and quality was negatively associated to outcomes for depression and general anxiety.

Our results indicate that CBM may have small effects on mental health problems, but it is also very well possible that there are no significant effects. Research in this field is hampered by small and low-quality research, and by risk of publication bias, and much of the positive outcomes is driven by extreme outliers.

CBM is a new development in the field of CBT, but advocating and expanding it to clinical practice is premature.

### **Aberrant Gaze Patterns during Public Speaking Predict Treatment Response in Social Anxiety Disorder**

**Nigel Chen, University of Western Australia**

Social anxiety disorder (SAD) is thought to be characterized by an attentional bias towards threat, and also the attentional avoidance of emotional social information. However, it remains to be determined whether such biased patterns of attention may predict treatment response to cognitive behavioural therapy (CBT). The aims of the present study were twofold. It was first sought to examine social anxiety-linked biases in attentional processing during a speech task stressor. The second aim concerned whether this biased attentional processing, as assessed by the speech task, may predict subsequent changes in social anxiety symptoms following CBT.

Clinically socially anxious and control participants were required to give a speech in front of a pre-recorded audience displaying emotional social gestures. Eye movements towards the audience display were recorded throughout the speech to provide a continuous assessment of attention. Socially anxious participants additionally completed eight weekly sessions of CBT.

Socially anxious individuals exhibited reduced total fixation time to emotional stimuli, compared to controls. At the onset of an emotional gesture, control participants were faster to engage with positive, relative to threatening gestures, while this bias was absent in socially anxious participants. Reduced total fixation time to emotional stimuli was further found to predict greater response to therapy for socially anxious participants.

The findings suggest that social anxiety may be characterized by an attentional engagement bias and the avoidance of emotional social stimuli. The findings further implicate the potential clinical utility of eye tracking in predicting treatment response.

The present paper describes a novel eye tracking task which may provide an assessment of the attentional patterns which characterize social anxiety disorder, and are associated with social anxiety symptom reduction following group-based CBT. The findings implicate that the present task may potentially provide a clinical marker of treatment response.

### **Investigating the relationship between Intolerance of Uncertainty and worry: An experimental manipulation**

**Tim Chapman, Newcastle University**

Intolerance of Uncertainty (IU) is a construct that is known to influence worry and is a maintaining factor in Generalised Anxiety Disorder. Although there are numerous studies indicating a correlational relationship between IU and worry, to date there has been relatively little research that has attempted to demonstrate a causal relationship between IU and worry. A small number of studies have previously attempted to demonstrate a causal relationship between IU and worry by experimentally manipulating IU with mixed results. This study addresses issues raised in previous studies concerning sensitivity and specificity of the experimental manipulation as well as employing an ecologically valid experimental design. Conducted entirely online using a mixed multi-media presentation, an analogue sample were randomly allocated to experimental conditions of high or low intolerance of uncertainty by manipulating reactions to surprises in everyday situations.

Meta-analysis of the previous studies indicate large effects sizes for the manipulation of uncertainty and medium effect sizes for the effect on worry or other similar outcome

measures. However all of these studies are open to alternative explanations for the reported findings rather than the specific manipulation of IU in the absence of hypothesis guessing. Results from this study are less subject to these explanations and provide a stringent and well powered test with adequate numbers of participants in each of the four conditions to detect the order of effects reported in previous studies.

This study provides the most stringent test to date of the causal role of IU on worry. At the time of submission, data collection is complete. This study will add to the existing literature by providing estimates of a truer and less confounded effect of IU on worry. Together the results of the meta-analysis and systematic critique of previous studies and the current study advance our knowledge in a significant way.

Although there is increasing evidence that IU predicts changes in symptoms during successful treatment, strong evidence of the causal role of IU is required. A causal relationship of IU leading to worry would provide the evidence needed to argue for and then facilitate the development of focused interventions for IU. This would have implications for the treatment of excessive worry and other anxiety symptoms across a range of psychological disorders.

### **The crucial role of danger controllability in anxiety-linked cognitive biases.**

**Lies Notebaert, University of Western Australia**

Individuals with high levels of trait anxiety have been shown to exhibit cognitive biases favouring the processing of threat, and research suggests that these biases are important contributors to anxiety dysfunction. However, a crucial function of both anxiety and attentional bias has until now been overlooked. Specifically, anxiety and threat processing are important adaptive functions. Anxiety prepares an organism for action aimed at minimising or avoiding danger, and preferential processing of threatening information is crucial to survival, as it allows fast and efficient responses to impending danger. Therefore, it is likely that danger controllability will have a profound impact on the manifestation of cognitive biases.

In two experiments, we investigated the role of danger controllability in anxiety-linked biases in attention and memory. In Experiment 1, high and low anxious participants completed an attentional task assessing attentional bias to a threat cue signalling either a controllable or uncontrollable danger. In Experiment 2, high and low anxious participants completed a recognition-memory task assessing memory bias for threat cues which had signalled either a controllable or uncontrollable danger.

Results showed an increased anxiety-linked attentional bias for threat cues signalling a controllable danger in Experiment 1, and an anxiety-linked memory bias which was restricted to threat cues signalling a controllable danger in Experiment 2.

Overall, this suggests that high trait anxious participants displayed increased selective processing of threat cues which predict controllable dangers, as compared to uncontrollable dangers. Theoretical implications regarding our understanding of cognitive biases in anxiety are discussed, as well as clinical implications for research and practice aimed at modifying these cognitive biases.

Research has shown that CBT reduces anxiety-linked cognitive biases. By determining the exact nature of these biases, the current research may enhance our understanding about the precise cognitive processes which could be targeted for treatment, thereby potentially contributing to increasing the effectiveness of CBT.

## **Goals and Self-regulatory Processes in Depression**

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### **Unique associations between anxiety, depression and motives for approach and avoidance goals**

**Alison Winch, Tees, Esk and Wear Valleys NHS Trust; Nicholas J. Moberly, University of Exeter; Joanne M. Dickson, University of Liverpool.**

This study investigated shared and unique associations between symptoms of depression, symptoms of anxiety and motives for personal goal pursuit. Participants were 136 undergraduates who generated approach and avoidance goals, each of which was rated on

intrinsic, identified, introjected and external motives. Anxious and depressive symptoms showed significant unique associations with specific motives: symptoms of depression were uniquely associated with intrinsic motivation for approach goals (but not avoidance goals), whereas symptoms of anxiety were uniquely associated with introjected regulation for both approach and avoidance goals. The findings suggest that reduced enjoyment of approach goal pursuit is unique to depression, whereas pursuit of goals in order to avoid negative outcomes is unique to anxiety. Links with regulatory focus theory will be discussed and the importance of understanding the relation between goal motivation and depression and anxiety in clinical practice will be highlighted.

### **Goal specificity, content, and function in depression**

**Joanne M. Dickson, University of Liverpool;** Nicholas J. Moberly, University of Exeter; Susan Mitzman, University of Liverpool.

Goal motivation is central to human experience, yet relatively little research has studied depression from this perspective. This research examines approach and avoidance goal content, goal function, and goal specificity in depression. The sample comprised 21 clinically depressed and 24 never-depressed individuals. Two separate measures were used to elicit participants' self-generated approach goals and avoidance goals. Coding schemes were used to assess goal content, goal function and goal specificity. Relative to controls, depressed individuals did not generate fewer goals nor did they differ in the reported importance of their goals. Results found that depressed individuals, relative to controls, generated more 'personally and psychologically' oriented approach and avoidance goals and fewer 'quality of life'-related avoidance goals. Furthermore, depressed individuals generated more 'self-functioning' approach and avoidance goals and fewer 'pragmatic functioning' avoidance goals than controls. As predicted, depressed individuals were less specific in defining their personal goals than controls. Our results extend our understanding of goal motivation in depression. Importantly, the findings have the potential to contribute to the ongoing development of more effective psychotherapies as personal goals are central to several therapeutic endeavours.

### **Approach and avoidance motivation in depression: A combined experience-sampling and fMRI approach**

**Natasha Bloodworth, University of Exeter;** Natalia Lawrence, University of Exeter; Nicholas J. Moberly, University of Exeter.

The desire to approach positive outcomes and avoid negative outcomes has long been held to be fundamental to motivation. However, people with depression have been found to have increased pessimism around approach-type goals, with some evidence suggesting that the underlying motivation for these goals might be more avoidant, with a lower expectancy of positive outcomes. It is proposed that these deficits in facets of approach motivation may contribute to key symptoms of depression, such as general hopelessness and anhedonia. This seems to be a bidirectional association, with the experience of anhedonia giving rise to a lack of approach motivation and this lack of approach motivation possibly leading to fewer rewarding experiences due to the reduction in, or absence of, the experience of reward. In order to investigate these relationships between anhedonia, approach motivation and goals, healthy participants recruited from the student population (N = 65) underwent a 7-day period of experience sampling (ESM) to provide a naturalistic measure of momentary affect, mood and goal-focused motivation. Functional magnetic resonance imaging (in a subset of n = 28) was then used to investigate individual differences in sensitivity of reward and punishment brain systems, which may be linked with the aforementioned trait approach and avoidance attributes. By combining these two approaches, we hope to obtain a more valid measure of individual motivational attributes, bringing together two separate literatures and examining whether basic measures of brain function are of relevance to everyday aspects of depression.

## **Disengagement from life goals during depression: Cognitive factors in suppressed motivation**

**Stephen Barton, Newcastle CBT Centre & Newcastle University;** Emma Burton-McCreadie, Newcastle University; Theresa Marrinan, Newcastle University, Mark Freeston, Newcastle CBT Centre & Newcastle University.

Studies suggest that depressed people hold onto their life goals even though they're less engaged with them. Consequently, depressed and non-depressed report a similar number of goals but non-depressed are more engaged in bringing them about. Nevertheless, non-depressed also have passive goals—those goals that they are not currently engaged in, perhaps due to attentional shifts or flexible self-regulation. This study compared depressed with normal disengagement. Groups of depressed and non-depressed participants generated current life goals and a highly valued goal with low current engagement was examined in more detail. Sub-goals were generated and participants made predictions as to what would happen if they engaged with the sub-goals. The groups had similar predictions for low difficulty sub-goals but depressed participants predicted lower rewards and higher threats for high-difficulty sub-goals. The results suggest that (i) the relevant cognitive biases operate at specific, sub-goal levels rather than generalized pessimism or hopelessness; (ii) depressed disengagement is due to the interaction of approach and avoidance systems under conditions of perceived high difficulty. Therapeutic implications are considered including possible impacts on attentional and ruminative processes.

## **Research on personal goals in depression: Should we hang on or let go?**

**Nicholas J. Moberly, University of Exeter**

Although motivational deficits are an important feature of depression, they have been relatively neglected within clinical psychology's empirical literature. Depression researchers have investigated reward processes in the laboratory, and a rich theoretical literature on depression and goal striving has accumulated in recent decades, but research using the personal goal construct has proceeded rather sporadically. This appears surprising given the ecological validity of idiographic goals as a motivational unit, and the focus on client goals in many forms of therapy. This talk will review findings in this area, organised using Austin and Vancouver's (1996, *Psychological Bulletin*) taxonomy of goal structure, process and content. Areas of convergent evidence will be summarised, and gaps and limitations in the current evidence base will be highlighted, including uncertainty about the causal status of goal processes in depression. By identifying promising new directions in this research field, a case will be made for persistence rather than premature disengagement.

## **New Developments in CBT for Chronic Fatigue and Somatic Symptom Disorders**

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### **Using a case series to explore the feasibility and acceptability of brief Cognitive Behavioural Therapy to reduce worry in Somatic Symptom Disorder.**

**Helen Mander, Southern Health NHS Foundation Trust**

Persistent health anxiety is common and associated with high levels of functional impairment and high healthcare costs. Cognitive Behavioural Therapy is currently the best established treatment; however engagement with psychological therapies is problematic. Worry is involved in perpetuating anxiety in those with somatic symptoms. Previous work with persecutory delusions has shown that an intervention which focussed on worry rather than paranoid beliefs was highly engaging and acceptable to participants and led to changes in both worry and persecutory delusions. The aim of the current study is to assess whether a brief intervention for people with persistent health anxiety focussing on worry rather than somatic symptoms might be similarly acceptable and effective.

Twelve participants with Somatic Symptom Disorder were recruited from one liaison psychiatry service (6 participants) and two mental health teams (6 participants) across two trusts. A manualised six-session worry-focussed CBT intervention was delivered, with measures of anxiety, distress and wellbeing completed before and after the intervention.

All participants engaged with the worry-focussed intervention. Descriptive analyses of pre-post questionnaires suggested a reduction in level of health anxiety and an increase in wellbeing. Qualitative feedback revealed that the intervention was well accepted. The findings suggest that a brief worry-focussed intervention may be feasible and acceptable to patients with extremely distressing somatic concerns. This case series is limited by its small sample and lack of control group. A further large-scale randomised controlled trial would be necessary to examine the clinical and cost-effectiveness of such an intervention. For service users who present with severe and distressing concerns about their health, a worry-focussed intervention may be an acceptable and engaging option.

### **Is Cognitive Behavioural Therapy effective in treating core symptoms of adult ADHD and associated difficulties? A comparison of treatment outcomes from routine clinical practice within and outside the confines of Randomised Control Trials**

**Denise Rogers, Kings College London/SLAM NHS Foundation Trust**

High proportions of adults with ADHD do not tolerate or respond optimally to first-line pharmacological interventions. This client group require replacement or concurrent psychological interventions to address high rates of comorbidity and associated functional impairment. This study aims to examine the efficacy of cognitive-behavioural therapy (CBT) in treating symptoms of adult ADHD and associated social impairment in routine clinical practice compared with a recent randomised control trial (RCT) carried out in the same service. Clinic outcomes will also be benchmarked against previously existing RCTs. Pre and post-therapy self-report measures for ADHD symptoms, social adjustment, depression and anxiety were compared across routine clinical practice (N = 102) and a RCT (N = 30) carried out in the same service. Outcomes were benchmarked against three additional RCTs using uncontrolled effect sizes.

There were no significant differences between routine clinical practice and the RCT across all measures. ADHD symptoms, social adjustment, anxiety and depression scores improved significantly from baseline to end of therapy in both studies. Clinic treatment effects were comparable with large effect sizes demonstrated in the benchmarking analysis for symptom reduction and larger than those demonstrated for functional improvements.

CBT is an effective and acceptable intervention in treating core symptoms of adult ADHD and associated difficulties in routine clinical practice. Patient accounts corroborate these findings with 77% improvement and 97% satisfaction rates reported post-therapy.

CBT is an effective intervention for adult ADHD in routine clinical practice and should be more widely available at both local and national levels.

### **Fatigue and cognitive-behavioural responses to symptoms in patients with autoimmune rheumatic diseases and chronic fatigue syndrome: a cross-sectional study.**

**Sheila Ali, South London and Maudsley NHS Foundation Trust**

Fatigue is commonly reported in autoimmune rheumatic diseases, and impacts upon quality of life. However it is inadequately addressed by clinicians. The aim of the current study was to investigate the fatigue and cognitive behavioural responses of participants with rheumatoid arthritis (RA), spondyloarthritis (SpA) and connective tissue disease (CTD), and to compare them with participants with chronic fatigue syndrome (CFS).

301 participants were included in the study. Participants completed questionnaire measures of fatigue, disability and cognitive-behavioural responses (the Chalder Fatigue Scale, the Work and Social Adjustment Scale, and the Cognitive behavioural responses questionnaire). The three autoimmune disease groups (RA, SpA and CTD) were first compared against each other on all measures. These three groups were then aggregated into one autoimmune rheumatic disease group (ARD) and compared against the CFS group on all measures. There were no significant differences between the RA, SpA and CTD groups for fatigue, disability, or any of the cognitive-behavioural responses. When compared with the ARD group, the CFS group scored higher for fatigue, disability, fear avoidance beliefs and avoidance/resting behaviour.

Fatigue in CFS and autoimmune rheumatic diseases may be perpetuated by similar underlying transdiagnostic processes, and may therefore benefit from similar transdiagnostic treatment approaches.

A transdiagnostic CBT-based intervention could be developed for autoimmune rheumatic diseases, to be delivered in rheumatology outpatient clinics

### **An experimental investigation of possible maintaining factors in Chronic Fatigue Syndrome in adolescents**

**Kate Lievesley, King's College London**

In adolescent Chronic Fatigue Syndrome, fatigue may often have been initially triggered by an infection. Other factors may then act to maintain the condition. Wessely et al. (1989) proposed that the individual starts to reduce their activity levels in an attempt to feel less fatigued, but in fact their exercise tolerance worsens and fatigue increases when they try to do more. Catastrophic interpretations of symptoms and beliefs such as 'if I continue with this activity I will get so exhausted I will end up bedbound', contribute to activity reduction and avoidance. It is suggested that the individual ends up in a vicious cycle of unhelpful cognitions and behaviours.

The aim of this study was to investigate hypothesised maintaining factors in adolescent CFS derived from Cognitive Behavioural Theory, using an experimental design. Experimental studies in adolescents with CFS have rarely been conducted. The potential maintaining factors under investigation were symptom focusing, expectations of performance, negative performance evaluation and misattribution of symptoms of stress. The performance tasks were attention, exercise and social presentation tasks.

The adolescents with CFS had lower pre-performance expectations and anxiety in comparison to the other two groups, particularly in relation to the social performance and exercise tasks. Self-evaluation of performance on tasks was lower in the CFS group than the control groups with higher scores for experienced difficulty, but their self-ratings were in line with their reduced objective performance. Adolescents with CFS (mis)attributed cognitive symptoms of stress to their illness rather than the stress of the performance task. Each of these factors may act to maintain symptoms or impairment.

Treatment could include behavioural experiments to help patients observe the consequences of different ways of processing their ongoing experience.

### **"It feels sometimes like my house has burnt down, but I can see the sky": A qualitative study exploring patients' views of Cognitive Behavioural Therapy for Chronic Fatigue Syndrome.**

**Federica Picariello, Health Psychology Section, IoPPN, King's College London**

Cognitive Behavioural Therapy (CBT) is currently the first line treatment for Chronic Fatigue Syndrome (CFS). Even though, the results from trials are promising, there is variability in patient outcomes. The aim of this study was to explore in-depth the experiences with CBT of adult CFS patients.

This was a qualitative study. Thirteen CFS patients, approaching the end of CBT, were interviewed via a semi-structured interview schedule. The data was analysed using inductive thematic analysis. In addition, prior to the interview, patients were asked to rate their satisfaction with CBT and perceived level of improvement.

The majority of patients were satisfied with treatment and reported marked improvements. This was evident from the ratings and corroborated by the qualitative data, yet recovery was in general incomplete. Patients often disclosed mixed feelings towards CBT prior to its start. Behavioural aspects of treatment were found useful, while more ambivalence was evident towards the cognitive aspects of treatment. The tailored nature of CBT and therapist contact emerged as important components of treatment, providing patients with support and validation. Engagement and motivation were crucial to gain benefits from CBT, as well as the acceptance of a psychological model of CFS. Illness beliefs around CFS and stigma associated with psychological treatments were also dominant topics, possibly impeding engagement with therapy.

The results underline that various factors can moderate the effectiveness of CBT, and a greater understanding of these factors may help to maximise CBT-related benefits and support patients who do not engage.

The findings of this study may shed light on why variability in improvements via CBT exists. Many factors emerged that can either facilitate or impede improvement. For example, sensitivity is necessary when approaching cognitive tasks and any beliefs that patients may hold in relation to CFS, in order to avoid offending patients and alienating them from CBT. Therefore, understanding in more depth the experience of patients with CBT is key in ensuring that more patients benefit from CBT, and that resources are used optimally.

## Cognitive Biases and Reactions to Adverse Events and Trauma in Children, Adolescents and Families

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### **Predictors of Posttraumatic Stress Disorder in Parents of Children Exposed to Motor Vehicle Collisions**

**Rachel Hiller, University of Bath**

Following a child's involvement in a traumatic event their parents are also at risk of developing posttraumatic stress disorder (PTSD) either via their direct involvement in the event or from hearing of their child's involvement. A parent's development of PTSD not only has adverse consequences for the individual, but also for the child. Despite this, we know little about risk factors for the development of the disorder in this population.

Ninety parents were assessed within one month of their child's involvement in a motor vehicle collision, and then again at six months and three years post-trauma.

Results supported previous findings from the adult- and child-PTSD literature, reporting psychological factors as more important in the development of PTSD, than demographic factors or objective trauma severity. However, results particularly highlighted the importance of post-trauma cognitions that would be unique to events where the child is also involved in the trauma, including subjective threat to the child during the trauma and post-trauma maladaptive cognitions regarding permanent damage to the child. Whether or not the parent was directly involved in the trauma failed to predict symptom trajectory.

Given that the parent's involvement in the trauma failed to predict symptom trajectories, both groups should be considered at-risk for the development of PTSD. In particular, endorsement of cognitions regarding risk to the child's life during the trauma and cognitions regarding the child being permanently changed by the event, both predict increased likelihood that the parent would experience persistently elevated PTSD symptoms.

Results highlight the importance of being mindful of the parent's own risk of developing PTSD, following child trauma. This study identified particular cognitions that should be monitored as risk factors for a parent's development of PTSD, and also potentially targeted in later treatment.

### **Understanding developmental norms in reasoning biases across adolescence**

**Rachel Slavny, Royal Holloway, University Of London**

The current study evaluates how several reasoning biases develop across adolescence in a community sample. Although there are clear associations between biases and psychopathology in young people (Schwartz & Maric, 2014) and they form a focus for cognitive-behavioural treatment, hitherto little is known about the developmental patterns these biases follow across this key developmental stage. This lack of understanding makes it harder for therapists to integrate knowledge of developmental norms into their formulations and treatments.

Seven reasoning biases, known to be associated with mental health difficulties in young people, were explored in a community sample cross-sectionally (N= 426) between early (11-13 years) and late adolescence (14-17 years) using self-report questionnaires. Psychological distress was also measured and controlled for as a covariate.

Cross-sectional analyses revealed that when controlling for psychological distress older adolescents showed significantly higher reasoning bias scores than younger adolescents on

four of the seven biases measured: threat interpretation, overgeneralizing, mind reading and attributional bias.

Preliminary analyses suggest there are developmental increases in some cognitive biases across adolescence that exists apart from changes in psychological distress. The current findings indicate that adolescence might be a key developmental period for changes in biased thinking patterns, and understanding the developmental trajectories of these processes in a non-clinical population is arguably a pre-requisite for further comprehending their association with psychopathology.

Understanding developmental patterns associated with reasoning biases will aid therapists during their formulation and treatment plans by forming a normative framework to compare the clinical population with.

### **Adverse life experience and psychological distress in adolescence: Moderating and mediating effects of emotion regulation and rumination**

**Mark Boyes, Curtin University**

Adverse life experiences in childhood and adolescence have been linked with poor psychological outcomes. There is also evidence that life stressors do not occur in isolation but are often inter-related and that accumulation of adverse life experience is an important risk factor for psychosocial maladjustment. Given many life stressors are uncontrollable, identifying mechanisms that explain or mitigate the relationship between adverse life experience and mental health is important. This study tested whether emotion regulation and rumination moderated and/or mediated the relationship between accumulated adverse life experience and psychological distress in adolescence.

In class, Australian high school students ( $n = 2637$ , 12–18 years, 68% female) from 41 schools completed well validated measures of adverse life experience, emotion regulation, rumination, and psychological distress and were followed up one year later ( $n = 1973$ , 75% retention rate).

Adjusting for age, gender, and baseline psychological distress, adverse life experience predicted psychological distress one year later. Expressive suppression and rumination were positively associated with psychological distress. Cognitive reappraisal was negatively associated with psychological distress and moderated the relationship between adverse life experience and psychological distress. This relationship was also partially mediated by cognitive reappraisal, expressive suppression, and rumination.

Promoting cognitive reappraisal and minimising expressive suppression and rumination may be useful strategies to improve mental health for adolescents who have experienced adverse life events. Future research should examine whether adolescents who have experienced adverse life events can be trained in effective emotion regulation strategies, and whether this training can prevent development of psychological maladjustment.

CBT approaches, which include enhancing emotion regulation skills as well as cognitive restructuring and reappraisal, have been demonstrated to be effective in reducing psychological distress in clinical samples. Based on current findings, future research should examine whether training cognitive reappraisal and teaching strategies to reduce expressive suppression rumination might prevent the development of psychopathology amongst vulnerable adolescents.

### **The prospective role of cognitive appraisals and social support in predicting children's posttraumatic stress**

**Caitlin Hitchcock, MRC Cognition and Brain Sciences Unit**

Although both social support and cognitive appraisals are strong predictors of children's posttraumatic adjustment, understanding of the interplay between these factors is limited. We assessed whether cognitive appraisals mediated the relationship between social support and symptom development, as predicted by cognitive models of posttraumatic stress disorder (PTSD).

Ninety seven children (Mean age = 12.08 years) were assessed at one month and six months following a single incident trauma. We administered self-report measures of cognitive

appraisals, social support and psychological symptoms, along with a diagnostic interview for PTSD.

Results indicated that cognitive appraisals at one month post-trauma mediated the relationship between social support at one month post-trauma, and PTSD severity at follow-up. Differences in this relationship were observed between child-reported social support and parent-rated ability to provide support.

Findings demonstrate the importance of considering the child's perception of social support, in addition to the parent's perceived ability to support their child. Our results also suggest that the positive influence of social support will occur through the wider system around the child, including grandparents, siblings and peers. Firm evidence was provided for the application of cognitive models of PTSD to children.

This study indicated that it may be beneficial for cognitive therapy, particularly the restructuring of negative appraisals, to also involve significant people in the child's life. Important people in the child's life may help the child to appraise the traumatic event in a non-catastrophic manner, and in doing so, crucially influence symptom development.

### **Developing a novel, picture-based tool to assess interpretation bias in adolescents** **Victoria Pile, King's College London**

Maladaptive interpretational styles may maintain distressing social fears in adolescence. Yet, few measures are available to assess these biases in adolescents and all rely on an individual's ability to read hypothetical scenarios and to imagine these happening to themselves. Here, we present self-report and physiological data from two studies aiming to validate a new, developmentally-appropriate picture-based tool that extends previous measures of adolescent interpretation bias towards a more ecologically valid assessment. Pictures of an avatar (from behind) interacting with one or more peers were created. Study 1: 20 female adolescents (aged 16-19) rated the likelihood of three interpretations (positive, neutral and negative) for each picture. Study 2: 53 female adolescents (aged 14-19) completed the measure whilst eye-gaze and pupil dilation were recorded. Additionally, the value of personalising pictures was assessed by replacing the avatar with a picture of the participant. All participants completed a measure of social anxiety.

Study 1: high socially anxious adolescents rated negative interpretations as more likely compared to their less socially anxious peers ( $t(18)=-2.79$ ,  $p<0.05$ ,  $r=.55$ ). The new measure correlated with established measures of interpretation bias (negative scale,  $r=.71$ ,  $p<0.01$ ) and demonstrated excellent internal consistency (Cronbach's  $\alpha$  for negative scale, 0.95). Study 2: personalized stimuli generated increased bias ratings and increased pupil dilation compared to pictures where the avatar was an unknown peer. Adolescents with increased bias ratings exhibited increased pupil dilation.

This novel picture-based tool extends existing measures of interpretation bias and can be used in conjunction with physiological measures of emotion processing.

These findings have direct implications as they (1) indicate that adult cognitive models of social anxiety can be applied to adolescents (2) provide a valid and reliable assessment tool to identify interpretation biases which could also be used as an outcome measure to assess the efficacy of CBT in modifying cognitions and (3) lay the groundwork to develop an interpretation bias training tool as an adjunct to CBT with the potential to boost therapeutic gains.

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## **Improving Access to Psychological Therapies: An Update**

### **Enhancing recovery rates in adult IAPT services**

**David Clark, National Clinical Advisor for IAPT, NHS England and University of Oxford**

The national recovery rate for patients who receive a course of treatment in IAPT services is approximately 45%, with a further 16% of patients showing reliable improvement that falls short of recovery. However, in over 60 local areas (CCGs) recovery rates now exceed 50% and in some areas rates are consistently above 60%. This presentation summarises research findings that provide clues about how to enhance recovery rates and introduces Public

Health England's Common Mental Health Disorders Profiling Tool which provides clinicians, commissioners and the public with a wide range of IAPT performance indices in an accessible format. It is hoped that services will find the Profiling Tool a further aid to service development.

### **Developing PWPs: implementing the PWP review**

**John Cape - Director of Psychological Therapies Programmes, University College London**

The Department of Health/NHS England commissioned review of Psychological Wellbeing Practitioner training ([www.ucl.ac.uk/pwp-review](http://www.ucl.ac.uk/pwp-review)) was published in March 2015. In addition to the summary report, there are nine supporting documents to the review. Implementing the review will have implications for IAPT services in addition to PWP courses and PWPs themselves. Key areas of implementation affecting IAPT services and PWPs more widely will be outlined. These include behaviour change models and strategies for PWPs, principles and types of patient assessment in IAPT services, PWP trainee competency assessments on patients in their IAPT caseloads, evaluating self-help materials used in IAPT services, and supporting PWP continuing professional development.

### **IAPT: Is it providing equality of access?**

**Kevin Jarman - IAPT Programme Manager, NHS England**

Over three million people have gained access to psychological therapies to treat depression and anxiety disorders since the IAPT programme commenced in October 2008. This presentation examines whether IAPT services are reaching adults across the age range, particularly older people and whether they are providing equality of access for people from black and minority ethnic communities.

### **Where next for the Children and Young People's IAPT programme ?**

**Kathryn Pugh - Child and Adolescent Mental Health Programme Manager, NHS England**

The Children and Young people's IAPT service transformation programme now covers services working across 68% of the 0-19 population. What has the learning been so far from the programme, what have been its key challenges and what does the future hold?

## **Cognitive Behaviour Therapy for Psychosis (CBTp) in Conditions of High Security – An Overview of Provision within the UK**

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### **CBT for psychosis for forensic patients: From Numbers to Narrative**

**James Tapp, , Broadmoor Hospital, West London Mental Health Trust; Alison Dudley , Broadmoor Hospital, West London Mental Health Trust**

The evidence base for CBT for Psychosis is well established and recommended in national guidance. However, much of the evidence that supports this practice comes from community and inpatient settings, with less knowledge about its impact for forensic patients. The current presentation describes a CBT for Psychosis group for forensic patients in a UK high secure hospital setting, and offers triangulated evidence on the impact of doing CBT for Psychosis in a group setting. Outcomes are provided from a wait list trial of the group, then from the expert by experience perspective of what had worked and been helpful for recovery, and finally a personal narrative as to the impact of the group is offered. When compared to wait listed participants, CBT for Psychosis graduates experienced positive and negative symptom reduction and improvements in interpersonal functioning following the group. No iatrogenic outcomes, in terms of negative impact on mood from participating in the group and discussing illness, were reported. An interpretative phenomenological analysis of semi-structured interview of 6 group graduates indicated 3 main subthemes of experience: I am not alone - learning through others and normalising and sharing, Making sense - remembering isn't easy, readiness vs coercion, understanding development of illness and symptoms and making new links with offending and Life beyond - learning coping strategies, stigma and trying not to come back. Some of these themes are further highlighted by an interview with a recent group graduate who tells his story

about the group.

### **CBT for Psychosis Service Development in a High Secure Context: Practice Considerations and Reflections**

**Debbie Green, Ashworth Hospital, Mersey Care NHS Trust**

CBT for psychosis (CBTp) is well established in community and less secure settings and has been recommended as part of NICE guidance as a treatment for Psychosis (CG178, NICE 2014). There is an evidence base suggesting the efficacy of CBTp, however not within a high secure setting. It is well established that the high secure population tends to be less motivated to engage in psychological work, have multiple presenting problems including personality disorder and substance abuse, can have more chronic difficulties, have difficulties building trusting relationships and have limited coping and problem solving skills. This has implications for the setting up of a CBTp service within a high secure setting. This presentation will explore how CBTp has been implemented at Ashworth and how this has been influenced by NICE guidance, service changes and by evaluating the effectiveness of our own interventions. The first part of the presentation will give a brief introduction to the development of the psychosis care pathway which was aimed at providing some structure to the treatment of patients with a diagnosis of psychosis within the hospital. The next part of the presentation will start to look at the effectiveness regarding the therapies that were being offered, particularly regarding group therapies. There will be a presentation of quantitative data regarding the effectiveness of the Approaches to Recovery in Psychosis group and the CBTp group. The final part of the presentation will look at how this evaluation led to a restructuring of the care pathway and a move away from group therapy and towards offering individual CBTp only, although will still offer the recovery focused mental health awareness group. Also during this part of the presentation the focus will be upon the model that is used to guide this work and the use of group supervision to support the workers and the work. This will include some case examples to illustrate the important elements of CBTp within a high secure setting.

### **Chief Complaint Orientated Cognitive Behavioural Therapy for Psychosis (C-Co) – An Organisational Case Analysis of development, application and impact.**

**Jonathon Slater, Rampton Hospital, Nottinghamshire Healthcare Foundation Trust**

Glenn Painter, Rampton Hospital, Nottinghamshire Healthcare Foundation Trust

**Cheryl George Rampton Hospital, Nottinghamshire Healthcare Foundation Trust**

In accordance with national guidance (CG178, NICE 2014), Cognitive Behavioural Therapy for psychosis (CBTp) is offered to patients detained in conditions of high security (HS) to aid recovery and transfer to conditions of lesser security. A broad and well established evidence base supports CBTp provision in less secure settings, however little research has been published relating to delivery within HS contexts. HS patients are typically less adherent, more complex and more chronic than their community counterparts. This necessitates the development of site and population specific modes of CBTp delivery, particularly with regard to adherence. Supported and funded by NICE, the CBTp Service was set up in order to develop and apply effective population and context specific CBTp interventions for patients at Rampton Hospital. Individual C-Co has been one such intervention that has proved particularly effective. An organisation-based case analysis is used to provide a multi-faceted insight into C-Co's development, application and evaluation. There are four parts to the presentation, each analysing C-Co from a different perspective. The presentation concludes with an exploration of aggregate impact. Implications for future practice are then discussed. Part 1 offers information about the CBTp Service and the subsequent development of C-Co, its underlying philosophy and principles and delivery framework. A case example of C-Co with a typical HS patient is briefly described. The fidelity of C-Co to core therapy competencies is then established using independent multi-rater CTS-R data. Part 2 provides a quantitative analysis of pre, post and longitudinal follow-up data referenced from a number of repeat outcome measures. An exploration and critique of the measures used, their application in HS, important trends within the data, the mode of analysis and significant findings are given. Understanding participant experiences is integral to increasing therapy quality. However, traditional modes of participant enquiry disadvantage

HS patients. Part 3 offers an insight into how collaborative group game design was used as a novel evaluation method within a participatory action research study of C-Co participant experiences. The approach, the resultant board game, playing strategy, prominent themes and reflections on development are discussed and critiqued. An opportunity to play the game and experience first-hand HS participant experiences of C-Co will also be provided via an app download. The final part describes findings from a thematic analysis of transcribed practitioner interview data (n=6). Semi-structured interviews were used to explore with practitioners their experiences of delivering C-Co. Core theme categories are defined followed by an exploration of linked sub-categories and commensurate properties. Some interesting results emerge with relevance for training, supervision and required competencies. A C-Co supervision model developed from the themes and further refined via a process of iterative dynamic consultation with practitioners is described.

### **Cognitive Behaviour Therapy for Psychosis in High Secure Services: An Exploratory Hermeneutic Review of the International Literature**

**Jonathon Slater, Rampton Hospital, Nottinghamshire Healthcare Foundation Trust**

Cognitive behavioural therapy for psychosis (CBTp) has proven efficacy in aiding recovery by reducing symptom experiences, yet the impact of CBTp in high secure contexts is less certain. This exploratory review aimed to identify CBTp approaches used in High Secure Hospitals and appraise impact. To facilitate this review an iterative literature search strategy and hermeneutic source analysis were utilised. Fourteen sources were identified, more than in previous reviews. CBTp interventions are provided internationally within High Secure Hospital contexts and include group and individual therapy and CBTp linked milieus. CBTp is an active component of treatment in High Secure contexts in the UK and internationally. Some modes of delivery have greater levels of efficacy, with more typical HS patients than others, as regards symptom improvement, risk and cost. Continued application and evaluation of CBTp in HS conditions is warranted. An algorithm of the most efficacious interventions is offered.

### **Training Frontline Staff in CBT: How to provide therapeutic interventions when you are not a therapist**

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#### **The impact of a short Cognitive Behavioural Training Programme on mental health staff knowledge and skills; trainee, mentor and manager perceptions**

**Michael Duffy, Queens University Belfast; Kate Gillespie, CT Training, Dublin, Republic of Ireland; James O'Shea, Health Service Executive, Southern Region, Waterford, Republic of Ireland**

A strong evidence base for Cognitive Behavioural Therapy has led to CBT models becoming available within mainstream mental health services. As the concept of stepped care develops new less intensive mental health interventions are emerging to be delivered by staff not trained to the level of accredited Cognitive Behavioural Therapists. These developments pose the question of how mental health staff can be trained in CBT concepts, models and techniques and how these can be appropriately applied as part of their practice in their normal settings. Method: This study evaluates the effectiveness of a short Cognitive Behavioural Therapy skills training programme provided with mentor support to mental health professionals in one region of the Irish Mental Health Service. The training was provided against a background of major financial cutbacks and reorganisation of mental health services. Results and Conclusion: The training resulted in subjective and objective gains in knowledge and skills that were maintained at 1 year follow up and improvements in practice and outcomes as reported by trainees, mentors and managers. The results suggest that a short well designed CBT skills programme can enable mental health staff to integrate basic CBT knowledge and skills into everyday practice producing improvements in practice and patient care. This presentation will report potential benefits and challenges of providing such a training programme to community based staff.

## **Training front line staff from Low and Middle Income Countries to deliver CBT: what can tell us about expanding access to CBT in the UK?**

**Andrew Beck, Salford CAMHS and University of Manchester**

There has been considerable recent interest in developing CBT training programmes in Low and Middle Income Countries (LMICs). Typically these countries have a chronic shortage of trained mental health professionals and very little prospect of developing a sufficient workforce of mental health nurses, psychiatric social workers, psychologists or psychiatrists to respond to the considerable unmet need for evidence based psychological therapies. Many LMICs do however employ undergraduate or graduate level health workers who work in rural and urban areas to deliver a wide range of health interventions including immunisation programmes, post-natal care and basic medical advice. There is a growing evidence base from countries such as Pakistan, India and Iran that these health workers can be trained to deliver simple CBT for depression and that the outcomes of these interventions are good. What these initiatives have in common is that although training might only take place over a few days there is ongoing, regular supervision from highly qualified mental health professionals, typically post-graduate psychologists, which ensures continued fidelity to the model and support for the health workers in applying this to their patient group.

## **“Do you feel ready to apply what you have learned?”: Formative self-assessment as an approach to facilitate learning and skills application in a CBT-skills training course.**

**Sarah Cameron, Newcastle University/Northumberland Tyne and Wear NHS Foundation Trust and Jo Stace, Northumberland Tyne and Wear NHS Foundation Trust/Newcastle University**

Research suggested that brief CBT training courses for frontline mental health workers can be effective in improving trainees' knowledge and competence. As well as the content of training sessions and provision of clinical supervision, there are other factors or strategies which are known to facilitate learning and are considered to be helpful when incorporated into the delivery of training programmes. This presentation will discuss a five day training course for mental health workers. The training course incorporated a formative self-assessment approach which was principally informed by theories of self-regulation, a person's ability to generate thoughts, feelings and behaviours to achieve personal goals, and self-efficacy, a person's belief that they have the abilities to perform a task. The aim of this approach within the course was to facilitate the trainees to develop their knowledge of CBT, their practical skills and most importantly to support them to actually apply these in their clinical practice. An evaluation of this course has been conducted and in this presentation we will focus on particular aspects of this evaluation (1) Trainees' reaction to the formative self-assessment process, (2) Trainees' confidence in CBT components, (3) Whether trainees' are applying skills in practice, (4) Any changes to how trainees perceive their own self-efficacy. The data for this evaluation were collected from four training cohorts; two working age adult and two older adult staff cohorts, working in both in-patient and community settings (total n=40). Preliminary analyses indicate: (1) Trainees reported that the formative assessment approach helped them to better focus in the course sessions (67% agreed, 13% strongly agreed, 10% unsure, 10% disagreed). (2) Trainees' confidence in their understanding of CBT components improved significantly by the end of the course. (3) Frequencies of 'yes' 'no' or 'missing/ambivalent' responses were examined in terms of whether trainees were actually applying CBT components in their clinical practice. Results suggested a significant association between the trainees' responses and the time point in the course (pre vs post). Most notably, there was an increase in the number of CBT components trainees were applying in practice and a reduction in missing/ambivalent responses by the end of the course. (4) Interestingly, there was significant improvement in the trainees' perception of their own self-efficacy at the end of the training course, when compared with initial pre course scores. The results will be discussed in greater detail, including a focus on the individual CBT components. The implications of the findings and ideas for future research will be also explored.

## **A trust wide CBT informed skills training programme for front line staff: Training non therapists to provide psychological interventions for depression and anxiety.**

### **Thomas Reeves, Northumberland, Tyne and Wear NHS Trust**

As part of a trust wide initiative to provide comprehensive evidence based care pathways for patients a training programme in CBT based interventions was established. A previous skills analysis indicated deficits in psychological knowledge and skills with significant numbers of front line staff across the trust. The challenge therefore was to develop and roll out a training programme which would equip staff with useable skills applicable to a wide range of clients presenting with non-psychotic disorders. The training was designed to provide the best evidenced approaches for depression and anxiety based problems. It also had to be easily delivered, to small groups of clinical staff with differing levels of skill and experience in a relatively short period of time.

In order to train staff and give on-going support the trainers followed a three stage plan for each training cohort:

1. Preparation of the teams prior to providing the training.
2. Provision of training over a discreet time period (five days).
3. Follow-up training supervision with longer term supervisory support within the team.

The training was initially developed for qualified staff working in community settings with a non-psychosis population, however as the training became established the training package was adapted for staff working with psychotic populations and non-qualified support workers.

The training was later developed further for staff working with an elderly population. This presentation will explore the initial development of the training materials and the theoretical underpinnings as well the additional modifications to include other populations. It will also describe the experiences from a trainer's perspective as the programme progressed over a two year period. Key learning points will be identified which will be of interest to trainers and supervisors in the NHS and other mental health care settings.

## **Focus on Team Formulation**

### **Patrick Roycroft, NTW Foundation Trust**

Staff such as Nurses, Occupational Therapists, Support Workers and Care Staff have for many years engaged and worked with people experiencing severe and complex mental health problems – often spending long periods of time with these service users but without the same level of support, supervision and recognition that qualified therapists are given. Many services are starting to recognise the value of the Psychological skills of their Frontline staff and are providing programmes of skills development which combine training and supervision in effective Psychological approaches taken from NICE recommended Psychological Therapies such as CBT and Family Therapy (FT). This welcome development builds on the significant engagement skills of many Frontline staff, and enhances them by bringing supervised evidence based therapy skills to more service users and Mental Health teams - but this development also presents a series of challenges. For service users with more complex problems a considered flexible approach to applying NICE guidelines is needed. Often more than one Psychological approach may be necessary – and several staff may be involved in delivering different approaches alongside medical and social approaches to care. Teams that appropriately train staff in different NICE recognised approaches such as CBT and FT are not just training staff in different approaches to treatment they are training their staff in different model specific ways of understanding and formulating mental health problems. How do we know that teams are effectively co-ordinating and using these frontline skills – including the model specific approaches to formulation embedded within them? How do we know that teams are using the different approaches in ways that complement each other and also are co-ordinated with the biomedical and social approaches to formulation treatment? How can we tell if a team has the tools to adaptively discuss, disagree and test ideas rather than become a conflict zone or a comfort zone in denial of difference? Research into clinician generated individualised formulation within Psychological therapies shows that the process is certainly not yet robust in terms of

demonstrable validity and reliability, and it has been argued that more defined approaches to formulation along with further research is the way forward. We will explore a similar line of argument in relation to team based formulation. We will look at the emerging evidence base seeking to define and research the content and process of team based formulation - particularly in Multidisciplinary Teams who work with service users with more complex and severe problems. Can investing in standardised approaches to Formulation help teams rise to the challenges above? We look at some evidence that suggests that it can – and that it can also enhance team effectiveness in a number of other important ways.

## Current Evidence on Stepped Care Treatment for Depression

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### **Knowns and unknowns in stepped care for depression: where are we now?**

**Peter Bower, NIHR School for Primary Care Research, University of Manchester**

Many guidelines suggest that depression services should be based on a 'stepped care' model. In 2005, we set out core assumptions relating to stepped care: equivalence of outcomes, economic efficiency and acceptability to patients. However, it is unclear whether the assumptions underlying the model are supported

There has been much research in stepped care, but little that relates to core assumptions of the model. At present, the best evidence relates to the equivalence assumption. Evidence concerning efficiency and acceptability is weak.

The evidence base for stepped care remains underdeveloped. This symposium will introduce some of the latest research in this area, and consider how far we have advanced in our understanding of this innovative model.

### **The effectiveness of stepped care treatment for depression: findings from a systematic review**

**Annemieke van Straten, VU University Amsterdam, The Netherlands;** Jacqueline J Hill, David A Richards: University of Exeter Medical School, University of Exeter, UK; Pim Cuijpers: Department of Clinical Psychology, VU University Amsterdam, The Netherlands

Many guidelines endorse the stepped care principle even though it is not clear how much evidence there is for the effectiveness of stepped care. Does stepped care really deliver similar or better patient outcomes compared to other systems? We performed a systematic review and meta-analysis of all randomised trials on stepped care for depression to answer this question.

We carried out a comprehensive literature search. We selected all: (1) randomized controlled trials (2) aimed at adults (3) with a DSM-IV depressive disorder or with depressive symptoms (4) investigating 'stepped care'. We defined stepped care as (1) the availability of more than one psychological treatment with different levels of intensity and/or the availability of more than one treatment modality (pharmacological and psychological treatments), and (2) systematic evaluations of outcomes at pre-specified time intervals with the explicit aim to determine the next treatment step. Selection of studies, evaluation of study quality, and extraction of data, was performed independently by two authors.

Ten studies were identified which could be used in the meta-analyses (4,580 patients). All studies used screening to identify possible patients and care-as-usual as a comparator. Study quality was relatively high. Stepped care had a moderate effect on depression (pooled six month between group effect size Cohen's  $d$  was 0.34; 95% confidence interval 0.20 to 0.48). We could not identify subgroups with more or less effect. The stepped care interventions were extremely heterogeneous with different number of treatment steps, different treatment components, different duration of the steps, different rules about stepping up and different professionals involved. Many studies were 'stepped collaborative care studies' and only a limited number of studies truly incorporated steps with increasing therapeutic intensity.

There is currently only limited evidence to suggest that stepped care should be the dominant model of treatment organisation. Evidence on (cost)effectiveness of stepped care compared with high intensity psychological therapy alone, as well as with matched care, is required.

### **Prevention of depressive and anxiety disorders among nursing home residents, what is the best approach?**

**Harm van Marwijk, NIHR School for Primary Care Research, University of Manchester;**  
Els Dozeman, Anneke van Schaik, Aartjan Beekman

Elderly residents of nursing homes are at high risk of developing a depressive or anxiety disorder (D/A), as they have several risk indicators (such as female gender, low socioeconomic class, presence of multiple chronic illness, functional limitations, and a small social network). We offered residents with D/A symptoms different steps to evaluate feasibility and (cost) effectiveness over treatment as usual.

In a pragmatic randomized controlled trial, we compared effects of a preventative intervention in fourteen homes versus usual treatment. We included 185 residents who scored at least 8 on the Centre for Epidemiologic Studies Depression Scale (CES-D), and were without a depressive or anxiety disorder, and without cognitive impairment. The participants received stepped care prevention (n = 93) or usual treatment (n =92). Participants started with watchful waiting and if they did not improve received a self-help intervention, and then psychological and life review and ultimately referral to their doctor. Our primary outcome was the incidence of major depressive or anxiety disorder during a year after inclusion.

The intervention did not reduce the incidence of D/A together: the combined incidence rate ratio (IRR) was 0.50 (95% confidence interval (CI) 0.23 to 1.12). Compared with usual treatment, the prevention program did reduce the incidence of depression (IRR 0.26, 95% CI 0.12 to 0.80) but not for anxiety (IRR 1.32, 95% CI 0.48 to 3.62).

The results suggest that the applied stepped care prevented depression among elderly in nursing homes, but not anxiety.

### **Stepped care treatment for depression: results of a mixed methods feasibility study (STEPS)**

**Jacqueline J Hill - Mood Disorders Centre, University of Exeter;** David A Richards,  
University of Exeter Medical School,; Willem Kuyken, , University of Oxford,

Stepped care is widely recommended and implemented as a means to organise depression treatment. However, we do not know if it is acceptable to patients and clinicians nor whether, compared with alternative systems, it achieves equivalent clinical effects for less cost. In 2009, NICE issued a research recommendation for a fully powered trial of stepped care. We report the results of preparatory work to address uncertainties associated with a large-scale evaluation of stepped care compared with high-intensity psychological therapy alone for the treatment of depression in adults.

Design: Mixed methods feasibility study involving a pilot randomised controlled trial and embedded semi-structured interviews. Setting: University of Exeter Mood Disorders Centre Accessing Evidence-Based Psychological Therapies (AccEPT) clinic facilities. Participants: 68 adults aged 18 years and older who met ICD-10 criteria for a depressive episode recruited from an IAPT service, and their therapists. Interventions: stepped care involving five sessions of low-intensity CBT delivered using guided self-help material over five weeks and, dependent on treatment response, between eight and 20 sessions of high-intensity CBT over a maximum of 16 weeks. Patients in low-intensity therapy were supported predominantly by phone; all high-intensity treatment sessions were face to face. Patients in the control arm of the trial received high-intensity CBT identical to the high-intensity treatment for patients in stepped care.

Outcomes: Quantitative trial data were collected on recruitment, retention, the pathway of patients through treatment and number of treatment sessions attended; we also measured variability in patient outcomes following stepped care or intensive psychological therapy and their correlation with patients' baseline scores. Measured outcomes were severity of depressive symptoms (BDI-I), worry and anxiety (GAD-7) and health-related quality of life

(SF-36). Qualitative data were collected on what people thought of the stepped care intervention and trial methods and procedures.

Data will be presented on: the number of patients at each step of recruitment and from whom we collected follow-up data; means and standard deviations on the BDI-I, GAD-7 and SF-36 at baseline and six-month follow-up - for each group; for each of the interventions, the number of sessions attended, the number and proportion of patients who declined any treatment, dropped out or completed therapy and, for stepped care participants, the number and proportion who stepped up to high-intensity therapy. Key themes on the acceptability of stepped care will be described. We will also present the emergent results of mixed methods analysis integrating the quantitative data on treatment attendance and the qualitative data on acceptability.

Implications for the feasibility and design of a fully-powered trial will be summarised.

## CBT for complex Trauma Reactions: A Series of Case Presentations

### **Treating PTSD using pre-emptive imagery re-scripting (ImRS) as an alternative to reliving in a refugee suffering with PTSD to multiple traumatic events“**

**Andy Pike, South Essex Partnership University NHS Trust and Kerry Young, Forced Migration Trauma Service, CNWL NHS Foundation Trust, London**

There are well-established protocols for the treatment of PTSD using trauma-focused CBT (tfCBT) (e.g. Ehlers et al., 2005). However, there is relatively little information about how to adapt tfCBT for PTSD resulting from multiple traumatic events, particularly in refugee populations. Currently, the weight of what evidence there is points to the effectiveness of Narrative Exposure Therapy (NET) (Schauer, Neuner Elbert, 2005) in the treatment of multiply traumatized refugees and asylum seekers (See Robjant and Fazel, 2010 for a review). This presentation will describe how NET was used as a first line treatment for a male refugee who presented with PTSD following a 25-year history of traumatic events. The techniques used and progress in therapy will be discussed. While NET has reliably produced very encouraging outcomes in recent trials, in this presentation we will show how we needed to deviate from the useful NET protocol as the treatment progressed. It emerged that the male refugee had long standing and firmly held beliefs about his own mental fragility. As a consequence of these beliefs, he came to the point where he did not feel confident that he could cope with the level of emotion generated by the treatment. We will discuss how we modified the treatment plan in the light of this new information. We were guided by a recent case series (Arntz, So van Breukelena, 2013) in which pre-emptive ImRS (i.e. re-scripting before the worst part of the traumatic event) was used to great effect while discussing multiple traumatic events in a refugee sample. We suggested this alternative treatment plan to the male refugee. We will describe how we carried out the work and the successful outcome of the intervention. Following this, useful pointers and advice will be drawn out for other clinicians embarking on similar work in the future. We hope that this case study will provide encouragement to other therapists working with complex trauma reactions.

### **Developing compassionate resilience for Treating complex PTSD: Preliminary service evaluation data of 12 session group.**

**Deborah Lee, Consultant Clinical Psychologist Berkshire Traumatic Stress Service.**

Since 2005 NICE has recommended a trauma focused CBT (Ehlers et al, 2005) approach to treating PTSD. The evidence base is strong and convincing, especially for Type I traumatic events, even when multiply experienced. Since 2005 much debate has arisen in clinical settings about best practice in treating complex PTSD, whilst retaining fidelity to the CBT model and we now see important and solid evidence emerging that phased based approaches are effective with complex PTSD presentations (Cloitre, 2012). Most evidence based practice suggests that phase 1 develops stabilisation, phase 2 develops psychological life skills and phase 3 attends to trauma memory work.

The therapeutic work presented in this talk can be considered as part of phase 2 as compassionate resilience enhances affect regulation, interpersonal functioning, problem solving and the ability to hold trauma memories with a caring compassionate mind.

Compassionate resilience enhances feelings of self-soothing and safeness in these memories and reduces self-critical maintenance cycles by developing compassionate self-talk. It helps the development of the capacity to self-soothe to those who feel deeply shamed about who they are and what they have been through.

The talk will present initial outcome data from the service evaluation of the 12 session group 'developing compassionate resilience' as part of a phased based approach to treating complex PTSD. The preliminary data suggests clinically significant changes in symptoms of PTSD, anxiety and hated self.

Key references:

Cloitre, M. et. al., (2010). Treatment for PTSD Related to Childhood Abuse: A Randomized Controlled Trial. *Am J Psychiatry* 2010;167:915-924.

Ehlers, A., Clark, D.M., McManus, F. & Fennell, M (2005) Cognitive therapy for posttraumatic stress disorder: development and evaluation. *Behaviour Research and Therapy*. 43, pp 413-431

Lee, D.A (2012). The compassionate mind approach to recovering from trauma, using compassion focussed therapy. Constable & Robinson. London

### **Trauma-focused cognitive-behavioural therapy for psychosis (tf-CBTp): A case example**

**Amy Hardy, King's College London & South London & Maudsley NHS Foundation Trust**

In contrast to clinician concerns about treating post-traumatic stress symptoms in people with psychosis, there is a growing evidence base for the efficacy of trauma-focused CBT techniques in this group (Meyer et al, 2014; van den Berg et al, 2015). However, trauma symptoms in psychosis often occur in context of other difficulties, such as depression, low self-esteem, anxiety, dissociation, hallucinations, paranoia and social adversity, which can present obstacles to recovery. Whilst NICE (2005) recommend a phased approach for treating complex post-traumatic stress reactions, the need for stabilisation work in trauma presentations is debated. Further, there is a dearth of evidence regarding how to integrate CBT techniques when intervening with psychotic and post-traumatic stress symptoms. A case from the Lambeth Post-Traumatic Stress in Psychosis Clinic will be presented to highlight the opportunities, challenges and dilemmas in working with people to manage the impact of trauma and psychosis on their lives. The case will illustrate how the evidence base for complex trauma can be used to guide formulation and intervention, and modifications to standard protocols where indicated. The use of trauma-focused CBT techniques, including reliving and imagery rescripting, will be described. The case will demonstrate how tf-CBTp can be acceptable, safe and useful in supporting service users' recovery.

### **Basic Processes in Positive Mood and OCD**

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#### **MindSurf: A new iPhone app to enhance awareness for improved mental health and wellbeing**

**Timothy Carey, Centre for Remote Health, a joint centre of Flinders University and Charles Darwin University**

Providing timely access to effective mental health treatments and resources is an important component of the successful amelioration of psychological distress. The benefits of early intervention are well recognised and the potential of e-technologies to enhance access to services is vast. Evidence indicates that resources such as online therapies and mobile phone app technologies can be effective in helping to reduce psychological distress and promote mental health and wellbeing and are also well received by some people. This paper describes the development of an iPhone app based on a transdiagnostic cognitive therapy to assist people in becoming more aware of their mental activity and improving their contentment and satisfaction.

A question bank was developed from the questions typically used in the transdiagnostic cognitive therapy the Method of Levels (MOL). The design for the app centred around the questions being pushed to a mobile phone user's phone at random times throughout the day.

A brief proof of concept study was conducted and then a pilot study with undergraduate university students.

For the proof of concept study, three questions in the form of text messages were sent to one participant at random times each day for a period of a week. The participant indicated that the questions were interesting and helpful. Indeed, the participant began to look forward to receiving the questions each day. In the pilot study, 22 participants received text messages over a 2 week period. Participants indicated that they experienced enhanced awareness and an increase in both general reflection and self-reflection.

The proof of concept study and the pilot study indicate that the mechanism of sending questions to people at random times throughout the day could be a useful way of helping people increase their awareness and become more focussed on important short-term and long-term goals. Based on these results an app called MindSurf has been developed and continues to be researched. Using MindSurf may be a helpful adjunct to therapy by assisting people to improve their awareness and self-reflection and to maintain a focus on important life goals.

Therapists can use MindSurf as one of their resources to assist clients to improve their present-focus, to increase awareness, and to promote mental health and wellbeing in a way that is enduring and resilient.

### **Disgust and heart rate changes in obsessive compulsive disorder (OCD)**

**Roman Duncko, Institute of Psychiatry, Psychology and Neuroscience, King's College London**

Disgust is a negative emotion often reported in anxiety disorders such as specific phobias, blood and injury phobia and OCD. This emotion has been shown to be more resistant to extinction and habituation and can be accompanied with a specific pattern of physiological activity. Disgust has been suggested as a factor contributing to a poor response to Cognitive Behaviour Therapy (CBT) in the treatment of OCD. However, only limited information is available about the phenomenology of disgust in clinical OCD.

Our aim was to explore the phenomenology of OCD and the physiological activity associated with the emotion of disgust in patients attending for treatment of OCD. State disgust and heart rate was measured in eleven participants during exposure relevant to their individual formulation.

All patients with contamination and most patients with blood and injury related fears experienced a prominent increase in state disgust during exposure. These patients also had absent heart rate acceleration during exposure. Disgust response correlated with heart rate response and Root Mean Square of Successive Differences (RMSSD).

Our findings show that a significant proportion of cases series with OCD can experience significant amounts of disgust with signs of increased vagal tonus during their exposure. Such experiences significantly differ from the concept of adrenergic activation used for psychoeducation in CBT and appraisals of harm and this may result in poorer therapeutic outcome.

Suggestions for modifications of current treatments will be discussed.

### **Trait mood impacts regulation of positive affect in healthy volunteers**

**Joanne Bower, University of Reading**

Regulation of positive affect is under-researched, despite evidence linking positive affect dysregulation to several mental health conditions (Carl et al, 2013). Previous research predominantly features clinical populations, with limited data from healthy volunteers. This study recruited healthy participants to investigate instructed regulation of positive affect using strategies previously examined with clinical populations.

76 undergraduates experienced a video mood induction and were given different instructions regarding their emotional response (uninstructed, enhance or minimise).

Analysis assessed individual differences in the impact of these instructions on reported mood change and the emotion regulation strategies adopted.

The minimise condition elicited the smallest increase in positive mood, with participants employing different emotion regulation strategies to those in other conditions. Trait mood

and emotion regulation styles impacted on these effects. For example, higher self-reported depression and hypomania were both associated with increased use of suppression in the uninstructed condition. Two online replications (total n=150) assessed the feasibility of internet studies of emotion regulation. Inter-relationships between trait measures were broadly replicated, positive mood induction was successful and elicited a range of emotion regulation strategies, which were influenced by instructions. However, emotion regulation instructions did not significantly affect mood change when elicited online. This project provides insight into regulation of positive affect in healthy volunteers, using processes relevant to clinical populations. Additionally, our replications highlight the successes and challenges associated with online studies investigating emotion regulation. Better understanding of processes underlying regulation of positive affect can inform targets for intervention, improving treatment efficacy when dysregulation of positive affect occurs.

## Modifying cognitive biases in interpretation and appraisal: New developments in experimental and clinical applications

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### **The effect of Moderate Intensity Exercise on Cognitive Bias Modification- Interpretation (CBM-I).**

**Bundy Mackintosh** and Charlotte Clarke, University of Essex

The aim was to investigate the effect of exercise on mood enhancement and its ameliorating effect on the symptoms of anxiety, depression, and stress.

Forty-eight frequent exercisers recruited in a private gym were assigned to an exercise group (cycling on a static bicycle for 30 minutes) or a control group. Participants completed questionnaires about anxiety, depression, psychological stress, and a cognitive interpretation bias measure before and after the study.

The interpretation bias was assessed via the Scrambled Sentences Test (SST). Each sentence had six words and the participant had to unscramble them into one statement, by missing out one word. Depending on the word left out, the sentence could get a positive/benign or negative/threatening meaning. The SST was completed under 'no load' and 'load' (six digit numbers had to be remembered after sentences had been completed). The SST was applied before and after the study.

Results showed that those who exercised experienced a decrease in negative/threat interpretation bias, in both the 'load' and 'no load' condition. However, the control group did not report such a decrease, i.e., the bias did not change. Moreover, there was a reduction in levels of anxiety, depression, and psychological stress in the exercise group. However, the control group did not change.

CBM holds potential for the management of clinical disorders and exercise is an effective accompaniment to psychotherapy. The effect of exercise on anxiety, depression, and stress is a promising avenue.

### **Training adaptive cognitive biases in obsessive-compulsive checking**

**Melissa J. Black** and Jessica R. Grisham, School of Psychology, The University of New South Wales, Sydney, Australia

Pathological doubting and checking is a common symptom presentation in obsessive-compulsive disorder (OCD). Previous research has established that compulsive checkers do not display an actual memory deficit, but lack confidence in their memories and experience intolerance of uncertainty regarding the completion of tasks. The focus of this study is on further examining the effect of a novel training procedure aimed at modifying these types of beliefs. We conducted an investigation of the application of interpretive cognitive bias modification (CBM-I) targeting maladaptive thinking styles related to memory distrust and intolerance of uncertainty in analogue OCD checkers. We examined the possible enhancement of CBM-I for OCD through imagery training and facilitated imaginal engagement. We also investigated whether imagery ability influenced engagement with verbal or imagery-enhanced CBM. The results provide mixed evidence that participants who received positive imagery CBM training may have interpreted novel ambiguous checking

scenarios more adaptively, checked less on a behavioural measure, and reported fewer negative beliefs relative to participants in the neutral imagery CBM condition. In addition, imagery ability did not appear to affect engagement with imagery versus standard verbal training. Findings on physiological measures of arousal in response to the task were mixed. CBM may be useful as an adjunct to traditional cognitive-behavioural strategies or as an online intervention to target maladaptive beliefs in OCD.

### **Integrating cognitive bias modification into a standard treatment package for adolescents with Obsessive Compulsive Disorder: A small randomized controlled trial**

**Elske Salemink University of Amsterdam;** Lidewij Wolters, de Bascule and Academic Medical Center, Amsterdam and Else de Haan, University of Amsterdam, the Netherlands  
It has been suggested that the misinterpretation of intrusions is an important problem in Obsessive Compulsive Disorder (OCD). The first line of treatment for adolescents with OCD is Cognitive Behavioural Therapy with exposure with response prevention and the modification of misinterpretations as the most important strategies. However, response rates vary between 40 and 65 %, thus there seems substantial room for improvement of OCD treatment in youth. Recently, promising Cognitive Bias Modification (CBM) training paradigms have been developed that target misinterpretations in anxiety. The aim of the current pilot study was to examine the added value of CBM-I training to CBT in adolescents with OCD. CBT patients were randomly assigned to either eight-sessions CBM-I training (n = 9), or to a placebo control condition (n = 7). Results indicated that relatively quick interpretations changed in response to the CBM-I training, while no such effects were observed on a more explicit measure of interpretations. Patients in the positive CBM-I training condition reported significantly less obsessive compulsive symptoms after training, and clinicians rated them as having significantly less obsessive symptoms. No such changes were observed in the placebo control group. This small randomised controlled trial is suggestive, although not conclusive, regarding the promising additive effects of OC-related CBM-I training in an adolescent clinical population.

### **Long term effects of Cognitive Bias Modification for Interpretation targeting anxiety and depression in adolescents: A randomized controlled trial**

**Leone de Voogd, University of Amsterdam;** Reinout Wiers, University of Amsterdam; Pier Prins, University of Amsterdam; Peter de Jong, University of Groningen; Elske Salemink, University of Amsterdam

In adolescence, there is a peak prevalence of anxiety and depression. Given the detrimental influence of these disorders on social and academic functioning and the associated risk of adult psychopathology, early prevention is highly important. Anxiety and depression are characterized by negative biases in information processing, like the tendency to interpret ambiguous situations in a negative way, the so-called interpretation bias. Previous research has shown that cognitive bias modification for interpretation (CBM-I) can change interpretive style, and many studies found corresponding positive effects on emotional functioning, although findings are still mixed (Menne-Lothmann et al. 2014). In the current study, we tested the effects of CBM-I in unselected adolescents. Participants (aged 11-18) were administered 8 online sessions (2x/week) of CBM-I (n=134), or placebo control training (n=164). Interpretation bias was assessed pre- and post-training and anxiety and depressive symptoms and secondary emotional measures were assessed pre- and post-training and at 3, 6 and 12 months follow-up. Short-term results showed that CBM-I was effective in changing interpretation bias and self-esteem. Positive effects on anxiety and stress-reactivity were found for adolescents who completed all trainings sessions. We are currently analyzing the follow-up data and will present long term effects. The results so far suggest that CBM-I might be a promising preventive intervention to change dysfunctional information processing and to improve emotional functioning. However, a substantial amount of training might be necessary, and further research is needed into other factors that could increase training efficacy. Given the relatively low training compliance, increasing adolescent motivation for CBM-I seems essential.

Menne-Lothmann, C., Viechtbauer, W., Höhn, P., Kasonova, Z., Haller, S.P., Drukker, M.

van Os, J., Wichers, M., Lau, J.Y.F. (2014). How to boost positive interpretations? A meta-analysis of the effectiveness of cognitive bias modification for interpretation. *Plos One*, 9, e100925. doi: 10.1371/journal.pone.0100925

### **Investigating pharmacological augmentation of Cognitive Bias Modification in analog posttraumatic stress**

**Marcella L. Woud , Ruhr-Universität Bochum, Germany;** Simon E. Blackwell, MRC Cognition & Brain Sciences Unit, UK; Susann Steudte-Schmiedgen, Technical University of Dresden, Germany; Michael Browning, University of Oxford; Emily A. Holmes, MRC Cognition & Brain Sciences Unit; Catherine Harmer, University of Oxford; Jürgen Margraf, Ruhr-Universität Bochum, Germany; Andrea Reinecke University of Oxford.

Posttraumatic Stress Disorder (PTSD) is characterised by dysfunctional interpretations of the trauma and its consequences. Experimental studies have shown that Cognitive Bias Modification – Appraisal (CBM-App) training can reduce dysfunctional interpretations and analogue trauma symptoms. The present study investigated whether CBM-App effects can be enhanced by means of cycloserine. This follows work suggesting that anxiety treatments in combination with cycloserine may be more effective. Here, it is assumed that cycloserine has beneficial effects on consolidation processes. Hence, we might expect similar effects in the context of CBM-App.

In the present study, half of the participants received a single dose of cycloserine (250mg), while the others received a placebo. During the highest plasma level, all participants underwent a trauma-symptom provocation task, followed by positive CBM-App. Before and after the CBM-App training, we assessed dysfunctional interpretations and intrusions (during the session and via a 24h intrusion diary).

[Cognitive behavioural interventions for individuals with tics and Tourette disorder – all you need to know to offer the best evidence-based treatments in your area.](#)

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### **Group interventions for children with Tourette Syndrome: A pilot randomised controlled trial comparing habit reversal training with an educational intervention**

**Katie Edwards, University College London and Rachel Yates, Guys and St Thomas NHS Foundation Trust;** John King, University College London; Tara Murphy, Great Ormond Street Hospital

Children with Tourette Syndrome (TS) typically experience a poorer quality of life<sup>1</sup>, with high rates of psychiatric co-morbidity. TS is also associated with specific impairments in neuropsychological functioning<sup>2</sup>. Habit Reversal Training (HRT) is a behavioural therapy with strong empirical support for the treatment of tics<sup>3</sup> when individually-delivered, however is yet to be evaluated in a group context. Educational group interventions provide information about tics and target impairing psychosocial and co-morbid difficulties. The objective of this study was to compare the effectiveness of HRT and educational groups in improving tic severity, quality of life and neuropsychological functioning. This study followed a single-blinded randomised and controlled experimental design, with pre- and post-treatment outcomes. Thirty-three children aged 9 to 13 years with TS or Chronic Tic Disorder participated in eight group sessions. Four parallel parent sessions were also provided. Evaluated outcomes were tic severity, neuropsychological functioning (response inhibition, cognitive flexibility and fine motor skill) and quality of life. Regular attendance in both groups suggested good feasibility and acceptability of the interventions. In an intention-to-treat analysis, significant improvements in tic severity (Yale Global Tic Severity Scale) were found in both groups ( $p = 0.001$ ,  $hp2 = 0.31$ , large effect size). Motor tic severity showed greater improvements in the HRT group ( $p = 0.01$ ,  $hp2 = 0.182$ , medium effect), which had focused directly on reducing tics. The medium to large effect sizes observed were comparable to individually-delivered HRT interventions<sup>2</sup>. Participants in both groups showed a tendency toward improvements in quality of life ( $p = 0.05$ ,  $hp2 = 0.118$ , medium effect). Additionally, both groups improved significantly on a test of response inhibition ( $p = 0.02$ ,  $hp2 = 0.20$ , medium effect). Group-based treatments for TS are both feasible and

acceptable for patients. HRT group treatment showed greater reductions in tic severity compared to educational group treatment. Both treatments were associated with improvements in perceived quality of life and inhibitory processes of neuropsychological functioning. Clinical implications and suggestions for future research will be discussed.

**Perceptions of treatment for tics among young people with Tourette syndrome and their parents: availability and access to cognitive behavioural interventions**

**Cristine Glazebrook, University of Nottingham**; Jose Cuenca, University of Nottingham; Georgina Jackson, University of Nottingham; Tara Murphy, Great Ormond Street Hospital; Isobel Heyman, Great Ormond Street Hospital; Chris Hollis, University of Nottingham

The involuntary movements and vocalizations associated with Tourette Syndrome (TS) can present significant challenges for young people with the condition. Clinical guidelines recommend behavioural therapy as a first line treatment for tics. Education is considered important to facilitate engagement with behavioural treatment and self-management of the psychosocial difficulties associated with TS. The aim of this study is to explore how children with TS and their parents perceive behavioural treatments for tics, their access to behavioural treatments and psychosocial education and their desired outcomes of treatment. Participants were 42 young people aged 10-17 with TS and 295 parents of children and young people with TS. Participants were approached via the Tourettes Action web page and through flyers and newsletters. Parents completed an online survey which gave a brief description of behavioural therapy including the key features of comprehensive behavioural intervention for tics (CBIT), habit reversal and contingency management. Parents were asked if their child had received this type of treatment and, if not, whether they would like it. Responses to open-ended questions were analysed using content analysis. Quantitative data were analysed descriptively using SPSS. In-depth, semi structured interviews were conducted with young people with TS and these were analysed using theme analysis. Parents' and young people's qualitative data were triangulated with parents' quantitative data to give a full picture of their experience of behavioural treatment, including contrasts with experiences of medication. Of the 42 young people with TS who took part in the interviews (76% male), 23 (54.8%) had taken medication for tics. Eight young people had received some form of behavioural treatment for tics (median number of sessions received = 4, range 1 to 20) with most (7/8) had also received medication. Behavioural therapies were considered helpful by the majority (6/8) although a similar number also expressed concern regarding potential difficulty mastering the techniques and time needed to develop skills. In contrast to medication, where side effects were common, unwanted effects from behavioural interventions were rare. However one young person perceived that the approach of learning a competing response had led to a new tic. Nearly half of young people who had not received a behavioural intervention felt that it could be helpful and perceived it as a natural way to control tics, but there was concern that the techniques could be time consuming and difficult to learn. A quarter of parents surveyed reported that their child had had behavioural treatments. Of those parents whose children had not had access to behavioural treatments, three-quarters would have liked their child to be offered them. Nearly 70% of parents had received information about TS: usually through CAMHS. Few parents had received information through primary care and the pathway of information into the child's school was also a concern. In addition to reducing tics, parents and young people felt that achieving control over tics was an important outcome of treatment as was managing the emotional aspects of TS. The results support the importance of improved access to psychosocial education and behavioural treatments.

**Disseminating cognitive behavioural treatments for tics – a shared-care model between a national centre and community teams with use of tele-medicine**

**Fiona McFarlane, National Tourette Syndrome Service, Great Ormond Street Hospital for Children and Rosemary Preston, Torbay and Southern Devon Health Care; Rasha Ravenscroft, 5 Boroughs Partnership NHS Foundation Trust**

Tic disorders are common, with approximately 10% of children meeting criteria for a chronic tic disorder, and 1% meeting criteria for Tourette syndrome. Approximately 25% of

these individuals will continue to experience significant difficulties with tics in adulthood. Tics are associated with functional impairment and reduced quality of life and patients often want treatment for these. There is now over 40 years of evidence supporting cognitive and behavioural interventions in tic management. However, few psychologists or therapists outside of specialist centres have had training in these meaning it is often difficult to access such treatment locally. This talk will consist of two case studies demonstrating good practice in terms of joint working between tier 3 and tier 4 services. In both cases this allowed access to cognitive and behavioural interventions for tic control for young people living a long distance from specialist centres. The talk will be jointly presented by CAMHS workers from Torbay, Birmingham and Great Ormond Street Hospital (GOSH). Different models of joint work are demonstrated by the two cases, devised according to the formulation of the young person's difficulties and the resources of the local teams. The first case study considers treatment of a 16 year old girl with Tourette Syndrome, Obsessive Compulsive Disorder, Self-harm and Anxiety who had spent a significant amount of time as an inpatient. She was referred by her local CAMHS to GOSH because of her frequent, distressing and impairing tics. After an initial assessment it was proposed that her main difficulties had a common thread, namely difficulty resisting an "urge" to do something (tic, self-harm or compulsion) and to manage the feelings resisting invokes. Exposure and Response Prevention, initially targeting the tics and then extending to the OCD and self-harm was proposed. A joint package of care was offered with a day 2 day intensive start to treatment at GOSH with the local therapist in attendance and follow up appointments delivered locally with GOSH joining by tele-medicine. The second case study considers treatment of a 14 year old boy with Tourette Syndrome, ADHD and anxiety. Again the tics were causing significant anxiety and distress and at one point left the young person unable to walk. In this case attendance at a psychoeducation group for teenagers with Tourette Syndrome was offered at GOSH with Exposure and Response Prevention being offered by the local therapist with supervision for this provided by GOSH. Both cases have had very good outcomes to date. We will consider both what enabled this and what lessons we have learned about effective shared-care.

### **Evaluation of cognitive behaviour therapy for paediatric obsessive-compulsive disorder in the context of tic disorders**

**Sophie Bennett, UCL Institute of Child Health;** Daniel Stark, Great Ormond Street Hospital for Children NHS Foundation Trust; Roz Shafran, UCL Institute of Child Health; Isobel Heyman, Great Ormond Street Hospital for Children NHS Foundation Trust & UCL Institute of Child Health; Georgina Krebs, Institute of Psychiatry & OCD and Related Disorders Clinic for Young People, South London and Maudsley NHS Foundation Trust

OCD is over-represented amongst children with tic disorders (TD), with estimates suggesting that over 50% of children with tic disorders also meet criteria for OCD (Lebowitz et al., 2012). This relationship has been well established in both the adult and child clinical literature and has recently been recognised in diagnostic classification systems, with the addition of a 'tic-related' specifier to the obsessive compulsive disorders in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013). However, there has been relatively little research on whether comorbid tic disorders influence response to cognitive behaviour therapy (CBT) for OCD. This study aimed to examine the outcomes of CBT for paediatric patients with OCD and a tic disorder compared to a matched group of children with OCD and no tics. Outcomes were compared post-treatment and at 3 or 6 month follow-up. Participants were 29 young people with tic disorders and OCD (OCD+TD) and 29 young people with OCD and no tics (OCD-TD) who were matched according to age, gender and baseline OCD symptom severity. All participants received a course of CBT and outcomes were assessed using the Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS). OCD symptoms reduced over the course of CBT to an equivalent extent in the OCD+TD and OCD-TD groups. Response or remission rates did not differ significantly at either post-intervention or follow-up between those with OCD+TD and those with OCD-TD. For both groups, response rates were high - 72% of both groups were classified as responders post-intervention and, at follow-up, 81% of the OCD + TD group and 82% of the OCD no tics group responded. Those with OCD+TD responded in

significantly fewer sessions than those with OCD without tics. Our findings indicated that CBT outcome for paediatric OCD with or without comorbid TD was the same. Having a comorbid TD did not impact the extent to which OCD symptoms improved over treatment, or on rates of response or remission. This encouraging finding suggests that standard CBT for OCD is an appropriate treatment for paediatric patients presenting with OCD and comorbid TD and modified treatment approaches are not generally required.

## Improving treatment of anxiety and depression in adolescence

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### **The Development and Evaluation of a National, Self-help, Online CBT Program for Child and Adolescent Anxiety**

**Susan Spence, Griffith University, Australia** ; Sonja March, University of Southern Queensland; Caroline Donovan, Griffith University

It is imperative that we find effective ways of preventing and treating anxiety disorders among young people. They are one of the most common mental health problems among children and adolescents, with point prevalence estimates of around 8%. If left untreated, they tend to persist and are associated with a range of adverse educational, social and emotional outcomes. They also represent a strong risk factor for anxiety disorders in adulthood, which in turn are associated with a range of adverse long-term consequences and financial burden to the community. Despite a good deal of evidence that CBT is an effective treatment for a high proportion of youth with anxiety disorders, the majority of clinically anxious young people do not receive the professional help they need. The internet has been proposed as a method of increasing access to mental health treatments. Indeed, clinician-assisted, internet-delivered CBT (ICBT) has shown promising results in treating anxiety in young people. Our research team has completed three randomised control trials demonstrating positive outcomes from clinician-assisted ICBT using BRAVE-Online. We have shown it to be significantly more effective than no intervention and as effective as face-to-face therapy when delivered with brief therapist assistance. The cost of providing therapist assistance and insufficient numbers of clinical therapists means that this approach is only able to reach a limited proportion of anxious adolescents. Self-help ICBT has been proposed as a way of treating larger numbers. This paper describes the development and evaluation of a self-help version of BRAVE-Online, without therapist support, in a national project across Australia. Participants are self-referred and include young people with a broad spectrum of anxiety problems of varying severity. The intervention can be accessed nationally, free of charge. Participants can complete 10 online sessions, of approximately 45 minutes each, once per week. Two booster sessions are then completed independently 1 and 3 months later. Sessions cover psycho-education about anxiety, body signs of anxiety, relaxation strategies, coping self-talk and cognitive restructuring, graded exposure, and self-reinforcement of "brave" behaviour. The online sessions are presented in an interesting, engaging manner, in age-appropriate language, with age-appropriate illustrations, and are designed to stimulate motivation and facilitate learning. Pages have been created to be visually appealing and interesting, with bright, eye-catching graphics including cartoon animation. Sessions comprise reading material, question and answer exercises, games and quizzes. For each strategy learned (e.g. cognitive restructuring), adolescents are provided with an example, and are then asked to apply the strategy to their own anxiety-provoking situations. Home tasks are scheduled at the end of each session, and reviewed at the start of the next session. The project commenced in June 2014, and the data indicate that there is a very clear demand for this type of intervention. Over a 7-month period from June to Dec 2014, approximately 1150 teenagers and 990 children enrolled in the treatment program. The paper will present data for the first year of the project, including numbers who commenced, demographic characteristics, treatment compliance, and impact upon anxiety.

### **The Effectiveness Of An Internet-Based Treatment (BRAVE-Online) With Adolescents With Anxiety Disorders: Does This Work In A Routine Clinical Setting And Do Parent Sessions Improve Treatment Outcome?**

**Polly Waite, University of Reading**

11% of adolescents meet criteria for an anxiety disorder and as children move into adolescence, anxiety disorders become more severe and there are higher levels of co-morbid mood disorders. CBT is effective in treating anxiety disorders in young people with remission rates of around 56%. However, evidence-based treatments have been developed principally for children between 7-14 years old. There is some preliminary evidence for the effectiveness of CBT designed specifically for anxious adolescents. An online CBT treatment, BRAVE Online for teenagers, has been shown to be effective, but to date, the programme has only been evaluated in a non-referred Australian population and therefore it is unclear as to whether this approach can be recommended for use within routine clinical care settings. There is some preliminary evidence to suggest that parenting behaviours may be associated with anxiety symptoms among adolescents, consistent with existing research with children across broad age ranges. As a result of this association, a number of studies of primarily younger children have involved parents in treatment as part of a family-based CBT, however in general, this has not led to substantially different treatment outcomes to individual CBT. The BRAVE programme includes additional sessions for parents, but this component has not yet been evaluated. To address these issues, 60 adolescents meeting criteria for an anxiety disorder were recruited from a specialist CAMHS service for young people with anxiety and depression in the UK. All adolescents received BRAVE, but were randomised to receive the treatment immediately or following a 12-week waitlist, with or without additional parent sessions. This presentation will summarize the findings in terms of the overall effectiveness of the programme immediately and at 6-month follow-up, and whether additional parent sessions were associated with improved outcome, and consider the implications for clinical services.

### **Improving Mood with Psychodynamic and Cognitive Therapies (the IMPACT trial) Shirley Reynolds, University of Reading**

Low mood and depression often emerge during adolescence, are highly prevalent (Costello, Erkanli, Angold, 2006), and can have long-term negative impacts (e.g. Halperin, Rucklidge, Powers, Miller, Newcorn, 2010; Rudolph Klein, 2009). Despite the impact of the disorder adolescent depression is relatively neglected and treatment outcomes lag behind those for adults with depression (Weisz, McCarty and Valeri; 2006). It is essential to understand better the clinical characteristics of young people with depression and to develop better treatment. This paper will describe the design and methods of a large, HTA funded, multi-site randomised controlled trial for adolescent depression. The aim of the IMPACT trial was to assess the effectiveness and cost effectiveness of in preventing relapse at 86 weeks. 470 adolescents with moderate to severe depression were recruited from routine NHS Child and Adolescent Mental Health services. Diagnosis was confirmed using the K-SADS structured clinical interview. Participants were randomized to one of three treatments that were delivered by NHS clinicians. Adolescents were assessed throughout treatment at 12, 26, 52 and 86 weeks by blinded research assessors. Costs of treatment and of the disorder were assessed. Characteristics of therapy, the therapeutic alliance, and therapist fidelity were assessed on a random subset of therapy sessions. A subset of participants, parents and therapists also took part in qualitative interviews at the end of treatment and a further subset took part in fMRI neuroimaging studies. The IMPACT trial has collected a rich set of data on a relatively large and diverse sample of young people with moderate to severe depression. This presentation will describe some key clinical characteristics of participants at baseline.

Young people who are referred to CAMHS with moderate to severe depression have complex and heterogeneous presentations and are at high risk of harm and long-term adverse outcomes. Relapse is common. Providing effective, acceptable, and appropriate treatment for this group requires significant adaptation to routine CAMHS practice including additional training and supervision of staff.

### **Brief Behavioural Activation for adolescent depression (BATD-A)**

**Laura Pass, University of Reading; Shirley Reynolds, University of Reading; Gemma Brisco, University of Reading; Hannah Whitney, University of Reading**

Behavioural Activation (BA) is an empirically supported therapy for the treatment of depression in adults, and is included in the NICE guidelines for treatment of adult depression. Despite the increasing evidence base for the effectiveness of BA with depressed adults however, there has been little investigation of using this psychological intervention with adolescents. The practical, structured approach, without cognitive focus, may be particularly appealing and engaging for young people for whom cognitive development is still ongoing and may be further compromised during a depressive episode. Two main treatment approaches have been developed in the adult field: a more comprehensive, 22 session BA protocol (developed by Martell and colleagues), and a briefer Behavioural Activation for Depression (BATD) protocol of 5-10 sessions (developed by Lejuez, Hopko and colleagues). Recently, a small number of studies have reported on the use of behavioural activation for adolescents, showing promising outcomes. However, these studies have largely focused on the longer, more detailed BA approach. This length of treatment may be difficult to implement in the UK National Health Service, and adolescents might struggle to engage for the whole treatment duration. This presentation will provide a background into the adolescent behavioural activation literature so far, and introduce an adaptation of BATD, for use with adolescents with depression symptoms (BATD-A) and specifically designed to be easily implemented with the NHS. It is hoped that following further evaluation, BATD-A could be successfully delivered by non-expert therapists as a low-intensity intervention to increase access to psychological therapies in CAMHS and other settings.

**Parent and Adolescent Experiences of an Online CBT Program for Anxiety Disorders  
Lydia Smith Smith, University of Reading and Katherine Smart, University of Reading**

Anxiety disorders are some of the most common mental health problems experienced in adolescence. Adolescents with anxiety differ in their clinical characteristics compared to children (Waite Creswell, 2014), however, psychological treatments (most commonly CBT) are often delivered to children and adolescents across large age ranges. Although CBT has been demonstrated to be effective, a significant proportion of young people continue to remain symptomatic at the end of treatment. In addition, there is (albeit mixed) evidence that adolescents may have poorer treatment outcomes than children (e.g., Ginsburg et al., 2011). Recently, treatments have been developed specifically for adolescents with anxiety disorders. BRAVE-Online for Teenagers was developed in Australia (Spence et al., 2011), and has been shown to be effective. This treatment approach is currently under evaluation with adolescents referred for treatment to child and adolescent mental health services (CAMHS). It is delivered over the internet with therapist support and involves psychoeducation and cognitive components, as well as exposure. Although it is assumed that all these components to good outcome, there has been little investigation of the relative impact of different treatment components. Similarly, it is unclear whether other components of treatment (e.g., mode of delivery, therapist involvement, additional parent sessions) are acceptable to both adolescents and their parents. In general, patients' perspectives have received limited attention in psychological therapy research, particularly those of young people and their parents. Hence further exploration of what adolescents and their parents think about treatment and what they find helpful or unhelpful, in relation to specific components of treatment, is warranted. In the current study, 13 adolescents (aged 14-19 years), who had participated in the BRAVE treatment trial, and 13 parents (6 of whom had also received parent sessions), undertook a semi-structured interview after completing their 6-month follow-up assessment. Questions were open-ended, based upon a topic guide and designed to invite participants to discuss, and then reflect upon, their experiences of treatment. Interviews were all audio recorded, transcribed in full, and analysed using thematic analysis. This presentation will report the findings of this study and discuss them in relation to how treatment could be further refined to enhance acceptability and efficacy.

Low Intensity Interventions: Adapting Delivery Models to Widen Access.

**Community-based life skills classes for individuals with low mood and depression.**

**Carrie-Anne McClay, University of Glasgow;** Katrina Collins, ; Lynsay Matthews, ; Caroline Haig, ; Alex McConnachie,; Jill Morrison; Pat Lynch, AWARE Defeat Depression; Louise Waters, University of Glasgow; Ilena Day, Action on Depression; Grainne McAnee, AWARE Defeat Depression and Christopher Williams, University of Glasgow.

Cognitive behavioural therapy (CBT) is recommended for the treatment of depression and anxiety. However, access is limited. Low-intensity approaches such as guided CBT self-help (bibliotherapy) can increase access to treatment and is recommended by UK guidelines. No previous research has explored the provision of group-based guidance/support for a bibliotherapy approach for depression and anxiety in community settings. The objective was to carry out a pilot study of a group guided self-help intervention, using community based recruitment methods. A randomised controlled comparing an 8 week CBT group guided self-help intervention to usual care. Recruitment and the delivery of the intervention were carried out in Glasgow and Derry/Londonderry in partnership with national depression charities. Fifty-three people were randomised, however we refer only to the forty-six participants who provided baseline data: 16 males and 30 females, aged 16 or over, with a PHQ-9 score of  $\geq 5$ , were recruited from the community. The mean age of the sample was 43.7 (sd = 13) and 93.5% of participants had suffered from low mood for a year or more. There was effective recruitment, randomisation, uptake and adherence with 21 Immediate Access (IA) and 25 Delayed Access Control (DAC) participants. The intervention was highly acceptable to participants attending on average 4.46 of the 8 sessions (sd = 3.06), 65.2% attended more than half of all sessions. The mean satisfaction on the Client Satisfaction Questionnaire was 28 out of 32 (sd = 4.8). The provisional results in the pilot suggest the intervention may improve both anxiety and depression. Participation significantly improved both levels of anxiety ( $p=0.001$ , 95% CI (1.87, 12.09) and depression ( $p=0.002$ , 95% CI (2.34, 16.23) in individuals taking antidepressant medication at 3 months compared to a delayed access control. At three months, data collection was achieved from 74% of participants. The trial successfully provided estimates of the sample size needed for the future planned trial, which will be discussed as part of this presentation. Low-intensity group-based classes may offer an alternative method of managing depression and anxiety and warrant further research.

### **Focus Group Examining Attitudes of Chinese-speaking International Students towards Online CBT Resources**

**Mengyi Zheng, Institute of Health and Wellbeing, University of Glasgow;** Carrie-Anne McClay, Institute of Health and Wellbeing, University of Glasgow; Jo Woodford, Institute of Health and Wellbeing, University of Glasgow; Sarah Harris, Institute of Health and Wellbeing, University of Glasgow; David Osborne, Institute of Health and Wellbeing, University of Glasgow

Online cognitive behavioural therapy has shown promise as a useful intervention for Chinese-speaking populations with mild to moderate mental health problems like low mood, anxiety, and depression. This focus group study was conducted to address Chinese-speaking international students' understanding of low mood, anxiety or depression, and explore their attitudes towards an online intervention (Chinese version of Living Life to the Full) and preferred support types. The focus group study used a sample of 15 Chinese-speaking international students at the University of Glasgow, and drawn from across course years. Eligible students were able to work through the online course and review linked online books, printed materials and research resources, such as Chinese and English language versions of key questionnaires prior to participating. The recordings from the 3 focus groups were transcribed verbatim and analysed by two researchers independently using a thematic analysis approach. Four main themes were identified: Perceptions of mental health problems, causes of mental health problems, treatments/help-seeking, and interventions. Participants reported sources of information relating to mental health problems: online and public media; and indicated cultural changes, loneliness, language difficulties, pressure at university, personality issues, and poor time management as the causes of mental health problems. Support types such as weekly support emails, professional support, and group support were discussed. This focus group study suggests that delivering online CBT to

Chinese-speaking international students who report mild to moderate low mood, anxiety and depression may be a feasible and desirable way to help them. The results of focus group study can help to inform a future substantive study, which involves adaptation to fit Chinese-speaking international students' lifestyle, as well as changes relating to the course content to reflect different understanding and expressions of distress.

### **From humble beginnings: Cognitive behavioural self-help for depression and anxiety in people living with long-term physical health conditions**

**Joanne Woodford, CEDAR, University of Exeter;** Paul Farrand, CEDAR, University of Exeter

Depression and anxiety are commonly experienced by people living with long-term physical health conditions. Despite high prevalence rates, access to evidence based treatments for comorbid mental health difficulties is limited, with little currently known about the overall effectiveness of cognitive behavioural self-help in the treatment of depression and anxiety in long-term physical health conditions. A systematic review and meta-analysis of randomised controlled trials examining the effectiveness of cognitive behavioural self-help in treating depression, anxiety and physical health symptoms in patients living with long-term physical health conditions was conducted. A systematic search of electronic databases, clinical trials, registers, conference proceedings and expert contact was conducted. Primary outcomes of interest were validated self-report or clinician administered measures of depression, anxiety and physical health symptoms. A meta-analysis examined: (1) the overall effectiveness of cognitive behavioural self-help in relation to outcomes of depression, anxiety and physical health symptoms; (2) clinical and methodological characteristics associated with effectiveness. 14 studies in total were identified as eligible for inclusion. Across the 11 studies treating depression symptoms a small effect size ( $g=-0.18$ ) was yielded. Similarly, a small effect size ( $g=-0.21$ ) was found for the 8 studies examining symptoms of anxiety. Only one study examining Multiple Sclerosis adopted a primary outcome of physical health related symptoms, yielding a large effect size ( $g=-1.14$ ). Planned moderator analysis identified no significant moderators of the main effect. The evidence base supporting the use of cognitive behavioural self-help for the treatment of depression, anxiety and physical health symptoms in people with long-term health conditions is limited. However this may potentially be accounted for by several methodological considerations, specifically a general failure in studies to recruit participants with clinical levels of depressive and anxious symptoms at baseline, potentially limiting the effect size estimates. Only one study targeted physical health symptoms as a primary outcome. Finally, the limited number of studies included in the review restricts the conclusions that can be made concerning the effectiveness of cognitive behavioural self-help for long-term physical health conditions.

### **Adaptations to behavioural activation for depression in long term conditions: A narrative systematic review**

**Sarah Harris, University of Exeter;** Paul Farrand, University of Exeter; Chris Dickens, University of Exeter Medical School

Depression is common in people with long term conditions (LTCs) and associated with more medical symptoms, greater functional disability and worse medical outcomes. Currently there is an increased emphasis in the NHS on an equal response to mental and physical health, and towards the two being treated together. As such it is important to establish the evidence base for psychological therapies in this population and to identify ways in which therapies can be adapted to increase access and acceptability for those with LTCs.

Behavioural activation (BA) represents a key and evidenced-based intervention for the treatment of depression, and is delivered as both a high and a low intensity intervention in IAPT. However the use of this intervention for depression in LTCs is currently unknown. This is the first systematic review to identify, synthesis and evaluate BA treatments, as well as identify and narratively review adaptations to BA to accommodate LTCs. Six electronic databases were searched for depression and BA, with LTCs manually screened, and all study designs included. Abstract and full text screening, data extraction and quality assessment was conducted by two reviewers. Forward and backward citation searching was conducted

on included studies and authors were contacted for unpublished work. Details of intervention components were extracted to identify any adaptations to the interventions. 18 studies were identified, including 11 single case studies/case series and 7 randomised controlled trials. The different types of BA were identified, with 12 studies adopting simple BA and 6 studies complex BA. Adaptations were identified to intervention content, including tailoring of materials/measures to the patient's LTC; strategies and resources for patients with neurological disorders; consideration of functional impairment on intervention components; additional psychological treatment components and a focus on caregivers. Adaptations were also identified to the delivery of BA, including those delivering and supporting the intervention, and delivery modality. Adaptations identified in this systematic review could be incorporated into low intensity BA interventions to increase access and suitability for people with LTCs and co-morbid depression. Some identified adaptations are more suited to high intensity interventions. Currently no conclusions can be drawn about the effectiveness of the identified adaptations and more research is needed to compare adapted to non-adapted interventions.

### **Therapists' Attitudes towards Computerised CBT; Does 10 years make a Difference?**

**David Osborne, The Academic Centre, Glasgow University;** Eugene Wong, The Academic Centre, Glasgow University; Mark O'Connor, The Academic Centre, Glasgow University; Chris Williams, The Academic Centre, Glasgow University

The Journal of Behavioural and Cognitive Psychotherapy published a paper in 2004 from a survey by Drs Graeme Whitfield and Chris Williams, looking at attitudes towards computerised self-help amongst BABCP-accredited practitioners across the UK. They surprisingly found only a small number of therapists were utilising computerised self-help (around 2.4% out of 329 respondents). Ten years on we have repeated this survey to ascertain whether, following NICE recommendations for computerised CBT (cCBT), wider public access to the internet, generational changes in therapist demographics and an expanded list of options for computerised self-help programmes, whether attitudes towards cCBT have changed. A survey questionnaire was constructed based on the one created by Whitfield and Williams in 2004, with more specificity added towards mild-moderate depressive disorders, where the bulk of evidence lies for cCBT. A list of 500 BABCP-accredited practitioners were randomly selected by the BABCP from their register, all of whom received the questionnaire pack with a stamped, self-addressed return envelope. Participants' names and addresses were stored electronically within secure, 128-bit encrypted files on an encrypted device, offering a double-layer of protection. Non-respondents were sent a second and third mailing, though due to a low return rate the third mailing included an extra leaflet advertising that all respondents would be entered into a random prize draw. The first mailing occurred in August 2014, producing 134 returns out of 500 (26.8%); the second mailing occurred in December 2014 and produced a further 39 returns, resulting in a 34.6% return rate. The third scheduled mailing was April 2015 and returns are awaited. Findings and comparisons with the Whitfield and Williams (2004) paper will be made, conclusions and discussion points drawn and made available for the Symposium.

## Theoretical and Research Advances in our Understanding of Anxiety in Autism Spectrum Disorders

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### **Intolerance of uncertainty as a framework for understanding anxiety in ASD**

**Jacqui Rodgers, Newcastle University;** Mark Freeston, Newcastle University; Anna Hodgson, Newcastle University

Anxiety is a significant problem for many individuals with an Autism Spectrum Disorder (ASD), affecting around 50% of individuals with ASD at some point in their lives. There is growing evidence that anxiety may present atypically in ASD and that the ASD related features of anxiety should therefore be considered in the development of assessment and treatment programmes. Individuals with ASD frequently present with multiple anxiety

disorders concurrently, making it difficult to develop tailored packages based on specific anxiety sub-types that will be applicable across the population with the condition. Effective interventions that target trans-diagnostic anxiety related mechanisms rather than anxiety content may therefore offer efficient and inclusive targets for treatment. Advances have been made in the development of interventions to tackle anxiety in ASD, largely based on the adaptation of CBT treatments to ensure that treatments are more accessible. There remains a paucity of interventions which are guided by theoretical models of ASD related anxiety. This paper will begin with a consideration of the utility of the Intolerance of Uncertainty (IU) model of anxiety as a starting point for the development of an ASD specific model of anxiety. Our research indicates intolerance of uncertainty (IU) is an important mechanism on the development and maintenance of anxiety in young people with ASD. In addition we will explore the relationships between anxiety, intolerance of uncertainty and some of the core features of ASD, specifically sensory processing atypicalities and restricted and repetitive behaviours and consider a preliminary ASD related model of anxiety which takes these features into account. We will then consider some preliminary evidence of the acceptability and feasibility of a novel parent group based intervention targeting IU for young people with ASD and anxiety (CUES: Coping with Anxiety in Everyday Situations), which is based on this model. The intervention was developed in consultation with parents and professionals. Two, eight week, parent based intervention groups were undertaken. The sample comprised parents of children with high functioning ASD aged between 8 and 12 years. The intervention included in-session activities and homework tasks. Outcome measures included the Spence Anxiety Scale (Parent Version), the Intolerance of Uncertainty Scale (Parent version) pre post intervention and assessment of changes in a target uncertain situation. Assessment of the acceptability and feasibility, attendance and drop-out were also recorded. The findings indicate that parents of young people with ASD consider IU to be an important target for intervention and view the CUES programme as valid and meaningful. The data available indicate that CUES may have promise as a targeted package to assist young people with ASD and their families to manage their responses to uncertainty. We will close with a consideration of further adaptations that can be made to the programme for use within education settings and with adults with ASD.

### **Exploring the cognitive aspects of social anxiety in adolescents with Autism Spectrum Disorders - does social anxiety impact self-perceptions of social performance?**

**Helen Wood, University of Bath;** Ailsa Russell, University of Bath; Eddy Draper, Oxford Health NHS Foundation Trust

Social anxiety disorder is considered to be the most prevalent anxiety disorder among young people and adults with autism spectrum disorder (ASD) who do not have co-occurring intellectual impairment. There is emphasis in the literature on social skills training when working with socially anxious young people with ASD. However, research with typically developing young people highlights the risks of reinforcing negative beliefs about social ability when doing this and suggests that socially anxious young people have negatively biased perceptions of their social skills. This paper will consider the current models and approaches for working with socially anxious young people with ASD compared with other populations, in particular considering a cognitive-behavioural model of social anxiety. It will then discuss findings from a recent study that aimed to investigate if adolescents and young adults with ASD who are high in social anxiety underestimate their social performance when compared with those low in social anxiety. Participants (n=40) aged 14-21 years completed measures of social anxiety before taking part in a video-recorded group discussion. Self and observer ratings of social performance were analysed. Results revealed that participants high in social anxiety rated themselves significantly poorer than did observers. The interaction between social anxiety group and rater was non-significant. Results from this study will be discussed with implications for clinical research and practice.

### **The role of attentional bias in anxiety disorders in ASD: research findings and treatment implications**

**Matthew Hollocks, University of Cambridge and Ann Ozsivadjian, Guy's & St Thomas' NHS Foundation Trust**

Children and Adolescents with Autism Spectrum Disorders (ASD) report significant levels of anxiety compared to their typically developing peers. While there has been some success in adapting CBT treatment developed for anxiety in non-ASD children, there has been little experimental evidence investigating whether the same anxiety related cognitive processes seen in non-ASD children are also related anxiety in ASD. Anxiety is associated with a range of differences in the processing of emotional stimuli, including increased attention towards threatening pictures or words and the negative interpretation of neutral stimuli. The experimental investigation of such processes not only provides insights into the psychological mechanisms of anxiety in ASD, but can inform the selection and adaptation of treatment strategies for this population. This paper will begin with the presentation of data from two independent studies investigating cognitive processing biases in children and adolescents with ASD. These studies used two versions of the well validated dot-probe attentional bias paradigm with emotional face stimuli (angry / happy / neutral) and emotional word stimuli (social threat/ physical threat/ neutral) to measure attentional bias to threat. While the second study also included a computerised ambiguous situation task which measured the propensity for participants to interpret neutral situations as being either physically or socially threatening. While the results varied between studies, they suggest that children with ASD and anxiety have a greater attentional bias towards threat (angry faces) and are more likely to interpret neutral situations as being more socially threatening. Despite these promising results further replication and research into a wider range of cognitive processes is required. The finding that anxiety in ASD is associated with similar cognitive processes found in non-ASD children with anxiety disorders supports existing research outcomes indicating that CBT based interventions can be useful in this population. However, given that many people with ASD are visual thinkers, and can have difficulty verbalising emotions, some may find traditional therapy involving verbal interchanges more difficult to engage with. We will conclude by discussing computerised attentional bias modification (ABM) as possible adjunct treatment approach in for children and adolescents with ASD undergoing CBT for anxiety.

**What mediates the relationship between autistic traits/ symptoms and anxiety? Findings from two studies and implications for psychological interventions for anxiety in Autism Spectrum Disorders**

**Iliana Magiati, National University of Singapore;** Clarissa Ong, Institute of Mental Health, Singapore; Xin Yi Lim, National University of Singapore; Julianne Wen-Li Tan, National University of Singapore; Shi-Min Liew, Institute of Mental Health Singapore; Nishta Thevaraja, Institute of Mental Health Singapore

Anxiety related difficulties are among the most frequently reported mental health challenges in individuals with Autism Spectrum Disorder (ASD). A consistent and positive association between autistic traits and anxiety symptoms has also been documented in unselected samples from the general population. Recent research and clinical efforts have focused on better understanding the phenomenology and the cognitive, behavioural and socio-emotional factors that may explain the high levels of anxiety in this population and a number of theoretical models have recently been put forward. In this paper, findings from two cross-sectional studies will be presented and discussed. The first study assessed anxiety symptoms in 241 6-18 year old young people with ASD attending special schools in Singapore via caregiver report. Few studies have explored the relationship between child characteristics and different types of anxiety symptoms, while no studies have examined the potentially differential relationship between different domains of autism-related symptoms (i.e. social/ communication autism symptoms as compared to repetitive/ stereotyped behaviors and interests) and anxiety. Thus, the independent and shared relationship between gender, age, adaptive functioning, social/ communication and stereotyped behavioural autistic symptoms with overall as well as specific anxiety subtype symptoms was examined. We found that gender did not play a role in rates of anxiety symptoms in this sample. Older children with higher adaptive functioning skills tended to present with more social and

generalized anxiety symptoms only. Severity of repetitive speech/ behaviour autism symptoms was the strongest predictor of total, separation, generalized, panic and OCD symptoms, but not social or specific phobia symptoms. Severity of social/ communication autism symptoms did not explain any variance in any of the anxiety symptoms measured when the other variables were taken into consideration. Findings from this study highlight the potentially important role of inflexible ways of thinking and stereotyped behaviors in explaining anxiety in ASD, although longitudinal studies are needed to establish the direction of this relationship. They also suggest that child characteristics may be differentially related to different anxiety subtypes. The second study explored the shared and specific role of five autistic-trait related mediators (social problem-solving, social competence, teasing experiences, prevention from/ punishment for engaging in preferred repetitive behaviors and aversive sensory experiences) in explaining the relationship between self-reported autistic traits and depressive, worry, social anxiety and obsessive-compulsive symptoms in a non-clinical sample of 252 Singaporean university students. All mediators except social competence were significant in explaining the relationship between autistic traits and depressive symptoms. Social competence was found to mediate the relationship between autistic traits and social anxiety symptoms only, while prevention from engaging in preferred repetitive interests and frequent aversive sensory experiences mediated the relationship between autistic traits, worry and obsessive-compulsive symptoms only. These results suggest that some of the mediators may contribute more generally to increased negative affect, while others appear more specifically relating to specific anxiety symptomatology. Findings from these two studies are discussed together and in light of their limitations. Implications for our understanding of the relationship between anxiety and autistic traits/ symptoms in both non-clinical and clinical populations are discussed, with a focus on potential promising adaptations in existing CBT informed interventions for young people with ASD (i.e. targeting sensory sensitivities as well as inflexible, rigid and repetitive patterns of thinking and behaving in the intervention programmes).

## New Ways of Looking at Hallucinations, Delusions and Paranoia

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### **Low intensity CBT for Distressing Voices: Efficacy, Feasibility and Protocol Design. Cassie Hazell, University of Sussex**

According to NICE (2014) recommendations people who have psychosis and are distressed by hearing voices should be offered at least 16 sessions of individual cognitive behavioural therapy (CBT). Despite this, figures show only 10% of people with psychosis are offered CBT, with demand on scarce therapist resources being identified as a key cause behind this (Schizophrenia Commission, 2012). With this in mind, the success of the IAPT approach in treating common mental health problems (Clark et al., 2009), has prompted research interest in the development of low intensity therapies for those with more complex mental health problems (Kingdon, 2013). However, this is a field in its infancy and many questions are yet to be answered.

This presentation summarises three studies that explore the potential of low intensity CBT for distressing voices. Study 1 is a literature review and meta-analysis of low intensity CBT for psychosis. Study 2 is a large scale staff survey drawing on Normalisation Process Theory. The study asked NHS mental health staff their opinions on a low intensity therapy for people distressed by hearing voices. Study 3 is a thematic analysis of focus groups conducted with people with a lived experience of hearing voices, asking about the content and structure of a new low intensity therapy protocol for distressing voices.

Findings from Study 1 suggest that low intensity CBT for psychosis in comparison to control conditions is effective at improving the global symptoms of psychosis and functioning, with therapist training not moderating these effects. Moreover, the number of sessions or contact hours used in these interventions did not predict improvements in symptom outcomes. The findings from Studies 2 and 3 are being collated at the time of writing.

This presentation will not only summarise the current state of the field regarding low-intensity CBT for distressing voices, but will also provide insight on both staff and patients views about this emerging treatment model.

The growing body of research demonstrating the effects of CBT for more severe mental illness could change the face of secondary care services. There is potential for primary and secondary services to become more similar, with the universal adoption of a stepped care approach when providing psychological interventions as more and more low intensity therapies are effectively developed.

### **Hypersensitivity to contingent behaviour in paranoia: a new virtual reality paradigm** **Miriam Fornells-Ambrojo, University College London**

Contingency in interpersonal relationships is associated with experiencing others as trustworthy and is involved in the development of secure attachment and mentalising. Paranoia is associated with a tendency to perceive intentionality when there is none and with safety behaviours. The study investigates interpersonal processes in paranoia by evaluating the impact of contingent behaviour on trust under controlled conditions in a new virtual reality paradigm.

Sixty-one healthy participants were randomly allocated using permuted blocks based on paranoia scores to a high or low contingency condition. They had a social interaction with an avatar programmed to be highly responsive or not (high/ low contingency). Perceived trustworthiness of the avatar and trusting behaviour (distance) were assessed alongside attachment style and anxiety.

Higher paranoia and dismissive attachment were associated with larger interpersonal distances from the avatar, and this safety behaviour suggestive of mistrust was independent of avatar responsiveness. Unexpectedly, highly paranoid individuals were the only group to show susceptibility to contingency manipulation and experienced the high contingency avatar as more trustworthy than his low contingency counterpart. Higher dismissive attachment was also associated with more subjective trust in both conditions.

Extreme paranoia is associated with hypersensitivity and preference for contingent behaviour, which might explain experiences of mistrust when others are not highly responsive in everyday social situations.

- Clinician's careful attunement and responsiveness to highly paranoid clients might be crucial for the development of a trusting therapeutic relationship
- Mistrusting behaviour in people with a dismissive attachment might paradoxically occur in the context of increased levels of subjective trust

### **Cognitive factors affecting compliance to command hallucinations**

**Takeshi Furumura, Higashi Owari National Hospital, Japan**

Traditionally, command hallucinations (CH) have been considered to be one of the risk factor for dangerous behaviour (Bleuler, 1924). However, CH are not sufficient to produce action in isolation and there are many mediating variables between compliance behaviours and CH (Braham et al., 2004). There are three factors potentially affecting compliance to CH (topography of voices, cognitions of voices, and negative person evaluations). We conducted a cross-sectional survey in order to verify the factors that affect the compliance behaviour to CH.

All of our 33 participants were diagnosed with schizophrenia (ICD-10), and with auditory hallucinations within 7 days before the survey. Sixty-three percent of participants were male with an average age of approximately 43 years. Their hallucination severity levels (PANSS; Kay, 1991) ranged from moderate to severe. We used the following three quantitative measurements for the assessment of risk factors: Hamilton Program for Schizophrenia Voices Questionnaire (van Lieshout & Goldberg, 2007), Beliefs About Voices Questionnaire-Revised (Chadwick et al., 2000), and Evaluative Beliefs Scale (Chadwick et al., 1999). This study was approved by the Ethical Review Board of Higashi Owari National Hospital and University of Tokyo.

Results of multiple regression analysis suggested that the frequency of compliance behaviour with CH was associated with clarity of hallucinations and omnipotence of voices. Negative self-evaluative beliefs were indirect risk factor for compliance behaviour. Clarity of hallucinations, omnipotence of voices, and negative self-evaluative beliefs are the risk factors for compliance behaviour.

These three factors will be the promising targets to control compliance behaviour to CH.

### **Does sleep predict functioning in people with a diagnosis of schizophrenia? An experience sampling study**

**Lee Mulligan, University of Manchester**

Sleep disturbance is common in people with a diagnosis of schizophrenia and has been associated with both severity of psychosis symptoms and symptomatic relapse (Waters et al., 2011; Xiang et al., 2008; Zarcone & Benson, 1997). There is also considerable evidence that problematic sleep can have a significant, negative impact upon perceived quality of life in individuals who experience psychosis (Hofstetter et al., 2005; 2008). However, to date, all research has been exclusively cross-sectional in nature and no studies have explored the impact of sleep on daily functioning (Krystal, Thakur & Roth, 2008). The current study aimed to rigorously explore this relationship, using ecologically valid methods.

20 individuals with a diagnosis of schizophrenia took part in the study. Each participant provided objective recordings of sleep across 6 days of actigraphy, in addition to subjective estimations of sleep via diary. Daily functioning, mood and psychosis symptoms were periodically assessed at 5 points throughout each day and the ESM schedules were personalised for each participant based on their habitual times of sleep onset and offset. Using multi-level modelling, this paper will explore the relationship between objective and subjective sleep parameters and daily functioning in people with a diagnosis of schizophrenia.

Potential therapeutic implications for the improvement of sleep and functioning in people who experience psychosis will be discussed, as will directions for future research.

This study could have a number of implications. If sleep is found to predict daily functioning in people who experience psychosis, it implies that CBT for insomnia (CBT-I) could have the potential to improve both sleep and functional recovery in people with a diagnosis of schizophrenia.

### **Goals and motivations of people with persecutory delusions**

**Natasha Vorontsova, Royal Holloway, University of London**

Cognitive behavioural therapies for psychosis require identification of personally meaningful goals, which can motivate clients to make the challenging changes needed for therapeutic progress. Outside therapy, too, goal-directed thinking has been causally implicated in the maintenance of depression, and may similarly contribute to the persistence of delusions. Research has shown that pursuit of some goals brings more wellbeing and task effectiveness than others, with goals that are more "self-concordant" - internally rather than externally motivated - leading to better outcomes. Goals motivated more by approach rather than avoidance have also been linked to higher wellbeing and less depression. The present study is the first known to examine the goals of people with persecutory delusions and their relationship to symptoms.

Thirty participants with persecutory delusions and schizophrenia-spectrum diagnoses completed measures of symptoms and a semi-structured interview regarding their goals and motivations. We hypothesised that higher Beck Depression Inventory scores would be associated with fewer approach motivations, more avoidance motivations and lower self-concordance of goals.

Two of the three hypotheses were supported. Higher levels of depression were associated with more avoidance motivations and lower goal self-concordance in the group.

These findings support an association of depression with low goal self-concordance and avoidant goal motivations in people with persecutory delusions, as has previously been found in groups without psychosis. This pattern is consistent with a proposal that depression might contribute to the persistence of distressing persecutory beliefs by interfering with the accessibility of personally motivating goals, a process which could be ameliorated using cognitive behavioural therapies.

It is suggested that supporting clients to identify self-concordant goals to approach valued achievements, rather than avoiding feared consequences, can facilitate positive therapeutic outcomes.

## New Developments in CBT for Eating Disorders: What can we do in real-life settings?

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### **Cognitive-behavioural therapy for outpatients with eating disorders: Effectiveness for a transdiagnostic group in a routine clinical setting**

**Hannah Turner, Southern Health NHS Foundation Trust, Emily Marshall, Lusia Stopa and Glenn Waller**

Whilst there is a growing evidence to support the impact of cognitive-behavioural therapy (CBT) in the treatment of adults with eating disorders, much of this evidence comes from tightly controlled efficacy trials.

To explore the effectiveness of CBT when delivered in a routine clinical setting.

Participants were 203 adults presenting with a range of eating disorder diagnoses, who were offered CBT in an out-patient community eating disorders service in the UK. The CBT delivered followed that described in published evidence-based manuals and included key elements of evidence-based practice such as: engagement; psychoeducation; developing a formulation; keeping a food diary; weekly weighing; dietary change; exposure; surveys; and cognitive restructuring. The treatment aimed to normalise eating, and to reduce weight controlling behaviours, abnormal eating attitudes, and body image concerns. Where necessary it also aimed to address broader psycho-emotional-social functioning, including identifying and managing emotions, improving self-esteem and reducing pathological perfectionism. Patients completed a measure of eating disorder pathology at the start of treatment, following the sixth session, and at the end of treatment. Symptoms of anxiety, depression, and psychosocial functioning were measured pre- and post-treatment. Approximately 55% of patients completed treatment, and there were no factors that predicted attrition. There were significant improvements in eating disorder psychopathology, anxiety, depression and general functioning, with particular changes in eating attitudes in the early part of therapy. Effect sizes were medium to large for both completer and intention to treat analyses.

These findings suggest that evidence-based forms of CBT can be delivered with strong outcomes in routine clinical settings. Clinicians should be encouraged to deliver evidence-based treatments when working in these settings.

### **Compassion-Focused Therapy for Eating Disorders: Development and preliminary outcomes**

**Ken Goss, Coventry and Warwick Partnership Trust, Coventry**

Compassion Focused Therapy (CFT) aims to help clients when shame and self-criticism play a major role in the development and maintenance of their of mental health difficulties.

Compassion Focused Therapy for Eating Disorders (CFT-E) was developed initially as an adjunctive therapy for standard CBT approaches to eating disorders. This presentation will outline:

- the development of this approach
- the role of shame, self-criticism and compassion in eating disorders
- outcome data for CFT-E

It will conclude by considering future directions for CFT-E treatment and research.

### **Brief cognitive-behavioural therapy for normal weight eating-disordered outpatients: Does half the dose mean half the effect?**

**Glenn Waller, University of Sheffield; Hannah Turner, Madeleine Tatham, Alison Bennetts, Julie Dodd, Lauren Ingram and Kate Bramwell**

While cognitive-behavioural therapy (CBT) for bulimia nervosa and other non-underweight eating disorders is reasonably effective in real life settings, there is a need for this to be delivered as efficiently and cost-effectively as possible.

To test the effectiveness of a ten-session, face-to-face CBT for bulimia nervosa and other non-underweight adult cases, delivered by junior clinicians.

Method: The sample consists of 41 patients (to date) who have been offered a ten-session version of CBT, with a strong focus on early behavioural change and later cognitive and body image work. The therapy is delivered in a routine clinical setting, with supervision.

Results: The attrition rate is approximately 25%. Among completers, 57% were abstinent from all bulimic behaviours at the end of treatment (intention to treat abstinence rate = 48%). There were also significant reductions in Eating Disorder Examination Questionnaire scores and frequencies of individual bulimic behaviours, using either form of analysis. Effect sizes were large. This brief CBT's impact was moderated by personality features, doing particularly well with individuals with poor interpersonal functioning.

This brief version of CBT has resulted in outcomes that are comparable with those of longer versions, despite being delivered by unqualified therapists. It indicates that many individuals with eating disorders could be treated with a much more efficient and cost-effective intervention. Further investigation is needed, including randomised controlled trials and exploration of the process of symptom change across different stages of therapy.

### **The effect of pre-treatment psychoeducation on eating disorder pathology among patients with anorexia nervosa and bulimia nervosa**

**Madeleine Tatham, Cambridgeshire and Peterborough NHS Foundation Trust; Elsa Athanasia, Julie Dodd and Glenn Waller**

Pre-treatment psychoeducation can be effective for bulimic groups, but little is known about its effect on patients with anorexia nervosa. This study investigated the impact of a pre-treatment psychoeducational intervention on outpatients with diagnoses of full or atypical anorexia nervosa (N = 62) or bulimia nervosa (N = 43). All attended a four-session psychoeducational group whilst awaiting outpatient treatment. They completed measures of eating and personality disorder pathology pre-intervention, repeating the measures of eating pathology post-intervention. Effectiveness was tested for each diagnostic group using completer and intention-to-treat analyses. Results confirm that such psychoeducational groups reduce unhealthy eating attitudes among bulimic patients, regardless of initial levels of eating and personality pathology. In contrast, the groups were not effective for anorexia nervosa sufferers. Such groups should be considered routinely during waiting periods for bulimia nervosa treatment, but further research is needed to determine how to help anorexia nervosa patients at this stage.

### **Developing and evaluating a body image group for patients with anorexia nervosa**

**Victoria Mountford, South Maudsley NHS Foundation Trust**

Body image disturbance can be enduring and distressing for individuals with anorexia nervosa and is implicated in the development, maintenance and relapse of these disorders. Although some treatments have been developed and evaluated, these are notably for individuals restored to a healthy body weight. This pilot study evaluated a group-based treatment – BodyWise - developed for use in full and partial hospitalization with patients with anorexia nervosa at low weight. The group was delivered and evaluated across three NHS Eating Disorder Services. Results demonstrated significant improvement for those who received BodyWise compared to treatment as usual for the primary outcome measure (Eating Disorder Examination – Questionnaire Shape Concern subscale) and other manifestations of body image disturbance including body checking and body image quality of life. BodyWise appeared acceptable to participants, and was deliverable within a busy eating disorder service. Consideration will be given to the process of development, evaluation and dissemination of new treatments in real-life settings. Future developments will be discussed.

[‘It’s not just what we do it’s the way that we do it’: improving clinical outcomes in CBT for complex chronic and recurrent depression through innovation in service delivery model](#)

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**"Hope at last? A patient's perspective on the long journey to NICE approved treatment for recurrent depression and beyond"**

### **Mat Rawsthorne, Academy for Recovery Coaching CIC, Nottingham**

This paper is an 'expert by experience' testimony of seeking treatment for depression in the current stepped care health economy. The paper will describe Mat's experience of accessing pharmacological and CBT treatments for depression as recommended by NICE Guidance through the Nottingham Specialist Depression Service, as a participant in the RCT which established the service. This will be contrasted with Mat's experience of seeking help in both IAPT and standard secondary care mental health services. This will be set in the context of the Recovery Model from the perspective of service user and carer, giving consideration to both traditional and modern treatments for depression. Attention will be given to the importance of the therapeutic alliance, the insider experience of using CBT strategies to manage depression and to what life is like after treatment in the SDS service. The audience will also gain insights into co-production within both research and service development.

### **How NICE concordant is treatment for depression in secondary care mental health services? The results of an audit of routine clinical practice in two NHS mental health Trusts**

**Neil Nixon, Nottinghamshire Healthcare NHS Foundation Trust and, University of Nottingham**

As part of a five year CLAHRC funded randomised controlled trial investigating the clinical and cost effectiveness of a Specialised Depression Service offering NICE recommended pharmacological and CBT treatments for chronic and recurrent depression (CLAHRC ND 2008-2012) an audit was conducted on the first eighty patients who entered the RCT in two of the three study sites: Nottinghamshire Healthcare NHS Foundation Trust and Cambridge and Peterborough NHS Foundation Trust. The purpose of the audit was to assess what pharmacological and psychological treatments participants had received in the 18 months prior to entering the RCT. The NICE guidance for the treatment of depression (CG90) was used as the benchmark against which practice was measured over the 18 month period prior to entering the study. The results of the audit found that pharmacological and psychological treatments for patients experiencing depression treated in secondary care mental health services did not meet NICE guidance recommendations. A calculation was made of the economic cost of these sub-therapeutic interventions.

### **Results from the CLAHRC Nottingham, Derby and Lincoln (2008-2012) Specialist Mood Disorders Team Randomised Controlled Trial.**

**Richard Morriss, Community Mental Health, NIHR collaboration for Leadership in Applied Health Research and Care (CLAHRC) East Midlands, Institute of Mental Health, University of Nottingham**

This paper presents the results from the CLAHRC Nottingham, Derby, Lincoln (2008-2012) Specialist Mood Disorders Team Randomised Controlled Trial. Across three centres, (Nottingham, Cambridge and Derby) 310 participants were referred to the study, 187 met the inclusion/exclusion criteria for the study and gave written informed consent. Of these, 93 participants were randomised to the specialist depression service and 94 to treatment as usual. The mean (range) age was 47 (20-84) years and 114 (61%) were female. The participants had suffered from depression for a mean (range) of 11.6 (range 0.5-50.6) years. At baseline, the participants were moderately to severely impaired with a mean (range) Hamilton Depression Rating Scale score of 22.6 (16-40), Beck Depression Inventory score of 33.7 (11-56) and Global Assessment of Function of 48.5 (21-65). By 6 months there were no significant differences in any of the depression or functions outcomes, by 12 months all depression outcomes showed a trend towards a significant improvement and by 18 months, all depression outcomes including the primary outcome variable were significant. Results for depression symptoms, function and cost effectiveness at 18 months will be reported. In conclusion, there is evidence for the clinical effectiveness of 12 month interventions from a specialist mood disorder team compared to community mental health team and psychiatric out-patient care for people with moderate to severe unipolar depression who have not improved after six months treatment in standard secondary care mental health services. There is no evidence of a difference in outcome at six months so brief intervention lasting six

months or less are unlikely to be ineffective in this chronic moderately severe depressed population.

### **Getting better informed about how to do what we know: developing a mood disorder service.**

**Marcus Barker, University of Nottingham**

The CLAHRC-NDL Mood Disorder project is a RCT comparing a specialised depression service to treatment as usual for people with chronic, recurrent depression. Initially, in order to attempt to understand how to bridge the second gap in translation from research to practice, an implementation framework was used to systematically identify the important barriers and drivers to the establishment of the service in a clinical setting. However, participants expressed difficulties at using the model; the language had little resonance with their own experiences. Four sites were identified with three successfully implementing the developed service as part of the trial. A nested qualitative study was conducted by a researcher and service user researcher. The predominant data set collected was formed from semi-structured interviews with service users, health professionals, service managers and commissioners. The narrative data collected from service users provided an insight into the diverse range of experiences of usual care for individuals with chronic and recurrent depression both within and between Trusts. The specialised service being trialled provided a collaborative care not commonly, arguably ever, experienced by service users with chronic and recurrent depression. The narrative data from health professionals, service managers and commissioners pointed towards multiple levels of fragmentation affecting delivery of services for these service users including the geographical challenge of equity in service provision. With a backdrop of changing services, cost savings and prioritisation, such services need to provide evidence of their success in the short to medium term to garner the support at all levels, especially at the commissioning level. Strong voices can get innovative services noticed, but the route to moving what we know to what we do involves a number of key decision makers and influencers at different levels with different drivers for change.

### **Hope for the silent majority: A Specialist Depression Service that delivers evidence based treatments for chronic and recurrent depression**

**Anne Garland, Nottinghamshire Healthcare NHS Foundation Trust**

The economic cost of depression has been clearly articulated in recent years. There is also a very real human cost (Horton, 2007) and as Richard Hornsby (2001) observes we still have some way to go in hearing and more fully addressing the plight of sufferers: 'Since we have closed our institutions we have sent those with profound despair and inability to cope into lonely rooms in which they eke out an existence with a quality of life that is perhaps less than zero. There is no longer any asylum for those in need, in the true and proper sense of the word. Depressives are an easy group to push aside because they do not make too much fuss. Part of society's response to depression must also be a push for better and more effective treatments'. The Specialist Depression Service (SDS) in Nottinghamshire Healthcare NHS Trust is a permanent evidence based treatment service that has emerged from a five year CLAHRC funded randomised controlled trial (2008-2012) which (alongside services in Cambridge and Derby) tested the clinical and cost-effectiveness of a specific service delivery model for the treatment of complex, chronic and recurrent depression in a secondary care mental health setting. The service has now been running for three years post RCT and operates using a collaborative care approach in which the service user, family and friends, CBT therapist, psychiatrist, GP and relevant others work together to treat depression. The service delivers NICE recommended pharmacological and CBT treatments for chronic and recurrent depression, as well as having integrated access to social inclusion, self-help and recovery based services. The service is open to anyone with a primary diagnosis of chronic and recurrent depression who meet criteria to enter secondary care mental health services. In this regard the usual suitability criteria used in CBT services are not applied. This paper will describe the service delivery model, which is evidence based, where patients receive up to 12 months of active treatment in the service and how this equates to improved clinical outcomes. Consideration will be given to the adaptations

required in the delivery of CBT interventions given the broad access criteria to the service. This will be illustrated using clinical case examples. Finally reflection on the opportunities and challenges the service grapples with in the current economic climate will be discussed.

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## Advances in Behavioural Activation

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No abstract provided.

### Is it Really OK to give Reassurance to People in Distress? Are you sure?

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#### **How do caregivers, anxiety sufferers and therapists understand and experience reassurance seeking? Is there room for new treatment interventions?**

**Brynjar Halldorsson, University of Reading**

Excessive Reassurance Seeking (ERS) is an under-researched and poorly understood behaviour that resembles the compulsive behaviours that are typically seen in obsessional problems. ERS can be complex, persistent, extensive, debilitating and may dominate the interactions of those involved. In addition to resembling compulsive checking in Obsessive-Compulsive Disorder (OCD) it may have the effect of transferring responsibility to another person. Investigation into ERS has been hampered by a lack of adequate definitions of the key concepts including 'reassurance' and 'support' and by limited understanding of the difference between support, appropriate reassurance, and pathological reassurance seeking and giving of the type often clinically considered to be crucial to the maintenance of emotional disorders. With some notable exceptions, the clinical wisdom is that therapists should simply refuse to give patients reassurance and caregivers should be encouraged to do the same. However, there are reasons to believe that this prescriptive approach is not necessarily helpful and practical. Indeed, as a response to distress in others such a reaction (withholding reassurance) would be at best inappropriate, and at worst rejecting and interpersonally destructive. During this presentation the author will describe a recent research paradigm, where qualitative and quantitative measures were applied to examine how people who suffer from anxiety problems understand and experience ERS, as well as how caregivers and therapists deal with it. Emphasis will be put on exploring the problems that are associated with withholding reassurance and discussing a newly developed treatment intervention that focuses on helping anxiety sufferers to overcome their excessive requests for reassurance.

#### **A qualitative investigation of Japanese carers' experience of providing reassurance**

**Osamu Kobori, Swnasea University; Daisuke Ikota & Eiji Shimizu, Chiba University, Japan**

Reassurance seeking is a common problem in clinically anxious populations, and is particularly obvious in obsessive-compulsive disorder (OCD). This study seeks to examine the way carers of individuals with OCD provide reassurance and the perceived consequences of such reassurance seeking using a qualitative analysis. A semi-structured interview was employed to ask Japanese carers to reflect on occasions when they provide reassurance, and its impact on themselves and others. Ten interviews were conducted, transcribed, and analysed in detail using thematic analysis. An overarching theme was identified in terms of frustration, suggesting that carers do not know if reassurance helps, and providing reassurance is not at all rewarding for them, but they have to devote a large part of their time for providing reassurance.

## **A preliminary investigation of attachment style, inflated responsibility and excessive reassurance-seeking behaviours in adolescents with OCD**

**Sasha Walters, University of Bath**

Cognitive models of OCD identify inflated responsibility as a vulnerability and maintenance factor which is associated with compulsive behaviours including excessive reassurance seeking (ERS; Rachman, 2002; Salkovskis, 1985). An emerging body of evidence has also implicated attachment styles in OCD symptom severity as well as the core cognitive components that maintain it (Doron, Moulding, Kyrios, Nedeljkovic, & Mikulincer, 2009; Haciomeroglu & Karanci, 2014). However, these models have largely been evaluated with adult samples and, with regards to attachment and ERS specifically, it is unclear how this translates to understanding clinically significant OCD presentations in young people. The aim of the current study was to test for the prevalence and specificity of a disorganised attachment representations, inflated responsibility and ERS in a sample of adolescents with OCD (n=19) compared with adolescents with other anxiety disorders (n=19) and healthy controls (n=19). Findings indicate that each of the variables are elevated among the clinical groups but there was little evidence of specificity between adolescents with OCD and other anxiety problems in terms of attachment, inflated responsibility or ERS. The outcomes are discussed in relation to findings from the adult literature and directions for future research and clinical practice are considered.

## **Working with Health Visitors on Postnatal OCD: are we teaching skills in Normalising or reassurance giving?**

**Katrina Rumball and Abigail L Wroe, Royal Holloway University of London**

Background Unwanted intrusions specifically related to a mother's infant and an increase in prevalence of Obsessive Compulsive Disorder (OCD) has both been observed in the perinatal period. Mothers, reluctant to share their experiences of intrusions through fear of the meaning of the intrusions and fear of being judged, are unlikely then to receive any normalising feedback on the occurrence of intrusions. Normalising is key part of Cognitive Behavioural Therapy for OCD, offered by therapists in the early stage of therapy, to aid the process of reappraising the meaning of the intrusions. Normalising at an early stage is therefore likely to be helpful in managing distress for mothers during the postnatal period, and potentially reducing the risk of developing clinical level symptoms of postnatal OCD (pOCD). Health visitors are key in identifying postnatal depression and signposting for support. Health Visitors may also be well placed to support mothers regarding distress around unwanted intrusions. However, the literature has demonstrated a lack of research and training of health professionals in pOCD.

The present study aimed to provide Health Visitors with an understanding of intrusions and the Cognitive-Behavioural model of OCD, equipping them with skills in identification and normalising. A key aim was to examine the effects of the training on mothers.

Method Health Visitors (n=26) attended a ninety-minute training session in pOCD and intrusions. This included skills in normalising. Questionnaires were completed before and after training, using hypothetical vignettes to ascertain consideration of pOCD. Half of the team received training at the beginning of the study. The remaining health visitors received a leaflet on wellbeing during the postnatal period. Mothers who saw these health visitors were compared to mothers who saw health visitors who had not received this training, forming an experimental group (n=51) and a control group (n=54). Mothers completed a questionnaire on occurrence of intrusions, distress around intrusions and compulsive behaviours (PTBC).

Pre and post-training health visitor data found increased consideration of pOCD. Mothers in the experimental group, compared to control group, rated significantly lower on how bothered they were by the intrusions they experienced. There was no significant difference between groups in time spent completing compulsions.

A short training session to Health Visitors may increase their knowledge and skills related to pOCD. This may also have beneficial effects for mothers regarding distress around intrusions. However, the mechanism for this difference between mothers in the

experimental and control groups is not clear. Did the health visitors use normalising skills that supported mothers? How might this differ from offering reassurance to mothers?

## Memory and Imagery in Depression and Anxiety

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### **Positive Imagery Cognitive Bias Modification via the Internet for Depressed Adults: A Randomized Controlled Trial**

**Simon E. Blackwell, MRC Cognition and Brain Sciences Unit, Cambridge;** Michael Browning, University of Oxford; Andrew Mathews, University of California, Davis and Institute of Psychiatry, King's College London; Arnaud Pictet, University of Geneva; James Welch, University of Oxford; Jim Davies, University of Oxford; Peter Watson, MRC Cognition and Brain Sciences Unit, Cambridge; John R. Geddes, University of Oxford; Emily A. Holmes, MRC Cognition and Brain Sciences Unit, Cambridge and Karolinska Institutet, Stockholm. Depression is characterized by impoverished positive future-orientated mental imagery (Holmes et al., 2008; Morina et al. 2011). That is, someone who is depressed may struggle to imagine anything other than negative events happening to them in the future. Targeting this neglected cognitive aspect of depression may provide a useful route for treatment development. Experimental psychopathology (e.g. Holmes et al., 2009) and preliminary clinical studies (e.g. Blackwell & Holmes, 2010; Lang et al., 2012; Torcan et al., 2014) using a cognitive training approach have provided initial support for the idea that repeated practice in generating positive mental imagery may be beneficial in depression. The current study tested a four-week internet-delivered version of this cognitive training, "imagery cognitive bias modification" (imagery CBM), in a randomized controlled trial (Blackwell et al., 2015). In this RCT, 150 people with current major depression were randomized to complete either the imagery CBM or a closely matched control program, and followed up for 6 months post-treatment. Adherence to the intervention was good, and feedback positive. The imagery CBM did not show the expected advantage over the control condition in reducing depressive symptoms as a whole in the full sample, with participants in both conditions showing equally large reductions. In exploratory analyses, compared to the control, imagery CBM significantly improved anhedonia over the course of the intervention. Further, compared to the control, imagery CBM improved depressive symptoms as a whole for those participants with fewer than five episodes of depression, and for those who engaged to a threshold level of imagery. These results suggest avenues for future development and applications of imagery CBM in the treatment of depression. Anhedonia in particular may be a useful treatment target for future work.

Reference:

Blackwell, S. E., Browning, M., Mathews, A., Pictet, A., Welch, J., Davies, J., Watson, P., Geddes, J. R., & Holmes, E. A. (2015). Positive imagery-based cognitive bias modification as a web-based treatment tool for depressed adults: a randomized controlled trial. *Clinical Psychological Science*, 3, 91-111. doi: 10.1177/2167702614560746

### **Cognitive bias modification for memory distrust and uncertainty in OCD**

**Melissa Black, The University of New South Wales;** Jessica Grisham, The University of New South Wales

Pathological doubting and checking is a common symptom presentation in obsessive-compulsive disorder (OCD). Previous research suggests that compulsive checkers do not display an actual memory deficit, but lack confidence in their memories and experience intolerance of uncertainty regarding the completion of tasks. The focus of this study is on examining the effect of a novel training procedure aimed at modifying these types of beliefs in a clinical sample diagnosed with OCD. We conducted an investigation of the application of interpretive cognitive bias modification (CBM-I) targeting maladaptive thinking styles related to memory distrust and intolerance of uncertainty in a clinical sample of OCD checkers. We examined the possible enhancement of CBM-I for OCD through repeated training sessions, and measured participants' self-reported symptoms and behavioural responses on both standardized and individualized tasks. Preliminary results provide mixed evidence that participants who received positive CBM training may have interpreted novel

ambiguous checking scenarios more adaptively and checked less on behavioural measures relative to participants in the neutral CBM condition. In addition, positive CBM training may have modified participants' idiosyncratic beliefs and behaviours. CBM may be useful as an adjunct to traditional cognitive-behavioural strategies or as an online intervention to target maladaptive beliefs in OCD.

### **Can we boost the effects of Internet-CBT with imagery-based cognitive bias modification (CBM)?**

**Alishia D Williams, Utrecht University, The Netherlands;** Kathleen O'Moore, Clinical Research Unit for Anxiety and Depression (CRUFAD); Simon E. Blackwell, MRC Cognition and Brain Sciences Unit; Jessica Smith, CRUFAD; Emily, A. Holmes, MRC Cognition and Brain Sciences Unit & Department of Clinical Neuroscience, Karolinska Institutet; Gavin Andrews, CRUFAD

Accruing evidence suggests that positive imagery-based cognitive bias modification (CBM) could have potential as a standalone targeted intervention for depressive symptoms or as an adjunct to existing treatments. We sought to establish the benefit of this form of CBM in a randomized controlled trial of a 1-week Internet-delivered positive CBM vs. an active control condition for participants (N=75, 69% female, mean age=42) meeting diagnostic criteria for major depression; followed by a 10-week Internet-based cognitive behaviour therapy (iCBT) program for both groups. Results of modified intent-to-treat marginal and mixed effect models demonstrated no significant difference between conditions following the CBM intervention or the iCBT program. In both conditions there were significant reductions in primary measures of depression and interpretation bias (Cohen's  $d$  .57–1.58, 95% CI=.12–2.07). Large effect size reductions (Cohen's  $d$  .81– 1.32, 95% CI=.31–1.79) were observed for secondary measures of distress, disability, anxiety and repetitive negative thinking. However, per protocol analyses conducted in the sample of participants who completed all seven sessions of CBM indicated between-group superiority of the positive over control group on depression symptoms and psychological distress following CBM and following iCBT. Results provide preliminary support for the successful integration of imagery-based CBM into an existing Internet-based treatment for depression with the potential to bolster effects of standard treatment. The lack of a differential effect between the two conditions in the full sample raises a number of important considerations. The selection of the most appropriate 'control' condition in future translational research trials is discussed.

## Eating Disorders, Impulse Control and Addiction

### **Make up your mind about food: A healthy mind-set attenuates attention for unhealthy food.**

**Jessica Werthmann, Institute Psychiatry, King's College London**

Recently, vast empirical interest emerged on the role of a food-related attention bias for overeating, obesity and restrained eating behaviour. However, studies testing individual differences (e.g., restrained eating) in attention bias for food have resulted in diverse findings. We tested experimentally if current motivational states, such as a "mind-set", rather than trait-like differences in eating behaviour, influence attention bias for food. Current mind-set was manipulated experimentally by inducing either a "health" or a "palatability" mind-set. Attention bias for food was measured by eye-tracking and response latencies (RL) during a visual probe task with high-calorie food and non-food pictures. Restrained eating was assessed.

An interaction of "mind-set" and restrained eating was observed: Simple slope testing revealed that a "healthy" mind-set attenuated attention bias for food, based on RL, in restrained eaters, while the mind-set manipulation did not affect attention processing of food pictures in unrestrained eaters.

Our study suggests that a mind-set focus on "health" versus "palatability", thus the current motivation for food, biases food-related attention, at least in individuals who are concerned about food intake, i.e. restrained eaters. This finding is important as it offers an alternative explanation for the diversity of previous findings on attention bias for food. Our results

imply that it is inaccurate to study between-group differences on trait-like variables when trying to understand the role of a food-related attention bias for eating behaviour and that it is necessary to account for current motivational state.

Cognitive theories of eating disorders and overeating postulate that an attention bias for food cues contributes to problematic eating behaviour. Our findings highlight that this attention bias might fluctuate with individual motivational states. Further examination of this relation is warranted, however, this research has the potential to inform on interventions targeting the motivation/cognition interface, such as CBT, in persons with problematic eating behaviour.

### **Integrating a brief motivational intervention for substance misuse into routine care in mental health inpatient settings: a pilot randomised controlled trial** **Hermine Graham, University of Birmingham**

This study evaluated the effectiveness and feasibility of a targeted brief motivational intervention, delivered in mental health inpatient settings, to improve engagement in treatment for drug and alcohol misuse.

Randomized controlled trial using concealed randomization and blind, independent assessment of outcome at 3 months

59 adult admissions to 6 mental health inpatient units in one NHS Trust, with schizophrenia related or bipolar disorder diagnoses, users of community mental health services and also misusing alcohol and/or drugs.

Brief Integrated Motivational Intervention with Treatment As Usual, or Treatment as Usual alone. The Brief Integrated Motivational Intervention was manualised and delivered jointly by trained inpatient and specialist practitioners. It aimed to engage participants in talking about their substance use and its impact on their mental health. The intervention took place over a 2-week period. A booster session was offered one month after the last session.

Main Outcome measures: The primary outcome was engagement in treatment for substance misuse at 3 months. Secondary outcomes included readiness to change, substance use and together with a cost-effectiveness analysis. Qualitative interviews with staff and participants assessed the acceptability of the intervention

59 inpatients (Brief Integrated Motivational Intervention n=30; Treatment As Usual n=29) consented and were randomised, mean age 38.6 years (SD 11.06), mainly male with a schizophrenia or schizoaffective disorder diagnosis, misusing cannabis, or alcohol. 50 participants were followed up at 3-months (84.7%). Brief Integrated Motivational Intervention was associated with a 62.1% relative odds increase in the primary outcome engagement in treatment (OR 1.63 (95% CI 1.01 to 2.65; p=0.047)). There was no significant difference in costs between the two groups. Participants and staff found the intervention a helpful and useful approach.

Mental health hospital admissions present a unique opportunity for short burst discussions about drug and alcohol use and can lead to modest changes in engagement in treatment which could be built upon post-discharge.

This study provides insight into the feasibility and acceptability of embedding a brief intervention, that facilitates re-evaluation of positive beliefs about substance use and builds awareness of how substance use and mental health may negatively interact, into routine clinical practice on mental health inpatient wards.

### **Effectiveness of a brief school-based body image intervention 'Dove Confident Me: Single Session' when delivered by teachers and researchers: Results from a cluster randomised controlled trial**

**Melissa Atkinson, University of the West of England**

This study investigated whether a 90-minute school-based body image intervention (Dove Confident Me: Single Session) could improve adolescents' body image and related health outcomes, and be successfully task-shifted to teachers.

British adolescents (N= 1707;11-13 years;50.83% girls) participated in a cluster randomised controlled trial [lessons as usual control; intervention researcher-led (RL); intervention teacher-led (TL)]. Body image, risk factors, and psychosocial and disordered eating

outcomes were assessed 1-week pre-intervention, immediate post-intervention, and 4-9.5 weeks follow-up.

Linear mixed-models showed post-intervention improvements for girls relative to control in body esteem (TL), life engagement (TL;RL), negative affect (TL;RL), dietary restraint (TL), and eating disorder symptoms (RL). Eating disorder symptoms (RL) and life engagement improvements were maintained at follow-up (TL). For boys, the only differences superior to control were an improvement in life engagement (TL;RL) at post-intervention and follow-up (RL), and a reduction in sociocultural pressures at post (TL). Unexpectedly, sociocultural pressures increased for girls at post only (TL;RL), and improvements were observed among the control group on some outcomes.

This intervention had short-term benefits for girls' body image and eating disorder symptoms, and some psychosocial outcomes among girls and boys. Multi-session interventions may be necessary for sustained improvements. Teachers can deliver this intervention effectively with minimal training, indicating broader scale dissemination is feasible.

Translating psychological interventions for delivery by non-expert providers is feasible, and necessary for widespread dissemination.

### **Pathways to Recovery: An innovative CBT-based inpatient treatment approach, 5 years on.**

#### **Andrea Brown, The Retreat**

In 2010, the Naomi Unit at the Retreat in York adopted a novel CBT based model for the inpatient treatment of people with eating disorders following a pilot study. The programme was created by a multidisciplinary team with service user involvement. Preliminary results were presented at the BABCP conference in 2010. In 2013 the team won the award for Psychiatric Team of the Year (working age adults) from the Royal College of Psychiatrists for this innovation. Here we present the results of the past 5 years' experience of using this model.

The Pathways to Recovery include 7 pathways: psychological, independent living, physical activity, physical monitoring, independent eating, self-catering and leave. These are arranged over three levels: medical stabilisation, gaining skills and transferring skills. The pathways incorporate the CBT principles throughout. In order to progress patients use planning and evaluation forms in collaboration with the multidisciplinary team. Transparency and collaboration are features of the programme and evident in all aspects of treatment.

101 patients have been treated using the Pathways to Recovery since they were adopted. The average length of stay is 6 1/2 months which is comparable to other specialist eating disorder services. What differentiates us from other services is the fact that the average BMI on discharge is within the healthy range. We will present outcome data including: EDE-Q, CORE-OM, RSE-S. Patients describe the Pathways to Recovery to be a positive experience and we will present a patients perspective.

We believe that the Pathways to Recovery is an innovative approach to treating inpatients with eating disorders. We have demonstrated that patients recovery is enhanced based on quantitative outcome measures. This is reflected in an improvement in self-esteem, self-worth and optimism for the future.

We believe that this model could be replicated in other inpatient units and also potentially day patient units. This model uses CBT at a systemic level which is highly effective and acceptable to staff and patients alike.

## **The Treatment of Traumatic Symptoms in Psychosis**

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### **CBT for the Treatment of PTSD within Schizophrenia**

**Craig Steel, University of Reading, C., Smith, B., Gottlieb, J., Rose, S., Enright, S., Baksh, F., Landau, S., Wykes, T., Rose, D., Hardy, A. & Mueser, K.**

Although CBT is an established evidence-based intervention for the treatment of PTSD, psychotic disorders have been an exclusion criteria within the associated clinical trials.

Studies estimate a prevalence of 15-40% co-morbidity of PTSD in those diagnosed with schizophrenia, indicating a significant clinical need. The aims are to evaluate the effectiveness, and patient acceptability, of CBT in reducing the symptoms of PTSD in individuals diagnosed with schizophrenia. A single-blind randomised controlled trial was conducted across two sites within the UK. Sixty-one patients with a diagnosis of schizophrenia and symptoms of posttraumatic stress syndrome were randomised to either 6-months of CBT or treatment as usual. The CBT intervention was a manualised approach consisting of psychoeducation, breathing training and cognitive restructuring. Dropout rates were low. Data on treatment outcome and patient satisfaction of the therapy will be presented. The results will be discussed alongside issues associated with screening for PTSD in this group, and potential dissemination of the intervention to health services.

**Psychological mechanisms mediating trauma and psychotic symptom associations: Investigation of intrusive memory, affect regulation, schema and depression.**

**Amy Hardy, Institute of Psychiatry, King's College London.**

A growing body of evidence supports a potential causal role for trauma in psychosis, particularly an association between childhood victimisation events, auditory hallucinations and paranoia (Bentall et al., 2014). Psychological processes implicated in this relationship include negative schemas, maladaptive affect regulation, trauma memories and emotion (Fowler et al., 2006; Gumley et al., 2010; Longden et al., 2012; McCarthy-Jones, 2011; Read et al., 2014; Steel et al., 2005). However, there has been relatively little comprehensive examination of these associations and underlying mechanisms in larger clinical samples of people with persisting psychosis. This study investigates the relationship between traumatic events and psychotic symptoms in a sample with ongoing, relapsing psychosis. Two hundred and twenty eight participants with a diagnosis of non-affective psychosis from the Psychological Prevention of Relapse in Psychosis Trial (Garety et al., 2008) completed assessments including the Trauma History Questionnaire, Scales for Positive and Negative Symptoms, Psychotic Symptom Rating Scales, Brief Core Schema Scale, Beck Depression Inventory and Self-Report Scale for Post-Traumatic Stress Disorder. Mediation analysis examining the associations between trauma type and psychotic symptoms, and mechanisms accounting for any identified associations, will be presented. The findings will be discussed in relation to cognitive-behavioural theories of post-traumatic stress in psychosis, and implications for clinical practice considered.

**Prolonged exposure versus Eye Movement Desensitization and Reprocessing versus waiting list for PTSD in patients with a psychotic disorder**

**David van den Berg, Parnassia Psychiatric Institute, The Netherlands; de Bont, P., van der Vleugel, B., de Roos, C., de Jongh, A., van Minnen, A. & van der Gaag, M.**

Post-traumatic stress disorder is highly prevalent in patients with psychotic disorders and negatively influences prognosis and wellbeing. Psychosis has been an exclusion criterion in PTSD treatment trials and clinical practice. Aim of this study was to examine the efficacy and safety of prolonged exposure (PE) and eye movement desensitization and reprocessing (EMDR) compared to waiting list (WL) in individuals with psychotic disorder. In the 'Treating Trauma in Psychosis trial (T-TIP) 155 patients with a psychotic disorder and comorbid PTSD were randomly assigned to PE, EMDR or Waiting List (WL). In the treatment conditions participants received eight 90-minute sessions of therapy. Standard protocols were used. Treatment was not preceded by stabilizing interventions or skills training. Baseline, post-treatment and 6-month follow-up assessments were made. Participants in both PE and EMDR showed greater reduction of PTSD symptoms than those in WL. Between group effect sizes were large. About 60% of the participants in the treatment groups achieved loss of diagnosis. Treatment effects were maintained at six-month follow-up for both PE and EMDR. Treatments did not result in serious adversities and actually reduced the amount of adversities and revictimization. Standard PE and EMDR protocols appear to be effective, safe and feasible in patients with psychosis.

**The effects of trauma treatment on comorbid symptoms in PTSD in psychotic patients**  
**Mark van der Gaag, VU University and Parnassia Psychiatric Institute, The Netherlands;** van den Berg, D., de Bont, P., van der Vleugel, B., de Roos, C., de Jongh, A. & van Minnen, A.

PTSD is characterised by many comorbid conditions such as depression, dissociation, psychosis, suicidality, and reduced social and vocational functioning. What is the effect of trauma treatment on comorbid symptoms? In the 'Treating Trauma in Psychosis trial (T-TIP) 155 patients with a psychotic disorder and comorbid PTSD were randomly assigned to PE, EMDR or Waiting List (WL). In the treatment conditions participants received eight 90-minute sessions of therapy. Standard protocols were used. Treatment was not preceded by stabilizing interventions or skills training. Baseline, post-treatment and 6-month follow-up assessments were made. Participants in both PE and EMDR showed greater reduction in delusions, but not in hallucinations. Depression was ameliorated in PE, but not in EMDR. Although treatment improved suicidal ideation, dissociation and social functioning these effects were not statistically significant. Reducing symptoms of PTSD is associated with reduced psychosis and depression in psychotic patients.

CBT Training and Supervision: Supporting the development of competence in basic training and beyond

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#### **Group supervision of supervision – an illuminative evaluation**

**Suzanne Byrne, King's College London**

It is recommended that in CBT and other 'talking therapies' clinical supervisors have space to reflect on their work and have supervision or support for their supervisory practice (Roth and Pilling 2008). To date little attention has been given in the literature to 'supervision of supervision', leading to a lack of clarity on both what it 'should' constitute and the nature of any benefits/effects. Early findings from an evaluation study of a 'supervision of supervision' group will be presented. Members of the group provide weekly group supervision for students on the PgDip in CBT (IAPT) training programme at the Institute of Psychiatry Psychology and Neuroscience (IOPPN) King's College London.

#### **Working with interpersonal process in CBT supervision**

**Stirling Moorey, South London & Maudsley NHS Trust**

Therapists can find themselves repeatedly falling into the same trap with certain types of patients or getting stuck session after session with the same patient. The problem usually lies not in the maladaptive beliefs of the therapist or patient but in the interaction between the two. This paper will introduce a simple tool for tracking problematic interactions between therapist and patient which can be used in supervision to identify unhelpful interpersonal patterns, and the underlying beliefs of patients and therapists that contribute to them. It can be used to pinpoint areas for further exploration of the patient's cognitions, for selecting intervention strategies to break the cycle and, because it is focused on the dyad, can be a non-threatening way in to discussing the supervisor's therapy-interfering beliefs.

#### **A qualitative study of the development of competence on a training programme in Cognitive Behavioural Therapy**

**Kate Sherratt, University of Reading**

The development of competence through clinical training is a widely accepted but rather mysterious process. There have been a range of studies using quantitative measures. These have produced mixed findings about the real impact of training on trainees' knowledge and skill development. Even where competence appears to have increased, a key difficulty highlighted by Muse and McManus (2013) has been the problem of separating the "wheat from the chaff" in terms of which training practices are most beneficial to student learning (e.g. didactic lectures, supervised practice, experiential workshops). None of these studies capture the internal journey that trainees embark upon when they begin their training as their own sense of competence develops, falters and matures in the process.

This presentation will focus on the findings from a brief qualitative study conducted with students undertaking IAPT High Intensity Training. A questionnaire was administered at the start, middle and end of the course asking trainees to comment on a number of areas. These included: their sense of a developing therapist identity, perceptions of change in their own practice, attributions for change, and how the course helped or hindered their change processes.

### **Training in Cognitive Behavioural Couples Therapy: a qualitative and quantitative investigation**

**Michael Worrell, Sarah Corrie, Central & North West London NHS Foundation Trust**

Whilst cognitive behavioural couples therapy (CBCT) is well established in the United States and elsewhere, it is currently experiencing significant growth and expansion in the UK. What is it like for therapists trained in individually focussed CBT to begin practicing CBCT? What clinical and professional challenges and rewards do they experience as they take on this new modality? This presentation describes the results of a qualitative investigation, using thematic analysis, of a group of individual CBT therapists who trained in CBCT and began applying this as a part of their regular clinical practice. Additionally, this presentation will describe the results of an audit study that examined the clinical outcomes for a group of individual CBT therapists who received training in CBCT and began applying this in routine practice.

### **The development and evaluation of an innovative e- learning resource for teaching CBT to Clinical Psychology Trainees**

**Neil Ralph, University College London**

The Health and Care Professions Council's standards for clinical psychology training in the UK dictates that all 'trainees' acquire proficiency in delivering Cognitive Behavioural Therapy (CBT). Clinical psychology training is a three year doctorate with knowledge and skill development occurring via lectures and placements in clinical settings. Lectures in CBT take place predominantly in the first year of a course however, trainees will practice the modality on most clinical placements throughout their three years. CBT training on the University College London (UCL) course is benchmarked against the Core Competency Framework (Roth and Pilling, 2007). Although sufficient classroom teaching in CBT is provided, it is not always possible for trainees to get an opportunity to benchmark their practice to the desired level whilst on clinical placement, especially once CBT teaching has ceased. Despite trainees receiving supervision from experienced clinicians on placement, the course is unable to adequately measure supervisors' level of skill in using CBT. In order to address these issues, UCL has devised an innovative e-learning resource that provides trainees with a catalogue of video tutorials that model the delivery of good enough CBT technique across a range of CBT competences; drawing upon social learning and experiential learning theories. The tutorials are delivered by competent practitioner level CBT therapists and use actors as clients. They are designed to be used in teaching as well as accessed through the internet at home or at a clinical setting. Innovative in these tutorials is the use of poor versions that demonstrate typical pitfalls, which can then be contrasted with the competent versions. This paper presents a small scale evaluation of the experience of using the tutorials, resulting in feedback that will be used to inform the future developments of programme.

### **Autistic traits across a range of clinical conditions: Clinical challenges and research developments**

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#### **Autism and autistic traits in non-autistic psychopathology**

**William Mandy University College London**

In this talk I will argue that autistic symptoms are commonly found in people who do not have a clinical diagnosis of autism spectrum disorder (ASD); and that these social and flexibility difficulties are risk factors for the development of non-autistic psychopathology. Evidence from clinical and general-population samples will be presented to show that

autistic difficulties co-occur with, and may indeed underpin, many cases of anorexia nervosa, conduct disorder and obsessive compulsive disorder. Thus, many individuals receiving clinical intervention for these disorders have substantial autistic difficulties that can be a barrier to successful treatment. The talk will finish by outlining ways of adapting existing psychological interventions to be suitable for individuals with autistic difficulties.

### **Autism Spectrum Disorders and Anorexia is there link? What it means in the context of the treatment?**

**Kate Tchanturia King's College London**

Anorexia Nervosa (AN) is a serious eating disorder with the highest mortality rate of any mental health problem. There is currently no first-line recommended treatment for AN with high relapse and treatment drop-out rates. One of the treatment challenges highlighted in recent years is the presence of elevated levels of autistic traits in the AN population. These traits, including cognitive inefficiencies in the set-shifting and central coherence have led to the development of new treatments in an attempt to specifically target the thinking styles found in the AN population. Experimental studies exploring the presence of autistic traits in AN including poor theory of mind, emotional intelligence, problems with expressing emotions and social anhedonia are presented. Two relatively new treatments for AN, namely Cognitive Remediation Therapy (CRT) and Cognitive Remediation and Emotion Skills Training (CREST) which aim to target some of the autistic-like traits found in people with AN have been piloted and delivered to patients with AN. Similarities in the presented domains are found between individuals with AN and those with Autism Spectrum Disorders (ASD). CRT and CREST have shown promising results in clinical trials, with changes in cognitive style following treatment, low treatment drop-out rates and high acceptability to both patients and therapists. There is strong evidence of cognitive similarities between individuals with AN and ASD, with therapeutic tools being informed by this research evidence. Future research will focus on whether individuals with co-morbid AN and ASD respond differently to treatment than patients with a diagnosis of AN alone.

### **Relationship between OCD and ASD; what happens to ASD traits following OCD treatment?**

**Amita Jassi South London and Maudsley NHS Trust, National Specialist OCD and related disorders clinic**

Obsessive Compulsive Disorder (OCD) is frequently reported in both children and adults with Autism Spectrum Disorders (ASDs) (McDougle et al., 1995; Russell et al., 2005 & Mack et al., 2010). There is often confusion in disentangling OCD compulsions from repetitive behaviours in ASD. However, symptoms of OCD found in the ASD population are comparable to those without ASD, with a few exceptions. Previous studies have found a significant correlation between ASD traits and OCD (Stewart et al, in prep). In this talk, I will be presenting data on the relationship between OCD severity (CY-BOCS) and ASD traits (Social Communication Questionnaire) in young people seen in a Specialist OCD clinic. Changes in ASD symptomology following OCD treatment will also be explored in both young people with and without ASD.

Anxious imagery in autistic and non-autistic populations

**Ann Ozsivadjian, Guy's and St Thomas' NHS Foundation Trust**

In the typically developing adult population, research has suggested mental imagery may play a role in the aetiology and maintenance of anxiety disorders such as social anxiety , OCD , and also eating disorders . Images can be extremely vivid, intrusive and more emotionally-laden than verbal thoughts; despite this, the latter have tended to be the focus of most cognitive behavioural research and intervention. Given that people with ASD are often thought of as 'visual thinkers', and experience high rates of anxiety disorders (prevalence rates of approximately 40% , compared to a rate of 2.4% in the typically developing population), we conducted an exploratory study investigating the role of imagery in anxiety disorders in ASD. In this talk, I will present qualitative and quantitative data from this study.

I will also discuss modifications to traditional CBT for people with ASD, with a focus on the added benefits of including imagery restructuring techniques in therapy.

## Beyond the trial centre: Researching and optimising PTSD techniques in routine clinical practice

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### **Imagery rescripting therapy: Session content, symptom improvement and the therapist experience**

**Caroline Salter, Royal Holloway, University of London;** Elle Parker, Royal Holloway, University of London

Intrusive images are a common phenomenon in Post-Traumatic Stress Disorder (PTSD; American Psychological Society, 2013). Imagery Rescripting (ImRs; Arntz Weertman, 1999) is an experiential technique for targeting intrusive images and is gaining popularity as a treatment for PTSD (Arntz, 2012). Although there is evidence to suggest that ImRs is an effective treatment of PTSD (see Arntz, 2012), it is currently unclear how ImRs works. The aims of the present studies were 1) to develop a coding scheme that captured important factors of ImRs session, 2) to apply this coding scheme prospectively to investigate how certain factors might relate to treatment outcome and 3) to understand therapists' experience of using ImRs and its efficacy. The first study used thematic analysis guidelines (Braun Clarke, 2006) as a basis for developing an ImRs coding scheme. Next, a single case experimental design was employed to track six participants over the course of their ImRs therapy for PTSD. Session content captured by the coding scheme was compared to changes in weekly outcome measures to investigate whether the presence of certain codes related to a reduction in PTSD symptoms. Results suggested a number of factors might be important for influencing treatment outcome including participant anxiety, the point at which change is introduced, the activation of old and new image and its associated emotions and cognitions, the believability of the re-script and whether ImRs has led to a change in attitude. The second study used grounded theory (GT) to investigate factors which led to a successful outcome by interviewing eight therapists who frequently used ImRs to treat PTSD. The GT analysis produced a model illustrating the process of using ImRs, consisting of four theoretical themes: using ImRs in PTSD, facing obstacles in working with the imagination, identifying the mechanisms of action and moving from the unknown to the known. The main suggested mechanisms of action involved re-establishing power and enabling an emotional shift to occur. Study strengths, limitations and clinical implications are discussed. Recommendations for future research including in-depth investigation of individual factors are suggested. Specifically, the need for increased understanding in to how ImRs might work is identified. In doing so, it is suggested that the use of ImRs can become a targeted, evidence-based intervention for traumatic memories that therapists can feel confident and comfortable using.

### **Returning to the scene of the trauma in CBT for PTSD: Why, when and how?**

**Hannah Murray, Traumatic Stress Service, South-West London and St George's NHS Trust;** Christopher Merritt, Institute of Psychiatry, Psychology and Neuroscience, King's College London; Nick Grey, Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Foundation Trust

Revisiting the scene of the traumatic event is often recommended as part of Trauma-focused Cognitive-Behavioural Therapy (TF-CBT) for Post-Traumatic Stress Disorder (PTSD). Yet, very little research has examined whether and how these visits are helpful in treatment, or how clients experience the site visit. Data is presented from a recent study carried out with service users who had revisited the scene of their trauma as part of TF-CBT (Murray, Merritt Grey, 2015). Feedback on the perceived usefulness of the visit was analysed qualitatively, using Grounded Theory methodology to generate a model of the effects of the site visit. Quantitative data were also gathered in order to assess various hypothesised functions of the site visit. Overall, the study found very high perceived usefulness reported by service users. The site visits appeared to have various functions, with themes including 'filling the gaps', 'learning from new experiences', 'different look and feel to the site' and 'facing fear and

overcoming avoidance', all emerging as processes which contributed to a sense of 'closure and moving on'. The role of the therapist in the site visit was also highlighted, as an emotional help and support, and to mitigate against any difficult experiences encountered. The qualitative and quantitative results fitted closely to the proposed functions of the site visit suggested by the Cognitive Theory of PTSD (Ehlers Clark, 2000). In addition to the study results, the presentation will include practical guidance about when and how to undertake a site visit in TF-CBT. Many therapists report a lack of confidence in using site visits and practical limitations to incorporating them in therapy. A framework for how to plan a site visit will be presented, covering areas such as engaging the client, risk assessment, as well as what to do while on the visit and how to manage potential problems. Case examples will be used to illustrate the key techniques, and to help therapists to achieve the maximum clinical benefit from the visit. Finally, the use of virtual and approximated site visits will be demonstrated, with the aim of helping clinicians to arrange site visits in difficult to access locations.

### **Intensive treatment formats for PTSD – Results of a case series, clinical guidelines and theoretical implications**

**Sharif El-Leithy, Traumatic Stress Service;** Hannah Murray, Traumatic Stress Service; Jo Billings, Berkshire Traumatic Stress Service

Trauma focused CBT has been shown to be effective in PTSD, and is recommended as first line treatment of choice (NICE, 2005). Generally this is delivered in a format of between 8-20 weekly sessions of 60-90 minutes each. However weekly therapy may not be ideal where the patient has significant commitments, such as work or childcare, and for those patients who desire more rapid symptom improvement. It may be that the weekly format is also based on assumptions about the process of therapy that are, to a large extent, untested. There has been recent interest in other treatment formats, particularly intensive programs where the therapy is delivered in multiple sessions each day, and across several consecutive days. Indeed a feasibility study of intensive cognitive therapy for PTSD (CT-PTSD) found equivalent outcomes and improved drop-out rates relative to weekly sessions (Ehlers, Clarke, Hackmann et al 2010). Compared to weekly sessions, intensive treatments may provide distinct advantages and be more acceptable to some patients. However there are particular challenges both for patient and therapist working in this format. This study presents the results of a case series of intensive CT-PTSD treatments, undertaken with a diverse group of patients across two routine clinical settings, and using a matched comparison group of those who undertook weekly therapy. The analysis also identified patient variables that might affect outcome differentially in intensive treatments, and are therefore relevant to treatment suitability. Examples are given of a range of intensive treatment formats, including classic intensive treatments over 1 week; "pulsed" treatments of 2 days across a number of weeks; and "enhanced" intensives, combining additional weekly elements in both the preparation (stabilisation) and consolidation (reconnection) phases. Case examples are presented, showing how the formats can be tailored to meet specific client presentations, such as patients with comorbid axis II disorders, multiple or sustained trauma histories including childhood sexual abuse, and with comorbid physical and pain problems. Video clips will also provide some qualitative data on patients' experiences of intensive treatments. Drawing on the case series, clinical implications, limitations and practice guidelines are then discussed. This includes how to plan for and structure intensive treatments for PTSD; procedural rules to help implement them successfully; and consideration of the advantages and challenges these formats present across the range of presentations in routine practice. Also discussed are the specific supervision issues and the possible role of intensive treatments in training and development of therapists. Finally there is consideration of how the results of intensive treatments might inform ideas both about patient recovery and the processes maintaining PTSD.

### **"Living a life that should not be lived" Survivor guilt: conceptualisation and treatment**

**Evelina Medin, Royal Holloway, University of London;** Yasmin Pethania, University of Surrey; Hannah Murray, Traumatic Stress Service, South-West London and St Georges NHS Trust; Gary Brown, Royal Holloway, University of London; Dora Brown, University of Surrey

'Survivor guilt' is commonly referred to in clinical settings and in popular culture, however the phenomenon has largely been neglected in trauma-related research. There is a scarcity of research on its phenomenology and underlying mechanisms, and there are no published studies to date that investigate treatment options for survivor guilt after trauma. Data is presented from two studies. The first study set out to understand how individuals interpreted and made sense of surviving a traumatic event where others had died. The study employed a qualitative methodology. Six participants that had a diagnosis of Post-Traumatic Stress Disorder (PTSD) and had survived a traumatic event where others had died were interviewed. Interpretative Phenomenological Analysis was used to analyse the interview data. The results generated a theoretical model related to the participants' experiences. Central to the model was persistent guilt about surviving and a sense of disenfranchisement to life (which could be conceptualised as shame) driving internal and external processes. The model will be presented alongside interview data that illustrates each component of the model. The second study was a small scale proof-of-concept trial of imagery rescripting as a therapeutic technique for survivor guilt. Imagery rescripting involves mental manipulation of distressing imagery with the aim to update its meaning and change the emotional valence of the imagery. Imagery rescripting is considered a particularly useful technique for clients with PTSD who experience strong feelings of guilt or shame. Ten participants attended two imagery sessions. Participants had a diagnosis of PTSD, had survived a traumatic experience where others had died and reported survivor guilt. The first session was a control session which focused on exploring and elaborating the distressing imagery. The second was an experimental session in which distressing imagery was modified using an imagery rescripting procedure. A flexible protocol was used and participants were encouraged to change the imagery in whatever way they felt would be helpful. The sessions were delivered consecutively as an additional component to standard Trauma-Focused Cognitive-Behavioural Therapy. The impact of imagery rescripting on the experience of survivor guilt, as well as related cognitions and images, will be presented. The respective contributions of exploration and rescripting techniques will be discussed. Case examples will demonstrate how creative mental imagery can be used to reduce survivor guilt after trauma. The rescripts that appeared most useful will be discussed in light of the mechanisms that may underpin survivor guilt as suggested in the model. Areas for further research will be highlighted and the implementation of small-scale research trials within routine treatment will also be considered.

## Travelling Symposium – Mind the Gap: Bringing Together Psychopharmacology and Cognitive Behavioural Therapy

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### **Experimental psychopathology and intrusive emotional memory**

**Emily A. Holmes, Medical Research Council Cognition & Brain Sciences Unit, Cambridge and Karolinska Institutet, Stockholm.**

Emotional, intrusive memories “flash upon the inward eye” causing distress across mental disorders. They can flash back to the past or flash-forward to the future. Intrusive memories of trauma are the hallmark of post-traumatic stress disorder (PTSD). “Flashforwards” to future suicidal acts or manic pursuits occur in bipolar disorder<sup>1</sup>. My group is interested in the form taken by intrusive memories – that is, mental imagery - using an experimental psychopathology approach.

Experimental psychopathology involves laboratory-based research aimed at discovering and explaining the aetiology and maintenance of psychopathological processes, potentially contributing to the amelioration of dysfunction through intervention and prevention. Neuroscience reveals that mental imagery involves an experience like perception in the absence of a percept: seeing in our mind's eye, hearing with our mind's ear and so forth. Imagery recruits similar brain areas to perception, enhances memory and learning, and has

a powerful impact on emotion. We discuss two areas introducing an imagery approach to treatment innovation.

(I) We lack preventative interventions after a trauma. We can exploit the properties of imagery (its vividness can be dampened by imagery-competing tasks) plus memory reconsolidation (it is labile when reactivated). After experimental trauma, using a cognitive blockade of memory reactivation plus the computer game "Tetris", reduced the frequency of intrusive memories<sup>2</sup>. Brief cognitive task protocols may provide a "cognitive vaccine" to prevent post-traumatic stress symptoms.

(II) Bipolar disorder treatments require improvement. We have hypothesized that bipolar disorder is characterised by an excessive use of mental imagery. Bipolar anxiety is highly prevalent, involving "flash-forwards" to future scenarios. We have developed a new treatment protocol to tackle such imagery, and thereby improve overall mood stability. These examples drew on cognitive science and neuroscience, animal and human work, pharmacology and CBT perspectives in their development. More broadly, bridging between different levels of mechanisms<sup>3</sup> - behavioural, cognitive, neural and molecular and so forth, may offer treatment innovations, including those that look little like existing ones.

1. Hales, S. A., Deeproose, C., Goodwin, G. M. & Holmes, E. A. Cognitions in bipolar disorder versus unipolar depression: Imagining suicide. *Bipolar Disorders* 13, 651-661 (2011)

2. James, E. L. et al. Computer game-play reduces intrusive memories of experimental trauma via reconsolidation update mechanisms. *Psychological Science* (in press)

3. Holmes, E. A., Craske, M. G. & Graybiel, A. M. A call for mental-health science. Clinicians and neuroscientists must work together to understand and improve psychological treatments. *Nature* 511, 287-289, (2014)

### **Psychological mechanisms of antidepressant drug action**

**Catherine Harmer, University Department of Psychiatry, Oxford,**

Cognitive and pharmacological approaches to depression are often considered independently from one another and can be viewed as competing explanations. However, recent evidence challenges this division and shows that antidepressants affect cognitive mechanisms important for the maintenance of depression very early in treatment. For example, a single dose of an antidepressant reduces negative affective bias in depression by increasing the recognition of positive facial expressions and enhancing memory for positive vs negative information (Harmer et al 2009). At a neural level, these early changes in emotional processing are related to re-tuning fronto-limbic circuitry important for the detection and response to biologically salient information. Hence, 7 days treatment with the SSRI escitalopram reduced neural response to negative facial expressions in depressed patients compared to double blind administration of placebo (Godlewska et al., 2013). Although these changes in neurocognitive processing occur before clinical changes in depression are seen, they are predictive of later clinical response. These results are therefore consistent with the view that antidepressants work via early correction of negative bias and the delay in response reflects the need for changes in processing to interact with everyday events, stressors and cues. As such, antidepressants may not be direct mood enhancers but affect the cognitive mechanisms important for maintenance of depression. These changes are seen with a range of different antidepressant agents, including those acting via different neurochemical targets such as ketamine and St Johns Wort. Early changes in emotional processing with psychological treatment have been studied less but a single session of cognitive behavioural therapy for panic disorder with agoraphobia was associated with reduced processing of threat before therapeutic response and this early change predicted subsequent recovery (Reinecke et al. 2013). These results suggest that effective treatments may target the processing of emotional information and that this may transcend traditional treatment divisions or boundaries. This approach offers a framework by which novel treatment approaches may be formulated and screened. In particular, this approach offers hypotheses about how to best combine psychological and pharmacological strategies for depression and anxiety.

Harmer et al., (2009) *Am J Psychiatry*. 2009 Oct;166(10):1178-84.

Godlewska et al (2012) *Psychol Med.* 2012 Dec;42(12):2609-17.  
Reinecke et al (2013) *Biol Psychiatry.* 2013 Jun 1;73(11):1064-70.

### **Experimental medicine approaches in anxiety disorders**

**David Baldwin, University of Southampton**

Although a large number of pharmacological and psychological approaches have been found efficacious in the short-term and long-term treatment of patients with anxiety disorders, many treatment-seeking patients will not respond to current interventions, despite having features suggestive of a good prognosis. Others will respond, but then stop pharmacological or psychological treatment early because of untoward effects such as treatment-emergent sexual dysfunction, drowsiness and weight gain, or reluctance to continue with previously successful homework tasks and techniques. Guidance from the British Association for Psychopharmacology summarizes treatment options for patients with anxiety disorders including those who have not responded to (or proved intolerant of) first-line treatments (Baldwin et al., 2014).

There is certainly much scope for refining animal models of anxiety disorders and the methods for establishing likely anxiolytic properties (Haller et al., 2013): but it has been argued that successful further development of novel anxiolytics is dependent upon a refined biomarker approach combining genetic, cognitive and neuroimaging measures (Insel et al., 2013). Confirming the potential benefit of novel treatments in the necessary large randomised controlled trials is a time-consuming and costly endeavor: so experimental medicine studies in healthy volunteers represent a useful 'proof-of-concept' approach for determining whether to proceed to these expensive pivotal efficacy studies.

Investigations of challenge of healthy volunteers with inhalation of air 'enriched' with 7.5% carbon dioxide (CO<sub>2</sub>) suggest this technique provides a robust experimental medicine model of generalized anxiety, mirroring the subjective, autonomic and cognitive features of GAD. Prior administration of duloxetine, memantine, instruction in mindfulness techniques, and use of transcranial direct current stimulation can all mitigate against at least some of the effects of CO<sub>2</sub> challenge: and suggest this model may be useful in the evaluation of potential innovative pharmacotherapies or psychotherapies at the proof-of-concept stage.

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### **Targeting core psychological dysfunctions in addiction**

**Matt Field, University of Liverpool**

Addiction can be successfully treated with pharmacotherapy, psychological treatments such as cognitive behavior therapy (CBT), or novel interventions such as cognitive bias modification. Unfortunately there is enormous variability in patient response to treatment, with multiple relapses the norm before patients eventually recover. Therefore it is important to develop and evaluate novel treatments for addiction, and to tailor treatment to individual patient characteristics if possible.

I will argue that we can maximise the speed and efficiency of the development of novel treatments if we focus on psychological dysfunctions that play a key role in addiction. I use the example of poor impulse control because it is associated with addiction and clearly implicated in its onset and in relapse to substance use after treatment. I will demonstrate that impulse control can be targeted and improved by conventional cognitive behaviour therapy (Ryan, 2013), but also by computerised cognitive training interventions (Jones & Field, 2013) and medications such as modafinil (Schmaal et al., 2014). Moreover, improvements in impulse control that arise as a result of these treatments may be associated

with recovery from addiction. There is no reason not to combine these different types of treatment, and further research is required to investigate if a combination of pharmacotherapy and psychological treatments can maximise improvements in impulse control, and if this would translate into improved treatment outcome. Furthermore, some addicted patients recover without formal treatment, and changes in impulse control may be associated with their recovery. I conclude that this general approach can be applied to other important psychological dysfunctions in addiction, such as affect regulation and automatic responses to substance-related cues.

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### Working with anxiety-disordered children: The importance of parents

#### **Guided Parent-delivered Cognitive Behavioral Therapy for Childhood Anxiety: Predictors of Treatment Response**

**Kerstin Thirlwall, University of Reading;** Cathy Creswell, University of Reading; Peter Cooper, University of Reading

Guided Parent-Delivered CBT (GPD-CBT) is a low intensity form of CBT that requires less therapist contact and fewer resources than standard forms of CBT for childhood anxiety disorders. This approach involves parents being guided in implementing CBT strategies in their child's day to day life and has been shown to be an effective treatment for anxiety disorders in children with outcomes similar to those found from more intensive CBT delivered face to face with children and parents. The treatment lends itself well to a possible 'stepped care' service model, in which low-intensity treatments are routinely administered and more intensive treatments are reserved for those who may require more specialist input. The success of this delivery model is, however, reliant upon clinicians making informed decisions regarding suitability for low-intensity treatment and 'stepping up' service users to higher intensity treatments when warranted. In order to aid clinical decision making, the current study investigated demographic and clinical predictors of response to Guided Parent-delivered Cognitive Behavior Therapy (GPD-CBT) in 125 clinically anxious children aged 7 – 12 years, who received GPD-CBT as part of a larger randomized controlled trial. Response was measured at two time points (post treatment and six month follow up) and was determined using two separate binary gages; recovery from primary diagnosis and recovery from all anxiety diagnoses. The findings from this study will be presented.

#### **Brief guided parent-led CBT for childhood anxiety disorders compared to Solution Focused Brief Therapy: A randomised controlled trial**

**Cathy Creswell, University of Reading;** Liz White, University of Reading; Hannah Fairbanks, University of Reading; Gemma Abitabile, PCAMHS Oxford Health NHS Foundation Trust; Monika Parkinson, University of Reading

Anxiety disorders in children are common and can be associated with long-term adverse outcomes. However families often struggle to access evidence based treatments. Guided parent-delivered CBT (GPD-CBT) offers a low intensity approach to treatment for children with anxiety disorders, and has established clear benefits over a waitlist comparison (Thirlwall et al., 2013). It remains unknown however whether this approach is more cost-effective than alternative brief treatments commonly used within child and adolescent mental health settings. This paper will present findings from a randomised controlled trial comparing this brief CBT approach to an alternative brief psychological treatment (Solution Focused Brief Therapy; SFBT). 136 children (5-12 years), referred to Oxfordshire Primary CAMH Service for a primary anxiety problem, were randomised to receive either GPD-CBT

or SFBT. Both treatments involved approximately 5 hours of therapist input. Blind assessors conducted diagnostic assessments post-treatment and at six month follow-up. Participating children and their parents also reported on anxiety and comorbid symptoms and provided information to inform a full health economic evaluation of outcomes. Clinical and economic outcomes will be presented and the implications for first-line treatments of childhood anxiety disorders will be considered.

**Fear-less Triple P: An intervention for the parents of anxiety-disordered children  
Vanessa Cobham, University of Queensland**

Anxiety disorders are the most common form of psychopathology reported by children and adolescents. They tend to be associated with significant psychosocial impairment, poor prognosis, development of other psychopathology, and poorer family functioning. The vast majority of anxiety-disordered children (>80%) never receive treatment. Child-focused CBT is the gold standard treatment, with an average diagnostic remission rate of 56% at posttreatment. To date, few programs have worked exclusively with the parents of anxiety-disordered children and adolescents.

Fear-less Triple P is a 6-session program designed to produce radiating effects within the families of anxiety-disordered children. Sixty-one families of anxiety-disordered children were randomly assigned to either a Waitlist (WL) control condition or the Fear-less condition. Diagnostic interviews, parent-report and self-report measures were completed at post-treatment, 3-mth, 6-month and 12-month follow-up. Across measures, the data indicates strong improvement for children in the Fear-less condition compared to children in the WL condition. These improvements are maintained (and indeed improve) over the follow-up period.

**How do Anxious Parents Respond to Children's Fear, and can their Behaviours be Modified?**

**Sam Cartwright-Hatton, University of Sussex; Donna Ewing, University of Sussex; Alison Pike, University of Sussex; Suzanne Dash, University of Sussex; Chian Mei Ang, University of Sussex; Ellen Thompson, University of Sussex**

Parents are thought to play a role in children's acquisition of fears, but the particular parenting processes involved in this are under-explored. Following Rachman (1977), we hypothesized that negative information, direct conditioning and vicarious learning would play a role. We hypothesized that a short tutorial, educating parents about these processes, would modify parenting behaviour, and result in increased confident behaviour in children. A group of parents with anxiety disorders and a group of parents without, were invited into the laboratory with their child (aged 5-9). The child was shown a list of potentially phobic stimuli (e.g. spiders, snakes, worms) and was asked to select two that they were afraid of. One of these stimuli was randomly selected and parents were given a box containing items relating to it (ranging from drawings to live or taxidermy-prepared animals) and were asked to help the child to approach them (beginning with the least fearful items and working up to the most). Videos of these interactions were coded for parenting behaviours (criticism, encouraging/reinforcing approach, encouraging/reinforcing avoidance, confident/fearful verbal information, positive/negative modeling) and for child fearfulness and approach. Parents were then randomly assigned to watch either a) a short film teaching behaviours that parents can use to increase 'bravery' in children, which covered the behaviours described above, or b) a control film. The exposure exercise was then repeated with the second fearful stimulus. Analyses indicated that a number of parenting behaviours were associated with children's fearfulness and approach behaviours. The video tutorial resulted in positive changes in parenting behaviours and increases in children's approach towards the stimuli. This was the case for both clinically anxious and non-anxious parents.

**Understanding and Treating Bipolar Disorder: Results from the PARADES  
NIHR Research Programme**

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No abstracts provided.

### **Experiences of delivering DBT-informed care across the Acute Care Pathway**

**Natalie Hulme, Southern Health NHS Trust** and Hannah Wilson, Southern Health NHS Trust

DBT has been shown to be an effective treatment for BPD both in outpatient settings (e.g., Linehan et al., 1999; Verheul et al., 2003) and within inpatient acute care services. Bohus et al., (2000 and 2004) have shown DBT care to reduce a number of factors in acute care adult mental health settings: inpatient days, emergency admissions, suicide attempts and the frequency and severity of suicidal and parasuicidal behaviour. Over the last five years Melbury Lodge, the acute care adult mental health hospital serving the area of West Hampshire (which includes a 24 bed adult mental health ward, an acute care mental health team (formerly CRHT) and a 10 bed regional mother and baby unit), has been developing and implementing a DBT-informed approach. This approach is delivered by a number of modalities; staff training, a brief DBT-informed emotional coping skills group programme supported by concurrent individual therapy sessions, daily mindfulness groups, consultation meetings for DBT trained staff, out of hours skills coaching, and in vivo chain analysis plus skills coaching supported by the ward nursing staff. The study will present our experiences of using a DBT informed approach across these settings. Data will be presented on the effectiveness of our 8 session emotional coping skills group including direct service user experience adding to the existing evidence base of such programmes (e.g. Sambrook, et al., 2007 and Durrant, et al., 2007). Staff views will also be shared on the impact the approach has had on their practise as well as the wider therapeutic milieu. We will also reflect on the challenges of maintaining this approach within acute care settings.

### **RO-DBT in practice with clients with severe eating disorders**

**Joanna Miatt, Derbyshire Healthcare NHS Foundation Trust** and Donald Wilbur, Derbyshire Healthcare NHS Foundation Trust

Working in a specialist community eating disorders service working with adults with severe Anorexia Nervosa is a challenge. given the lack of clinical evidence for effective psychological treatments for people with anorexia nervosa , NICE 2004 (currently under review). As a specialist community eating disorders team we started to explore which treatments may be beneficial in clinical practice. In 2010 the team looked at the application of standard dbt to with clients with anorexia nervosa. In 2013 the team started to explore the application of RO-DBT to this client group. This presentaion looks at the main themes of the model, the specific factors consider in applying this to clients with severe anorexia nervosa and our preliminary thoughts about the value of this therapy.

### **Development of an adapted DBT programme in a high secure forensic learning disability service - ten years on**

**Bridget Ingamells, Nottinghamshire Healthcare NHS Trust** and **Catrin Morrissey, University of Nottingham**

This presentation focuses on the process of developing and modifying standard DBT intervention in order to apply it effectively within a high secure service for men with intellectual disabilities and forensic backgrounds. With the first pilot programme being delivered in the service in 2004, this process has continued for more than 10 years. The approach has culminated in a published adapted skills programme manual and accompanying materials ("I can feel good", Ingamells and Morrissey, Pavilion, 2014), which can be used with a wide range of client groups. The adaptations to the processes and techniques, content of skills modules, and to the individual therapy mode will be described. However the overarching theme is that there needs to be consistent innovation by therapists in order to deliver 'what works' for this complex group of clients.

### **DBT with disadvantaged ('street') children in India**

**Fiona Kennedy, Greenwood Mentors Ltd,** and David Pearson, Greenwood Mentors Ltd

Adversity has profound effects on child development and child and adult mental health. In India, in 2006, 48 per cent of children under five were stunted in their growth. The effects of malnutrition and neglect go further than this. When a child's growth slows, psychological development slows or stops. Cognitive, behavioural, emotional and attachment problems commonly result. This paper describes the authors' work with Dream A Dream, a non-governmental organisation in India. The mentoring programme pairs privileged Indian volunteers with rescued street children. Training for mentors is DBT based, including acceptance (validation), and behaviour analysis and change, these sessions use modelling and role play to teach mentors to manage the relationship, build an attachment and empower the young person to solve problems. The Life Skills Assessment Scale, a standardised published scale we developed, along with qualitative data, has shown great improvements in life skills acquisition as compared with other young people not receiving the mentoring programme. Over the past nine years, around 1,500 mentors have been trained and gone onto mentor approximately 3,000 young people. Many are now young adults with jobs and relationships, and an ongoing connection with the mentor that helped them so significantly at a time of transition. It may prove possible over time to bring CBT to the developing world using existing models of delivery. Given the vast prevalence of adversity and failure to thrive, however, this type of targeted service using volunteers with no mental health background is an option we believe has the potential to match the challenges posed by the sheer size of the problem.

## Therapist Drift in the Delivery of CBT: Convergent evidence from multiple perspectives

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### **What is really going on in the therapy room? Patients' self-reported experiences of cognitive behavioural therapy for eating disorders.**

**Natasha Cowdrey, University of Sheffield**

The focus of the limited amount of research examining the content of psychological therapy has generally been from the clinicians' perspective, using their retrospective accounts of the therapy provided. Such studies examining clinicians' self-reported use of CBT for the eating disorders indicate that patients are offered treatment that deviates significantly from evidence-based protocols. This presentation will consider the patient's perspective, asking what they experienced in CBT for their eating disorders. It will present findings from a survey-based study examining what techniques were delivered as part of their CBT, and patients' perceptions of the acceptability of what is and what is not delivered. Patients reported variable use of evidence-based and unsupported techniques, with clinicians falling into different groups, delivering different patterns of treatment. Those 'types' of therapy were related to patients' self-rated outcomes. Finally, characteristics of the patient and therapist were examined to see if they influence the pattern of intervention delivered. Limitations of the study will be considered alongside directions for future research, before considering the clinical implications of the findings.

### **Therapist drift in delivering CBT for eating disorders: Formulating the problem**

**Glenn Waller, University of Sheffield**

It is well established that therapists offer CBT for eating disorders far less often than evidence-based guidelines would suggest, and that when they do offer CBT it is commonly delivered in sub-optimal ways. This presentation will consider the reasons why we routinely fail to use evidence-based methods when they would be indicated. It will present evidence from a series of studies, showing that we are influenced by our emotions (e.g., anxiety), our beliefs (e.g., regarding different elements of CBT that are worrying to deliver), our safety behaviours (e.g., avoidance of key elements), our failure to use manuals/protocols, and our lack of knowledge of those methods. The interaction between these elements will be considered to explain how non-delivery of CBT for eating disorders is maintained. Suggestions will be made for how we might adopt a CBT perspective in ensuring that CBT clinicians stay on track to deliver the optimum therapy for eating disorders.

### **Therapist self-appraisal and use of CBT for treating anxiety disorders**

### **Zachary J. Parker, University of Sheffield**

The literature suggests that cognitive behaviour therapy (CBT) for anxiety used in a real world clinical setting does not have as strong an effect as found in efficacy studies. This presentation will address potential causes of the difference between efficacy and effectiveness outcomes in the treatment of anxiety disorders. Evidence will be shown that core clinical skills (e.g., exposure) are not being utilized as expected according to the manuals for treatment. This is evidence that therapists may not be delivering interventions at optimal levels. Despite evidence to the contrary, therapists still tend to believe that their own abilities are superior to those of their peers, and those estimations are related to their personality characteristics. Suggestions will be made for how to improve delivery of CBT for anxiety, and future research will be outlined.

### **Clinical supervision: The role of patient, therapist and supervisor characteristics**

#### **Chloe Simpson-Southward, University of Sheffield**

Psychological treatments for depression are not always delivered consistently or effectively. Supervision of therapists is often assumed to keep therapy – and therapists – on track. While there are numerous theoretical models of supervision, there are very few empirical studies assessing what actually happens in supervision or its impact on therapy and, ultimately, patient outcomes. This talk discusses two recent studies which take an experimental approach to investigating the content of clinical supervision for therapists working with patients with depression. Supervisors indicated their supervision focus for a series of vignettes, each representing a patient's case brought to them by their supervisee. The vignettes varied in either patient characteristics (case complexity) or therapist characteristics (anxiety level and gender). As might be expected, patient case complexity had an impact on the focus of supervision. Less expected is the finding that therapist anxiety impacts supervisory focus but only when the therapist is female (this is regardless of supervisor gender). Finally, naturally occurring supervisor clusters emerged based on supervision focus. Which cluster supervisors fell into was related to their personal characteristics. Findings indicate that supervisors are influenced by factors outside of supervision. Those factors might cause them to drift away from stressing the importance of evidence-based aspects of therapy. This supervisory drift may, in part, lead to therapist drift.

## **Adults with Severe Mental Health Conditions: Investigating the Benefits of Carer Interventions**

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### **Promoting the Inclusion of Families within the Acute Inpatient Care Pathway**

#### **Rumina Taylor, South London and Maudsley NHS Foundation Trust**

The Schizophrenia Commission (2012) showed carers to save the public £1.24 billion per year but that they were not receiving adequate support or treated collaboratively. Research has confirmed that caregivers experience high levels of distress especially in the context of inpatient admissions (Boye Malt, 2002). Clients from our wards are often discharged back into the care of their family. Working more closely with family members is likely to have benefits for risk management in the post-discharge period and has the potential to reduce readmissions. There is evidence that family intervention in psychosis (FIp) does work in consistently reducing relapse (NICE; National Institute for Health and Care Excellence, 2014). A number of national policies have highlighted the importance of working collaboratively with carers and clients and that FIp should be offered to all those with psychosis (NICE, 2014). Therefore, we were keen to improve access to psychological intervention for clients and carers from our wards. Three different types of intervention across the acute wards within the Gresham Unit (Gresham 1, 2, and PICU) were implemented over 18 months. A family 'awareness-raising' teaching session was provided to staff. A carers' clinic was made available on Gresham PICU and Gresham 1 and on Gresham 2 structured family work was offered to clients with a schizophrenia spectrum diagnosis and their families. This consisted of Behaviour Family Therapy (BFT; Falloon et al., 2006) as recommended by NICE (2014). In addition to evaluating the rate of attendance and carer

satisfaction, the number of ward complaints received was collected. Structured family work was evaluated using pre-post questionnaires assessing carer and client distress, wellbeing, and perceptions of illness. Readmission rates were recorded using patient notes. A total of 48 staff attended training. There was an increase in the number of family-staff interactions on PICU following training. Sixty carers attended the clinic with 100% being very satisfied/satisfied and all stated they would recommend the service. FIp has been provided and 76% of carers/clients reported having made a lot of progress during the sessions and 81% felt they would be able to continue to make a lot of progress. Pre/post outcome measures showed client and carer distress reduced and well-being increased; family members felt less burdened; carers also perceived their loved ones' illness as less threatening, meaning they had a greater understanding and felt more in control of symptoms. Prior to FIp 62% of carers reported having someone to confide in. This increased to 92% following FIp. Data on readmissions over a 3, 6-month, and 1 year period at this time shows clients are extending their time in the community following FIp suggesting this intervention supports greater resilience. Client and carer complaints reduced since implementation of the service. Despite the difficulties implementing family work on the wards thus far, it remains highly indicated given the evidence base, NICE (2014) guidelines, and the Triangle of Care (2013). This study has shown that it is possible to develop and implement an effective service within the acute pathway in a relatively short time frame.

**Acceptability and feasibility of self-help Cognitive Remediation Therapy for Anorexia Nervosa delivered in collaboration with carers: A qualitative evaluation of a pilot study.**

**Katie Lang, Kings College London;** Janet Treasure, Kings College London; Kate Tchanturia, Kings College London

Anorexia Nervosa (AN) is an eating disorder with no recommended first-line treatment. Cognitive Remediation Therapy (CRT) is showing great promise in helping patients reduce high levels of cognitive rigidity and excessive detail focus, a processing style which could make engaging in psychological therapies difficult. CRT has shown to be successful in both individual and group formats, and positive qualitative data has been gathered from both service users and clinicians. The aim of the current study was to assess the use of CRT as a self-help treatment delivered in collaboration with carers. Six families underwent a six-week self-help CRT intervention. Feedback was gathered from qualitative interviews and analysed using thematic analysis. Neuropsychological outcomes were also collected. Participant's feedback regarding the intervention was generally positive, with participants describing a number of benefits such as it creating a space for families to spend time together outside of the eating disorder, acting as a 'gateway' for more emotional work and helping participants to gain insight into their cognitive profiles. These preliminary findings suggest that self-help CRT delivered in collaboration with carers is an acceptable form of treatment, and adds to the growing literature supporting CRT for eating disorders.

**Early course psychosis carers cognitive model of illness rapidly improves with brief group psychoeducation**

**David Raune, Central & North West London Foundation NHS Trust** and Shireen Rahim, Central & North West London Foundation NHS Trust; Naomi Glover, University College London; Gareth James, University College London; Roya Afshar zadegan, University of East London; Saal Seneviratne, Central & North West London Foundation NHS Trust; Chris Ugochukwu, Central & North West London Foundation NHS Trust

Evidence is accumulating that carers beliefs about psychosis - such as the content, cause, course, and consequences of the psychosis for themselves and patients - are important influences on early course psychosis carers psychological outcomes (Barrowclough et al., 2014; Jansen et al., 2015). Specific example outcomes include well-being (Addington et al., 2003), positive experiences and subjective burden (Onwumere et al., 2008), Expressed Emotion (Dominguez-Martinez et al., 2014) and burnout (Onwumere et al., in press). We therefore tested if a brief early intervention psychoeducational group, which included a specific therapeutic focus and measurement of a range of key illness beliefs, could improve those beliefs. A Clinical Psychologist (DR) and a Consultant Psychiatrist (SR) devised a three-

session (total six hours) psychoeducation group intervention. Session 1 focused on the nature, causes and consequences of psychosis. Session 2 focused on factors that drive carers' psychological outcomes and cognitive-behavioural strategies that may reduce such outcomes. Session 3 focused on overall caring styles (Kuipers et al., 2010) and cognitive-behavioural strategies for specific common problems in psychosis, including additional problems raised by the group attendees. Bibliotherapy was used in the form of the Oxford booklet for Carers (Rouf et al., 2008), a self-help booklist, and a copy of the psychoeducational intervention powerpoint handout. Carers' beliefs about psychosis were measured before and after the intervention using a self-report questionnaire mainly based on a brief adapted version of the Illness Perception Questionnaire for Relatives (Lobban, et al., 2005). A single question was devised for each belief dimension on a 0-100% scale. Wilcoxon Signed Ranks test without and with Bonferroni correction tested for statistically significant changes. One-hundred-and-forty-nine carers attended across four groups. Carers were mainly female, mainly mothers, and more than one-quarter ethnically non-White. Sixty-seven (45%) of carers attended at least two sessions, and provided complete before and after effectiveness data. Statistically significant changes ( $P < 0.05$ ) occurred in carers on a range of key beliefs about psychosis. Our study shows that brief group psychoeducation can rapidly improve early course psychosis carers key beliefs about illness. Services may wish to consider including this type of clinically and economically efficient intervention. Future intervention research could now test the extent to which changing these early and clearly rapidly malleable beliefs leads to improvements in a range of carer negative and positive psychological outcomes.

### **The impact of caregiving in Hoarding Disorder: piloting a brief psychoeducational group for relatives of hoarders**

**Claire Thompson, Institute of Psychiatry, King's College London;** Lorena Fernández de la Cruz, Karolinska Institutet / King's College London; David Mataix-Cols, Karolinska Institutet / King's College London; Elizabeth Kuipers, Institute of Psychiatry, Psychology and Neuroscience, King's College London; Juliana Onwumere, Institute of Psychiatry, Psychology and Neuroscience, King's College London

Hoarding Disorder (HD) is a newly recognised mental health condition in the DSM-5 (APA, 2013) which is commonly associated with substantial functional disability and represents a major public health burden. It is becoming increasingly clear that hoarding problems can also have a major impact on the relatives (carers) of people who hoard. Carers of people who hoard have high levels of caregiver burden, equivalent to that experienced by carers of people with dementia (Drury et al., 2014), and poor quality relationships with their hoarding relative (Tolin et al., 2008). Previous research has suggested that carer interventions would be well received and improve carer distress and interactions (Sampson et al., 2012; Chasson et al., 2014). However, we have only limited understanding of the overall impact of hoarding on family members and only one small study has reported outcomes for carers. Further exploration and evaluation of interventions to address the needs of carers of people with HD is indicated. The aim of the current study was to evaluate the impact of a brief CBT based intervention for carers of people with HD in terms of understanding of HD, wellbeing, burden, and coping efforts. Twelve carers of people with HD took part in a 6-week manualised psychoeducational CBT-based group, with a 1 month follow-up. Measures were taken at pre, post and follow-up. The results indicated a significant improvement in carer well-being, positive experiences of caregiving and understanding of HD after the group. Hoarding disorder can have a substantial negative effect on families. The data presented offers encouraging findings that that carer interventions in HD might be helpful in improving carer understanding, positive aspects of caregiving and well-being. Future directions and clinical implications will be discussed.

### **What should clinicians do to best support relatives of people with Bipolar experiences?**

**Fiona Lobban, Lancaster University**

Relatives supporting people with Bipolar Disorder face many challenges. Some of these are common to relatives supporting people with other long term mental health problems, such as psychosis. Consequently, the recent NICE Guideline for Bipolar makes many cross references to the guideline for psychosis and schizophrenia when recommending support for carers. However, there are also some important differences which lead to specific needs for relatives, requiring more tailored interventions. Here we explore the qualitative experiences of relatives of people with Bipolar and their self-identified needs, review the evidence for effective targeted interventions, and draw out the consequent clinical and research recommendations.

## Rumination and Cognitive Processes in Depression

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### **The contribution of transdiagnostic deficits in disengaging internal attention to rumination and worry**

**Ann Martin, The University of New South Wales;** Michelle L. Moulds, The University of New South Wales

It is well established that repetitive thought processes such as rumination and worry are involved in the aetiology and maintenance of emotion-based disorders such as depression and anxiety. However, relatively little is known about the mechanisms that drive such unconstructive repetitive thought. The impaired disengagement hypothesis (Koster, De Lissnyder, Derakshan, & De Raedt, 2011) postulated that rumination and worry are the result of deficits in an individual's ability to disengage their attention from salient negative material. While there is some support for this hypothesis, methodological factors have limited the conclusions that may be drawn from existing studies. The stimuli used in previous studies have been inconsistent and have failed to distinguish between threat-related stimuli and negative stimuli more generally. As a result, the extent to which the attentional deficits observed in rumination and worry represent a transdiagnostic mechanism also remains unclear. The present study aimed to resolve the methodological considerations that limit inference by modifying the stimuli and computations previously used with the Internal Shift Task (IST; Lo & Allen, 2011). The modified IST included three task versions which alternately examined disengagement from threat-related stimuli, dysphoric stimuli, and emotionally neutral stimuli. Preliminary results suggest that both rumination and worry are associated with attentional deficits that are specific to disengaging from negatively valenced mental representations. These findings provide insight into cognitive vulnerabilities that may drive unconstructive repetitive thought and undermine treatment effectiveness. However, it should be noted that these findings do not allow for causal inferences and a subsequent experiment is planned to assess causality by training attentional disengagement.

### **The relationship between mind wandering and positive emotion experience in depression.**

**Grace Fisher, Mood Disorders Centre, University of Exeter;** Barnaby Dunn, Mood Disorders Centre, University of Exeter; Kim Wright, Mood Disorders Centre, University of Exeter

Anhedonia – a loss of interest and pleasure – is a core symptom of depression that predicts poor prognosis but is arguably relatively neglected in classic CBT approaches (Dunn, 2012). To improve the capacity to treat anhedonic symptoms in CBT, we need to understand what psychological mechanisms cause it. One mechanism shown to blunt pleasure experience in the general population is mind wandering – the tendency for our minds to drift from the here and now onto our own private thoughts and feelings (Killingsworth & Gilbert, 2010). While we know that mind wandering is elevated in depression, it has yet to be evaluated if this elevation in part drives anhedonia in the disorder. This talk will present recent data from a series of studies evaluating this claim. First, data examining the link between mind wandering and pleasure experience during lab tasks and naturalistic positive events will be presented. Second, the manipulation of mind wandering using mindfulness approaches and how this alters positive emotion experience will be discussed. Clinical implications of this

research and whether we should weave mindfulness into targeted treatments of anhedonia will be considered.

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### **Cognitive vulnerability to depression recurrence during low mood as a function of the number of prior depressive episodes**

**Katie Chung, The University of New South Wales; Michelle L. Moulds, The University of New South Wales**

Risk of depression recurrence is positively associated with the number of major depressive episodes (MDEs) that an individual has previously experienced; in individuals who have experienced one MDE, about 50% will go on to experience depression recurrence, with the risk increasing by 16% with each successive MDE experienced (Solomon et al., 2000). While there is robust evidence that the number of prior MDEs is a strong predictor of future depression vulnerability, less is known about the underlying cognitive mechanisms. The Differential Activation Hypothesis (DAH; Teasdale, 1988) proposes that over successive MDEs, the associations between low mood and depressogenic cognitive processes form and strengthen. Consequently, after each successive MDE, the extent to which a low mood reactivates depressogenic cognitive processes increases. This heightened cognitive reactivity to low mood then increases the likelihood that otherwise transient low moods will intensify and persist into depression recurrence. While this is a widely cited theory, the hypothesis that cognitive reactivity to low mood increases with the number of prior MDEs has yet to be directly tested; however, findings in the broader depression literature do provide indirect support for this prediction. In this experiment, the extent to which participants endorsed dysfunctional attitudes was indexed before and after a sad mood induction. The difference in pre-post mood induction scores was then analysed as a function of the number of MDEs that an individual had previously experienced. In contrast with both the DAH and previous studies using the same protocol, preliminary analyses suggest that recovered (n = 43) and never-depressed (n = 84) individuals did not exhibit differential shift in their endorsement of maladaptive beliefs from pre- to post-mood manipulation. Moreover, and counter to the primary and novel hypothesis of this study, participants who had experienced one or two prior MDEs did not differ from those who had previously experienced three or more MDEs. Further investigation of the DAH is warranted, with a focus on the potential roles that cognitive control and mood regulation strategies may play in moderating cognitive reactivity to low mood.

### **Reducing Stress and Preventing Depression (RESPOND)**

**Lorna Cook, Mood Disorders Centre and SMART Laboratory, University of Exeter;**

Edward Watkins, Mood Disorders Centre and SMART Laboratory, University of Exeter  
Current treatments have a limited ability to reduce the considerable global burden of depression. Prevention is therefore identified as a priority to reduce its prevalence. Despite some evidence for effective preventive interventions, there remains considerable scope to increase their efficacy and availability. One proposal to improve efficacy is to target interventions at known risk factors for depression, such as rumination. Rumination-focused CBT (RFCBT) targets depressive rumination and in a randomised controlled trial was found to effectively reduce acute symptoms of depression and relapse rates in patients with residual symptoms. Prevention requires widespread coverage, with the internet seen as a potential tool for increasing accessibility. RFCBT has been adapted for use as a preventive intervention and online delivery. Internet-RFCBT (i-RFCBT) consists of six modules and includes psycho-education, mood diaries, on-line experiential exercises using audio-recordings, pictures, and video vignettes of students' experiences of the therapy. The key strategies include coaching participants to spot warning signs for rumination and worry, and then to make IF-THEN plans in which an alternative strategy is repeatedly practised to the warning signs. These strategies include: being more active, slowing things down, breaking

tasks down, opposite action, relaxation, concrete thinking, becoming absorbed, self-compassion, and assertiveness. A Dutch prevention trial of RFCBT in 251 high-risk adolescents with elevated worry and rumination found both forms of the intervention (supported i-RFCBT and group-delivered RFCBT) equally reduced depressive symptoms and onset of depressive episodes over a one year follow-up, relative to no treatment control. However, incidence rates were only estimated from self-report in this trial. The current randomised controlled prevention trial aims to extend the Dutch trial in the UK, with the addition of diagnostic interviews. 235 high risk young adults (aged 18-24), selected with elevated worry/rumination scores, recruited through universities and internet advertisement, were randomised to receive either guided i-RFCBT, supported by clinical psychologists or mental health paraprofessionals, unguided (self-help) i-RFCBT, or no treatment control. The inclusion of an unguided version aims to assess any benefit of increased availability and reduced costs of self-help versus potential increased therapeutic benefits and adherence in the guided version. The primary research question tests whether guided i-RFCBT reduces onset of depression and/or generalised anxiety disorder over a 12-month period, as assessed with Structured Clinical Interview for Diagnosis 3 months (post-intervention), 6 months, and 15 months after randomisation. Secondary outcomes will be collected on symptoms of depression and anxiety; levels of worry and rumination, measured at the same time points. As the unguided version is previously untested we will also assess the feasibility and acceptability of data collection procedures, levels of attrition, effect size and acceptability of the unguided i-RFCBT intervention. We will present an overview of i-RFCBT and progress to date of the RCT.

## Suicidality: Basic Processes, Interventions and Staff Experience

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### **Life after suicide: Practitioners speak about their experiences of working with suicidal clients and the impact it has on them if their client dies**

**Susan Scupham, Metanoia Institute and Middlesex University**

The purpose of this research was to explore the question 'working with suicidal clients: what are the effects on the practitioner'?

The study used a mixed method approach to examine practitioners' experiences. The first phase of the research was a quantitative survey in which practitioners' (n=110) provided information on their experiences. The second phase of the study was qualitative and explored via interviews the effects of client suicide on practitioners (n=15). A narrative thematic analysis approach was used to analyse the interview transcripts.

The findings identified practitioners' experienced strong feelings in response to the death of their clients such as shock and shame. Thoughts such as failure and self-blame. Practitioners acknowledged changes in their behaviour such as avoidance about working with suicidal clients and concern with note taking.

Practitioners reported the impact of the manner in which they had been informed about the death of their client. Some practitioners had been taken aside and spoken to in a sensitive and caring way, while others had been left a note on their desk or found out in a team meeting.

Trainees may benefit from having discussions around personal beliefs, a need for openness about their fears of working with suicidal clients, vigilance with regard to relational responses and demystifying the process of investigation into serious incidents such as suicide within organisations.

Research indicates the death of a client is the greatest fear practitioners' experience. It is a time when practitioners' own negative core beliefs can surface. Yet it has to be survived in order to provide robust clinical care and support for other clients who may be struggling.

### **Implicit responses to life and death: Implications for psychopathology and suicidality**

**Laura Rai, National University of Ireland, Maynooth**

Implicit responses may be defined as brief and immediate evaluations made toward particular stimuli. A burgeoning literature measuring implicit responses toward life and death has shown that implicit tasks can predict suicidality above and beyond existing means

of assessment (Nock et al., 2010). The current programme of research sought to extend this work.

The Implicit Relational Assessment Procedure (IRAP), a relatively new measure of implicit responding, was used to present various propositions regarding life and death. It was hypothesised that normative participants would demonstrate stronger 'pro-life' implicit responses on the IRAP relative to participants scoring high on traditional self-report measures of psychopathology. 180 undergraduate participants completed two implicit tasks and a range of self-report measures, including assessments of depression, anxiety, hopelessness and self-esteem.

Specific response patterns on the IRAP distinguished participants with sub-clinical psychopathology from normative participants. For example, normative participants showed a greater bias towards 'I don't deserve a negative life' than participants who showed sub-clinical depression. Findings also highlighted the role of psychological flexibility as a mediator of the implicit outcomes. That is, participants who scored high on experiential avoidance showed stronger and more rigid responses on the IRAP.

The current research thus suggests the utility of the IRAP as a measure of sub-clinical psychopathology. Implications of the current findings and the predictive validity of implicit measures will be discussed within the domains of suicidality and psychopathology more generally.

Through the use of implicit methodologies, the current research highlights particular thoughts and cognitions that are associated with sub-clinical psychopathology in an undergraduate population. These thoughts, and how the individual client appraises them, may be targeted in CBT for such populations.

### **Cognitive Behaviour Suicide Prevention for prisoners: findings from the PROSPeR study (to form part of a Group of Papers: Psychological approaches to working with people experiencing suicidality)**

**Daniel Pratt, University of Manchester**

Cognitive behaviour therapies are effective at reducing suicidal behaviour, especially when designed, tailored, and implemented to focus on suicidality (Tarrier et al, 2008). Prisoner interventions have been shown to be most effective when they have been well-designed, targeted, and systematically delivered with cognitive-behavioural approaches a particularly successful type of intervention for offenders (McGuire, 2002). The aim of this study was to evaluate a novel Cognitive Behavioural Suicide Prevention (CBSP) therapy based upon an empirically validated psychological model of suicidal behaviour (Tarrier et al, 2013).

This paper will summarise and present findings from the Prevention of Suicide in Prisons (PROSPeR) study; a pilot randomised controlled trial of CBSP for prisoners identified to be at risk of suicide (n=31) compared to usual treatment (n=31).

The CBSP group improved differentially to the group receiving usual treatment on the primary outcome measure of repeated suicidal behaviours. Further analysis of secondary outcomes, including suicidal ideation, depression, and hopelessness will also be presented.

The main finding of this paper is that a Cognitive Behavioural Suicide Prevention intervention can be feasibly and acceptably delivered within the challenging context of a custodial setting. To exemplify this intervention approach, this paper will also present a summary of a case study from the PROSPeR study.

CBSP is a feasible psychological intervention and has the potential to reduce the likelihood of future suicidal behaviours.

### **Psychiatric staff experiences and beliefs about working with suicidal inpatients (to form part of a Group of Papers: Psychological approaches to working with people experiencing suicidality)**

**Yvonne Awenat, University of Manchester**

Despite implementation of measures to improve the physical safety in psychiatric wards, inpatient suicides account for 14% of all suicides in England. Treating suicidal inpatients forms a major component of the everyday workload of psychiatric ward staff, yet little is known about how they perceive this aspect of their work, including their beliefs and

attitudes about suicidality and suicidal inpatients and how this impacts on care. NICE guidelines (2011) recommend CBT for suicidal patients yet inpatients rarely receive any psychological interventions. It is important to understand the beliefs and attitudes of ward staff in order to engage them to support provision of CBT to improve patient outcomes within chaotic and unpredictable wards.

Individual qualitative interviews with psychiatric ward staff using Thematic Analysis were used to understand psychiatric ward staff's experiences and beliefs about working with suicidal inpatients.

Ward staff have little preparation for this complex and demanding work and hold predominately biomedical beliefs concerning the aetiology and consequently the required treatment for suicidal inpatients. Staff's limited knowledge of the psychological influences for and treatments of suicidality and organizational risk focused culture may present challenges to delivering inpatient therapy.

There is a role for CBT in psychiatric wards but organizational culture and staff education will require prior attention.

Understanding ward life and the work of ward staff is paramount to achieving their support for successful implementation of psychological therapy within ward settings.

## Advances in the Treatment of Depression and Anxiety

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### **Long-term effectiveness and cost-effectiveness of cognitive behavioural therapy as an adjunct to pharmacotherapy for treatment resistant depression in primary care: follow-up of the CoBaIT trial**

**Nicola Wiles, University of Bristol**

Cognitive behavioural therapy (CBT) is an effective treatment for depression, including for individuals whose symptoms have not responded to treatment with antidepressant medication. However, there is little robust evidence of effectiveness or cost-effectiveness over the long-term (3-4 years). Given the educational approach that underpins CBT, it has the potential to result in a benefit that is sustained well beyond the end of therapy. Evidence to substantiate and quantify the potential for long-term benefit is needed in order to inform decision-making. The aim of this long-term follow-up of the CoBaIT trial was to examine whether CBT (given as an adjunct to usual care that included pharmacotherapy) was effective and cost-effective in reducing depressive symptoms and improving quality of life over the long-term (3-5 years) compared with usual care alone for primary care patients with treatment resistant depression (TRD).

All those who had consented to take part in the CoBaIT trial, had not withdrawn during the 12 month follow-up and who had given their consent to being re-contacted were eligible to participate (n=430). Data were collected by postal questionnaire and, for a subset, from GP notes. The primary outcome was depressive symptoms on the Beck Depression Inventory (BDI-II). Health and social care costs were compared with quality-adjusted life years (QALYs) in a cost-utility analysis. All analyses were by intention-to-treat.

Of the 430 potential participants, 3 had died, 10 were excluded by their GP and 21 could not be traced, leaving 396 potential participants. Two hundred and seventy five individuals (69%) completed a questionnaire (intervention: n=149; usual care: n=126). Follow-up was completed an average (median) of 45.5 months from randomisation (range: 38.4, 61.6). At follow-up, the mean BDI-II score for the intervention group was 19.2 (SD 13.8) compared with a mean BDI-II score of 23.4 (SD 13.2) for the usual care group (repeated measures analysis over 46 months: difference in means -4.7 (95%CI: -6.4, -3.0) p<0.001). The average annual cost of trial CBT per participant was £343 (SD £129). The mean annual incremental cost to the NHS was £281 and the adjusted annual QALY gain was 0.052 (95%CI: 0.003, 0.102). The incremental cost-effectiveness ratio was £5,374 per QALY. This represented a 92% probability of being cost-effective at a threshold willingness-to-pay of £20,000.

CBT as an adjunct to usual care was an effective treatment for primary care patients with TRD and represented good value-for-money over the long-term.

Clinicians need to discuss referral for CBT with patients for whom antidepressants are not effective. This is a cost-effective treatment for a condition that leads to most disability in Western countries. More investment is needed.

### **Everyone counts: assessing equality of access and retention in a primary care psychological therapy service**

**Jeremy Oliver, Royal Holloway, University of London**

Equal access to psychological treatment is a central tenet of the Improving Access to Psychological Therapy (IAPT) programme and the NHS value that 'everyone counts'. A clinical audit was undertaken in a Step 4 IAPT service to establish whether referrals reflected local population and national IAPT referral demographic profiles and whether certain groups disengaged early from treatment.

Anonymised audit data was extracted from the electronic clinical record system. 1269 clients had started or ended treatment between 1 January 2013 and 31 December 2013. Chi-squared tests and odds ratios were used to establish whether there was any association between demographic category and the number of clients moving between each stage of the care pathway.

Overall, demographic profiles were found to be consistent across referral, assessment and treatment, indicating fairly good equality of access to all stages of the care pathway. However, the odds of men dropping out of treatment were higher than for women. There were greater odds of ethnic minority clients failing to reach assessment stage. Clients with partners had lower odds of attending assessment or completing treatment. Finally, clients with a disability had lower odds of completing treatment once started.

These findings were presented to clinicians and managers in the relevant NHS Trust. Positive actions were agreed, including introducing a leaflet to help clients discuss their referral with partners and considering paying for transport to help disabled clients stay in treatment.

Every CBT therapist working in an NHS setting is duty-bound, under the NHS Constitution, to help promote equal access to treatment. Therapists could encourage their service to run a similar audit and take similar actions to improve equal access, where relevant.

### **The enduring effect of cognitive behavioural therapy as an adjunct to pharmacotherapy for treatment resistant depression in primary care: a qualitative follow-up of the CoBalT trial.**

**Lydia French, University of Bristol**

Cognitive behavioural therapy (CBT) aims to teach the patient skills to help them manage their depression, skills that they will be able to use when the therapy is finished. The long-term follow-up of the CoBalT trial found that CBT (as an adjunct to usual care that included pharmacotherapy) was an effective and cost-effective treatment for patients whose depression had not responded to antidepressant medication over, on average, 46 months.

We conducted a qualitative study to explore how patients continued to manage their depression over the long-term, and the extent to which they continued to use the CBT techniques learnt and had incorporated them into their lives.

Telephone interviews were held with participants who had received CBT in addition to usual care in the CoBalT trial and had been followed up long-term (3-5 years after randomisation). Maximum variation in the sample was aimed for, according to whether the participant's depression had improved, remained the same or worsened, their gender, socio-economic status, age and trial centre (Bristol/Exeter/Glasgow). Participants were asked about their trial experiences, how they had managed their depression since the trial, and what strategies they had used. Interviews were audio-recorded, transcribed and analysed thematically.

20 participants were interviewed in total. Analysis of the interviews suggested that all the participants had benefited from receiving CBT, at the time of therapy, due to having contact with a therapist and feeling able to 'off-load' negative thoughts and experiences. However, it was also apparent that for some it had been a 'learning' process which they had actively engaged with. These participants reported how CBT had changed their core beliefs and attributions about themselves, and how adopting techniques such as questioning negative

thoughts, using distraction and rationalising, and confronting challenging events had helped them to manage their depression. Only participants whose depression had continued to improve over the long-term, reported being able to do this.

Our findings suggest that patients who actively engage with CBT as a 'learning' process at the time of therapy may change their core beliefs and attributions about themselves, and may learn specific techniques to cope with their depression that, if practised, enable them to effectively manage their depression long after completing therapy.

CBT may be most effective long-term for those patients who view it as a 'learning process', whose core beliefs and attributions about themselves change and who practise the techniques to manage their depression.

### **Exploring mechanisms of change in schema therapy for chronic depression Fritz Renner, MRC Cognition and Brain Sciences Unit, Cambridge, Maastricht University**

The underlying mechanisms of symptom change in schema therapy (ST) for chronic major depressive disorder (cMDD) have not been studied. Two potential key mechanisms underlying symptom change in ST are changes in schemas and the therapeutic alliance. One challenge in studying mechanisms of change is demonstrating that putative mechanisms precede change in symptoms. In this talk I focus on the temporal relation between the therapeutic alliance and depressive symptoms.

To disentangle the temporal relations between the therapeutic alliance and depressive symptoms we drew data from a single-case series of ST for cMDD. Patients with cMDD (N=20) received on average 78 repeated weekly assessments over a course of up to 65 individual sessions ST. Focusing on repeated assessments within-individuals, we tested whether (1) therapeutic alliance ratings predicted symptom change (2) symptom change predicted therapeutic alliance ratings or (3) symptoms and alliance ratings changed concurrently.

Change in symptoms was not temporarily related to overall alliance ratings. Repeated goal and task agreement ratings (specific aspects of alliance) of the same session, completed on separate days, were at least in part predicted by concurrent changes in symptoms.

Alliance ratings did not predict subsequent symptom change. Self-reported alliance ratings seem to be at least in part coloured by changes in current mood state.

Therapeutic alliance ratings improve when depressive symptoms improve. Clinicians should be aware that alliance ratings can be coloured by the current mood state when assessing the therapeutic alliance during treatment.

### **Seven decades of social anxiety: A treatment case study Excellence Award Winner 2014**

#### **Ann O'Hanlon, Queens University Belfast**

Presenting Problems: Changing demographics means that more people are growing older than ever before. With this change, comes an increase in the number of retired adults who need / seek support. Three such adults presented for CBT in N Ireland; each presented initially with symptoms indicative of depression, but were then diagnosed with co morbid social anxiety. None had heard of social anxiety before treatment, and on presentation, each reported never being "a good mixer with others" hence never considering therapy or CBT support.

Case Conceptualisation and Intervention: Each of the three clients were over aged 65 years, and each reported significant disruption and distress socially. Symptoms included avoiding meeting or engaging with others, and fears that they would make mistakes socially and be judged harshly. All experienced both a significant fear and a marked avoidance of social situations where they might feel embarrassed or be judged for mistakes. This fear interfered significantly with their daily routines, and contributed to feelings of loneliness and isolation. Core beliefs around not being important or making mistakes easily contributed to rules around keeping people at bay to regain some control and off-set potential criticisms: "if I keep others at a distance, they won't see my mistakes".

Outcomes: Full recoveries were made in all cases. In each presentation, therapy began with interventions addressing low mood and limited self-care, while the remaining sessions addressed worries about making mistakes socially and being judged negatively. Drawing on Clark & Wells social anxiety model these clients gained insights about why they felt as they did. A wide range of interventions were used, including thought records to consider assumptions and worries. Behavioural experiments also provided really great ways to enable clients to check out their worries that others would be nasty or judgemental around mistakes. These experiments included: giving compliments to others, playing the piano badly in public, dropping a tray of cutlery in a busy restaurant, and being videoed giving a speech to peers in the Republic of Ireland about retirement in N Ireland.

Review and evaluation: In each case, time was taken to build trust given awareness of the potential for client embarrassment when discussing deeply personal concerns. In drawing out the model, each client would begin to understand the factors that were inadvertently contributing to this anxiety, particularly negative thinking, and an extensive array of safety behaviours. Unwittingly, these safety behaviours had denied clients opportunities to test their appraisals of danger so that these then persisted unchecked, despite repeated non-occurrence. Each client had spent many decades with a paralyzing social anxiety, that had caused significant distress, disruption and confusion. Their lives have changed however, as each now reports excitement and enjoyment in a new social world that has now opened up. What are the potential implications for the everyday clinical practice of CBT?

- Older people with social anxiety can make a full recovery with CBT, even when that anxiety has been present for around 70 years
- Dropping safety behaviours is crucial to successful outcomes; this can be done effectively and in a graded way through homework assignments and behavioural experiments
- Clark & Wells social anxiety model offered a really useful way to understand Margaret's present situation (Wells & Clark, 1997).

## Cognitive and Family Factors in Anxiety and Depression in Adolescence

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### **Interpretation of ambiguity: Differences between children and adolescents with and without an anxiety disorder**

**Polly Waite, University of Reading**

Theory and treatment of anxiety disorders in young people are commonly based on the premise that interpretation biases found in anxious adults are also found in children and adolescents. Although there is some evidence that this may be the case, age has not typically been taken into account in studies, which is surprising given the normative changes in cognition that occur throughout childhood. In order to identify whether associations between anxiety disorder status and interpretation biases differ in children and adolescents, we compared the responses of children (7-10 years) and adolescents (13-16 years) with and without anxiety disorders (n = 120) on an ambiguous scenarios task. This presentation will discuss the findings of the study, consider whether it is necessary for theoretical accounts of interpretation biases in anxiety disorders in children and adolescents to distinguish between different developmental periods, and consider the clinical implications of the findings for each age group.

### **Expressed emotion in adolescent anxiety and mood disorders**

**Jennifer Collins, University of Oxford; Polly Waite, University of Reading; Cathy Creswell, University of Reading**

Family factors are consistently implicated in models of adolescent anxiety and mood disorders. The literature suggests the importance of three parenting dimensions in particular; over control or over protection; rejection, lack of warmth or criticism; and anxious rearing or modelling of anxious behaviour. Research has suggested roles of these parenting dimensions in both anxiety disorders (e.g. Thirwall Creswell, 2010) and mood disorders (e.g. Sullivan et al., 2012) in adolescents. Expressed Emotion (EE; Leff Vaughn, 1985) is a useful paradigm for measuring the potential roles of parental factors in adolescent

anxiety and mood disorders. EE is a measure of the emotional attitudes and feelings expressed from one family member towards a relative with mental health difficulties (Leff Vaughn), and it has been used increasingly in research with adolescents. EE can be dichotomised into 'high' or 'low'. A classification of high EE is made in the presence of higher rates of criticism, hostility, or emotional over-involvement (Magana et al., 1986). High EE has been associated with greater risk of developing an anxiety or mood disorder (Burkhouse, Uhrlass, Stone, Knopik Gibb, 2012), as well as greater symptom severity (Przeworski et al., 2012). EE can also be categorised into sub-constructs, namely 'emotional over-involvement' (EOI) and 'criticism' (CRIT). Research has indicated EOI and CRIT may be differentially associated with anxiety and mood disorders; EOI has been associated with anxiety disorders (e.g. Hirschfeld, Biederman, Brody, Faraone, Rosenbaum, 1997) and CRIT with mood disorders (e.g. McCleary Sanford, 2002). The Five Minute Speech Sample (FMSS; Magana et al., 1986) is a succinct paradigm for measuring EE, and has demonstrated good validity and reliability for use with adolescents (Jacobsen, Hibbs, Ziegenhain, 2000). This study aimed to adapt the FMSS paradigm to make it more sensitive for use with an adolescent population, and to examine the diagnostic specificity of EE in adolescent anxiety and mood disorders. The present study used the FMSS to examine parental EE in three groups of adolescents: 1) Those with a primary diagnosis of an anxiety disorder, 2) those with a primary diagnosis of a mood disorder, and 3) a non-clinical control group. The sample consisted of approximately 80 adolescents between the ages of 13 and 18. Adolescent diagnoses were assessed through separate diagnostic interviews with adolescents and their parents, using the Anxiety Disorders Interview Schedule Child and Parents Versions (ADIS-C/P; Silverman Albano, 1996) and the Schedule for Affective Disorders and Schizophrenia for School Aged Children (K-SADS; Kaufman et al., 1997) for anxiety and mood disorders, respectively. Parental psychopathology was assessed using the short form of the Depression, Anxiety and Stress Scale (DASS-21; Lovibond Lovibond, 1995). This paper will present the findings of the study and will outline how the findings may enhance understanding of family factors in adolescent anxiety and mood disorders.

### **Interpretation biases in adolescent depression**

**Laura Pass, University of Reading** and Faith Orchard, University of Reading; Shirley Reynolds, University of Reading

Negative interpretation biases are theorised to play a key role in maintenance of both anxiety and depression, and are a target for change in Cognitive Behaviour Therapy (CBT). The anxiety literature shows support for a negative (specifically, threat oriented) interpretation bias in anxious adults. In contrast, interpretation bias research in adult depression is limited, and findings so far have been mixed. Biased interpretations related to anxiety are commonly assessed using ambiguous scenarios but until recently, they had not been modified specifically for depression. In the last few years researchers have started developing ambiguous scenarios to be used with depression, including the Ambiguous Scenarios Test (AST-D). This questionnaire has been used to provide evidence for the presence of a negative interpretation bias in adult low mood. It is not clear whether these biases can be measured in adolescents, and whether they are associated with adolescent low mood or clinical depression. This talk will present data from an adapted adolescent version of the Ambiguous Scenarios Test (AST-DA) and a novel neutral sounds task. These tasks were completed with a sample of adolescents referred to CAMHS for low mood. To address whether the diagnosis of depression is relevant to the presence of interpretation biases, the difference between those who did and did not meet criteria for depression within a clinically referred population was compared. In addition, these groups were compared to a community group of adolescents with low depression symptoms, and a community group of adolescents with elevated depression symptoms. Data will also be presented on the associations between parental and adolescent interpretation biases.

### **Memory biases in adolescent depression**

**Faith Orchard, University of Reading** and Laura Pass, University of Reading; Shirley Reynolds, University of Reading

A well-supported memory-based bias found in adults with low mood is the tendency to over-generalise autobiographical memory (OGM). When asked to describe a specific event that has happened to them in response to a cue word (e.g. 'loved'), depressed adults provide more general descriptions than non-depressed adults. OGM has been found in relation to positive, as well as negative, cue words and is believed to contribute to the maintenance of depression whereby patients with more overgeneralised memories take longer to recover. Another memory bias that has been found in adults, is incidental recall memory bias, where individuals with depression are less likely to remember positive information than healthy individuals and more likely to remember negative information. The findings for OGM and recall memory in adolescent depression are less clear. Data was collected on both types of memory bias, with a sample of clinically depressed and healthy community adolescents. This talk will present preliminary data from the Autobiographical Memory Test (AMT) interview, using both positive and negative cue words, and the results will be discussed in comparison with the recall memory bias data. This talk aims to identify whether adolescents with depression demonstrate the same memory biases as adults, or whether only some of the biases are observed.

## The Singer and Not the Song? Evidencing therapists effects across the IAPT stepped care model

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**Dave Saxon, University of Sheffield**

### **Variability in practice: Therapist effects in an IAPT service delivering CBT and Counselling**

**Aim:** To determine the size of therapist effects and variability in effectiveness, for depression (PHQ-9) while controlling for case-mix at step 3 of IAPT services.

**Methods:** Multilevel modelling (MLM) of routinely collected service data (June 2010 – Oct 2013). The sample comprises 10600 patients and 100 practitioners (CBT and counselling). A multilevel model containing significant predictors (case-mix variables) was constructed and the model residuals, with their 95% CIs, were used to categorise the outcomes of a therapist as average or significantly above or below average. The impact of therapy type (CBT or counselling), number of sessions, and ending (completed therapy or not) were also assessed by including them in the models.

**Results:** There was a significant therapist effect after controlling for case-mix variables (patient intake severity and employment status). Type of therapy ending was also a significant predictor of outcome while type of therapy was not.

**Discussion:** The effect size is discussed in the context of being derived from a single IAPT service and the restrictions in the outcome measure.

### **Therapist effects and moderators of effectiveness and efficiency in psychological wellbeing practitioners: A multilevel modelling analysis**

**Nick Firth, Michael Barkham & Stephen Kellett**

The study investigated whether psychological wellbeing practitioners (PWPs) working within IAPT are differentially effective (i.e., therapist effect size) and differentially efficient (i.e., rate of clinical change).

Routine clinical outcome data (depression, anxiety, and functional impairment) were collected from a single IAPT service. A total of 6111 patients were treated by 56 PWPs. Multilevel modelling (MLM) determined the size of the therapist effect and examined significant moderators of clinical outcomes. PWPs were grouped according to below average, average, and above average patient outcomes and compared on clinical efficiency. Therapist effects accounted for 6–7% of outcome variance that was moderated by greater initial symptom severity, treatment duration, and non-completion of treatment. Clinically effective PWPs achieved almost double the change per treatment session. As treatment durations increased beyond protocol guidance, outcomes atrophied. Treatment non-completion was particularly detrimental to outcome.

PWPs appear to be differentially effective and efficient despite ostensibly delivering protocol driven interventions. Implications for services, training, and supervision are outlined.

## **Examining practitioners' personal aspects that contribute to effective practice**

**Jo-Ann Pereira, Michael Barkham & Stephen Kellett**

**Aim/Purpose:** The current study aimed to identify how key personal aspects of practitioners' resilience, empathy and mindfulness contribute to patient outcomes of psychological therapies in routine practice in an IAPT service.

**Design/Methodology:** The study examined quantitative (routinely collected IAPT data) and qualitative data from IAPT practitioners. N = 37 practitioners completed measures of resilience (CD-RISC), empathy (BES-A), and mindfulness (MAAS) and provided written responses to open-ended questions relating to their routine practice. Patient depression scores (PHQ-9) of the 37 practitioners who each treated a minimum of 20 patients were analysed, with a total of N = 5,408 patients seen within a period of 3.4 years. The study used a synthesis of single level benchmarking, multilevel modelling and thematic analyses. Findings on practitioner effectiveness were yoked to quantitative and qualitative findings on practitioners' personal aspects of resilience, empathy and mindfulness.

**Results/Findings:** Findings revealed that when treating patients with moderate depression, more effective practice was associated with higher levels of resilience relative to cognitive empathy. In contrast, when treating patients with moderately severe to severe depression higher levels of mindfulness and/or combined resilience and mindfulness were associated with more effective practice. Across all practitioner aspects, combined resilience and mindfulness was the largest significant predictor of patient outcome ( $\beta = 0.046$ ,  $p < .05$ ).

**Discussion:** Findings suggest that resilience and mindfulness have a potential to inform the future training of practitioners. More research however is necessary as the current findings are limited to the specific measures and features which may have been unique to the current single service sample.

## **Our beliefs about the therapeutic alliance: Good clinical judgement or overvalued ideas?**

**Glenn Waller, The University of Sheffield**

While there is little doubt that a good therapeutic alliance is necessary for effective therapy, there is less clarity about whether it is sufficient for change. This presentation will review the evidence that the alliance is a driver of therapeutic change, the evidence that symptom change is a driver of therapeutic alliance, and more complex pathways of interaction. Having established that baseline, there will be consideration of whether clinicians' perspectives on the alliance are accurate or helpful, and the intra-individual factors that influence how much we emphasise the scientific and the interpersonal elements of therapy.

## **Developments in CBT for psychosis: Targeting key psychological processes**

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### **Does decentred awareness mediate the relationship between psychotic-type experience and distress?**

**Tabitha Rothwell, University of Southampton and Katherine Newman Taylor, University of Southampton;** Helen Bolderstone, University of Bournemouth; Nick Maguire, University of Southampton; Charlotte Deveson, University of Southampton

Psychosis is often severely distressing and disabling. In order to support people's recovery, we need to understand the psychological processes mediating the relationship between psychotic phenomena and distress, and target these in therapy. CBT for psychosis has significant but modest benefits to date. If we are to improve our interventions, cognitive theory and therapy need to be more closely aligned in this area. Treatments can be derived more systematically from theoretical paradigms that have been tested with analogue groups, and lab work can be directed towards testing specific components of our psychological models and interventions. Current cognitive theory and 'third wave' approaches, such as ACT, assume that it is our relationship to paranoia and voices that predicts emotional and behavioural consequences (following Fresco et al., 2007; Teasdale et al., 2000; 2002). If we can identify mediators of distress we may be able to isolate key targets for therapeutic intervention. This paper describes two parallel studies examining the possible mediating

role of cognitive fusion and self-compassion (two aspects of decentred awareness) in the relationship between psychotic-type experience and distress. General population samples completed measures of paranoia, hallucinations, cognitive fusion, self-compassion and distress. Mediational analyses yielded significant indirect effects, with medium to large effect sizes, suggesting that the degree to which we fuse with paranoid cognition or hallucinatory experience, and respond with self-compassion, predicts distress. We discuss the implications both for our understanding of the maintenance of distressing psychosis, and for clinical interventions aimed at these aspects of decentred awareness.

### **The role of mental imagery in paranoia**

**Lusia Stopa, University of Southampton;** Gemma Bullock, University of Southampton; Katherine Newman Taylor, University of Southampton

Current cognitive models of paranoia incorporate many of the processes implicated in the anxiety disorders. Mental imagery has been identified as a key factor in the maintenance of anxiety disorders (Clark, 1999), and features prominently in theoretical accounts of PTSD (Ehlers Clark, 2000) and social phobia (Clark Wells, 1995; Rapee Heimberg, 1997). Rescripting techniques involve holding emotion-inducing imagery in mind, and modifying the content and meaning to reduce affect. These approaches have been shown to be effective with both clinical and non-clinical groups (see Arntz, 2012; Holmes Matthews, 2010 for reviews) but, with notable exceptions, remain untested in people with psychosis (Pearson et al., 2013). This study examined the impact of imagery manipulation in people with high non-clinical paranoia. A mixed design with one between-subjects variable (type of self-imagery) and one within-subjects variable (time – pre and post imagery manipulation) was used. Thirty participants with high levels of non-clinical paranoia were allocated alternately to a positive or negative self-image condition. Image scripts were used to elicit the positive and negative imagery. All participants completed self-report measures of paranoia, anxiety, self-esteem, mood and self-compassion. Paranoia-related negative imagery led to increases in paranoia and negative mood, and decreases in self-esteem, self-compassion and positive affect. Conversely, positive imagery led to reductions in paranoia, negative mood and anxiety, and increases in positive affect, self-esteem and self-compassion. This suggests that imagery manipulation may affect paranoia, self-beliefs and mood. Cognitive behavioural models of paranoia might usefully include imagery explicitly, as well as verbal cognition, and mental imagery may be a valuable target for therapeutic intervention.

### **Using a value affirmation task to attenuate paranoid thinking in students**

**Jessica Kingston, Royal Holloway University of London;** Lyn Ellett, Royal Holloway University of London

It is well established that paranoid thinking commonly occurs, in an attenuated form, in the general population (e.g., Ellett, Lopes Chadwick, 2003). The experimental investigation of paranoid thinking is beginning to validate key theoretical assumptions about the phenomenology and underlying mechanisms of paranoia. For example, paranoia can be triggered in virtual environments (Freeman et al., 2008) and by exposure to high self-awareness and failure feedback (Bodner Mikulincer, 1998; Ellett Chadwick, 2007). Several lines of independent research suggest that threats to one's self-esteem trigger an increase in paranoid thinking (e.g. Thewissen et al., 2011), perhaps because paranoid attributions function to resolve the self-esteem threat (Bentall et al., 2001). Although there has been great experimental interest in understanding paranoid thinking in non-clinical samples, there has been relatively less research investigating factors that may alleviate it. Within the social psychology domain, a substantial literature documents the psychological benefits of reflecting on core and cherished values. Self-affirmations have shown substantial efficacy in attenuating defensive processing when faced with a threat to one's self-esteem (McQueen Klein, 2006). This study used an experimental design to determine whether affirmation of a core value attenuates paranoid thinking in a student sample. University students (N = 55) were randomised to either a value-affirmation or non-affirmation control condition before exposure to a paranoia-induction manipulation (high self-awareness plus failure feedback).

Paranoid cognitions were measured before (T1) and after (T2) the value-affirmation task and after the paranoia-induction task (T3). Depressive cognitions were also measured at T3. Affirming a valued domain had a direct and significant effect on reducing state paranoia. Participants who affirmed a valued domain had significantly lower state paranoia following the paranoia induction task, as compared to the control group. This effect was not attributable to differential changes in depression across groups. These findings suggest that self-affirmation is effective in reducing state paranoia in a non-clinical sample and future research may usefully determine the applicability of self-affirmation in the attenuation of paranoia in clinical samples.

## Super-vision: Seeing the Way Forward

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### **The Supervisor Competency Scale: development and psychometric properties**

**Sarah Rakovshik**, Helen Kennerley, Kate Muse, Gillian Butler and Sue Clohessy, Oxford Cognitive Therapy Centre (Oxford Health NHS Foundation Trust) and University of Oxford  
Therapist competence is crucial to CBT's effectiveness - and sound supervision and continued guidance in good practice is crucial for developing therapist competence. In developing the Supervisor Competency Scale (SCS), we rose to the challenge of devising an assessment of CBT supervisor performance that targets key supervision competencies and core skills whilst being simple enough to be used routinely. We intend the SCS to be useful across supervisory settings and so initial trials involved CBT supervisors working in a range of settings, using varied supervision formats and practising in several European countries. This presentation describes the evolution of a tool for assessing the quality of CBT supervision and the results of a validation examining its psychometric properties.

### **How trainees on a psychotherapy course perceive a supervision session and what they bring forward to the next therapy session**

**Anna Törnquist**, Scandinavian Academy of Psychotherapy Development/ University of Oxford

This study aims to acquire knowledge, from the perspective of the trainees, as to what in particular in the supervision process contributes to the therapy process. How do the trainees describe what is perceived to be important in the supervision session and what particular parts of what is perceived as important in the supervision session do the trainees bring forward to the therapy session?

A qualitative approach was used with thematic analysis of the participants' written diaries after supervision and therapy sessions. The research was located at an education centre that aims to provide all the different steps in psychotherapy training. This presentation will present the results of this study and the relevance they may have to providing effective supervision.

### **Supervisory Supervision - Conceptual Model and Practical Guidance**

**Stephen Barton**, Newcastle CBT Centre (NTW Foundation Trust) & Newcastle University

Over the past 5 years the Newcastle CBT Centre has increased its provision of supervisory supervision, partly in response to the national growth of CBT supervision. We have extended our "cakestand" model to conceptualise the key functions of supervising supervisors, grounded in the experience of providing such supervisory groups. The learning curve has been steep and rewarding. This paper will present key aspects of the extended model, illustrate its implementation with recent examples - some successful, some less so - and suggest important dos and don'ts in developing a supervisory practice.

### **Supervision Distance Learning: a sneak preview**

**Helen Kennerley**, Oxford Cognitive Therapy Centre (Oxford Health NHS Foundation Trust)/ University of Oxford

OCTC has been running supervisor training courses for over 15 years. The courses get good feedback, but are limited to those who can attend Oxford-based training. Give that the

importance of supervisor training is gaining prominence both nationally and internationally, it seemed an obvious next to make the OCTC travel!

We have developed a distance learning programme based on our current programme and comprises: reading material, learning exercises, vignettes and video recordings of supervision in action and Skype-type supervision of supervision (SoS) sessions. We have received preliminary feedback on its usability from 5 continents and now we plan to pilot it in 4. We will evaluate its impact using the Supervisor Competency Scale (SCS). This BABCP presentation offers you a sneak preview of the programme .

## Clinical Roundtables

### Supporting Parenting in the Context of Parental Mental Illness: How can Adult Mental Services Help?

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Sam Cartwright-Hatton, University of Sussex; Rachel Calam, University of Manchester; Clair Pollard, Westminster IAPT Primary Care Service.

Dr Helen Startup. Clinical Adult Psychologist. Sussex Partnership NHS Foundation Trust and South London and Maudsley NHS Foundation Trust. It is widely accepted that parents who have mental health difficulties have children with increased risk of mental illness themselves. For example, in one study, parents with an anxiety disorder had children who were seven times more likely to have an anxiety disorder themselves, compared to children of healthy parents.

What is less well known, is that much of the intergenerational transmission of risk is not genetic but environmental. And, if it is environmental, then there is much that we can do to reduce the risk. In particular, the research suggests that where parenting skills are strong, the risk of mental health problems appearing in the next generation is much reduced. Moreover, there are now signs that interventions focussed on parenting in those with mental illness have much to offer in reducing risk in offspring.

Despite this growing evidence that children of those with psychological disorders are at risk, and that there is much that we can do about this, most adult mental health services are yet to take up the challenge of supporting parenting in their clients.

This roundtable is designed to bring together those working in adult mental health services with those whose expertise lies in childhood mental health. The roundtable will begin with a brief presentation by each of the speakers, reviewing an area of clinical or research interest from a range of angles. Thereafter, the conversation will be open to the room. It is hoped that the roundtable will clarify the barriers to working with parenting in adult mental health settings, and spark some ideas for surmounting these.

### Dilemmas and Challenges in CBT Supervision

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Michael Worrell, Central and North West London NHS Foundation Trust; Cory Newman, University of Pennsylvania, Helen Kennerley, Oxford Cognitive Therapy Centre; Stirling Moorey, South London and Maudsley NHS Trust, Sarah Corrie, Central and North West London NHS Foundation Trust

Clinical Supervision in CBT remains an area that requires further research and theoretical development. Whilst there has been an increase in conference presentations that focus on supervision, these have tended to be at a fairly abstract level. This clinical roundtable will give participants the opportunity of hearing how a panel of leaders in the field respond to a range of supervision challenges and dilemmas that may occur in supervision across different contexts. This will include challenges and dilemmas that focus on ethical aspects of practice, the development of competence and metacompetence as well as managing difficult interpersonal process in individual and group supervision contexts. Additionally the format for

this session will allow for a high degree of audience participation with audience members invited to present their own experience of supervision challenges and dilemmas. This will allow participants to reflect upon and develop their own understanding of how to formulate and respond appropriately to supervision challenges and dilemmas. This will support their ongoing development as CBT supervisors.

## Panel Debate

### Panel Debate: Current Approaches for Addressing Traumatic Memories in Distress-Related Disorders: Commonalities and Differences, Indications and Contradictions

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Thorsten Barnhofer, FU Berlin Germany; Gary Brown, Royal Holloway University of London; Jonathan Wheatley, City and Hackney Primary Care Psychology Florian Ruths, South London and Maudsley NHS Trust; Jennifer Wild, University of Oxford

Recent conceptualizations of emotional disorders suggest the presence of a broad category of distress-related disorders that include depression, generalized anxiety, a range of personality disorders, and traumatic stress disorders (Watson, 2005). Whilst there are important differences between these disorders, they appear to share a common transdiagnostic contributor to onset: negative and, often, traumatic experiences. In fact, early adversity and trauma are important risk factors for distress-related disorders, and recent research demonstrates how, as depression becomes more recurrent and chronic, underlying cognitive vulnerabilities acquire a dynamic that share similarities with those of traumatic memories. What is common to the treatment of these disorders is the necessity to address memories of negative and traumatic experiences and their effects. Yet approaches to do so may differ considerably depending on the particular disorder and a client's individual presenting characteristics. High rates of comorbidity between distress-related disorders present further challenges to clinical decision-making.

Our panel will compare different treatment approaches in the domain of distress-related disorders, exploring their commonalities and differences, indications and contraindications. Following an introduction to the subject, brief presentations will outline different treatment approaches to negative and traumatic memories. Jonathan Wheatley will talk about cognitive therapy for intrusive memories in depression, Thorsten Barnhofer will describe mindfulness-based approaches to addressing difficult memories in depression, Florian Ruths will talk about addressing traumatic memories within the context of schema therapy for patients with personality disorders, and Jennifer Wild will provide an overview on the use of imagery re-scripting techniques to address traumatic memories in social anxiety disorder and reliving and updating to address trauma in post-traumatic stress disorder. Panel discussion of the presentations will invite comments and questions from the audience. Gary Brown will bring together the different perspectives as a discussant.

The discussion is aimed at refining our views of how and where to use particular approaches to addressing negative and traumatic memories in the treatment of distress-related disorders.

## Clinical Skills Classes

### Brief Behavioural Activation for Adolescents with Depression

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**Shirley Reynolds, Charlie Waller Institute, University of Reading; Laura Pass, Charlie Waller Institute, School of Psychology, University of Reading**

Background: Behavioural Activation (BA) appears to be a very effective treatment for depression in adults and may be a promising treatment for young people. We have adapted brief BA (Lejuez, et al., 2011) for use in routine CAMHs (BATD-A, Pass et al., 2014) and piloted this with 10 young people. Key elements include the involvement of parents, a focus on identifying young people's values, optional problem solving sessions, and manuals for young people and their parents.

BATD-A involves 8 weekly one-hour sessions, and a 30 minute review session one month later. BATD-A is simple to explain, simple to understand and reasonably straightforward to incorporate into an adolescent's life. Engagement in treatment has been very good, BATD-A is acceptable to young people and their parents, and our single case data suggests significant reduction in symptoms of depression.

This skills class will demonstrate the use of Brief BA with adolescents who are depressed. It will focus particularly on engagement of young people in treatment, linking values to activities, and working with parents and young people. Case examples will be used to highlight specific challenges and techniques and to show how Brief BA effectively reduces symptoms of depression and improves young people's functioning.

Objectives: Participants will acquire the following skills:

1. Engaging depressed young people and parents in Behavioural Activation
2. Helping young people to identify their values in three key areas - self, people that matter and things that matter.
3. Linking values to activities
4. Dealing with conflict and disagreement between young people and parents

Modalities: In this workshop the components of Brief Behavioural Activation for depression in adolescents (BATD-A) will be taught through instruction, modelling, and practice (role-plays).

Implications: CBT clinicians working with children and young people may find that Brief BA for adolescents is a useful first step treatment for low mood and depression. Brief BA highlights the importance of engaging young people, identifying their values and incorporating these into treatment.

References: Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten Year Revision of the Brief Behavioral Activation Treatment for Depression (BATD): Revised Treatment Manual (BATD-R). *Behavior Modification*, 35, 111-161. doi: 10.1177/0145445510390929.

Pass, L., Brisco, G., Whitney, H., & Reynolds, S. (2014). Treatment manual for Brief Behavioural Activation for Depression in Adolescents (BATD-A). Unpublished manual, Charlie Waller Institute, University of Reading UK. (This will be made available to delegates prior to the skills class).

Leaders: Shirley Reynolds and Laura Pass are clinical psychologists who work in the Anxiety and Depression in Youth (ANDY) research clinic at the University of Reading. Their current clinical research is focused on adapting and improving psychological treatment depression in young people.

## Adapting Cognitive Behavioural Interventions for People with Autism Spectrum Disorders

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No abstract.

Exposure and Response Prevention: Adapting skills you already have to the treatment of tics

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**Fiona McFarlane, Great Ormond Street Hospital; Tara Murphy, Great Ormond Street Hospital**

Background: Tics are sudden involuntary movements or sounds, and are highly prevalent in child populations with approximately 18% of children and young people having a tic at some point. Tic disorders are common, with approximately 10% of children meeting criteria for a chronic tic disorder, and 1% meeting criteria for Tourette syndrome. Approximately 25% of these individuals will continue to experience significant difficulties with tics in adulthood. Functional impairment and reduced quality of life are associated with tics, with a detrimental impact on school/work, home and social functioning.

There is now a good evidence base for behavioural treatment of tics using behavioural techniques such as Exposure and Response Prevention (ERP). Despite this, few children or adults can access such treatment outside of national specialist centres, with many local clinicians feeling they lack the skills or training to provide this intervention. This workshop aims to address this gap by demonstrating how already available skillsets and techniques can be adapted to treat and reduce tic severity .

Objectives: By the end of the class, participants will:

1. Know the key diagnostic criteria for Tourette Syndrome and Tic disorders in children and adults and their associated assessment tools.
2. Revisit the principles of ERP and how this applies to tic treatment.
3. Understand how tics are reinforced by the relief of the premonitory urge and how treatment needs to focus on breaking this cycle.
4. Be able to use ERP to treat tics (following an evidence-based manualised treatment).

Modalities: A brief theoretical background will be followed by case examples and role play. Where possible video material from therapy sessions will be used to help illustrate the nature of treatment.

Implications: Knowledge gained in the workshop will enable clinicians to apply techniques they are already familiar with to the treatment of tics and Tourette Syndrome. This will help address the difficulty many sufferers have in accessing treatment locally.

References: Verdellen, C. et al (2003) "Exposure with response prevention versus habit reversal in Tourettes's syndrome: a controlled study ." Behaviour research and Therapy 42 501-511

Wile, D.J & Pringsheim, T.M. (2013) "Behaviour Therapy for Tourette Syndrome: A systematic Review and Meta-analysis" Current Treatment Options in Neurology 15: 385-395

Verdellen, C., van de Griendt, J., Hartmann, A., & Murphy, T. (2011). European clinical guidelines for Tourette Syndrome and other tic disorders. Part III: behavioural and psychosocial interventions. European Child & Adolescent Psychiatry, 20(4), 197–207.

Leaders: Dr. Fiona McFarlane is a clinical psychologist in the National Tourette Syndrome Service at Great Ormond Street Hospital. She regularly provides behavioural therapy for tics with high success rates and training. She has been involved in a RCT looking at group based behavioural interventions for tics which has recently been submitted for publication.

## Introduction and Key Skills of Cognitive Behavioural Couple Therapy

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### **Dan Kolubinski, Efficacy, Marion Cuddy, South London & Maudsley NHS Foundation Trust and Laura McMurray**

Background: Cognitive Behavioural Couple Therapy has increased its presence in the UK over the past several years. Based on the model developed by Epstein and Baucom (2002), CBCT has been shown to be helpful in the treatment of couple-specific issues, such as relationship satisfaction, sexual dysfunction and infidelity, as well as individual psychopathology and chronic medical conditions. There is a demonstrable relationship between all of these domains, whereby relationship satisfaction impacts psychopathology and vice versa. This skills class will provide a summary of the CBCT model and provide an overview of basic assessment and intervention skills. Particular emphasis will be placed on behaviourally-based communication skills training and the development of positive reciprocity in the relationship.

Objectives: By the end of the class, participants will:

1. Be aware of key domains that contribute to relationship functioning

2. Have a good understanding of the CBCT model the principal interventions used in Cognitive Behavioural Couple Therapy

3. Be able to introduce communication skills training to clients

Modalities: This skills class will be didactic in the delivery of the CBCT model and demonstration of interventions and will provide an opportunity to practice basic techniques in role-plays and small groups.

Implications: The utility of CBCT in treating both individual and relationship-based distress makes it an ideal treatment modality for practitioners, as evidenced by its increasing use in IAPT services and by private practitioners. This skills class will provide a basic understanding for clinicians, which will lay a foundation that they can then build upon.

References: Epstein, N., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach*. Washington, DC: American Psychological Association.

Fischer, M. S., Baucom, D. H., Hahlweg, K., & Epstein, N. B. (2014). *Couple Therapy*. In S. G. Hofmann (Ed.), *The wiley handbook of cognitive behavioral therapy* (pp. 703–725). Oxford: Wiley-Blackwell.

Whisman, M. A., & Baucom, D. H. (2012). *Intimate relationships and psychopathology*. *Clinical Child and Family Psychology Review*, 15, 4–13.

Leaders: Dan Kolubinski is a CBT-therapist with the London-based private practice Efficacy and Chair of the BABCP Couples Special Interest Group.

Dr Marion Cuddy is a clinical psychologist specialising in CBT for individuals and couples.

She works in the NHS and is the Chair-elect of the BABCP Couples Special Interest Group.

Laura McMurray is a psychologist with IAPT service in Camden and Islington where she is the lead for Behavioural Couple Therapy.

**Staying composed, compassionate, and constructive in conducting CBT sessions with clients who struggle with being composed, compassionate, and constructive!"**

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### **Cory F. Newman, University of Pennsylvania, Perelman**

School of Medicine, Philadelphia, PA, USA

Scientific background and description of skills class:

The cognitive-behavioural therapist's ability to maintain a positive, mature, caring stance is put to the test when the clients express mistrust, criticisms, demands, threats, or otherwise exhibit therapy-interfering attitudes and behaviours. This skills class will describe how CBT practitioners can combine methods of self-awareness, self-application of CBT coping skills, conceptualization of the client's problematic reactions, limit-setting, and task-focused behaviours in order to keep therapy on a constructive track. The result can be a therapeutic confounding of the client's negative expectations, improved outcome for the client, the bolstering of the therapist's professional confidence, and a more rewarding experience overall for clients and therapists alike. This skills class will draw from the following sources in the professional literature:

- Schema-focused therapy (see Young et al., 2003, below)
- The Self-Reflection/Self-Practice Model for CBT Practitioners (see Bennett-Levy et al., 2015, below)
- Selected principles from DBT (e.g., Linehan and colleagues)
- CBT models of efficacious therapeutic relationships (see Gilbert & Leahy, 2007, below)

Key learning objectives:

1. Learn to assess and conceptualize clients' problematic behaviours and beliefs that otherwise impede the course of treatment.
2. Maintain the ability to feel and express accurate empathy, even when clients act in ways that challenge (and perhaps even mistreat) the therapist.
3. Utilize methods of self-reflection and self-practice to cope with difficulties in treating certain clients, and in maintaining professionalism and self-confidence.
4. Craft interventions in such a way that will increase the reluctant clients'

likelihood of collaborating, via the use of metaphors, narratives, hypothetical questions, appropriate self-disclosure, and well-chosen words that fit the case conceptualization (i.e., that would predict goodness of fit with the client's sensibilities).

#### Training modalities

- Didactic lecture / PowerPoint slides
- Presenter role-playing
- Video of representative CBT session material in real time footage

#### Key references

- Bennett-Levy, J., Thwaites, R., Haarhoof, B., & Perry, H. (2015). *Experiencing CBT from the inside-out: A self-practice, self-reflection workbook for therapists*. New York: Guilford Press.
- Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., ... Arntz, A. (2006). Outpatient psychotherapy for borderline personality disorder: A randomized trial of schema-focused vs. transference-focused psychotherapy. *Archives of General Psychiatry*, 63, 649-658.
- Gilbert, P., & Leahy, R.L. (Eds.) (2007). *The therapeutic relationship in the cognitive-behavioral psychotherapies*. New York: Routledge.
- Kuyken, W., Padesky, C. A., & Dudley, R. (2009). *Collaborative case conceptualization: Working effectively with clients in cognitive-behavioral therapy*. New York: Guilford Press.
- Strauss, J.L., Hayes, A.M., Johnson, S.L., Newman, C.F., Barber, J.P., Brown, G.K., ... Beck, A.T. (2006). Early alliance, alliance ruptures, and symptom change in cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology*, 74, 337-345.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford Press.

#### Implication for everyday clinical practice of CBT

Therapists and clients working together as a collaborative team is a hallmark of CBT. However, not all clients have the requisite psychological skills to be an optimal partner in their own treatment, at least not at first. Highly competent therapists are able to view their clients' difficulties (e.g., poor emotional self-regulation; a significantly avoidant or attacking mode of relating with the therapist; lack of trust and/or sincerity) not simply as obstacles to therapy but as opportunities for case conceptualization and the crafting of more well-targeted interventions. Further, therapists who can master such an approach will be less vulnerable to feeling helpless and hopeless in treating challenging clients, and thus will improve not only client outcomes but also their own sense of professional self-confidence and personal self-awareness.

#### Brief description of presenter

Cory F. Newman, Ph.D., ABPP is Director of the Center for Cognitive Therapy, Professor of Psychology, in Psychiatry at the University of Pennsylvania Perelman School of Medicine, and Adjunct Faculty at the Beck Institute for Cognitive Behavior Therapy. Dr. Newman is a Diplomate of the American Board of Professional Psychology, and a Founding Fellow of the Academy of Cognitive Therapy. Dr. Newman has served as a protocol therapist and supervisor in a number of large-scale psychotherapy outcome studies. He is an international lecturer, having presented scores of cognitive therapy workshops and seminars across North America, as well as fifteen countries in Europe, South America, and Asia. Dr. Newman is the lead author on dozens of articles and chapters on the therapeutic relationship, clinical supervision, and cognitive therapy for a wide range of disorders. He has authored or co-authored five books, including *Core Competencies in Cognitive-Behavioral Therapy*, published by Routledge in 2012.

## Targeting the self in the cognitive-behavioural treatment of Obsessive-Compulsive Disorder

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## **Mike Kyrios, Australian National University, Australia**

Scientific background and description of skills class:

Theoretical discourse and recent research have emphasized the association between Obsessive Compulsive Disorder (OCD) phenomena and self constructs such as ambivalence about one's self-worth, perceptions about the importance of the moral domain in establishing one's self-worth, and dissonance between implicit and explicit self-worth. Theorists have developed a conceptual model of OCD where concerns about transgressions in the moral domain and their impact on self concept are prominent. The conceptual model incorporates cognitive, self-construal, mood and behavioural factors, and has direct implications for engagement with affected individuals and their treatment. Following from this model, interventions that target self-concept can be integrated with traditional cognitive-behaviour therapy strategies for OCD in order to enhance engagement and treatment outcomes. For instance, previous research has shown that poorer resolution of self-ambivalence following CBT predicts relapse in compulsions at 6 to 12 month follow-up. Self-based strategies from a range of frameworks, inclusive of narrative therapy, Acceptance and Commitment Therapy, metacognitive therapy and psychoanalytic therapies, can be used to enhance CBT. This clinical skills session will illustrate some of these skills.

Key learning objectives:

1. Understand the range of self constructs that can be used to understand vulnerabilities to OCD cognitions and symptoms
2. Learn to integrate self-based conceptualisations into cognitive-behavioural treatment formulations
3. Develop engagement and intervention skills that target the self in the treatment of OCD

Training modalities

1. Cognitive-behaviour therapy
2. Self-based strategies using attachment and psychodynamic, narrative, Acceptance and Commitment Therapy, and metacognitive conceptualisations

2-3 key references

1. Bhar, S. & Kyrios, M. (2007) An investigation of self-ambivalence in Obsessive-Compulsive Disorder. *Behaviour Research & Therapy*, 45, 1845–1857.
2. Doron, G. & Kyrios, M. (2005). Obsessive Compulsive Disorder: A review of possible specific internal representations within a broader cognitive theory. *Clinical Psychology Review*, 25, 415–432.
3. Kempke, S. & Luyten, P. (2007). Psychodynamic and cognitive-behavioral approaches of obsessive-compulsive disorder: Is it time to work through our ambivalence? *Bulletin of the Menninger Clinic*, 71, 291-311
4. Rachman, S. (1997). A cognitive theory of obsessions. *Behaviour Research & Therapy*, 35, 793-802

Implication for everyday clinical practice of CBT

Given the complexities and limitations associated with managing clients with OCD, practitioners often need additional conceptual frameworks and skills to improve engagement and outcomes related to psychological treatment. This workshop will provide practitioners with a broader range of case and treatment formulation skills in managing OCD.

Brief description of presenter(s)

Professor Michael Kyrios is currently Director of the Research School of Psychology at the Australian National University having previously undertaken academic, practice, professional & administrative roles. He was the senior clinical psychologist at the Royal Melbourne Hospital for over a decade, and has previously held major academic posts at the University of Melbourne and Swinburne University of Technology where he was Director of the Brain & Psychological Sciences Research Centre and the National e-Therapy Centre. Professor Kyrios is the current President of the Australian Psychological Society (APS). Michael's research and clinical work has focused on obsessive-compulsive spectrum disorders, anxiety and mood disorders, depression, chronic medical illness, and

psychological treatments, including e-therapies. His research and conceptual frameworks encompass behavioural, cognitive, neuropsychological, developmental and self-based methodologies.

## Cognitive Remediation Therapy for Anorexia Nervosa

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### **Kate Tchanturia, South London and Maudsley NHS Trust**

The typical neuropsychological profile seen in people with adult anorexia nervosa is characterized by strengths as well as inefficiencies. These strengths include superiority on tasks that require directed analytic effort (Lang et al., 2014). On the other hand, relative inefficiencies are found on tasks which involving flexibility/set shifting skills (Tchanturia et al., 2012). This domain of difficulties includes tasks which involve cognitive switching.

In a recent systematic review, the therapeutic benefits of Cognitive Remediation Therapy (CRT) have been summarised. CRT minimises drop-out rates from treatment and is a strong tool for engagement in treatment. It leads to cognitive improvements following therapy sessions, and some studies have documented functional improvements.

The principles of Cognitive Remediation Therapy and available evidence will be presented to workshop attendees, along with video demonstrations and role play exercises. In this skills workshop, we describe how this understanding of innate vulnerabilities can be translated into treatment in a CRT framework. We will demonstrate the gist of the intervention, and ask participants to role-play exercises that we use in individual and group CRT sessions, specifically tailored for adult anorexia nervosa patients.

Learning Objectives are:

- a) To offer experiential assessment of participants' cognitive style.
- b) To demonstrate some exercises from the manual.
- c) To discuss how CRT can be modified for young people with anorexia nervosa.

References:

- 1) Tchanturia K, Lounes N, Holtum S (2014) Cognitive remediation in anorexia nervosa and related conditions: A systematic review. *European Eating Disorders Review* 22(6):454-62
- 2) Tchanturia K, Lloyd S, Lang K (2013) Cognitive Remediation in eating disorders *International Journal of Eating Disorders Special Issue*. 46(5)492-496 (IF 3)
- 3) Lang K, Lopez C, Stahl D, Tchanturia K, Treasure J (2014) Central coherence in eating disorders: An updated systematic review and meta-analysis; *World Journal of Biological Psychiatry* 1:1-14
- 4) Tchanturia K, Davies H, Harrison A, Roberts M, Nakazato M, Schmidt U, Treasure J, Morris R (2012) Poor cognitive Flexibility in Eating Disorders: Examining the Evidence using the Wisconsin Card Sorting Task *Plos one* 7(1) e2833

## Group Psychoeducation for Bipolar Disorder

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No abstract.

## Using Social Skills Training in Clinical Practice with Children and Adolescents

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### **Sue Spence, Griffith University, Australia**

Many children with emotional and behavioural problems show deficits in social skills in their interactions with other people, such as peers, less familiar adults, and in some instances with family members. Such deficits, not surprisingly, tend to lead to adverse social outcomes and impair effective social relationships. Clinicians, therefore, frequently identify social skills deficits as an issue during the cognitive behavioural analysis, and it is important that a component of the intervention focuses on rectifying social skills deficits. If social skills deficits are left untreated they are likely to result in adverse interpersonal consequences that, in turn, may perpetuate or exacerbate issues such as depression, anxiety,

and conduct problems. Thus, if poor social skills are not tackled during treatment, the long-term effectiveness of psychological therapies may be reduced.

This workshop will focus on the developing practitioner skills in identifying social skills deficits and using specific strategies for enhancing social skills with young people, including modelling, behavioural rehearsal within and between sessions (including the use of role-play and reverse role-play methods), and feedback.

Key learning objectives:

1. To be able to identify social skills deficits
2. To be able to use strategies of modelling, behavioural rehearsal and feedback to teach social skills with young people
3. To be able to engage young people in role-play and reverse role-play for behavioural rehearsal of social skills

Training modalities

2 hour duration

Video demonstration, didactic content, experiential, role-play, case exemplars.

2-3 key references

O'Shea, G., Spence, S.H., Donovan, C.L. (2014). Interpersonal factors associated with depression in adolescents: are these consistent with theories underpinning interpersonal psychotherapy? *Clinical Psychology and Psychotherapy*. DOI: 10.1002/cpp.1849

O'Shea, G., Spence, S.H., Donovan, C.L. (2014). Group versus individual interpersonal psychotherapy for depressed adolescents. *Behavioural and Cognitive Psychotherapy*. doi:10.1017/S1352465814000216

Implication for everyday clinical practice of CBT

The skills learned during the workshop will be applicable as a treatment component for a significant proportion of young clients, presenting with a broad spectrum of emotional and behavioural issues. Clinicians will be better equipped to identify social skills problems and to make use of social skills training methods within their clinical practice, where appropriate, in order to enhance treatment outcomes.

Sue Spence is Professor Emeritus in the School of Psychology and Australian Institute of Suicide Research and Prevention, Griffith University, Brisbane, Australia. Her previous academic appointments include Head of Psychology at the University of Queensland, Australia, and academic positions at the University of Sydney, Australian, and at the Institute of Psychiatry in London. She is a clinical psychologist, and her research and practice focuses on the assessment, treatment and prevention of anxiety and depression in children and adolescents. Sue pioneered social skills training interventions for young people and these approaches are now routinely embedded in cognitive behavioural approaches with a wide range of emotional and behavioural disorders. Along with her colleagues, she developed the BRAVE-Online program, an internet-delivered, clinician-facilitated treatment program for child and adolescent anxiety, which now has a strong evidence-base. A current study is examining the benefits of including social skills training in an online, CBT intervention for children and adolescents with social anxiety disorder. She has recently published in the area of interpersonal psychotherapy for depressed adolescents, which includes a strong focus on enhancing social skills. She is the developer of the Spence Children's Anxiety Scale, a well-established measure for assessing anxiety disorder symptoms in children and adolescents; a measure which is widely used internationally and which has been translated into multiple languages.

## Identifying and addressing conflict as a source of psychological distress

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**Tim Carey, Centre for Remote Health, a joint centre of Flinders University and Charles Darwin University; Sara Tai, University of Manchester**

Background: The importance of conflicted states of mind in the manifestation of psychological distress is implicitly or explicitly acknowledged in many approaches to therapy. In Metacognitive therapy, for example, there are references to people being in "two

minds” about worrying. Acceptance and Commitment Therapy discuss the tendency for people to “wage wars” against their own inner lives and Motivational Interviewing highlights the importance of ambivalence in people’s distress and their efforts to change. Curiously, however, addressing conflict directly is not a common feature of cognitive and behavioural therapies. One of the cornerstones of cognitive therapy is the statement from Epictetus that people are disturbed not by things but by the view which they take of them. From this perspective, thoughts could be considered to be “things” and, therefore, no single thought is disturbing in and of itself. A thought that “I will never find lasting love and happiness” is only disturbing relative to other thoughts the person simultaneously has such as “I want to find lasting love and happiness”. Psychological disturbance arising in terms of the relativity of different thoughts to each other is the essence of the formulation of psychological distress as conflict. In this workshop, clinical material will be used to demonstrate the presence of conflict across a range of presenting problems. The importance of making conflict a central focus of therapy will be discussed and questioning techniques will be introduced to highlight conflict during the therapeutic conversation and to promote the resolution of this conflict and the dissipation of psychological distress.

Objectives: By the end of the workshop the participants will have had opportunities to:

- Identify intrapersonal conflict as a key component of psychological distress;
- Learn questioning techniques to highlight and explore conflict;
- Recognise different forms of conflict in clinical practice, and;
- Discover ways of incorporating conflict into the formulation of clients’ problems.

Modalities: In this workshop a range of training modalities will be used including: didactic, group discussion and problem solving, role play, DVD demonstrations and experiential activities.

Implications: Practitioners will learn to identify the conflicted components of a client’s psychological distress and will begin to use different questioning techniques designed to highlight and address the conflict. Practitioners will be able work more effectively and efficiently by incorporating a conflict formulation into their repertoire of therapeutic techniques and strategies.

References: 1. Carey, T. A. (2008). Conflict, as the Achilles heel of perceptual control, offers a unifying approach to the formulation of psychological problems. *Counselling Psychology Review*, 23(4), 5-16.

2. Mansell, W., Carey, T. A., & Tai. S. J. (2012). *A transdiagnostic approach to CBT using Method of Levels therapy: Distinctive features*. London: Routledge.

3. Carey, T. A., Mansell, W., Tai, S. J., & Turkington, D. (2014). Conflicted control systems: The neural architecture of trauma. *Lancet Psychiatry*, 1, 316-318.

Leaders: Professor Tim Carey PhD is Director of the Centre for Remote Health in Alice Springs. He is a clinical psychologist and Director and Vice-President of the Australian Psychological Society (APS). Professor Carey is a clinician, teacher, and researcher who has been developing and evaluating MOL in Australia and the UK since the 1990s.

Dr Sara Tai is Senior Lecturer in Clinical Psychology at Manchester University. She is an experienced practitioner, researcher, and trainer of CBT and MOL. She provides supervision and workshops internationally and is involved in research on psychoses and bipolar disorders in China, USA, Europe, and the UK.

## How to assess and treat disturbed body image in individuals with eating disorders

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### **Victoria Mountford, South London and Maudsley NHS Foundation Trust**

Background: Disturbed body image is a complex phenomenon that individuals with eating disorders find highly distressing and clinicians can find daunting to treat. This skills class workshop aims to teach clinicians how to understand and treat disturbed body image using cognitive behavioural therapy (CBT) in a clear and straightforward manner. Techniques including behavioural experiments and exposure will be demonstrated. Participants will understand how body image links to broader concepts including identity. The increasing relevance of technology (e.g. photo shopping, social media) to body image – particularly in

younger individuals – and how to address this in therapy will be considered. In addition, participants will be encouraged to reflect on how their own beliefs and experiences regarding body image may relate to the work.

Objectives: By the end of the skills class, participants will

1. Develop skills in assessing and formulating disturbed body image
2. Have a framework for treating disturbed body image in individual and group formats
3. Enhance CBT skills such as behavioural experiments and exposure
4. Have an awareness of issues that may affect this work including social media and one's own body image.

Modalities: A combination of experiential exercises, group discussion and vignettes will be used to demonstrate key points. Audio/ video material and role play will offer delegates the opportunity to observe and practice therapy skills.

Implications: This workshop will be extremely useful for those clinicians who work with individuals with eating disorders, giving them a clear understanding and framework with which to address disturbed body image, in individual or group format.

References: 1. Mountford, V.A., Brown, A., Bamford, B., Saiedi, S., Morgan, J.F. & Lacey J.H. (In press). BodyWise: Evaluating a body image group for patients with anorexia nervosa. *European Eating Disorders Review*. DOI: 10.1002/erv.2332

2. Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V., & Russell, K. (2007). *Cognitive-behavioural therapy for the eating disorders: A comprehensive treatment guide*. Cambridge University Press.

3. Farrell, C., Shafran, R., & Lee, M. (2006). Empirically evaluated treatments for disturbed body image: A review. *European Eating Disorders Review*, 14, 289-300.

Leaders: Dr Vicki Mountford is a clinical psychologist at the Eating Disorders Service at South London and Maudsley NHS Foundation Trust. She combines her clinical practice with research and teaching. Her interests include body image, cognitive behaviour therapy and the delivery of such treatments. She is a BABCP accredited practitioner, supervisor and trainer. She has published 28 peer-reviewed articles and a number of books and chapters.

## Using technology to enhance delivery of face-to-face Cognitive Behavioural Therapy

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### **Richard Stott, Institute of Psychiatry, Kings College London; Emma Warnock-Parkes, Oxford University**

Background: Technology is transforming many areas of our lives. However, there is very little research on using technology in face-to-face therapy. Our team, run by Professors David Clark and Anke Ehlers, specializes in developing novel ways of delivering Cognitive Therapy in anxiety disorders. The treatments have evolved over time, with the emergence of readily available and powerful technology such as smart phones and the internet. During our clinical trials we have developed a number of innovative ways of using technology that enhance face-to-face therapy. This may be one factor in explaining the increasing effect sizes of our treatments in recent years. During this skills class participants will have demonstrated and be able to practice a number of novel ways of using technology to enhance any CBT session. By the end of the class participants will be able to apply what they have learnt to their everyday practice transdiagnostically.

Objectives: By the end of the class, participants will be able to

- 1) Use technology to assist in evidence based imagery interventions
- 2) Utilize technology, including smartphone apps, to aid components of therapy e.g. behavioural experiments
- 3) Develop confidence using a variety of online resources e.g. Google Streetview for stimulus discrimination and site visits in PTSD treatment
- 4) Use technologically mediated communication alongside sessions to improve therapy adherence
- 5) Understanding the ethical issues of technology use in therapy

Modalities: The skills class will use video and live demonstration and allow participants the opportunity to practice novel skills presented across a range of disorders. Participants may benefit from bringing along smartphones, tablets or laptops, but this is not essential.

Implications: The skills class is applicable to treating all disorders and will arm clinicians with the confidence and knowledge of using novel ways to deliver therapy effectively.

References:

Leaders: Dr Richard Stott is a Clinical Psychologist at King's College London and the Centre for Anxiety Disorders and Trauma at the Maudsley Hospital, and is also a technology specialist. Over the past 10 years he has helped develop and refine the cognitive treatments for anxiety disorders, including internet-based treatments.

Dr Emma Warnock-Parkes is a Clinical Psychologist Researcher at King's College London and Oxford University. Emma specializes in further developing the efficacy of cognitive therapy in comorbid conditions, and has developed innovative ways of delivering therapeutic interventions utilizing technology.

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## Age Appropriate Augmented CBT with Older People: Wisdom Enhancement

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No abstract.

## Poster Presentations 1 (Wednesday)

Drive for thinness and cognitive bias: Is attention drawn towards or away from the torso?

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**Layla Hamadi, University of Oxford;** Robert Davies, University of Lancaster; Giles Anderson, Oxford Brookes University

Cognitive bias causes the brain to selectively focus attention on specific stimuli and is implicated in the maintenance of a range of disorders such as eating disorders

Individuals with disordered eating process words and images associated with food and body shape stimuli differently to controls but it is unclear whether this effect leads individuals to fixate on, or avoid, such stimuli. Eye tracking studies, using drive for thinness as a measure for disordered eating, have found conflicting results regarding whether high drive for thinness causes participants to avoid or fixate on images of the female torso (a body region associated with assessing changes in weight). There is further disagreement in the literature whether an effect of drive for thinness on attention can be found in the general population. Participants: 48 female participants aged 20-66 (median 32.7 years) were recruited from the general population. Experimental task: Participants were presented with screens containing face and torso images from either the left or right hand side of the body and asked to select the odd one out. Measures: Reaction times and eye movements were recorded. Drive for thinness was measured using the Eating Attitudes Test (EAT). Analysis: An ANCOVA with EAT score as the covariate was used to determine effect of drive for thinness on reaction time and dwell time. EAT scores ranged from 0-56, with a mean of 7.65. A score of 20 or above indicates a high level of concern about dieting, body weight and problematic eating behaviours. In the 'Torso as Distractor' condition the torso is not the correct answer but could cause a slower reaction time in those with higher drive for thinness (a 'salient' distractor)

All participants were slowed down in the condition with the salient distractor. Those with high drive for thinness were slowed more significantly. The time spent looking at the correct image varied across the conditions. Those with high EAT scores looked longer at face images in both conditions where a torso was present. Our findings support the theory that images with high body salience may disrupt attention in those with high drive for thinness in the general population. Higher EAT scores were associated with a longer amount of time looking at face images,

suggesting an avoidance of the torso. These findings may add to current evidence that avoidance is a therapeutic target.

## Should third wave therapies, be the first choice in the treatment of eating disorders?

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### **Joanne Augustus (nee Fear), The Priory Hospital Bristol**

Since the publication of NICE guidance for the treatment of eating disorders in 2004, the provision of psychological therapies has been transformed, both in primary and secondary care. Cognitive behaviour therapy (CBT) is still recognized as the treatment of choice for bulimia and binge eating disorders. However, the evidence base for CBT in the treatment anorexia is considerably weaker. Given the increasing complexity of patients referred into services, there is a clear need for third wave therapies to offer choice and flexibility, to promote recovery. Third wave therapies includes, dialectical behaviour therapy (DBT), acceptance and commitment therapy (ACT), schema therapy, mindfulness-based cognitive therapy (MBCT), and metacognitive therapy (MCT). In particular, mindfulness based interventions have gained much attention, in the treatment of depression and more recently anxiety. This poster will present the different therapeutic models used to treat eating disorders and their associated evidence bases. To review randomized controlled trials, longitudinal studies and pilot studies that have been conducted within the last 10 years, demonstrating the efficacy and effectiveness of third wave therapies. The results demonstrate important developments in the treatment of eating disorders. They also show a developing evidence base and in practice the potential to effectively treat complex patients, using third wave therapies. Despite the growing availability of third wave therapies in everyday practice, there remains a lack of empirical evidence to support its effectiveness. However, this presents an opportunity to conduct research, especially in comparative studies e.g. ACT compared to CBT and DBT compared to psychodynamic therapy, in the treatment of eating disorders. With an emerging evidence base, there will be a growing choice of psychological therapies for patients to access, beyond or to use in conjunction with, the traditional CBT model. In addition, there will also be a greater choice of training models for the therapist to offer the patient. However, the use of supervision will be of paramount importance to ensure therapist drift is kept to a minimum, in order to maximise the appropriate application of third wave therapies.

## Can Tetris disrupt intrusive memories while sparing other aspects of trauma memory? Theoretical puzzle and therapeutic promise

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**Alex Lau-Zhu, MRC Cognition & Brain Sciences Unit, Cambridge;** Rik Henson, MRC Cognition & Brain Sciences Unit, Cambridge; Emily A. Holmes, MRC Cognition & Brain Sciences Unit, Cambridge

Involuntary, intrusive memories of trauma represent a hallmark symptom of Post-Traumatic Stress Disorder. Laboratory studies have shown that performing the visuospatial computer game Tetris soon after an experimental trauma (i.e. during memory consolidation) reduces subsequent intrusions. Theoretically, the underlying memory processes remain unclear. Therapeutically, it may be important to preserve one's ability to voluntarily remember trauma. Therefore, this study uses novel memory measures to investigate whether other aspects of memory for experimental trauma are also disrupted, in addition to intrusions. The trauma film paradigm is an experimental analogue for trauma. Soon after exposure to a stressful film, participants were randomly assigned to either play Tetris or No-task. They kept a one-week diary of film-related intrusions. They then returned to the laboratory and completed memory tests: free recall, perceptual priming and visual recognition. This study replicated the effect of Tetris (vs. No-task) on reducing diary intrusions. However, there were no significant group differences on measures of voluntary memory: free recall or visual recognition. Interestingly, there was also no significant difference on another measure of involuntary memory: perceptual priming. Tetris appears to reduce intrusions while sparing recall, recognition and priming of the same underlying memory for experimental trauma. This selective interference is theoretically puzzling: it challenges traditional perspectives on memory, which would expect a general memory disruption. Nevertheless, the findings are therapeutically promising: mitigating the distressing intrusiveness without 'erasing' the underlying

trauma memory may be more ethically desirable. These findings suggest that the use of a simple cognitive tasks, such as the computer game Tetris, may be of clinical value for preventing intrusive memories following psychological trauma, possibly without the legal and ethical ramifications of full memory 'erasure'.

## Effectiveness of Finding Work Course using CBT practice in a South West London IAPT Service

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**Stephen Charlery, Wandsworth IAPT; Melissa Oshinowo, Wandsworth IAPT**

The Wandsworth IAPT Finding Work Course has been successfully running for 3 years as a group intervention using CBT techniques

Our approach:

Group Work

Role Play

Motivational Interviewing

Behavioural Activation

Guest Speakers

Group Discussion

Video/ DVD Clips

Benefits of working in a group:

- Shared learning and ideas
- Hearing stories/ experiences
- Networking
- Motivation
- Supportive environment
- Reduces isolation

The 5 week programme covers the following topics:

Motives for attending the course, Benefits & Barriers of returning to work; The importance of exercise and nutrition when looking for work; CV preparation, application form filling and personal statements;

Interview preparation and techniques; Disclosure of mental health in the workplace, Taking the initiative in job searching, the use of Social media; Visitors from various partner organisations.

120 people have attended the course with 40% achieving sustainable employment. We are pleased to report that over the three years there has been a 65% attendance rate. By using a CBT approach in a Finding work course group setting it was shown that many clients had made improvements in their wellbeing and recovery and examples are illustrated below:

Snapshot of Minimum Dataset (MDS) Score:

Patient 1

Generalised Anxiety Disorder Score (GAD) went from 13 to 7 by the end of treatment

Patient Health Questionnaire score (PHQ) went from 19 to 12 by the end of treatment

Work and Social Adjustment Score (WSAS) went from 13 to 8 by the end of treatment

Patient 2

Generalised Anxiety Disorder Score (GAD) went from 27 to 8 by the end of treatment

Patient Health Questionnaire score (PHQ) went from 21 to 7 by the end of treatment

Work and Social Adjustment Score (WSAS) went from 38 to 26 by the end of treatment

We also use PEQs (Patient Experience Questionnaires) to capture client feedback and experience

There is research evidence to show that work is good for our mental health (Waddell & Burton)

There is also evidence that being unemployed renders people vulnerable to becoming depressed, less active and, as a result, less able to find subsequent employment.

There are a number of important reasons for this tendency:

Firstly, being unemployed is an unpleasant experience for most people and dwelling on this situation will inevitably lower your mood;

Secondly, unemployment removes daily structures and routines so that there is a danger of drifting into a state of mental and physical flux if insufficient attention is paid to maintaining a daily routine.

## Causes, complexity and consequences of CFS/ME and depression: A qualitative study

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**Maria Loades, University of Bath;** Anna Taylor, University of Bristol; Esther Crawley, University of Bristol

Paediatric CFS/ME has a prevalence of 0.2-2.4% and is defined by RCPCH as 'generalised disabling fatigue persisting after routine tests and investigations have failed to identify an obvious underlying cause'. Approximately one third have co-morbid depression, but little is known about why depression develops, the relationship between depression and CFS/ME and what treatment strategies might be helpful.

This study aimed to explore the relationship between Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) and depression in young people, hypothesizing that depression is secondary to CFS/ME and mediates outcome. Young people aged between 12 and 18 with a HADS (Hospital Anxiety and Depression Scale) depression subscale score of >9 were recruited from follow-up appointments with the Bath Paediatric CFS/ME Service. We conducted nine semi-structured interviews using a topic guide structured on their response to the HADS and covering: why they thought they had become depressed, whether their CFS/ME preceded the depression, and their views on treatment. The following themes emerged: Causes of depression: most children described the depression as being caused by their CFS/ME. Reasons given included: impact on school, impact on family, no energy to enjoy things and lack of control. One child described their low mood pre-dating their fatigue. Complexity: Children described a complicated interaction between their mood and fatigue. In some cases, they understood the circular relationship between mood and fatigue. Consequences and conflict: both CFS/ME and depression had a significant impact on the child's quality of life. Treatment approaches for the CFS/ME appeared to be in conflict with treatment for mood as they concentrate on reducing activity that may have improved the child's mood. This is the first study that suggests that depression is often secondary to paediatric CFS/ME and is caused by the impact CFS/ME has on quality of life. This suggests that CFS/ME treatment should include strategies to prevent the development of depression. The treatment approaches used for mood and fatigue appeared to be in conflict with each other. Further research needs to be done to develop treatment approaches that can be effective in the presence of both CFS/ME and depression. CBT is the main evidence-based treatment for both CFS/ME and depression in children and young people. However, there are some inconsistencies between CBT for CFS/ME, which involves activity management (often curtailing enjoyable activities, at least temporarily) and CBT for depression which includes activity scheduling (increasing activities that give a sense of pleasure and/or mastery). The findings of this qualitative study can help clinicians working with young people who have both CFS/ME and co-morbid depression to tailor their interventions to best fit thus enhancing collaboration and treatment outcome, and will inform the development of potentially efficacious treatments.

## Demonstrating the benefits of going 'back to basics' in the treatment of a client with complex long-term problems, including OCD

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Rachel Marsh, University of Bath

Mrs G presented with extreme OCD amid multiple physical complaints, 20+ years of mental health services, numerous diagnoses and a plethora of treatments, none of which had any lasting impact on the OCD.

It was hypothesised that beliefs about God, low self-esteem (LSE) and experiences of loss following periods of happiness had led to associations between happy thoughts or doing wrong with punishment by God through harming her son. Feelings of happiness or wrong doing were avoided; if this failed Mrs G engaged in extensive rituals to terminate/minimise her obsessions.

Sixteen CBT sessions aimed to help her understand her OCD (short term goal), reduce rituals to < 1 hour per day (medium term goal) and no longer be troubled by her obsessions, compelled to do her rituals or feel upset by not doing them (long term goal).

Y-bocs ratings reduced from 40 (extreme) to 19 (moderate) and her belief that 'God will harm her son because she has been or is a bad person' reduced from 90-100/100 to 40/100 after 16 sessions.

Short-term meaningful change can be made in long-standing complex presentations with disorder specific, time-limited CBT.

A fresh CBT approach to formulation with a detailed assessment can be extremely valuable for long-term 'treatment resistant' cases.

Discussions with the Trust Priest were invaluable for managing anxieties around challenging religious views in the context of OCD. This consultative approach enabled open, sensitive exploration with the client and is highly recommended.

## CBT and MBCT with an older adult to improve self-esteem and reduce the symptoms of depression and anxiety

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Rachel Marsh, University of Bath

Mrs P was referred following an overdose, was low in mood, highly anxious and at risk of becoming emotionally isolated.

It was hypothesised that early experiences led to a negative global self-schema and dysfunctional assumptions about being worthless. To maintain control and cope, rules for living and standards were developed. Critical incidents activated the negative self-schema and dysfunctional assumptions, leading to a depressive vicious cycle, reinforcing the dysfunctional beliefs. Concerns about not meeting standards and rules for living maintained a vicious cycle of anxiety, also reinforcing negative beliefs.

The cognitive formulation indicated that standard CBT targeted at low self-esteem, combined with elements of MBCT, would likely be helpful in treating the symptoms of depression and anxiety.

Anxiety and depression symptomology moved below the clinical threshold on the GDS and GAI over 10 one-hour weekly sessions. Heavy use of 'self-blame' was reduced by the end of therapy; Mrs P was noticeably using alternatives for 'should' such as 'I could' or 'if I want to' and demonstrated greater compassion for herself and the situation she was in.

We worked together using Fennell's cognitive model for LSE to create distance from old negative perspectives; develop mindful awareness of negative thinking biases; step out of auto-pilot; develop curiosity and flexibility in thinking and start to alter cognitive content. This case demonstrates that the integration of CBT and tools from MBCT, based on Fennell's cognitive model for LSE, can have a positive effect on symptoms of anxiety and depression in an older adult.

## Does cognitive reactivity to low mood increase with the number of prior depressive episodes?

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**Katie Chung, University of New South Wales;** Michelle Moulds, University of New South Wales

As the number of major depressive episodes (MDEs) previously experienced by an individual increases, so does his/her risk of depression recurrence; individuals with 4 prior MDEs face a 90% chance of becoming clinically depressed again. According to the Differential Activation Hypothesis (DAH; Teasdale, 1988), this is due to an increasing cognitive reactivity to low mood over successive MDEs (i.e., depressogenic patterns of thinking become more readily and quickly reactivated by low mood), which increases the likelihood that low mood will intensify and persist into clinical depression. While this has yet to be directly tested, findings in the broader depression literature provide indirect support for this hypothesis.

Structured clinical interviews were conducted to determine if participants had previously met criteria for a MDE, and if so, how many. Recovered (n = 78) and never-depressed (n = 109) participants then completed self-report measures of cognitive reactivity to low mood, tendency to ruminate when sad, and depressive attributional bias. Consistent with previous research, recovered individuals reported greater cognitive reactivity compared to never-depressed controls. However,

contrary to the predictions of the DAH, individuals with 3+ prior MDEs do not differ significantly from those with 1-2 prior MDEs in the extent of their self-reported cognitive reactivity. While this seems to suggest a positive outlook for recurrently depressed individuals, the findings suggest that the DAH warrants further investigation in studies that (i) include sad mood inductions and (ii) eliminate the influence of potential moderating variables. Beyond theoretical implications for cognitive models of depression vulnerability, there are clinical implications regarding early intervention, case formulation, and relapse prevention.

## Investigation into the Efficacy of the Emotion Focused Formulation Approach (EFFA) for patients identified as benefiting less from protocol driven interventions in an IAPT (Improving Access to Psychological Therapies) Service

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Jack Siou, italk Southern Health NHS Foundation Trust and Solent Mind; Morad Margoum, italk Southern Health NHS Foundation Trust and Solent Mind.; Hazel Nicholls, italk Southern Health NHS Foundation Trust and Solent Mind; **Isabel Clarke, italk Southern Health NHS Foundation Trust and Solent Mind.**

EFFA, an integrated third-wave formulation based approach, previously piloted in acute services (Clarke, 2008, 2009; Durrant, Clarke, Tolland & Wilson, 2007; Araci & Clarke; in submission) was adapted for IAPT services. Arising from auditing a patient cohort with limited recovery from existing interventions, a Strategic Health Authority project was funded to develop a service for this group. The audit identified the target group as having problems exacerbated by complex trauma (normally characterised by relationship difficulties and chronicity). The approach incorporates consideration of past trauma and relational aspects of therapy into its collaborative formulation and facilitates motivation towards clear treatment protocols for IAPT therapists. The present study evaluates the efficacy of this approach. Implementing a quasi-experimental design, a comparison is drawn between two experimental groups (n=60) and control group (n=30). Using a brief-interpersonal functioning measure to screen for caseness and an assessment of model fidelity, convenience sampling identified relevant cases. The two experimental groups differed according to supervision levels. The standardised depression (PHQ-9) and anxiety measures (GAD-7) are used to measure therapeutic response and a three-way factorial ANOVA is applied to establish effects of the different groups on outcome measures. Post-hoc analyses are employed to explore the interactions. At the time of submission, conclusions could not be drawn regarding the study as the final experimental group had not completed the intervention. The conclusion intends to identify the different recovery rates between each experimental group and explores the consequences for service delivery and this client group who typically represent 'unmet need'. The evaluation of this new approach for the proportion of IAPT referrals identified by audit as benefiting less from protocol driven interventions by reason of complication arising from early trauma, attachment issues and complexity will contribute to everyday clinical practice.

## Case report using Emotion Focused Formulation Approach in an IAPT service

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Mel King, italk Southern Health NHS Foundation Trust and Solent Mind; Hazel Nicholls, italk Southern Health NHS Foundation Trust and Solent Mind.; Isabel Clarke, italk Southern Health NHS Foundation Trust and Solent Mind; **Jack Siou, italk Southern Health NHS Foundation Trust and Solent Mind**

Miss A presented to the IAPT service, with moderate anxiety and depression, to address her inability to maintain intimate relationships with men. Sexual abuse at age 7, past self-harming behaviours and subsequent relationship difficulties led to the decision to include Miss A in the Emotion Focused Formulation Approach (EFFA) pilot. EFFA, designed for patients who do less well with NICE prescribed therapies, takes into account the impact of past traumas on current problems. Assessment identified that intimate relationships re-ignited her fear of being harmed by men. The formulation tracked how early abusive experiences led to Miss A's coping with this overwhelming affect by emotionally distancing herself from her partner while appearing to be connected. This coping strategy, effective in the short-term, ultimately led to the relationship foundering. Intervention will target Miss A's ability to tolerate the aversive emotion, recognise it

as historical and so develop true intimacy. This will be measured using the PHQ9 for depression and GAD 7 for anxiety and an idiosyncratic self-report measure of genuineness and closeness. To be completed at end of therapy. The evaluation of this new approach for the proportion of IAPT referrals identified by audit as benefiting less from protocol driven interventions by reason of complication arising from early trauma, attachment issues and complexity will contribute to everyday clinical practice.

## Effectiveness of a CBT based Anger Management Course in Routine Clinical Practice in a South London IAPT Service

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**Alexander Sim, Wandsworth IAPT; Helen Layton, Wandsworth IAPT**

Anger has far reaching effects on individuals, relationships and communities. In a 2008 poll by the Mental Health Foundation 12% of those polled said they had trouble controlling their anger, 32% said they have a close friend or relative who has difficulty controlling their anger, 20% said they had ended a relationship with someone because of that person they behaved when they were angry (Boiling Point Report, 2008) and having an angry outburst even puts you at increased risk of a heart attack or stroke (Mostofsky, Penner & Mittleman, 2014). It is therefore important that, when anger is causing problems, mental health services provide effective treatments to help people manage it. There are various psychological models and treatments for anger, ranging from psychoanalytic attachment and theory of mind models (Joseph & Macleod, 2014), humanistic (Rothschild, 1999) and systemic models (Robins & Novaco, 1999) to REBT (DiGuiseppe, Eckhart & Tafrate, 1999) and CBT (Deffenbacher, 2011) based models. In a meta-analysis of treatment approaches, Del Vecchio and O'Leary (2004) found a large effect size for both individual and group CBT treatments for anger difficulties. However, despite an extensive literature search, no research could be found that evaluates the effectiveness of CBT based Anger Management Groups within IAPT services. This study will evaluate the effectiveness of an 8 week CBT based Anger Management Course at Wandsworth IAPT, a South London IAPT Service. The Anger Management Course was evaluated on "movement to recovery" on depression and anxiety measures, patient experience collated from patient feedback forms and reduction in State Trait Anger Expression Inventory (STAXI-2) scores. As the Anger Management Course has been run at Wandsworth IAPT since it became an IAPT service in 2009, a retrospective audit of all 22 groups run between 2009 and 2015 was conducted. Throughout the running of these groups, outcome data was collected on a session by session basis for each service user by means of the Patient Health Questionnaire (PHQ-9) and the Generalised Anxiety Disorder Questionnaire (GAD-7). The PHQ-9 consists of 9 questions designed to assess a client's level of depression (Kroenke, Spitzer, & Williams, 2001). The GAD-7 consists of 7 questions designed to assess a client's level of anxiety (Spitzer, Kroenke, Williams, & Löwe, 2006). Comparing service users' scores for the PHQ-9 and the GAD-7 from their first group session and their last, their "movement to recovery" was calculated. "Moving to recovery" is defined by IAPT as the number of people who at initial assessment had a PHQ-9 score of 10 or more or GAD-7 score of more than 8, but at final session did not (IAPT, 2011).

IAPT services are encouraged to achieve a target of "half of those who complete treatment, moving to recovery" by 2015 (HSCIC, 2013), i.e. 50% of the total number of people seen by the service "moving to recovery" by 2015. In line with IAPT central's criteria for the calculation of "moving to recovery", this study only included those who attended more than one session of the groups, as these were the only patients with two data points from which to compare psychometric scores and calculate "movement to recovery". Additionally, in line with guidelines produced by IAPT central (HSCIC, 2013), those service users whose scores were below 10 on the PHQ-9 and below 8 on the GAD-7 at their first data point are classed as "non-caseness" and are not included in calculating recovery rates, as "non-caseness" is deemed not severe enough to chart "movement to recovery". Patient Experience Questionnaires from the same period were collected, collated and analysed. After comments were collated, they were grouped according to similarity in content by a Psychological Wellbeing Practitioner at the service. Once these comments had been grouped together, each group of comments was labelled with a particular theme. Some comments were assigned to more than one theme. From late 2013 onwards, a disorder specific questionnaire, the State Trait Anger Expression Inventory-2 or STAXI-2 (Spielberger, 1999) was introduced alongside the PHQ9 and GAD7, to specifically assess changes in self-reported anger levels pre

and post intervention for the further 7 Anger Management Courses. For analysis, this measure was then separated into State Anger, Trait Anger and Anger Expression. As this measure takes a long time to complete, this could only be administered at first and last session, not on a session by session basis, so if participants dropped out, then unfortunately no post intervention STAXI-2 was collected from them.

From the full retrospective audit of “movement to recovery” 199 people were booked on Anger Management Courses in the service, of which 92 attended at least one session and 107 did not attend the course at all; this equates to a 46% attendance rate and 54% non-attendance rate. Of the 92 that attended at least one or more sessions, 21 had “non-caseness” at their first data point and so were excluded, leaving a total of 71 where 47 “moved to recovery” in their outcome scores (66% “moving to recovery” rate). 100% of respondents to the Patient Experience Questionnaire agreed or strongly agreed that “the service has helped me to have a better understanding of my problems” and that “I had confidence in my therapist and his / her skills and techniques”.

Comments in the comments box section were almost entirely positive too. The positive comments highlighted skilled group facilitators, comprehensive and useful course content and the group environment itself facilitating learning, motivation and change. 28 participants completed the course, and thus the STAXI-2, between late 2013 and 2015. From these:

#### Anger Expression

-pre-intervention Anger Expression mean was 54.93 (SD= 12.37) and post-intervention mean was 43.25 (SD= 15.38),  $r= 0.67$ . Thus the effect size for reduction in Anger Expression was 1.031. A large effect size.

#### State Anger

-pre-intervention State Anger mean was 19.79 (SD= 6.58) and post-intervention mean was 16.54 (SD= 2.40),  $r= 0.32$ . Thus the effect size for reduction in State Anger was 0.621. A medium effect size.

#### Trait Anger

-pre-intervention Trait Anger mean was 23.75 (SD= 6.85) and post-intervention mean was 20.79 (SD= 6.33),  $r= 0.51$ . Thus the effect size for reduction in State Anger was 0.456. A nearing medium effect size.

A medium/nearing medium effect size in reduction of State and Trait Anger is certainly positive, but as the Spielberger (1999) highlights, the most destructive part of anger is its negative expression, so a large effect size in the reduction of Anger Expression is encouraging. A “moving to recovery” rate of 66% exceeds IAPT’s target of 50% of clients “moving to recovery” between first and last contact. The results also exceed the “moving to recovery” rate of the Wandsworth IAPT service as a whole, where the overall “moving to recovery” rate is estimated at 46% for 2014. This suggests that although the Anger Management Course does not primarily target symptoms of depression or anxiety, it is still able to induce a reduction in pathology in those areas, perhaps due to the overlap of symptoms but also possibly because by addressing anger difficulties, guilt and worry (more measured by the PHQ9 and GAD7 respectively) about anger is in turn reduced. An average 54% non-attendance rate for the Anger Management Course is however a cause for concern, as the overall non-attendance rate for individual therapy at Wandsworth IAPT is approximately 25-30%. However, it was not possible to isolate the non-attendance rate for those seeking individual treatment for anger difficulties, as anger is not separated out as a distinct diagnosis. As an area for future development, it would be important to explore reasons for the high non-attendance rate, as this may improve the Anger Management Course uptake rates. Though research has suggested that those with anger difficulties are especially ambivalent about accessing treatment, and it is possible the group environment deterred them even more. The thematic analysis of PEQ comments showed that the group environment itself contributed to an improved experience for participants and participants often wanted more sessions of group therapy, or at least some follow-up sessions. It would be useful to investigate which group process factors, such as universality or group cohesiveness (Yalom, 1970), contribute to improved outcomes. The main implication of these findings is that anger problems can be effectively treated in IAPT services using a group CBT intervention, which potentially operates at a lower cost (Bonin, Beecham & Brown, 2012) and can accommodate more participants than individual CBT, without increasing service users’ waiting times.

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## Measuring Compulsive Checking Behaviours in the Laboratory

**Melissa Black, School of Psychology, UNSW AUSTRALIA;** Jessica Grisham, School of Psychology, UNSW AUSTRALIA

Studies investigating cognitive bias modification (CBM) procedures or computerized treatment techniques have traditionally included self-report measures of outcomes. However, it is vital for these studies to include multi-method assessments including behavioural tasks and physiological measures in order to examine links between cognition, behaviour, and physiology and to address concerns regarding demand characteristics. This study sought to compare different behavioural assessment techniques for compulsive checking, with the aim of identifying key factors that may inform development of future procedures for computerized interventions. Across multiple studies, a number of assessment measures of checking behaviours were compared. These included questions about a Memory Game (Alcolado & Radomsky, 2011), data entry, sorting out salivette tubes, sorting out lollies (Ladouceur et al., 1995), and a probabilistic inferences task (Garety, Hemsley, and Wemsley, 1991). Some of these tasks asked about participants' perceptions of their performance. Recordings of task performance were used to code checking behaviours. Most studies were conducted with unselected or analogue student samples, and although some techniques showed differences between those indicating high versus low levels of checking symptoms, the tasks did not appear to be sensitive to experimental manipulations of interpretive biases.

The results suggest that further research is needed to optimize behavioural measures of compulsive checking. These results will be considered in the context of behavioural tasks used in other laboratories. Improving behavioural coding procedures, evoking a greater sense of responsibility and tailoring procedures to idiosyncratic checking behaviours may be necessary in order to improve behavioural measures. Research in the laboratory is crucial in determining what may be effective in the everyday practice of CBT. However, many studies only examine self-report data in determining outcomes. The links between cognition and actual behaviour must be studied, despite challenges in developing a standardised, experimentally sound, and ecologically valid procedure for the laboratory.

## Taking Steps - Recovery Through Therapy

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**Jonathon Slater, Nottinghamshire Healthcare NHs Trust;** Glenn Painter, Nottinghamshire Healthcare NHS Trust

Although individual CBT for Psychosis (CBTp) has proven efficacy and should be routinely offered, studies evaluating participant experiences are limited, particularly in conditions of high security (HS). HS patients are disadvantaged by traditional methods of evaluation. Chief Complaint Orientated CBTp (C-Co CBTp), a variant of CBTp, is offered in HS. This study aimed to evaluate participant experiences of individual C-Co CBTp within HS conditions. Collaborative group game design was used as a novel method of participatory action research to evaluate participant experiences of C-Co CBTp. Visual representation and descriptive and thematic analysis were used to analyse generated data. Dynamic participant validation of descriptions and themes was integral to the analysis. 15 participants (patients and practitioners) developed a life size game representing their experiences of C-Co CBTp and offered feedback on the process. The game comprised of 24 squares, each depicting and describing a therapy experience, and three sets of game play cards. Game play cards moved players around the game squares in a way which participants felt mirrored their therapy journeys. The rich quality of generated data suggests that participatory action research using collaborative group game design is a viable means of evaluating HS participant experiences of C-Co CBTp, although replication is warranted to determine generalisation. Findings corroborate and add to the current evaluation literature. Particular emphasis was placed on collaboration, the therapeutic relationship, therapy as a non-linear process, and vulnerability and hope.

A number of potential implications emerged for everyday clinical practice including the use of CBTp variants such as C-Co CBTp to successfully engage typically non-adherent HS patients experiencing persistent and often chronic psychosis. The value of novel means of participant evaluation and the need to emphasise sensitive collaboration and communication when engaging individuals with complex health experiences were paramount.

## "I always thought I was different", patient's experience of CBT for Psychosis groupwork in a forensic setting

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### **Alison Dudley, Broadmoor Hospital**

NICE guidelines recommend the use of talking therapies for schizophrenia, suggesting it can enhance the management of symptoms and therefore compliments pharmacological treatment (NICE, 2009). Research that support this guideline has predominantly been conducted within adult in-patient services and early intervention services. There is increasing evidence from forensic mental health settings that also appear to support the effectiveness of the use of CBT for psychosis (Williams, et., al 2013). One source of evidence that has not been explored is the patient experience of this treatment. The aim of the study was to explore the patient's experience of attending and completing a specific groupwork intervention whilst being detained in conditions of high security. This approach also enhances the therapists understanding of the changes made by the patient within therapy (Newton et al., 2007) and ensures responsivity to individual needs (Berry and Hayward, 2011). A semi-structured interview was used to collect data. The researcher used open questioning to aid the participant to respond in an open and honest manner about their experiences. Extensive consideration was given to the research question and a question guide was produced to aid the interviewer which included prompts in case of difficulties in remembering or a lack of understanding in the questions. Interpretative phenomenological analysis (IPA) was selected because it offers a means of accommodating a realist and relativist philosophical position and in so doing adopts a flexible epistemological position allowing an in-depth analysis of individuals to explore the defining features of lived experience (Smith, 2004; Ware and Ravel, 2007). It also enables people to understand their experiences from a psychological perspective (Larkin, Watts and Clifton, 2006). IPA is widely used in clinical and health psychology because it shares the same importance of making sense of experiences (Smith 2004). Eight participants who had recently completed the CBT for psychosis group were invited to participate in the study. Two potential participants declined, and the other six agreed. All participants were male forensic patients detained under the Mental Health Act (1983). Inclusion criteria included participants between the ages of 18 and 75, who had completed at least 12 sessions of the group within the past two years. Exclusion criteria included:

- anyone who was floridly psychotic
- were unable to engage in an interview.
- any potential participant who had left the hospital.

Three main superordinate themes were drawn out of the participants experiences. The themes included:

I am not alone - learning through others and normalising and sharing; Making sense - remembering isn't easy, readiness vs coercion, understanding development of illness and symptoms and making new links with offending; Life beyond - learning coping strategies, stigma and trying not to come back. The theme "I am not alone" highlighted the importance of having the opportunity to share the experiences of the participants and understand the similarities as well as the differences between themselves. It is important to acknowledge that whilst group interventions are not always promoted as an effective method (Payne and Marcus, 2008), this study supports factors such as universality, learning opportunities, cohesion and personal growth which are not available in individual therapy (Yalom, 1983, DeLucia-Waack and Nitza, 2014). Theme two focused on making sense, both in relation to mental illness and links with offending behaviour. It highlighted a number of examples that suggested it was difficult for some participants to learn or retain information presented in the group. The development of time-lines enabled patients to create living documents of their histories, enabling them to turn early chaotic experiences into a coherent narrative (Moore and Ramsden, 2012). Theme three highlighted the importance of life beyond high security. This was understood in relation to living a fulfilling life despite having a diagnosis of mental illness, a history of being an offender and an ex patient of high security. The priority task in relation to recovery is the holding and instilling of hope for patients (Hogan, 2003). A strength of the study is that it offers a perspective on evidence of what works that can be overlooked. Another strength is to avoid potential influences by the researcher interviews where conducted by someone who was independent to the group. One limitation of the study is the choice of method focuses on individual experience and cannot therefore inform a generalisable experience of CBT for psychosis in a group format. One implication for practice is that due to the

treatment is often offered later on in the participant's pathway by which time symptoms are generally managed through the use of anti-psychotic medication, which reduced the opportunities to put some of the coping strategies into practice and could only be explored hypothetically. A clinical implication could be that in line with the curative factors of groupwork, it is important to consider the composition of therapists and patients when planning group interventions.

### Using their VOICE: The relationship between inpatient views of their care and the frequency of adverse events.

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**Ailsa Munro, The University of Manchester;** Sarah Jones, The University of Manchester; Gillian Haddock, The University of Manchester

Service users often report viewing inpatient wards as untherapeutic and unsafe environments (Department of Health 2002). Given the high levels of incidents currently reported on inpatient wards it is important to take service user's views of this environment into account and explore whether these may relate to the number of behavioural incidents these same service users are involved in. Adverse patient behaviours contribute to the stress of the environment on inpatient wards, this combined with the need for effective risk management and the emphasis placed on the need to learn from previous incidents make it important to focus on identifying the range of possible underlying factors and to listen to the opinions of patients involved in these incident reports. This poster will present a comparison of Service User scores on a Perception Questionnaire VOICE (Views of Inpatient Care) and the frequency of their behaviour-related adverse events- captured by incident reports completed by ward Staff. The sample consists of individuals participating in a Suicide Intervention study. Participants were asked about a number of themes including their views of staff, medication, the overall environment and their care and treatment. The poster will present results on the analysis of participants' scores on the VOICE questionnaire and the frequency of their behaviour related adverse events. Qualitative data from "any other comments" written by participants will also be considered. Inpatient wards can be challenging and dangerous places for Service Users and Staff. This study will look at the potential role of inpatients' views in helping us think more about the adverse behaviour that frequently occurs and is recorded in this environment. Understanding more about service user's views of inpatient settings and investigating whether this is helpful in understanding particular behaviours could have important consequences for developing ways of managing risk and improving safety on the ward. In addition to this data captured on patient views could have implications for the consideration of future treatment/approach options including talking therapies such as Cognitive Behavioural Therapy.

### Increasing access to Psychological Services for those with recurrent depression: A large multi-centre group CBT Programme

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**Sue Lane, Birmingham and Solihull Mental Health Foundation Trust;** Fay Cook, Birmingham and Solihull Mental Health Foundation Trust; Kinza Janjua, University of Birmingham; Nasreen Fazel-Short, Birmingham and Solihull Mental Health Foundation Trust

There is growing evidence that group based cognitive behavioural therapy (CBT) for major or recurrent depression is a promising alternative or adjunct to individual psychological therapy. A large practice based, multi-centre CBT programme was developed in 2011 in Birmingham and Solihull with the aim of improving access to psychological therapies and reducing the requirements for care following participation in the programme. A group programme (pre-group sessions, 16 week group and up to 6 post-group sessions) were designed using CBT, mindfulness and elements of compassion focused therapy (CFT). Groups were open to all clients who had recurrent depression and had received standard care to date in secondary mental health settings. Effectiveness was measured with the Beck Depression Inventory- (BDI-II), Clinical Outcomes in Routine Evaluation (CORE) and the Dysfunctional Attitude Scale (DAS). 161 clients were accepted into 19 groups across Birmingham and Solihull. Completed data sets were collected for 93 (57.8%) clients. Paired t tests revealed significant change on all outcome measures. The reliable change index indicates reliable change on the BDI-II and CORE, but not the DAS.

The findings from this large scale community based group programme for recurrent depression show promising outcomes for such an intervention. Groups may be a cost-effective way to increase access to psychological therapies and provide evidence based treatment to a large number of individuals. The rationale for including mindfulness and CFT are discussed as well as the implementation and governance for a large, city wide continuous CBT programme. Further areas of research are also considered.

This is an ongoing practice based study looking at improving access to psychological therapy for those with recurrent depression in a large city. It discusses the implementation and outcomes of this CBT group programme and considers further research questions which will help to improve its effectiveness.

## The Efficacy of Low Intensity CBT Resources for Use in Chinese-speaking Populations: A Systematic Review

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**Mengyi Zheng, University of Glasgow; Carrie-Anne McClay, University of Glasgow; Sarah Wilson, University of Glasgow; Chris Williams, University of Glasgow**

Low intensity CBT resources are now firmly embedded into many healthcare services. These self-help resources, including computerised CBT (CCBT) have the potential to save therapist time, reduce waiting-lists, cut traveling time, and reach populations who cannot easily access other more traditional forms of treatments, for example, Chinese-speaking populations. We conducted a systematic review of low intensity CBT resources for use in adult Chinese-speaking populations. We were particularly interested in studies involving Chinese speaking international students. Randomised controlled trials were identified through systematic searches of the following electronic databases: MEDLINE, PsychINFO, EMBASE and PSYCHOLOGY AND BEHAVIOR. 823 papers were identified from these four databases. After screening and reviewing, 8 papers were included in the final analysis. Two studies focused on computerised CBT resources, four on CBT resources delivered by booklet or manual, and two on videotape or DVD CBT courses. Mental health problems, such as anxiety, depression, and PTSD, were mainly discussed within these studies. The results of the systematic review suggest that Low Intensity CBT Resources, such as the self-help website, online courses, and skills training DVD, are effective interventions for reducing mental health problems like anxiety, depression, and PTSD in Chinese-speaking populations. However, no studies specifically involve Chinese speaking international students. Low intensity CBT resources are a promising addition and complement to existing treatments among Chinese-speaking populations. CCBT has the potential to have a major role in the future delivery of cognitive behavioural therapy to an important increasing group of Chinese-speaking international students.

## Group CBT for Body Dysmorphic Disorder - a pilot study

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**Augusta Chandler, SW London & St George's Mental Health NHS Trust; Sharon Benson, SW London & St George's Mental Health NHS Trust**

Body Dysmorphic Disorder (BDD) involves an extreme preoccupation with one or more features that are not that noticeable or abnormal to others. This preoccupation is accompanied with compulsive behaviours such as mirror checking, avoidant behaviours and distressing emotions such as shame, anxiety and depression. BDD treatment usually consists of Cognitive Behavioural Therapy delivered on an individual basis, as recommended by NICE (2005). To date there is very limited research for CBT delivered on an individual or group basis. Some American studies show encouraging results for BDD Group CBT. Referrals for the BDD group were invited from across SW London & St George's Trust - primary and secondary care - to the Trust wide OCD & BDD Service. Each individual was screened for suitability for the group. The sample at start of group was 8. The group ran for 8 weeks with a 2 month follow up group, lasted 2 hours and was facilitated by Augusta Chandler and Sharon Benson, CBTs. The format included psycho-education, skills training, goal setting and review. Change in symptoms were measured using therapist and self-rated measures at the start, end and follow up (2 months). The following graphs show improvements in symptoms, with the percentage improvement for each rating scale. Yale Brown Obsessive Compulsive BDD Scale (YBOCS BDD) was 26.8 at assessment, 15.8 at

discharge and 14 at follow up = 48% improvement. Cosmetic Procedures Screening (COPS) was 52.6 at assessment, 38.5 at discharge and 33.8 at follow up = 36% improvement. Becks Depression Inventory (BDI) was 25.3 at assessment, 16.6 at discharge and 15.3 at follow up = 40% improvement. Montgomery & Asberg Depressions Scale (MADRS) was 22.8 at assessment, 13.5 at discharge and 12.5 at follow up = 40% improvement. Sheehan Disability Scale was 17.1 at assessment, 12 at discharge and 10 at follow up = 41% improvement. Attendance and Drop outs – there were 2 drop outs and of the remaining 6 treatment completers – 50% attended 100% of the groups and 50% attended 84.6% of the groups.

Some qualitative comments include -

- “ Being in a group, I no longer felt isolated. By listening to others I found ways to handle my BDD plus I was given tools to help me cope. It has been a very positive experience.”
- “realising I am not alone by listening to others.”
- " I think the therapy for BDD is great. It gave me an opportunity to meet other people who suffered with similar thoughts and identify with them.” This is a ground breaking mode of therapy for people with BDD. It gave the opportunity for a group of people who are typically ashamed and isolated by their condition to work together, develop a shared understanding for their problems, offer peer support and learning - elements of therapy which are absent in individual therapy. The therapists derived great satisfaction in enabling this process. This is a vastly under researched area of clinical practice, but our results seems to mirror the successful outcomes noted in previous studies (Wilhelm 2011, Rosen 1995). This pilot study suggests that CBT delivered via a group is as clinically and cost effective, if not more, than individual CBT, and warrants further groups to be offered to individuals.

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## Beliefs in Compulsive Hoarding: An examination of their development over time

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**Sinead Lambe, University of Bath; James Gregory, University of Bath; Paul Salkovskis, University of Bath**

Hoarding is characterised by the accumulation of, and failure to discard a large number of objects of seemingly little value to the point that living spaces can't be used for their intended purpose. Studies indicate that hoarding often develops early in adolescence, but usually remains undetected until 40 or 50 years. It is therefore difficult to disentangle the effects of chronicity from causal factors. Possessions are often described as providing a sense of comfort, security or anchors to valued memories, whilst the acquisition of new possessions results in a feeling of elation. These positive elements may contribute to the development of hoarding behaviours and subsequently help to maintain the problem due to their reinforcing nature. However over time secondary problems such as the deterioration of living spaces, low self-efficacy and shame may become secondary maintaining factors. This study aims to examine how beliefs about hoarding and its impact changes over the course of the disorder. The study employed a cross-sectional between-subjects design comparing three groups: a young hoarding group, an older hoarding group and a non-clinical benchmarking group. Participants were recruited through the media, voluntary organisations and support groups. Diagnosis was confirmed using the Structured Interview for Hoarding Disorder. The outcome data from treatment trials indicates that people with hoarding (with and without co-morbid OCD) receiving the currently best available interventions are likely to do less well compared to people with OCD alone (Saxena, 2008); are more likely to drop out of treatment (Steketee et al., 2010); and will require a significantly longer course of treatment (most studies describe offering in excess of 25 sessions across the course of a year) (Tolin, 2010). This poor outcome data suggests that hoarding disorder is a poorly understood clinical problem. it is

hoped that better understanding the cognitive and behavioural factors (and the extent of their independence and interdependence) will make it easier to develop targeted treatment approaches and will guide therapists on what elements are key in the development of the problem and what aspects are a consequence of living with this debilitating problem for a number of years. Beliefs about possessions, the impact of hoarding and motivation and self-efficacy to change were compared across the three groups. Differences in co-morbid psychological difficulties were also examined. Results are presented and discussed. Implications for the understanding and treatment of compulsive hoarding are considered.

## Exploring metaphor use in CBT: identification method and co-construction of shared metaphors

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**Fiona Mathieson, University of Otago, Wellington;** Jennifer Jordan, University of Otago, Christchurch; Maria Stubbe, University of Otago, Wellington

Metaphors are pervasive in language and common in psychotherapy. There is an enthusiastic practice-based literature on metaphor advocating therapist use of metaphors. Some authors suggest that collaborative co-construction and transformation of client metaphors may be a rich source for conceptualising clients' problems and enhancing CBT, through the development of a shared language. However, the empirical study of metaphors in CBT has tended to be put in the 'too hard basket', largely due to the lack of a consistent, reliable approach to metaphor identification and the challenges of finding appropriate methodology to study this language-based activity. The discourse dynamics approach, recently developed by linguists, was used to identify metaphors in 48 CBT session transcripts and to evaluate the reliability and utility of this approach. In addition, co-construction of metaphor by clients and therapists in 12 CBT sessions was explored, describing the nature and extent of client and therapist responses to each other's metaphors. Metaphors were not particularly frequent in the CBT transcripts and were used more frequently by therapists than clients. Reliability of the identification approach was satisfactory. Five response categories found will be described. The suitability of this methodology for investigating this area of practice is discussed. Implications for future research will be considered. Attention to client metaphor and awareness of potential responses may assist in the development of metaphoric themes and enhance conceptualisations.

## Does control mediate the relationship between self-complexity and posttraumatic psychological adjustment?

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**Kerrie Channer, UEA;** Laura Jobson, UEA

Posttraumatic stress disorder (PTSD) is a trauma and stressor-related condition, which may develop following exposure to actual or threatened traumatic experiences. Previous research illustrated that the trauma memory may become central to a survivor's life story, resulting in a trauma-centred identity.

This thesis focused on the changes to one's identity following a trauma, utilising the theory of self-complexity (SC). Research suggests that more complex self-representations moderate the adverse effects of stressful life events on one's mental health, as greater complexity allows the impact of adversity to remain localized. However, this hypothesis had only been tested in one study looking at trauma. Furthermore, a recent study found that greater self-complexity was only beneficial if people perceived their various self-aspects to be under their control. This research brought together the findings pertinent to SC, control and PTSD. To answer the research question 'is the relationship between PTSD symptomatology and SC, mediated by control?' One-hundred and ninety-four trauma survivors from the general public were recruited into this study. The inclusion criteria were; a good command of English, aged 18 or above with an experience of trauma. The study was administered online and involved the completion of a SC task, three measures of posttraumatic psychological adjustment, a depression measure and brief demographic questions. This study found greater negative self-complexity was associated to poorer posttraumatic psychological adjustment, a process which was mediated by control.

Control mediated the relationship between self-complexity and posttraumatic psychological adjustment in a non-clinical adult sample. The self-complexity tool could be used in clinical practice for clinicians to better understand the impact of traumatic events on one's sense of self.

## The delivery and evaluation of a pain management programme by Psychological Wellbeing Practitioners within an IAPT setting in the North of England

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**Laura Miller, South West Yorkshire Partnership NHS Trust** Helen Marshall, South West Yorkshire Partnership NHS Trust; Corinne Mallinson, South West Yorkshire Partnership NHS Trust; Caroline Williams, South West Yorkshire Partnership NHS Trust

According to the British Pain Society, almost 10,000 British people suffer from pain which is chronic in nature (British Pain Society, 2005). Moreover, around 19% of European adults suffer chronic pain of moderate to severe intensity, 21% of which had also been diagnosed with Depression (Breivik et al. 2006). In relation to cost savings, it has been suggested that offering a psychological therapy to people with physical and mental health problems reduces the need for additional services therefore reducing costs (London School of Economics and Political Science, 2012). A 3 day training package focused on using the 'Pain Toolkit' (Moore & Cole, 2009) and 'Pain Management Plan' (Lewin, 2010) was delivered by specialists in the field of pain management to PWP's in a South Yorkshire town. Training focused on developing skills and confidence in using Cognitive Behavioural Therapy (CBT) based materials with people who suffer with chronic pain. The management of depression for people with a chronic physical health problem is recommended within the "NICE Guideline 91 - Depression in adults with a chronic physical health problem: Treatment and management". The pain management package focussed on key elements of the NICE guideline and therefore to enhance the service offer, a trial as a step 2 comprehensive package was agreed as a service offer with a parallel service evaluation. A service evaluation using quantitative and qualitative methodology was undertaken by a PWP, to assess its effectiveness and utility within an IAPT service at step 2, with a view to meeting the needs of the local population. The population was made of people seeking IAPT based treatment and the evaluation was on routine clinical practice and therefore the sample was a convenient method as people entered treatment. The service evaluation was approved by the local Clinical Audit and Research Governance Dept. as an evaluation of routine clinical practice. Data was collected from routine measures taken as part of the IAPT service specification (IAPT minimum data set). Clients who accessed the service for pain management were invited for an intervention which focussed on pain management and were provided with the PHQ9, GAD7, WSAS, IAPT phobia scales (also referred to as 'IAPT measures') and Subjective Pain Level was measured using a Visual Analogue Scale (VAS) which ranged from a score of 0 (no pain) to 10 (severe pain). The IAPT outcome measures and the VAS were provided pre and post intervention to assess clinical outcomes. A clinician questionnaire, designed by the author, was provided to treating PWP's to gauge their perception of client satisfaction and the barriers to treatment. The form was both quantitative (yes/no) responses and qualitative elements were focussed on client satisfaction and the barriers to treatment, where clinicians were invited to write their views on these topics. Data was collected and analysed by the PWP undertaking the service evaluation, who was also a treating step 2 clinician. Data analysis was supported by an experienced Senior Clinical Psychologist and the IAPT data quality lead and overseen by the Clinical Lead and Consultant Psychotherapist. A total of 11 service users (males = 5, females = 6) participated in the Step 2 intervention. Ages ranged from 21-79 years. Self-reported length of chronic pain experience ranged from 26 to 240 months (2 years 2 months to 20 years). Out of the 11 treatment offers, 5 of the total who entered treatment had experienced some pain management support prior to the package. Service users presented with a range of mental health difficulties including low mood, depression and anxiety in addition to chronic pain and/or fibromyalgia. Of those that entered the package 5 completed the full treatment programme. For those who completed and engaged within the pain package (n= 5; 45% of cases) an improvement in mood (PHQ-9), anxiety (GAD-7), impact on social and occupational functioning (WSAS) and overall pain level and quality of life was demonstrated. The attrition rate was 54.55%. Clinician feedback suggested alcohol misuse negatively influenced engagement in the programme. Furthermore, having additional life

stressors also negatively influenced engagement. Client factors were also considered by reporting clinicians who stated the package was not what the clients expected (n=1). Furthermore, a low level of self-belief in their ability to engage in agreed tasks also affected positive engagement. Overall, the evaluation suggests that completion of the package can facilitate an improvement in mood, functioning and pain level and impact with moving to recovery depression and anxiety scores being achieved for four out of five treatment completers. In total eleven clients entered the package and five completed treatment. The attrition rate of 54.55% is a figure which is slightly higher than the average psychotherapy attrition rate of 46.86% (Wierbicki & Geno, 1993). This slight increase may reflect the opinion that people with long term conditions may often face more barriers to accessing services than people without such conditions (Department of Health, 2008). These barriers could include the practicalities of getting to appointments and the impact of a long term health condition on clients' ability to engage fully with the demands of treatment. This fits with the clinician feedback which suggested that one client's pain affected their ability to fully engage in the package. One notable issue with this service evaluation is that with the attrition rates recorded and the small sample of clients entering treatment, statistical significance cannot be determined due to the lack of statistical power. The qualitative data gained from the clinician feedback also suggests that completing the package can lead to improvement in mood without the need for additional interventions. Gaining clinician feedback was extremely useful, however what is not captured through this method or within the current evaluation is the service user perspective for either treatment completers or non-completers. This information would be invaluable and provide additional insight into the accessibility and palatability of this intervention. Overall, the treatment was found to have utility as a clinical intervention within the IAPT service and from the service evaluation results, a pain management group at step 2 was recommended and is now offered as low intensity intervention.

## Beyond IAPT

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### **Michael Scott, Private Practice**

Improving Access to Psychological Therapies (IAPT) is a UK funded initiative to ensure the wider dissemination of evidence-based psychological therapies. At its' inception the UK Government goal was that 50% of those accessing IAPT recover from a diagnosable condition. The author has conducted an independent assessment of IAPT clients using the gold standard of a structured diagnostic interview, SCID [First et al (1997)], collected client's views of their treatment and reviewed their records. The overall mean recovery rate across all disorders was 11.3%, clients had a mean of 1.5 disorders. IAPT successfully treats the tip of the iceberg of clients falling far short of Government targets. Analysis for the one half of subjects for which PHQ9 data were available confirmed the findings of the structured diagnostic interview. Examples of client's dissatisfactions will be given to illustrate the empirical findings. The results need to be confirmed by an independent study of consecutive attenders at IAPT using a standardised structured interview. IAPT should not be regarded as the only template for the dissemination of services, consideration should be given to having a comprehensive and reliable assessment of clients at the outset and a tracking of those clients ensuring that there is fidelity to an evidence-based treatment protocol.

## Becoming a more mindful practitioner: The effectiveness of a Mindfulness-Based CBT Course in meeting training needs for clinical staff in Adult Mental Health Urgent Care Services

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**Catherine Moorhead, Northumberland, Tyne and Wear NHS Foundation Trust;** Jill Winfield, NTW NHS Foundation Trust; Mark Freeston, NTW NHS Foundation Trust and Newcastle University

This paper describes a service development which arose from an adult mental health inpatient ward team who wanted to be able to work more effectively to help patients who had major difficulties with emotion regulation. It was proposed that enhancing mindfulness through a mindfulness-based CBT programme within the core staff team would enhance therapeutic milieu and therefore general outcome associated with engagement and recovery. The training delivered was an 8 week mindfulness-based CBT programme which had been adapted to meet the specific

needs of this group of staff. A double baseline design based at one month apart was used. Standardised and non-standardised measures were administered at pre, mid, post and at follow-up points. Workshops and interviews supported the investigation of staff experience of the training and their observations about potential impact of this upon patient care. Results showed that with the delivery of the mindfulness training, staff reported a development of mindfulness which had a positive impact upon their well-being and perceived ability to respond skilfully to challenging situations at work and at home. Staff also identified that they were able to recognise their own emotion regulation strategy and begin to model ways to support patients to manage difficulties in a different way. This adapted mindfulness training course appeared to be effective in meeting the need for a group of clinical staff to develop mindfulness. The potential impact upon patient engagement has been identified but further research into this area is indicated. The delivery of basic mindfulness-based training to support the development of mindfulness in clinicians can be an effective and low-cost way of enhancing patient care and engagement in recovery. Clinicians who have developed mindfulness could be better equipped to support patients who are struggling with emotion regulation difficulties by using and modelling their own experience of how to disengage from unhelpful cognitive and behavioural patterns.

## Internet-delivered Cognitive Behavioral Therapy for Anxiety Disorders in Egypt; A randomized controlled trial

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**Reham Aly, Egyptian Association of Cognitive Behavior Therapy;** Hisham Ramy, Egyptian Association of Cognitive Behavior Therapy

Cognitive Behavior Therapy has been proven effective through a strong body of evidence for many psychiatric disorders especially anxiety disorders. Yet the application of CBT in Egypt for patients suffering from different types of anxiety disorders has been hindered by many obstacles including scarcity of qualified skilled therapists. In an attempt to deliver CBT evidence-based techniques to all requiring patients, a randomized trial was conducted through adaptation of therapy manuals for anxiety disorders to be used on computers & via the Internet to examine its applicability & efficacy for Egyptian patients. Forty patients suffering from different types of anxiety disorders are randomly assigned to receive cognitive behavioral therapy either in-person or through communication via the Internet. Therapy was based on the evidence-based manuals of CBT sessions for anxiety disorders "Treatments that work" & consists of a structured sessions of CBT techniques that is either presented personally for one group or communicated via the internet (emails & chats). Data are collected at baseline, post-intervention & after 6 months for follow-up. In addition a clinically significant assessment was conducted after end of therapy. 40 patients were assessed according to the DSM-IV to be suffering from anxiety disorders. A Prior assessment was conducted using the Structured Clinical Interview for DSM Disorders (SCID). All patients then received two in-person sessions for treatment formulation & psychoeducation regarding the disorder & CBT. Patients was randomized into two groups; a control group of in-person sessions & an e-treatment group. Both groups received 8 sessions of therapy. A post-treatment assessment revealed two drop outs in each group. A statistically significant change was detected on both groups (p value 0.19) & Effect size of -0.1 +/- 0.05 on Beck Anxiety Inventory & 0.28 +/- 0.14 on Hamilton Anxiety Scale for both groups of treatment. Significant changes were also noted on the Quality of Life Scale post-treatment assessment. Internet-assisted CBT for patients suffering from anxiety disorders is effective in a sample of Egyptian Patients. Based on statements of the Egyptian Ministry of Communications and Information Technology, 2009 that; around 16.26 million Egyptian citizens are using the Internet with a monthly growth rate of 2.15%. In addition to that an average estimate of weekly users of IT clubs in Egypt is 190,016 users / week & that the Internet usage in urban & rural areas has reached 21.7% & 12.7% respectively. Internet-delivered CBT can help patients with difficult or no access to therapy in Egypt

Nowadays, Internet is in everybody hands. A practical usage of of the internet is to use it in applying the evidence-based CBT for patients otherwise cannot reach help. More research on application & efficacy is required to build on evidence for this intervention in Egypt. Yet; in the future we might see an iphone application based on the CBT techniques & applicable to Arabs & Egyptians as well; who knows?

## The phenomenology of distressing, intrusive imagery and positive imagery experiences in early psychosis

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**Jennifer Laing, University College London;** Tristan Morland, North East London NHS Foundation Trust; Miriam Fornells-Ambrojo, University College London

Intrusive mental imagery is viewed as an important transdiagnostic process, yet little is known about imagery in early psychosis. This research study sought to address this by investigating the phenomenology of intrusive, distressing imagery and positive imagery. Thirty-one service users from Early Intervention in Psychosis services participated in this mixed-methods study. The content, characteristics and appraisals of recent imagery experiences were examined using established interview schedules. Participants generated positive future-oriented images, and rated their vividness and perceived likelihood during a prospective imagery task. Symptom measures including social anxiety and depression were completed to characterise the sample in relation to imagery experiences. Approximately three quarters experienced a distressing, intrusive image in the previous month. Image content related to a range of themes including loss, an inadequate self, external threat and a dangerous self. A higher proportion experienced a recent positive image. Themes included loving, intimate relationships, enjoyable times with peers and family, achievement of personal goals and escape from current circumstances. Image appraisals varied in terms of their perceived dangerousness, benefit or harm and the images' source. Depression and social anxiety were negatively associated with the vividness and perceived likelihood of intentionally generated positive prospective images. Contrasting image themes appeared to relate to idiosyncratic concerns, values and goals. The relationship between depression and positive imagery may influence motivation issues and goal directed behaviour in psychosis. The assessment of both distressing and positive imagery appears warranted. Working with imagery (frequency, content and appraisals) may represent a valuable element of therapy in early psychosis.

## Utilization of empirically supported treatments among psychologists in public and private practice in Singapore

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Jeffrey Ong, National University of Singapore; **Iliana Magiati, National University of Singapore;** Shian-Ling Keng, National University of Singapore; Kathryn Ponniah, National University of Singapore

Despite considerable research, training and dissemination efforts internationally, current research indicates that utilization of empirically supported treatments (ESTs) for common mental health conditions among psychologists and mental health professionals in general is surprisingly low. There are large individual differences and rates likely differ across organizational settings as well as countries. The present study aimed to (i) investigate the utilization of ESTs among psychologists in Singapore - a country where psychology is a relatively new discipline and mental health services are developing at a formidable rate in the last 10-20 years; and (ii) to explore the role of setting (public versus private practice), attitudes and perceived barriers towards EST in psychologists' EST utilization for depressive, bipolar, anxiety and eating disorders and psychosis. Survey packages, including an adapted survey by Jameson, Chambless and Blank (2009), the Evidence Based Practice Attitudes Scale and a modified version of the BARRIERS scale, were mailed out to 217 psychologists who were identified following a comprehensive search of over 700 public and private hospitals, clinics and organizations in Singapore. Of those, 88 responded. Public sector psychologists in Singapore were more likely to report the use of ESTs in their practice, reported a higher proportion of ESTs among the treatments they used, and were more likely to rank ESTs as the treatment they most frequently used as compared to private sector psychologists. Interestingly, higher utilization of ESTs was not associated with more favorable attitudes towards ESTs nor with fewer perceived barriers towards the use of ESTs. Findings will be discussed in relation to existing international literature; ways in which utilization of ESTs can increase in public and private settings will also be explored. Findings from this paper contribute towards better understanding how and why evidence-based psychological treatments are utilized for the treatment of mental health conditions and some of the factors influencing their utilization in countries where psychology is a new and growing, but not well established, discipline.

## Chronic Fatigue Syndrome: Comparing outcomes in White British and ethnic minorities after Cognitive Behavioural Therapy

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**Tom Ingman, King's College London, Institute of Psychiatry, Psychology and Neuroscience;** Sheila Ali, Chronic Fatigue Research and Treatment Unit, South London and Maudsley NHS Foundation Trust; Kamaldeep Bhui, Wolfson Institute of Preventive Medicine, Barts and The London School of Medicine and Dentistry, Queen Mary University of London; Trudie Chalder, King's College London, Institute of Psychiatry, Psychology and Neuroscience

There is no clear evidence that CBT, one of the most promising treatments for CFS (White et al., 2011) is effective in ethnic minority groups (Bayliss et al., 2014). This is concerning given that CBT may be biased towards Western cultures (Kantrowitz & Ballou, 1992) and research indicating that ethnic minorities with depression and psychosis have poorer CBT outcomes (Schneiderman et al., 2004; Rathod et al., 2005), and that culturally adapted CBT may be more effective (Chowdhary et al., 2013; Rathod et al., 2013). The aim of this study was to establish whether UK-based ethnic minorities with CFS differ from White groups with regards to CBT treatment outcome, and whether cultural adaptation is necessary. Data from 63 (19.0%) ethnic minority and 268 (81.0%) White British participants with CFS who were referred to a UK specialist service were collected at baseline and after CBT. Pairwise comparisons revealed that both ethnic minority and White British participants significantly improved in fatigue severity ( $p < .001$ ), physical functioning ( $p < .001$ ) and work and social adjustment ( $p < .001$ ). Independent-samples t-tests showed that ethnic minorities improved despite exhibiting significantly higher baseline damage beliefs ( $p = .012$ ), catastrophizing ( $p = .025$ ) and avoidance-resting behaviour ( $p < .001$ ) compared to White British participants. To our knowledge, this study is the first to indicate that CBT is effective for treating CFS in ethnic minority groups. Results also suggest that unhelpful baseline cognitions and behaviours should not act as a barrier to good post-treatment outcomes in ethnic minority groups. These findings are clinically important as they indicate that cultural adaptation for CBT is not always necessary.

## Study protocol for a randomised controlled trial of a cognitive-behavioural prevention programme for the children of parents with depression: the PRODO trial

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**Belinda Platt, Department of Child and Adolescent Psychiatry, University Hospital Munich;**

Johanna Loechner, Department of Child and Adolescent Psychiatry, University Hospital Munich; Kornelija Starman, Department of Child and Adolescent Psychiatry, University Hospital Munich; Gerd Schulte-Körne, Department of Child and Adolescent Psychiatry, University Hospital Munich

Depression is one of the most common psychiatric illnesses worldwide, but is nevertheless preventable. Since the children of parents who have depression are at greatest risk of developing depression themselves, prevention programmes for this population are a major public health priority. Here we report the study protocol of a randomised controlled trial (Clinical Trials NCT02115880) of a group-based psychological intervention for families with i) at least one parent who suffers (or has suffered) from depression and ii) at least one child who has no current or previous psychiatric diagnosis. Eligible families will be randomly allocated to receive either a German adaptation of the 12-session cognitive-behavioural Raising Healthy Children intervention (Gesund und glücklich aufwachsen;  $N = 50$ ), or no intervention (usual care;  $N=50$ ). The primary outcome (child diagnosis of an episode of depression) will be assessed at 15-month follow-up. The secondary outcomes (child psychopathological symptoms) will be assessed immediately following completion of the intervention (6-months), as well as at 9- and 15-month follow-up. The study is still in the recruitment phase, but we hypothesise that children in the intervention condition, compared with those who do not receive the intervention, will show fewer symptoms of psychopathology, and be less likely to meet diagnostic criteria for a depressive episode, at follow-up.

Despite their elevated risk of developing depression, there is little formal support available for the children of parents with depression. This study provides an important step in the development of more effective depression prevention measures, which are needed if the personal, social and economic burden of depression is to be reduced. This study serves to evaluate whether family- and group-based CBT is effective in preventing depression, in the children of depressed parents. The results of the trial could inform the implementation of similar prevention programmes for this at-risk group.

## Defining components of audiologist-delivered psychological therapy for tinnitus-related distress: A scoping review

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**Dean Thompson, University of Nottingham;**

Deborah A. Hall, University of Nottingham; Dawn-Marie Walker, University of Southampton; Derek J. Hoare, University of Nottingham

Tinnitus is associated with depression and anxiety disorders, severely and, for some people, adversely affecting quality of life and functional health status. Cognitive Behavioural Therapy (CBT) and other psychological therapies that challenge negative thinking and maladaptive behaviours have been tested with this population, resulting in a convincing level of evidence, enough to warrant its recommendation for use in practice in the UK. However this evidence is limited to psychologist-delivered therapy, at odds with recommendations for services in the UK to expand the audiologist's role to providing psychological support including delivering CBT. Testing the feasibility of this approach would first require a standardized protocol of psychological support for audiologists to follow. To support the development of such a protocol the aim of the present research was to identify all potential observable, replicable and irreducible components of psychological therapy delivered to people with tinnitus. A scoping review of literature published since 1980 was conducted, including searches of public medical databases and the grey literature. Search results were examined to establish that they pertained to psychological therapies for adults with tinnitus. The components of the clinical protocols reported within these records were extracted and examined using inductive thematic analysis to organise the records into discrete and irreducible active ingredients of psychological therapies. Gaps in the literature and the direction of future research are discussed.

## Guidelines for Using Therapist Self-Disclosure in Cognitive Behaviour Therapy

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**Angela McNaught, Massey University, Auckland, New Zealand;** Emma Johnston, Massey University, Auckland, New Zealand

The therapeutic relationship has long been recognised as an important tool for facilitating change. Within this relationship, one possibility for creating such change is therapist self-disclosure (TSD). Described by Hill and Knox (2001) as “statements that reveal something personal about the therapist” (p. 413), they differentiate TSD from “immediacy statements” where a therapist might reflect upon an immediate emotional reaction about the client or the therapeutic relationship. There are a number of broad and helpful guidelines for employing TSD (see Knox and Hill, 2003) and these are largely based on ethical principles, good clinical practice, maintaining the therapeutic relationship, and addressing client needs, all ideas which transcend theoretical orientation. However, different theoretical models have different ideas about appropriate levels of disclosure, ranging from very limited to quite a lot, but increasingly therapists are adopting the middle ground and engaging in moderate amounts of TSD (Farber, 2006). To date, there is very little literature exploring TSD within the context of CBT. This study explored how experienced CBT trained clinical psychologists made decisions around self-disclosure. In-depth interviews were conducted with six such therapists, and two key themes emerged: why TSD might be used in CBT; and the rules for its use. On the basis of these results a number of guidelines for TSD have been developed that fit with the guiding principles of CBT. This presentation aims to provide practitioners and educators alike with potential guidelines to help them determine the appropriate use of TSD within their practice.

## Rumination and voices: an analogue study of the role of perseverative thought processes in voice-hearing

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**Samantha Hartley, University of Manchester;** Sandra Bucci, University of Manchester; Anthony P Morrison, University of Manchester

Rumination is a type of negative perseverative process linked with depression (Nolen-Hoeksema and Morrow, 1993). Recently, research has demonstrated high levels of rumination in psychosis (Hepworth, 2011), and cross-sectional studies have indicated a role for rumination in auditory hallucination proneness (Jones and Fernyhough, 2009). Traumagenic models have also asserted that ruminative thoughts concerning past traumas might be falsely interpreted as voices (Fowler, 2006). The aim of the current study was to experimentally test whether stressful material, when subject to ruminative processing, will give rise to more cognitive intrusions which, in the context of anomalous auditory material (Feelgood & Rantzen, 1994) and especially in the presence of key metacognitive beliefs (Morrison, 2001), will augment the experience of voice-hearing phenomena. An analogue sample of 102 students was presented with stressful film material portraying interpersonal violence and aggression. Participants were randomised to either ruminate on this material, or distract themselves. Following this manipulation, participants were presented with anomalous auditory material and asked to record any words and distress experienced. Recordings were subsequently coded for eligibility and associations with the film content. Data on trait rumination, hallucinatory proneness, metacognitive beliefs and state paranoia were also collected. This paper will explore the difference between groups in the number, content and distress of voice-hearing experiences, links with metacognitive beliefs and predisposition to hallucinatory phenomenon and ruminative processing. The implications for cognitive and traumagenic models of psychosis, along with future therapeutic and research directions, will be discussed. If ruminative processing is related to post-stress intrusions and psychosis-like experiences, potential clinical implications include fostering more adaptive processing styles, especially in those with experience of trauma. These might involve detached mindfulness (Wells, 2005), mindfulness ACT-based approaches (Hayes, Strosahl, & Wilson, 1999) or modifying beliefs around the perceived utility of rumination (Papageorgiou and Wells, 2004) for those experiencing (or at risk of) psychosis.

### The Voices Research Clinic

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**Mark Hayward, Sussex Partnership NHS;** Clara Strauss, Sussex Partnership NHS; Christina Mueller, Sussex Partnership NHS

The Voices Research Clinic in Sussex Partnership Trust aims to (1) improve access to CBT for individuals who hear voices; (2) maximise and sustain therapeutic benefits; and (3) create an environment for innovation and researching the real-world effectiveness of psychological interventions. The Voices Clinic provides a three-level care pathway for secondary care patients who are distressed by hearing voices.

Level 1: a four-session individual therapy using the principles of Coping Strategy Enhancement (Tarrrier et al., 1993). The intervention seeks to identify, adapt and systematically implement coping strategies from the patient's existing repertoire. Level 2: a 12-session Person Based Cognitive Therapy (PBCT) group that integrates cognitive behaviour therapy for psychosis with a mindfulness-based approach (Dannahy, Hayward, Strauss, Turton, Harding & Chadwick, 2011). Level 3: a four-session individual intervention to consolidate learning from the PBCT group. Early findings following the Level 1 intervention are encouraging, with improvements evident in frequency of voice-hearing, voice-related distress, controllability of voices (all measured by PSYRAT-AH) and progression towards a personal goal (measured by CHOICE). This paper will present post-intervention data at each level for the initial cohort of 47 patients. The Voices Research Clinic offers a model for the delivery of CBT for voices that has the potential to maximise outcomes for patients as well as providing an environment for further research. This paper will share lessons learnt from this innovative environment. The three-level care pathway is feasible as an adjunct to standard mental health services. Brief CBT-based interventions can be offered to voice-hearing patients irrespective of diagnosis and potentially lead to improvements in voice-hearing and general well-being outcomes.

## Adaptation of a measure of anxiety for children with high functioning autism spectrum disorder

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**Jacqui Rodgers, Newcastle University;** Sarah Wigham, Newcastle University; Jeremy Parr, Newcastle University; Emma Honey, Newcastle University; Helen McConachie, Newcastle University; Mark Freeston, Newcastle University

Many children with autism spectrum disorders (ASD) experience high levels of anxiety. A widely used measure for typically developing children is the Revised Child Anxiety and Depression Scale (RCADS). There is growing evidence that anxiety may present atypically in children with autism necessitating adaptation of existing anxiety measures to ensure they are suitable for use with children with ASD.

An adapted version of the RCADS-ASD was developed based on empirical evidence of anxiety phenomenology in ASD, and three new subscales were created (sensory related anxiety, intolerance of uncertainty and phobias). Content validity was refined during focus groups with parents and clinicians. Adapted 76 item parent and 74 item child measures were piloted with children with ASD aged 8-15 years and their parents (N=150). We found both child and parent report measures to have promising psychometric properties. Internal consistency ranged from alphas of .67 to .91 (child) and .78 to .93 (parent version). Convergent and divergent validity with other measures were established. One month test-retest reliability was demonstrated for child ( $r = .9$ ,  $p < .01$ ;  $z = 0$ ,  $p = .6$ ) and parent versions ( $r = .79$ ,  $p < .01$ ;  $z = 0$ ,  $p = .88$ ); and parent/ child agreement ( $r = .64$ ,  $p < .001$ ;  $z = 0$ ,  $p = .31$ ) was high. Parent RCADS-ASD ratings correlated significantly with reported child sensory processing abnormalities and repetitive behaviours, providing further evidence of links between core ASD characteristics and anxiety. Preliminary evidence indicates the RCADS-ASD is valid and reliable measure in both parent and child form for use with children with ASD. Clinicians' access to appropriate anxiety measures should facilitate more accurate assessment, guiding and enhancing evaluation of treatment. Our findings indicate that the use of adapted measures tailored to the needs of young people with ASD and anxiety may improve assessment and provide important information regarding ASD related anxiety phenomenology to guide treatment planning.

## An investigation into religiosity, spirituality and OCD: A comparison of participants with and without religious obsessions

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**Benjamin Marram, Newcastle University;** Patrick Rosenkranz, Newcastle University; Siti Alias, Newcastle University; Christina Morley, Newcastle University; David Veale, South London and Maudsley NHS Trust; Mark Freeston, Newcastle University

Research evidence and practice-based evidence suggests that there is a relationship between religiosity, spirituality and obsessive-compulsive disorder (OCD) (Abramowitz et al, 2004). However, there is variability in how researchers have investigated this relationship in terms of design, participants sampled and measurement of the constructs of interest. Further, there are few studies that have investigated this relationship among participants who report the presence of clinical levels of OCD symptomology (Kaldestad, 1992; Agorastos et al., 2012). Furthermore, there is little empirical research investigating how those with and without religious obsessions differ on variables associated with the cognitive model of OCD (e.g. responsibility, thought action fusion, ego-dystonicity, etc.) and on religious and spiritual variables. Online advertisements were placed on OCD charity websites in the UK (OCD-UK, OCD Action), the US (IOCDF) and with a Dutch charity (Dwang.eu). Information about the research was disseminated via social media platforms including Twitter and Facebook. Participants were asked to complete a series of online questionnaires including demographic information, historical or current involvement with mental health services, OCD symptomatology, religious or spiritual beliefs, details on their experience of OCD (e.g. TAF, guilt), the content of their obsessions, the frequency duration and intensity of their obsessions and finally, whether or not they experienced religious obsessions. If they identified the presence of religious obsessions, they were asked further questions in relation to the thought or thoughts they experienced. One hundred and seven people completed the online survey investigating the relationship between religiosity, spirituality and OCD. Of these, 94.4% met one

or more of time, distress and interference criteria for OCD with 70.1% meeting all three. 46% of participants reported experiencing religious worries. Those who reported religious obsessions (compared to those who reported other types of OCD) did not report more OCD symptoms overall but did report more obsessions as measured by the OCI-SV. They also reported greater guilt, negative mood, more severe obsessions, more emotional upset related to their thoughts, and higher levels of ego-dystonicity, and feelings of responsibility and various types of thought-action. In addition, 62.1% of those who described themselves as religious reported religious obsessions compared to 26.5% who described themselves as not religious. Those who reported religious worries also showed greater engagement in religious behaviour and reported higher levels of theistic and non-theistic spirituality, intrinsic religiosity and extrinsic religiosity. This research highlights that within this particular sample, participants that reported the presence of religious obsessions experienced a more intense experience of OCD symptomatology than those without religious obsessions. This included greater levels of factors associated with cognitive model of OCD e.g. responsibility, guilt and thought-action fusion. Further to this, they were also more involved with and religion and more religious and spiritual overall, both in terms of behaviour and motivation. To the author's knowledge this is the first research that has directly examined differences in symptomatology, cognitive variables, and religion in a sample with clinical levels of OCD where those reporting religious obsessions make up a significant part of the sample. This research supports the proposition that OCD can 'hijack' important parts of an individual's personal beliefs and values leading to distress and suffering. Finally, it further develops the application of the cognitive model of to an important subtype of OCD, namely, religious obsessions. Further research could support the development of specific interventions for those who experience religious obsessional content.

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## Evaluating the role and proposed benefits of the Socratic Method in CBT

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**Gavin Clark, University of New England;** Sarah Egan, Curtin University; Craig Baker, University of New England; Lisa Harrison, University of Western Sydney

The Socratic Method has been described as an important and distinctive component of CBT interventions. However, it has been subject to little empirical investigation and its value within therapy remains unclear. A survey of expert CBT researchers (N=13) was conducted regarding the role of the Socratic Method within evidence-based CBT interventions. Thematic analysis of responses suggests that the Socratic Method is considered a potentially useful though non-essential component of CBT. A systematic review of the literature identified five assumptions regarding the proposed benefits of employing the Socratic Method: (i) engaging patients in the Socratic Method will help reduce distress associated with, and belief in, unhelpful cognitions; (ii) engaging in the Socratic Method will allow patients to develop skills in the re-evaluation of cognitions and unhelpful processes; (iii) conclusions reached by patients through the Socratic Method are more likely to be memorable and convincing; (iv) the Socratic Method will increase patient engagement and reduce resistance in therapy; and (v) Socratic questioning will improve CBT outcome. Two experimental studies were conducted to evaluate whether assumptions (i) and (iii) were supported when comparing an online analogue of the Socratic Method versus a didactic-information giving approach. Results supported assumption (iii) and partially supported assumption (i), though the superiority of a Socratic versus didactic approach in promoting belief change was not demonstrated. The findings of the study will be discussed in terms of areas for future research and mechanisms through which the Socratic Method may be hypothesised to exert beneficial effects within therapy.

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## Is Intolerance of Uncertainty transdiagnostic? Exploring the associations between Intolerance of Uncertainty and symptom severity in Italian clinical samples

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**Gioia Bottesi, Department of General Psychology, University of Padova;** Marta Ghisi, Department of General Psychology, University of Padova; Veronica Tesini, Department of General Psychology, University of Padova; Paola Schiavi, Servizio di Psicologia Clinica, "Mater Salutis" Hospital, Legnago (Italy); Enrico Razzetti, Department of General Psychology,

University of Padova; Mark Freeston, School of Psychology, Institute of Neuroscience, Newcastle University

Intolerance of Uncertainty (IoU) refers to a set of negative beliefs about uncertainty and its consequences (Koerner & Dugas, 2008); its transdiagnostic nature has been increasingly demonstrated (Carleton et al., 2012; Gentes & Ruscio, 2011). Evidence suggests that IoU comprises two distinct components: “prospective IoU”, a future-oriented strategy employed to gain certainty (a desire for predictability driving individuals to repetitively seek for as much information as possible about perceived threats), and “inhibitory IoU”, an avoidance strategy preventing individuals from acting when they found themselves in ambiguous situations (i.e., “uncertainty paralysis”, Birrell et al., 2011; Carleton et al., 2012). Specific associations between these dimensions and different psychopathologies have been reported (e.g. Carleton et al., 2010; McEvoy & Mahoney, 2011, 2012). The present study aims to: 1) examine associations between IoU and symptom severity in Italian clinical samples; 2) test whether the two IoU components play different roles in different disorders. Although there is a significant evidence base in English-speaking samples, there is little attention in the Italian context to date. Patients with GAD, OCD, PD, and depression (n=20 each group) will complete the following measures: the Intolerance of Uncertainty Scale-12 (Walker et al., 2010), the Penn State Worry Questionnaire (Meyer et al., 1990), the Obsessive Compulsive Inventory (Foa et al., 1998), the Beck Anxiety Inventory (Beck et al., 1998), and the Beck Depression Inventory-II (Beck et al., 1996). Recruitment is on-going. The results will be compared with existing findings in the largely English-speaking literature with a particular focus on cross-cultural issues. Replicating that IoU has transdiagnostic relationships across cultures increases support for the need of transdiagnostic interventions that target IoU. Any differences in the patterns found argue for culture or language specific variations of our understanding of IoU and how it make be targeted.

## Poster Presentations 2 (Thursday)

### Focus Group Examining Attitudes of Chinese-speaking International Students towards Online CBT Resources

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**Mengyi Zheng, University of Glasgow;** Carrie-Anne McClay, University of Glasgow; Sarah Wilson, University of Glasgow; Chris Williams, University of Glasgow

Online cognitive behavioural therapy has shown great promise as a useful intervention for Chinese-speaking populations with mild to moderate mental health problems like low mood, anxiety, and depression. This focus group study was conducted to address Chinese-speaking international students’ understanding of low mood, anxiety or depression, and attitude towards an online intervention (Chinese version of Living Life to the Full) and required support types. The focus group study used a sample of 15 Chinese-speaking international students drawn from across course years in order to establish and refine the delivery of the intervention and evaluation. Eligible students were able to work through the online course and review linked printed materials and research resources, such as Chinese and English language versions of key questionnaires prior to participating. The recording from the 3 focus groups were transcribed verbatim and analysed by two researchers independently using a thematic analysis approach.

Four main themes were identified: knowledge of mental health problems, causes of mental health problems, treatments/help-seeking, and interventions. Participants reported sources of information relating to mental health problems: online, media, and church; and indicated cultural changes, loneliness, language difficulties, pressure at university, personality issues, and poor time management as the causes of mental health problems. Support types such as weekly support emails, professional support, and group support were discussed. This focus group study suggests that delivering the online CBT to Chinese-speaking international students who report mild to moderate low mood, anxiety and depression may be a feasible and desirable way to help them. The study also seeks participants’ comment back on the course content in order to understand how best to provide support that engages and encourages use.

The results of focus group study can help to inform a future substantive study, which involves adaptation of online CBT to fit Chinese-speaking international students' lifestyle, as well as changes relating to the online course content to reflect different understanding and expressions of distress.

## Mental imagery as an emotional amplifier: bipolar disorder, anxiety and depression

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**Heather Mitchell, MRC Cognition and Brain Sciences Unit, Cambridge, UK;** Martina Di Simplicio, MRC Cognition and Brain Sciences Unit, Cambridge, UK; Susie Hales, Department of Psychiatry, University of Oxford; Emily Holmes, MRC Cognition and Brain Sciences Unit, Cambridge, UK; Karolinska Institutet, Stockholm, Sweden

Mental imagery has been identified as a potential 'amplifier' of emotional states in bipolar disorder (Holmes, Geddes, Colom, & Goodwin, 2008). Compared to unipolar depression, individuals with bipolar disorder experience higher emotional impact of intrusive future imagery and more preoccupying and compelling suicidal imagery (Hales, Deeprose, Goodwin, & Holmes, 2011). In unipolar depression and anxiety there is an impairment in the ability to vividly imagine positive future events (Morina, Deeprose, Pusowski, Schmid, & Holmes, 2011). This study compared mental imagery characteristics in 4 patient groups and non-clinical controls. There were 5 participant groups: bipolar depressed, bipolar euthymic, unipolar depressed, anxious and healthy controls. The Impact of Future Events Scale (IFES) indexed the emotional impact of future, personally-relevant imagery and The Prospective Imagery Task (PIT) measured mental imagery characteristics (vividness, likelihood and pre-experiencing) for 10 negative and 10 positive future events. A semi-structured mental imagery interview was used to investigate the characteristics of their 'most significant image' reported from times of anxious, depressed and high mood. The bipolar depressed, unipolar depressed and anxious groups scored higher on the IFES than healthy controls, indicating greater emotional impact of intrusive future images. On the PIT, compared to controls, depressed, anxious and bipolar depressed participants rated negative future events as more vivid and more likely to happen. Further, compared to controls, the bipolar depressed and unipolar depressed group rated positive future events as less likely to happen. Mental imagery interview findings will be discussed, including the higher prevalence of suicidal imagery at times of low mood in bipolar disorder. Findings underscore the importance of examining emotional mental imagery in clinical groups. Clinical implications for CBT will be explored. These findings suggest that existing psychological treatments could be improved with the addition of imagery-focused techniques, such as positive imagery or imagery re-scripting, which could be used to reduce the emotional impact of intrusive future images and promote stronger positive imagery of the future. Higher reports of suicidal imagery in bipolar disorder suggest that this aspect of cognition ought to be investigated during clinical assessments and may be important for evaluating risk.

## 'Really living'; Parents experiences of mindfulness one year after completing the Mindfulness Based Childbirth and Parenting (MBCP) programme

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**Amber Sedgfield, Universities of Coventry and Warwick;** Maret Dymond, Oxford Mindfulness Centre; Jo Kucharska, University of Coventry; Magdalena Marczak, University of Coventry

Background: Pregnancy, childbirth and early parenthood is often a time of uncertainty, stress and transition, which can have important consequences for the parent-infant relationship, parents' relationship and infant development. Recently, a number of quantitative studies have reported that mindfulness-based interventions have shown a reduction in depression, anxiety, childbirth fear and stress in pregnant women. The Mindfulness Based Childbirth and Parenting (MBCP) programme was formally adapted in the USA from the Mindfulness Based Stress Reduction programme to include antenatal education (Duncan & Bardacke, 2010). It is equally inclusive for both pregnant women and their birth support partners. In 2012, the MBCP programme was piloted in the UK, demonstrating similar quantitative findings regarding parents' mental health (Warriner

et al. 2013). This is the first study from a UK sample to gather a qualitative account of parents' experiences of mindfulness during the early parenting period.

**Method:** Ten participants (7 mothers and 3 fathers) were recruited from a total of 34 group members who attended the first two MBCP groups facilitated in the UK, via self-selected sampling. Participants were interviewed using semi-structured interviews when their children were approximately 1 year old. Interviews were audio-recorded and transcribed verbatim. Data gathered was subject to Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 1999).

**Results:** Two superordinate themes emerged from the interviews 'Getting closer to really living' and 'Greater connectedness and attunement'. Participants experienced a greater connection and more balanced approach to life which appeared to enhance their emotion regulation, interpersonal relationships and the parent-infant relationship. MBCP was perceived as a beneficial and supportive group that enabled them to develop a calmer approach to living with life's demands which suggests that participants adopted mindfulness as a life skill within their daily lives.

**Conclusion:** The findings from this study support the emerging quantitative studies showing that mindfulness can enhance parents' emotional well-being during pregnancy and that these benefits can extend into the postnatal period. Parents' experiences are discussed in the context of existing literature. The clinical implications for practice and future research are discussed.

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## Case report using a Mobile CBT Application in homework to support face-to-face CBT treatment

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### **Morad Margoum, Cogitate Software Ltd**

With the ubiquity of mobile technology but its relatively untested presence in CBT, this report explores the experiences of an individual presenting with anxiety and their participation in using face to face CBT with a cross-sectional formulation (Padesky & Greenberger, 1996) and Thought Challenging (Beck, Rush, Shaw & Emery, 1979) application to support the intervention. Mrs P presented with anxiety in social situations and consequent negative evaluations of herself. Assessment identified that Mrs P would become anxious prior to social gatherings, this had led to significant avoidance and subsequent isolation. With a presentation that was inconsistent with a social phobia formulation. Cross-sectional formulations were used to understand the maintenance of her anxieties. The intervention will target Mrs P's anxieties prior to social situations and evaluations of her self-efficacy. Face-to-Face treatment will incorporate the use of standard CBT techniques. A mobile application will be used to support the intervention. To be completed at the end of therapy. An evaluation scale will also be used to provide feedback relating to out of session work. The growth of mobile technology has been exponential in the last decade, this has changed the face of many disciplines. Since CBT depends significantly upon out-of-session work. The case study will consider the utility and efficacy of technology in helping people change. The growth of mobile technology has been exponential in the last decade, this has changed the face of many disciplines. Since CBT depends significantly upon out-of-session work. The case study will consider the utility and efficacy of technology in helping people change.

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## Investigating the Impact of a Psychological Model of Recovery on the Work of Acute Inpatient Staff

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**David Araci, Southern Health NHS Foundation Trust; Isabel Clarke, Southern Health NHS Foundation Trust; Charlotte Gatherer, CAST - Southern Health NHS Foundation Trust; Kerry Matcham, Recovery College - Southern Health NHS Foundation Trust**

Southern Health NHS Foundation Trust has implemented a service wide, psychological model of recovery built upon third wave and CBT therapeutic interventions. The Intensive Support Programme (ISP) runs in all four of the service's acute inpatient hospitals and the community home crisis teams. Large numbers of staff, in various roles, have received ISP training in order to provide a consistent message of recovery and understanding to the service user. The current poster details a study that evaluates the impact of ISP across a variety of acute staff. Ten participants were recruited via posters within the hospitals that asked for staff feedback around their work.

Interviewers had been through services and collaborated in generating semi-structured interviews (Smith, 1995). Thematic analysis (Braun & Clarke, 2006) was employed for analysis to uncover themes related to the impact of ISP on staff. Data currently being analysed. The findings will increase understanding of the implementation of a service wide psychological model applied to acute mental health. Findings highlight strengths of the approach, how it has impacted the work of the individual and staff teams, and perceived benefits to the service user. Results also detail potential barriers in implementing a large scale approach. These findings will aid in developing the service in order to make it more accessible to staff, and ultimately, more beneficial to the service user.

## Worry, Rumination, and Distraction: Effects on Recovery From Stress

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**Lora Capobianco, University of Manchester;** Adrian Wells, University of Manchester; Julie Morris, University of Manchester

The strategies individuals use to regulate their cognition and emotion may play an integral part in how quickly they will recover from a stressful situation. In the metacognitive model (MCM) emotion dysregulation is caused by particular thinking styles related to an individual's metacognitions (Wells & Matthews, 1994; 1996). The MCM proposes that emotional reactions are maintained by the activation of a type of coping or self-regulation dominated by worry, rumination and ironic coping strategies that impair flexible cognitive control (Wells & Matthews, 1994, 1996; Wells, 2000). Both worry and rumination appear to effect emotional regulation and prolong recovery from natural or laboratory based stress exposure. However, so far studies have not directly compared the effects of worry and rumination and examined each of these against a control mentation strategy. Furthermore, they have not examined effects on subjective as well as physiological indices of emotion and recovery in the same paradigm.

Fifty four undergraduate participants completed a modified version of the Trier Social Stress Test (TSST; Kirschbaum, Pirke & Hellhammer, 1993) and then were randomly assigned to one of the three emotion regulation conditions. Negative affect and galvanic skin response measurements were obtained at six different time points. Individuals in the worry condition reported a prolonged recovery from stress in comparison to the distraction condition ( $p < 0.05$ ). Interestingly, galvanic skin response measurements indicated a prolonged recovery for rumination when compared with the distraction condition ( $p < 0.05$ ).

We did not observe significant differences between worry and rumination, but we did find different effects of these strategies compared with the control condition. It may be that worry impacts more on self-report (subjective) indices of stress symptoms whilst rumination impacts more on physiological (GSR) parameters. If this turns out to be the case it may help to explain why some reaction in which rumination predominate (i.e. depression) is accompanied by a flattening of subjective affect but increase in somatic responses. The clinical implications of the present findings must remain highly tentative, but the data suggests that interventions that reduce the propensity to self-regulate after stress exposure with strategies of worry and rumination may reduce prolonged or delayed stress reactions.

## 'Low intensity' Interventions for couples: a way of making behavioural couple therapy more accessible in IAPT?

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**Marion Cuddy, Southwark Psychological Therapies Service**

Brian Sreenan, Southwark Psychological Therapies Service; Janet Wingrove, Southwark Psychological Therapies Service; Clare Kenyon, Southwark Psychological Therapies Service  
Since 2011, a number of IAPT services have offered behavioural couple therapy (BCT) for depression as a 'high intensity' treatment option. However, despite encouraging findings regarding its efficacy, BCT provision and uptake remain very limited. A number of factors are to blame for this, including the practical difficulty faced by many couples in scheduling regular sessions, due to childcare, work, or other commitments. In an attempt to make BCT more accessible, we are piloting two BCT-based 'low intensity' interventions in Southwark Psychological Therapies Service. These are:

1) 'Weekend Workshops for couples', focussing on psycho-education, communication skills and problem solving training and practice (e.g. Hahlweg et al., 1998). Workshops are aimed at groups of 3-5 couples. Individual couples also attend a pre-group assessment, and a follow-up appointment 6-weeks after the group.

2) 'OurRelationship' (Doss et al., 2013), an online guided self-help programme for couples based on the integrative behavioural couple therapy model (Jacobson & Christensen, 1996). This programme helps couples to identify a 'core issue', which is then addressed through three phases (observe, understand, and respond). The programme includes both individual and couple-based tasks and takes approximately 5-6 hours to complete. Couples are offered up to four 15-minute consultations with a therapist to guide them through the programme.

The poster presentation will include a case example illustrating each intervention. The benefits and challenges of offering a range of BCT options in IAPT will be discussed. This poster will offer reflections on the experience of adapting the BCT model to deliver 'low intensity' interventions.

## Biased diagnoses? Meta-analyses of the effects of gender, ethnicity, and unstructured assessment

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**Jan Cwik, Mental Health Research and Treatment Center, Department of Psychology, University of Bochum, Germany;** Eva Merten, Mental Health Research and Treatment Center, Department of Psychology, University of Bochum, Germany; Marcella Woud, Mental Health Research and Treatment Center, Department of Psychology, University of Bochum, Germany; Lorika Shkreli, Mental Health Research and Treatment Center, Department of Psychology, University of Bochum, Germany; Silvia Schneider, Mental Health Research and Treatment Center, Department of Psychology, University of Bochum, Germany; Jürgen Margraf, Mental Health Research and Treatment Center, Department of Psychology, University of Bochum, Germany

Misdiagnosis of a mental disorder can potentially yield meaningful outcomes to a patient. The literature has considered the gender and ethnicity of the patient, along with the diagnostic method used, as being crucial factors contributing to a misdiagnosis. However, the studies in the literature so far not provide sufficient evidence to support these considerations. This study aims to clarify these diagnostic issues.

Three meta-analyses of peer-reviewed studies of misdiagnoses in adult mental disorders were conducted. The factors of interest were related to the patients' ethnicity and gender, and the diagnostic accuracy of the open clinical judgment-approach. In case of significant effects, we estimated sensitivity, specificity, and likelihood ratios. All three meta-analyses were checked for publication biases. The meta-analyses concerning ethnicity-related misdiagnoses (10 studies) and gender-related misdiagnoses (22 studies) revealed no significant biases. The results of the meta-analysis concerning the diagnostic accuracy of the open clinical judgment-approach showed high rates of misdiagnoses, with poor diagnostic accuracy. To date, search for diagnostic biases focused on the association between misdiagnoses, gender and ethnicity. However, as indicated by the results of our meta-analyses, these are not the major concerns. Instead, relatively little attention has been given to the diagnostic accuracy of the still preferred open clinical judgment-approach. The high rates of misdiagnoses related to open clinical judgment could be easily fixed using structured diagnostic instruments. The study illustrates that structured diagnostic should be used to reduce misdiagnoses and mistreatment.

## Schema-Focused therapy on a male complex needs ward in a low-secure mental health setting

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**Erica De Lange, St. Andrew's Healthcare;** Henck van Bilsen, St. Andrew's Healthcare; Jamilah Motala, St. Andrew's Healthcare; Lucinda Robertson, St. Andrew's Healthcare; Emma Freeman, St. Andrew's Healthcare

The Early Maladaptive Schemas are self-defeating, core themes or patterns that people keep repeating throughout their lives (Young, Klosko & Weishaar, 2003). These early Schemas relate to the basic emotional needs of the child. When these needs are not met in childhood, schemas

develop that lead to unhealthy life patterns in adult life (van Vreeswijk, Broersen, & Nadort, 1992). Each of the Schemas represent specific emotional needs that were not adequately met in childhood or adolescence. The Schema Questionnaire (Young & Brown, 2003) was identified as the outcome measure for this programme and was collected both prior to the group and upon completion. The group aimed to introduce service users to basic Schema work; to strengthen the healthy adult mode; weaken maladaptive coping modes so that the person can get back in touch with core needs and feelings; to create awareness of basic schema-driven life patterns; and to learn how to get core emotional needs met in everyday life (Weertman & Arntz, 2007). This poster will summarise the outcomes of this group intervention where all 16 of the Schema group therapy course sessions were offered to service users over a period of 18 weeks as a ward-based group, over September 2014 to January 2015 (Farrell, Shaw & Webber, 2009). The evaluation of group therapy using Schema-Focused therapy on a complex needs ward in a low secure mental health setting.

## Development and validation of the State/Trait Emotion Regulation Questionnaires (STERQ)

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**Joanne Bower, University of Reading;** David Angell, University of Reading; Anastasia Christakou, University of Reading; Craig Steel, University of Reading  
Research into the regulation of positive affect is hindered by a paucity of measures addressing limited regulation strategies (Carl et al, 2013). Furthermore, there is no existing state measure of emotion regulation, with current research relying on ad hoc adaptation of trait questionnaires. The State/Trait Emotion Regulation Questionnaires (STERQ) were developed to address these issues. Items were selected from existing emotion regulation measures (regardless of valence). The resulting state and trait scales were incorporated into an online mood induction study (n=407) for item reduction and factor identification. A second study (n=198) tested the resulting 12 item trait and 13 item state scales using confirmatory factor analysis and validation against existing measures. Principal axis factoring identified reliable factors of emotional intrusion and avoidance (trait and state), emotional expression (trait only), emotional awareness and harnessing (state only). The second study replicated this structure with acceptable reliability and model fit. Good convergent validity with measures of mood and emotion regulation was demonstrated, for example positive associations between emotional intrusion, dampening (responses to positive affect scale) and self-reported depression (depression, anxiety and stress scale). The state scale also showed sensitivity to change, with significant differences in subscale scores across two mood inductions. These data support using the STERQ in emotion regulation research. The trait scale complements existing measures of positive affect regulation, whilst the state scale provides a validated tool for emotion regulation research, useful for investigations with clinical and non-clinical populations. Improved measurement of positive affect regulation enables research that can inform targets for interventions specific to positive mood and its dysregulation.

## Working flexibility within a CBT model: Treatment of OCD in the context of Asperger's Syndrome

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**Nina Grant, Institute of Psychiatry, Psychology & Neuroscience;** Jeremy Oliver, Royal Holloway, University of London; Sinead King, Institute of Psychiatry, Psychology & Neuroscience; Janet Wingrove, Southwark Psychological Therapies Service, South London & Maudsley NHS Foundation Trust; Andre Tylee, Institute of Psychiatry, Psychology & Neuroscience

“Ian” is a 32 year old White British man who was diagnosed with Asperger’s Syndrome in 2014. “Ian” presented with a complex diagnostic profile, and was assessed for personality disorder prior to his diagnosis of ASD. “Ian” also has rapid-cycling moods. “Ian” was referred for psychological treatment for obsessive-compulsive disorder and was seen for 16 sessions by a trainee clinical psychologist. “Ian’s” difficulties were conceptualised using a CBT for OCD approach (Exposure Response Prevention; ERP), pioneered by Salkovsiks (1985). Initial sessions focussed on engagement and doing travel training to enable “Ian” to attend sessions at the outpatient clinic using public transport, which was facilitated by an assistant psychologist. Further sessions then

used the CBT for OCD approach including repeated in vivo exposure prevention work, both in session and continued by Ian between sessions. Progress was made towards goals set by this client, which is supported by standard outcome measures. “Ian’s” treatment was modified to take in to account his Asperger’s Syndrome, which can complicate the application of CBT to ritualised behaviours that may be more commonly seen in ASD. This case example demonstrates that taking a flexible approach and adapting a model to work with the client’s presentation can lead to rapid gains that can be maintained over time. The modification of a standardised CBT model for OCD and how this can be made relevant to someone with a developmental disorder.

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## Resilience is related to clinical good outcomes in Bipolar Disorder

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**Ainara Echezarraga, Psychology Faculty; Department of Personality, Assessment and Treatment, University of Deusto (Spain);** Carlota Las Hayas, Psychology Faculty; Department of Personality, Assessment and Treatment, University of Deusto (Spain); Ana González-Pinto, Psychiatry Service, Santiago Apostol Hospital (Spain); Fiona Lobban, Spectrum Centre for Mental Health Research, Division of Health Research, Furness College, Lancaster University (England); Steven Jones, Spectrum Centre for Mental Health Research, Division of Health Research, Furness College, Lancaster University (England)

Resilience is defined as a dynamic process in which behaviours and attitudes are changed to face adversity and to develop or regain mental health. The aim of this study was to examine relationships between resilience and recovery-related variables in Bipolar Disorder (BD). A total of 120 patients diagnosed of BD (62.5% women), with a mean age of 45.83 years old ( $SD = 10.77$ ) took part in the study. Resilience Scale-25 (RS-25) was completed along with measures of quality of life, functioning, symptoms and personal recovery. Descriptive analysis and correlations between these variables were analyzed. The RS-25 correlated significantly and positively with quality of life ( $r = .64, p < .001$ ), well-being ( $r = .62, p < .001$ ), personal recovery ( $r = .76, p < .001$ ), and negatively with functional impairment ( $r = -.62, p < .001$ ) and bipolar symptoms ( $r = .63, p < .001$ ). Higher scores in resilience (indicated by the RS-25) were related to good clinical outcomes (higher quality of life, well-being, and personal recovery, and lower functional impairment and bipolar symptoms). Consistent to previous studies with other mental disorders, good outcomes in mental health were related to higher resilience in people having BD. CBT therapies could promote mental health in BD by developing interventions focused in increasing characteristic resilience behaviours and attitudes.

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## Trauma-focused CBT: adjusting outcome expectations in response to current threat

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**Jeremy Oliver, Royal Holloway, University of London**

Robert (pseudonym), a middle-aged man, was referred to a secondary care outpatient psychology team for PTSD treatment after witnessing a murder and being told to flee his home country on threat of death. He was experiencing daily flashbacks, nightmares and auditory hallucinations relating to the murder incident. He presented as severely depressed, had not worked since the incident and rarely left his house because he believed he was still in danger of being found and killed. Ehlers and Clark’s (2000) cognitive model of PTSD provided a useful framework to elicit Robert’s beliefs prior to the trauma that ‘life is dangerous’ and his strong sense of current threat to his life. A three-phase Trauma-Focused CBT intervention was used (Courtois & Ford, 2009): stabilisation (including sleep work), trauma memory work (including re-living and emotion hot-spots) and reclaiming life (including behaviour activation). Robert became more active and started making future plans to return to education. Avoidance and re-experiencing symptoms reduced, but hyperarousal remained consistently high and he continued to have frequent nightmares. However, the content of these nightmares changed - they related to threat to life, but the imagery associated with the trauma incident itself dissipated. When ongoing threat to life is indicated, some outcomes such as reduction in frequency of nightmares and a reduction in hyperarousal may not occur. This could be an adaptive response to real-life circumstances and therapists may need to look at other subtle changes to see whether CBT is having an effect. When delivering Trauma-Focused CBT,

outcome expectations may need to be adjusted to account for ongoing events for which a high state of arousal is adaptive but which do not directly form part of the trauma memory.

## Cognitive Behavioural Therapy (CBT) for Adolescent Obsessive-Compulsive Disorder (OCD) Complicated by Separation Anxiety: A Case Study

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### **Ania Grozdziej, University of Bath**

Anxiety disorders are amongst the most prevalent mental health disorders experienced by children and young people, and are often comorbid with another affective condition. Yet there is lack of research evaluating the treatment outcomes of comorbid conditions in young children and adolescent. This paper aims to address this gap by describing a CBT treatment of a young person with obsessive-compulsive disorder (OCD) and comorbid with separation anxiety. The approach adopted in this report draws on the developments made in the adult field of OCD treatment, and is guided by the cognitive model of OCD (Waite & Williams, 2009). The present paper sets out to discuss an assessment, formulation driven CBT treatment of a 14-year-old boy struggling with separation anxiety and an associated array of obsessions and compulsive behaviours. The Revised Child Anxiety and Depression Scale (RCADS, Chorpita et al., 2000) measure with subscales including: separation anxiety disorder (SAD), social phobia (SP), generalized anxiety disorder (GAD), panic disorder (PD), obsessive compulsive disorder (OCD), and depression was administered at baseline, pre and post-treatment in order to evaluate treatment progress. Following fifteen sessions of CBT, obsessive-compulsive symptoms and associated separation anxiety had reduced to non-clinical levels. This case study provides encouraging results indicating the effectiveness of the cognitive model of OCD in reducing symptoms of OCD and comorbid separation anxiety disorder (Salkovskis & Warwick, 1985). Given the need for further research into the cognitive approaches to adolescent OCD treatment, the present paper offers a unique contribution to the field by evaluating the effectiveness of CBT, with an emphasis on the cognitive approach, for adolescent OCD and separation anxiety. The present case study suggests the applicability of the CBT model to treatment of adolescent OCD and comorbid separation anxiety in a specialist CAMHS setting often characterised by high levels of complexity. Overall, the present report contributes to the evidence base of CBT for OCD, and suggests that this model has the potential to be successfully applied to treat OCD with comorbid separation anxiety symptoms in adolescent population.

## The role of schemas in psychosis: a narrative review

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### **Ania Grozdziej, University of Bath; Lorna Hogg, University of Bath**

Schemas or core beliefs are frequently targeted in psychological approaches to psychosis. However, its precise role in the formation and maintenance of psychosis is unclear. Schema theory can shed a new light on our understanding and clinical approaches to psychosis. Therefore, this article reviews the existing research on the impact of schemas in psychosis and discusses it in relation to theory development and clinical practice. A literature search was performed to identify studies investigating the role of schemas in psychosis. Articles were identified through a literature search in Embase, MEDLINE and Science Direct. Electronic databases were searched from inception until October 2014. A broad concept of schemas was used to identify as many relevant articles as possible. Studies investigating a concept of self-esteem were excluded. The literature search identified 753 studies of which 21 met the inclusion criteria. The reviewed studies found significant associations between negative self and other schemas and positive symptoms of psychosis in both clinical and sub-clinical samples. Negative schemas were found to be linked to trauma. This review highlights the importance of focusing on schemas and points out to the potential role of negative self and other schemas in the development and maintenance of psychosis. The results suggest that schema theory can offer a valuable contribution to our understanding of psychosis, and has the potential to inform future research and treatment of psychosis. Limitations of the present research are discussed. Clinical and theoretical implications of findings are outlined, and possible directions for future research are suggested. The present study indicates that schemas may offer a promising way of conceptualising the development of psychosis, and possess potential as a therapeutic focus of the future interventions for people with

psychosis. Greater understanding of the pathways from schemas to psychosis and the role of trauma in this process could contribute to the development of suitable preventative or therapeutic interventions for people with psychosis or those at high risk of developing psychosis or relapsing (Fisher et al., 2012; Smith et al., 2006). Furthermore, although schema therapy in its original form is not implicated for individuals with active psychosis (Young, 2003), clinicians could adapt their formulations and apply schema-based interventions to their work. For instance, individuals with psychosis may benefit from schema focused psychological interventions aimed at increasing their awareness of the links between life events, schemas, and psychosis.

## A trans-diagnostic cognitive behaviour therapy group in a secondary care mental health service

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**Emily Garner, University of Bath;** Chris Gillmore, Avon and Wiltshire Mental Health Partnership NHS Trust; Claire Lomax, Newcastle University

Due to the growing evidence base supporting the hypothesis of common processes across different mental health problems, trans-diagnostic interventions are receiving increased research attention. Trans-diagnostic approaches have the potential to produce better outcomes, to reduce waiting times and to increase cost-effectiveness in stretched mental health services. Research into trans-diagnostic group Cognitive Behavioural Therapy (CBT) has demonstrated positive results in participants with anxiety disorders, with some studies extending the inclusion criteria to secondary and comorbid symptoms. This study evaluates a trans-diagnostic CBT group delivered by a secondary care mental health team and includes participants with a range of diagnoses typical of this population. The intervention consisted of 13 90-minute group sessions and three individual one-hour sessions. Outcomes were measured using the Work and Social Adjustment Scale and CORE-10. Pre- and post-group data collected from five cohorts (n=51) were analysed. Post-group outcomes showed significant improvements compared to pre-group scores. These significant differences remained in an intention-to-treat sample with a medium to large effect sizes. The results suggest that the positive effects of trans-diagnostic group CBT are not limited to participants with anxiety disorders and that patients with a range of diagnoses may benefit equally from this approach. Although there are limitations to this evaluation it provides an ecologically valid initial investigation into trans-diagnostic group CBT in a sample typical of secondary care mental health services, with promising results. Trans-diagnostic group CBT may be an effective treatment for a range of diagnoses seen in secondary care mental health services. It could also be more cost-effective, with the potential for shorter waiting times, than individual interventions.

## The Treatment of a Severe Blood-Injection-Injury Phobia: A Child Case Example

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**Vera Hughes, University of Bath**

Blood-injection-injury phobia (BII) is characterised by an intense fear and avoidance of stimuli or invasive medical procedures associated with blood, injections and injury. BII phobia is a serious problem, leading to avoidance of necessary medical interventions and life-saving treatments. BII phobia is distinct from other specific phobias in that it often involves a strong vasovagal response (e.g., fainting). This paper describes the case of an eight year old girl (MH) referred to the psychology service within her general hospital by her paediatrician for support in managing a severe BII phobia which manifested as significant anxiety and vasovagal syncope (fainting) on exposure to blood and medical interventions (e.g., blood tests, injections). MH had experienced a number of hospital admissions in her early years. Unfortunately, MH found these admissions distressing and on a number of occasions she had fainted whilst undergoing medical procedures. It was hypothesised that these negative early experiences resulted in MH's BII phobia which was maintained through a process of negative reinforcement. Her parents responded to her anxiety by protecting her from being exposed to fear inducing stimuli including holding off from taking her for necessary blood tests and medical examinations. MH was offered eight weekly sessions, treatment focussed on applied tension training (Kosak & Montgomery, 1981; Ost & Sterner, 1987) and in vivo exposure. Adaptations to the therapy process to account for MH's age included the use of stories and pictures to help explain the treatment process and systemic working with MH's

parents as co-therapists. By the end of therapy, MH had achieved all steps of her exposure hierarchy and successfully undergone a blood test at the general hospital without experiencing syncope. MH reported a reduction in psychological distress and a reduction in fear of blood and medically related stimuli. This case report shows the successful application of applied tension techniques and in vivo exposure for BII phobia in a young child. To date published research on BII phobia has predominately focussed on adult samples, with one recent case study focussing on two adolescent patients (Mednick & Claar, 2012). To the authors knowledge this is the first case study reporting on the effectiveness of applied tension and exposure work in children.

## Psychological factors in Parkinson's disease

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**Vera Hughes, University of Bath;** Paul Salkovskis, University of Bath; Leon Dysch, Community Neuro and Stroke Service, Bath; Robin Fackrell, Royal United Hospital NHS Trust  
Parkinson's disease (PD) is chronic and disabling condition. It can interfere hugely with a person's life, affecting ones future goals and aspirations. It is understandable therefore that research indicates high levels of anxiety and depression among individuals with the disease. To date, however, few studies have focussed on the specific psychological factors that may underpin emotional distress in individuals with PD. This study aims to further explore individuals' reactions to PD, looking specifically at anxiety relating to health (i.e, health anxiety) and the impact of this on quality of life, psychological distress and perceptions of cognitive and physical performance. A quantitative cross-sectional design was employed. A total of 52 patients with PD took part in the study. Participants were asked to complete questionnaire measures assessing health anxiety, mood, and quality of life. Further, participants were asked to complete two tasks assessing cognitive and physical functioning. Measures of actual and perceived performance were taken. A main group comparison between participants with relatively high or relatively low health anxiety was made, based on a median split. A community sample of similar age and gender (N=26), not suffering from PD, were also recruited in order to benchmark the two group comparisons; i.e. to establish how performance and/or ratings in the two index groups relates to those found in a group unaffected by PD. Results will be presented. Data has been gathered and is being analysed currently.

Implications for, clinical practice and future research will be discussed. The National Service Framework for Long-term Neurological Conditions (2005) and the BPS Briefing Paper on psychological services for people with PD (2009) highlight the need for further research into the psychological management of patients with PD. Recent evidence has started to accrue suggesting the potential benefits of CBT in the treatment of anxiety and depression in patients with PD. To develop more extensive psychological interventions, there is a need to understand the modifiable psychological processes and mechanisms involved. It is anticipated that this study will add to the currently limited literature on psychological processes in adjustment to PD and point the way forward for appropriate psychological intervention (e.g., CBT for health anxiety).

## Young Children have Social Worries too: Validation of the adapted SWQ-P for Children aged 4 to 8 years

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**Suzannah Ravenscroft, University of Reading;** Helen Dodd, University of Reading; Shirley Reynolds, University of Reading

Young children are often described as being shy or quiet around others, but these informal terms don't capture more significant social worries that may be indicative of early social anxiety. In comparison to middle childhood, relatively little is known about the stability and development of social anxiety in early childhood. This study provides an initial validation of an adapted version of the Social Worries Questionnaire – parent version (SWQ-P; Spence, 1995). The SWQ-P was originally developed for parents to report on 8-17 year olds. For this study it was adapted for use in relation to children aged 4 to 8 years old. Content validity, internal consistency, and test-retest reliability over two time points were assessed and convergent validity was assessed with an age-appropriate measure of general child anxiety. Parents of 174 children from a community sample aged 4 to 8 years ( $M = 5.84$ ,  $SD = 1.36$ ) completed the adapted SWQ-P at time 1, two weeks later 109 of these parents completed the questionnaire again (time 2).

The adapted SWQ-P had excellent (>.80) internal consistency and a one-factor model. Test-re-test reliability was strong and there was evidence of convergent validity ( $r > .50$ ). These promising results indicate that the adapted SWQ-P may be a reliable and valid measure of social anxiety in children aged 4 to 8 years old. This measure will allow researchers to gather more information about social anxiety over childhood and investigate the role of these early social worries in later childhood anxiety disorders.

## Living with Mental Illness: a Cognitive Behavioural Group Programme for Women in Secure Settings

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**Clive Long, St Andrew's Healthcare;** Ellen Banyard, St Andrew's Healthcare; Olga Dolley, St Andrew's Healthcare

The provision of psycho-educational groups for people diagnosed with schizophrenia is an important part of successful treatment. The value of such interventions is less clearly established in secure settings with no reports on women. Gender differences in the manifestation of schizophrenia highlight the importance of a gender specific intervention. An eleven session Living with Mental Illness group programme for women in a secure psychiatric setting is described and evaluated. A pre-post evaluation design used a variety of self reported and observational measures. Group completers were compared with non completers. Group completers showed improvements in insight, knowledge and feelings about schizophrenia, increased hope and greater self-compassion. Pre-post group findings were reflected in improved ratings of on ward behaviour, fewer risk behaviours, improved engagement and less symptomatology. Such interventions, as part of a broader treatment initiative, can be associated with clinical improvement that is both illness specific and which leads to improved engagement with care initiatives. The needs of patients who do not complete treatment need to be regularly reassessed. Findings are discussed in the context of the issues characteristic of real world evaluations and the need to allow the long term benefits of group CBT treatment. CBT psycho-education groups for secure inpatients with schizophrenia need to address gender specific differences in the manifestation of the condition.

## Hearing Voices: Piloting a voice-hearer-facilitated hearing voices group in a high secure setting

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**Jonathon Slater, Rampton Hospital**

Voice-hearer facilitated hearing voices groups have proved successful in non-forensic contexts. A forensic pilot using cognitive behavioural principles was developed to determine whether similar gains could be achieved within a high secure context. The 8 patients who attended the Hearing Voices Group (HVGrp), their Named Nurse, Psychologist and Responsible Clinician were invited to be interviewed (n=26) using a questionnaire consisting of both open and closed questions developed by the HVGrp facilitators. All interviews were conducted by an independent researcher who transcribed and analysed all data. Interview responses were recorded on the questionnaire by the interviewer or where interviewees' wished to scribe for themselves this was facilitated. Interviews lasted between 10 and 30 minutes and were kept informal to try and enable interviewees to feel able to speak openly. Patient respondents were seen on a 2:1 basis as the interviewer was not privy to patients' histories and was only informed of necessary risk information for security reasons. 25 interviews were conducted with patients (n=7), Nurses (n=8), Psychologists (n=4) and Responsible Clinicians (n=6). One patient declined to participate. Responses from closed questions were analysed using frequencies; responses to open questions were transcribed and where appropriate analysed using thematic analysis. As some participants gave short or no explanations to their answers a full qualitative analysis was not always viable; in this case representative examples were carefully selected and reported. Results indicated that as a result of the group the majority of patients felt better able to talk more openly to their multidisciplinary teams, understood their voices better, felt less isolated, did not think about reducing or stopping their medication as a result, felt they had a more objective understanding of medication, found sharing coping methods useful and felt the group had given them more hope. Responses from healthcare professionals largely corroborated these results, but also raised

concerns about facilitation and increasing the forensic focus. The pilot has demonstrated that voice-hearer facilitated hearing voices groups which adopt a CBT format are viable within high secure contexts and have utility with regard to progress towards conditions of lesser security. However, further refinements for context are warranted to enhance gains.

## CBT for Health Anxiety: A Systematic Review and Meta-analysis

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**Kate Cooper, University of Bath;** James Gregory, University of Bath; Ian Walker, University of Bath; Sinead Lambe, University of Bath; Paul Salkovskis, University of Bath

Health anxiety (HA) is characterised by preoccupation with the belief that one has a serious illness, based on the misinterpretation of bodily sensations. HA is a common mental health problem, affecting approximately 0.8% of the population, with a further 2.2% of the population presenting with subclinical HA. Cognitive behavioural treatment for health anxiety (Salkovskis, Warwick, & Deale, 2003) has been found to be effective in a number of trials. The current study aimed to systematically review the literature to date to investigate the efficacy of CBT for HA. Randomised controlled trials of cognitive behavioural therapy for people with HA were selected for this review. The intervention used was cognitive behaviour therapy, including psycho-educational approaches, but not third-wave CBT. A systematic search of the literature was conducted using a number of databases, and papers were screened for inclusion by two individuals. Data was extracted onto a standardised data table, and a risk of bias assessment was also undertaken. Standardised mean difference effect sizes (Cohen's *d*) were calculated for health anxiety outcomes at pre, post and follow up. 14 studies (21 comparisons) were included in the meta-analysis, with a total of 1544 participants. A meta-analysis of the effect of CBT compared to all control conditions on health anxiety outcome scores at pre- and post- treatment, 6-month and 12-month follow up, and a large effect size was found for each of these comparisons. The funnel plot was symmetrical, suggesting there was no publication bias. This paper extends the existing evidence base by conducting the first systematic review of CBT for HA since Thomson & Page (2007), and adding more recently published papers to the meta-analytic review published more recently by Olatunji et al. (2014). This systematic review and meta-analysis identified 14 studies which investigated the effect of CBT for people with HA, compared to waitlist, TAU, medication and placebo medication, and other psychosocial interventions. A strength of this review was the separation of the diagnostic categories of HA and MUS, with only studies which included participants with HA included. A limitation of this review is the lack of inter-rating for the risk of bias assessment. This research adds weight to the evidence base supporting the use of CBT for HA, and shows that it is equally effective in people with medical health problems as those without, suggesting that clinicians should be using this approach for this group of clients.

## Evaluating the effectiveness of group therapy for OCD

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**Paul Quinn, Belfast Health Trust;** Gerard McAleer, Belfast Health Trust; Ann O'Hanlon, Queens University Belfast; Rachel Johnson, Queens University Belfast

Common mental health problem after depression, addictions and social anxiety. Most of the interventions to date have focused on one-to-one CBT, but the current project aimed to evaluate the effects of a 15-week group therapy on men and women with DSM-V diagnosis of OCD living in the greater Belfast area. Four groups have been in process to date involving around 8-12 men and women per group, aged 18-65 years. For each group, participants completed surveys at baseline, and every 3 sessions approximately; these included the Patient Health Questionnaire (PHQ-9) (Spitzer et al, 1999) the GAD-7 (Spitzer et al, 2006), The Yale Brown Obsessive Compulsive Scale (Rosario-Campos et al, 2006) and the Hospital Anxiety and Depression Scale. Psychoeducational interventions included information to the OCD model, techniques to manage anxiety, and the use of exposure response prevention. Three sets of home visits were also carried out during the course of therapy incorporating of exposure response prevention. These home visits occurred at approximately sessions 4, 8 and 12. Follow-up visits were carried out at around 3 months post therapy. Results to date reflect improvements on all measures. Measures of anxiety and depression decreased pre- and post- assessments, and these improvements were maintained at 3-month follow-up. Home visits were valued by participants. These included facing feared

activities such as hand-washing, drinking/eating using utensils belonging to another person, and leaving the home without extensive checking of locks and cookers. Participants found the groups very effective and helpful. They valued the professional input, alongside peer opportunities for learning, support, advice and encouragement from others going through the same experience. They found this support empowered them to try harder as they did not want to let others down in the group. Clinically, group therapy offers an effective way to manage time and resources. Group therapy incorporating exposure response prevention is effective with adults who have OCD.

## Weeding out the sad flower of depression: Psychological treatment of depression in later life using CBT augmented with IPT techniques

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**Andrew Merwood, University of Bath, UK; Anna Strudwick, 2Gether NHS Foundation Trust**

AB, a woman in her late 70s, was referred for therapy with low mood and suicidal ideation. This was triggered by a fall resulting in physical disability and a loss of independence. AB's difficulties were conceptualised as depression using a six cycles cognitive-behavioural formulation (Moorey, 2010). Due to AB's interest in gardening, this was referred to as a "sad flower", a metaphor used extensively throughout therapy. AB identified longstanding beliefs related to her depression, which became the "roots" of the sad flower. AB also described life events that had preceded her depression and triggered feelings of grief, most notably the death of her husband. These events became the "stem" of the sad flower. The primary intervention was CBT for depression, adapted for later life (Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2004). Specific techniques (e.g. behavioural activation, thought challenging) were used to help AB "pull off the petals" from the sad flower, in order to "weed out" depression. To work with AB's grief, techniques from Interpersonal Therapy (IPT) were used to facilitate mourning and re-establish relationships (Klerman, Weissman, Rounsaville, & Chevron, 1984).

Quantitatively, the pre-post change in AB's symptoms on the Geriatric Depression Inventory was negligible. Qualitatively, AB reported feeling less hopeless and more able to talk to people about her emotions at the end of therapy. The main strength of this case study is the creative use of an idiosyncratic formulation and extended metaphor during therapy. This helped to engage the client. However, this should be interpreted in the context of minimal change in depressive symptoms. This poster outlines the utility of CBT for the treatment of depression in later life following adverse life events. The use of IPT techniques during therapy highlights some of the similarities between CBT and other therapeutic modalities recommended for the treatment of depression. An additional implication is the importance of developing a creative, idiosyncratic formulation as a foundation for treatment when using CBT.

## IAPT at Together Women's Project Leeds: Audit of engagement and clinical outcomes

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**Toby Chelms, Leeds Counselling (Leeds IAPT)**

This paper outlines the results of 12 month audit/evaluation of an IAPT clinic within a female only probation environment in Leeds; comparing outcomes to those of the general IAPT population. This report is based on available PCMIS data for all clients who were referred to the IAPT clinic at TWP Leeds between March 2012 and March 2013. Total referrals, therapy completion, recovery rates, appropriateness of referrals and information on inappropriate referrals were investigated and summarised in relevant graphs. We looked at learning from these results in order to maintain and improve the service and to look towards future expansion and role out into similar probation settings. These results can help inform future clinic locations and provision of IAPT CBT in order to improve access to Clients who would not normally self-refer or feel able to engage.

## Providing Cognitive Behavioural Therapy for Suicide Prevention (CBSP) on inpatient wards: What are the challenges? (to form part of a Group of Papers: Psychological approaches to working with people experiencing suicidality)

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### **Emma Evans, University of Manchester**

Suicidal behaviour can often be a reason for inpatient admission to hospital and psychological interventions are often not easily accessible on inpatient wards, if offered at all. This is despite the evidence of its effectiveness for a range of mental health difficulties. Previous studies have shown promising results for effectiveness of Cognitive Behavioural Therapy for Suicide Prevention (CBSP) both within the community and in prison. The current feasibility RCT trial is researching the acceptability and feasibility of providing CBSP on inpatient wards. The challenges of providing therapy on an inpatient ward will be discussed. Participants who are allocated to treatment plus therapy receive 20 sessions of CBSP whilst on an inpatient ward, which continues to be offered once participants have moved back into the community. CBSP therapy is currently being adapted for use within an inpatient and community settings where participants who are suicidal receive once or twice weekly therapy sessions for six months.

This presentation is clinically based and will focus on reflections of both the potential opportunities and challenges in providing CBSP to inpatient wards. Illustrative case material will be presented.

Inpatient wards can often be challenging places to work. Providing psychological interventions within a challenging environment to people who are often in a crisis brings some unique opportunities and challenges for therapists. Providing CBSP on an inpatient ward may offer a sense of containment and hope for the suicidal patient, at a time when the ward can be a difficult and challenging time for the patient.

### **Compassion-focused training for nursing staff working on complex needs wards in a low-secure mental health setting**

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**Erica De Lange, St.Andrew's Healthcare;**Henck van Bilsen, St.Andrew's Healthcare; Motala Jamilah, St.Andrew's Healthcare; Cooper Emma, St.Andrew's Healthcare; Robertson Lucinda, St.Andrew's Healthcare; Watkins Kelly, St.Andrew's Healthcare

Compassion Focused Therapy (CFT) has been developed to assist people who experience high levels of self-criticism and shame. The therapy was developed by Professor Paul Gilbert (Gilbert, 2009) and is based on evolutionary, cognitive and behavioural psychology and falls under the umbrella of 3rd wave CBT approaches. The training focused on identifying key negative emotions and self-critical thoughts and assisted staff to develop alternative and more compassionate ways of relating to themselves and others (Cole-King & Gilbert, 2011). The Fears of Compassion Scale (Gilbert, 2010) and the Forms of Self-Criticising or Attacking and Self-Reassurance Scale were identified as the outcome measures for this programme and was collected both prior to the group and upon completion. Continued evaluation with qualitative responses was also collected throughout the training. The training aimed to provide participants with an overview of the model and to help participants develop their own individualised models of CFT. Once staff members have an understanding of the development and maintenance of their difficulties they are then invited to try a number of different skills and strategies that they can apply in their everyday lives. It is hoped that this will help them to develop a repertoire of tools to draw on in times of difficulties and to cultivate self-compassion and kindness towards others (Cole-King & Gilbert, 2011). The application of Compassion-Focused therapy on complex needs wards in a low-secure mental health setting.

### **Patient experience of psychological therapy: A thematic analysis with participants from an IAPT service**

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**Nina Grant, Institute of Psychiatry, Psychology & Neuroscience;** Jeremy Oliver, Royal Holloway, University of London; Sinead King, Institute of Psychiatry, Psychology & Neuroscience; Janet Wingrove, Southwark Psychological Therapies Service, South London & Maudsley NHS Foundation Trust; Andre Tylee, Institute of Psychiatry, Psychology & Neuroscience

Depression and anxiety within the general population are a continuing and significant problem. Patients presenting with mild to moderate levels of these disorders are now commonly referred to Increasing Access to Psychological Therapy services. This project seeks to understand the

experience of patients receiving psychological therapy in one IAPT service. Semi-structured interviews were conducted with 18 patients, with questions focussing around expectations of therapy, experience of homework, structure of sessions, perceived usefulness of therapy, and therapeutic endings. Data were analyzed using thematic analysis. Key features of cognitive behaviour therapy were present in participants' descriptions of therapy. For example, empathy and normalisation was described by one participant "I felt like [the therapist] really got it every time I didn't have to correct [the therapist] and say well actually, I didn't really mean that" and also offering a client-centred approach "When I explained that I didn't really see it as depression [the therapist] was happy to work with me on how I felt and what my feelings were". Some participants felt that whilst CBT had been helpful they may need further support "I would probably find it more helpful to have a way of managing those core [emotional] responses which I think is beyond the scope of CBT". CBT was reported to be a positive subjective experience overall, but with periods of conflicting emotions, such as feeling sad to be ending treatment but pleased to be considered well-enough to be discharged. Understanding the experiences of patients who receive therapy. Whilst outcome measures are routinely collected using standardised forms, anonymous, open-ended feedback is rarely able to be collected. This information can inform service provision within primary care psychology services.

## An Evaluation of the Hearing Voices Educational Mobile App

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### **James Kelly, Lancashire Care NHS Foundation Trust**

Despite prevalence levels estimated to be between 4 and 15% in many western cultures voice hearing is considered a taboo experience (Longden, Madill & Waterman 2012). Indeed people who hear voices are often labelled as psychotic and are treated with fear and suspicion. Ando et al (2011) to go so far as to suggest that hearing voices that are distressing is one of the most stigmatized experiences in psychiatry. Thus there is a pressing need to ensure healthcare professionals are equipped to meet the challenge of providing voice hearers with empathetic, therapeutic and empowering care. To do so it is imperative that clinicians fully appreciate the devastating impact that voice hearing can have on the individual's physical and psychological wellbeing. The Hearing Voices Mobile App was developed by pooling the expertise of a wide range of healthcare professionals, learners and voice hearers to devise a comprehensive educational package to support and promote an understanding of the challenges faced by people who hear voices. Simulation is a central to the pedagogy of the App with users given the opportunity to engage in a number of cognitive and social tasks whilst using headphones to listen to auditory footage of voices. The sense of reality is enhanced by the mobility of the app as learners can carry out simulation exercises in any environment. The App has been designed in collaboration with the Hearing Voices Network and they played a central role in developing the auditory recording which should assist in addressing Waxman's (2010) calls for simulations to sufficiently mimic real-life situations to enable learners to suspend disbelief. A recent study by Chaffin (2013) showed some promise for the use of simulation in this area finding that students acknowledged more understanding of their clients and more empathy for the challenges voice hearers faced which led them to want to show more patience during interactions. However McNaughton, Ravitz, Wadell & Hodges (2008) are amongst a significant number of authors calling for further research to evaluate the implications of different simulation technologies in psychiatry. Here we will present the findings of an empirical investigation (in progress) into the use of this simulation technology for healthcare professionals, voice hearers and their relatives. The research study adopts a mixed methods design combining quantitative pre and post simulation attitudinal survey data with rich narrative data gathered via focus group interviews.

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## Factors affecting recruitment into a feasibility randomised controlled trial of supported cognitive-behavioural self-help for depressed informal carers of stroke survivors (CEDArS Trial )

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Medical advances have resulted in increased life expectancy across the developed world. However, an ageing population leads to a significant increase in people living with chronic physical health conditions and greater provision of informal care, placing informal carers at greater risk of poor mental health. Currently no psychological treatments tailored to informal carers of stroke survivors exist. This study reports on the feasibility of recruiting depressed informal carers of stroke survivors into a randomised controlled trial. A feasibility randomised controlled trial comparing supported CBT self-help, supported by psychological wellbeing practitioners, with treatment-as-usual for depressed informal carers of stroke survivors. Comparisons were made between recruitment methods encompassing general practice screen and mail out; referral from stroke healthcare settings and community outreach. Additionally, data on the diagnosis of depression, symptoms of depression and anxiety, functional impairment, carer burden, quality of life, and stroke survivor mobility skill, self-care and functional ability were collected at four and six months post-randomisation. 20 informal carers were recruited over 10-months yielding a randomisation rate of 0.08%. Factors affecting recruitment included under-recognition of informal carers within general practice and gate-keeping by stroke healthcare professionals and community organisations. Informal carers' reasons for non-participation identified significant barriers to accessing treatment including guilt, sense of duty, reaction of stroke survivor, lack of time and lack of recognising depressive symptoms. Significant difficulties with recruitment highlighted important concerns pertaining to informal carer identification within healthcare settings and barriers experienced by informal carers of stroke survivors to accessing psychological support for depression. Further research is required into how to improve the identification of informal carers, especially within primary care, and how to increase the acceptability of psychological support provision for informal carers of stroke survivors. A key implication for clinical practice relates to the significant barriers to accessing psychological support for depression experienced by informal carers of stroke survivors. Health professionals working with informal carers of stroke survivors, or their care recipients, should be made aware of these significant barriers in order to attempt to provide support that recognises and takes account of these barriers.

## Relationships between resilience and recovery-related variables in Bipolar Disorder

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Resilience is defined as a dynamic process in which behaviours and attitudes are changed to face adversity and to develop or regain mental health. The aim of this study was to examine relationships between resilience and recovery-related variables in Bipolar Disorder (BD). A total of 120 patients diagnosed of BD (62.5% women), with a mean age of 45.83 years old (SD = 10.77) took part in the study. Resilience Scale-25 (RS-25) was completed along with measures of quality of life, functioning, symptoms and personal recovery. Descriptive analysis and correlations between these variables were analyzed. The RS-25 correlated significantly and positively with quality of life ( $r = .64$ ,  $p < .001$ ), well-being ( $r = .62$ ,  $p < .001$ ), personal recovery ( $r = .76$ ,  $p < .001$ ), and negatively with functional impairment ( $r = -.62$ ,  $p < .001$ ) and bipolar symptoms ( $r = .63$ ,  $p < .001$ ). Higher scores in resilience (indicated by the RS-25) were related to good outcomes of mental health (higher quality of life, well-being, and personal recovery, and lower functional

impairment and bipolar symptoms). Consistent to previous studies with other mental disorders, good outcomes in mental health were related to higher resilience in people having BD. CBT therapies could promote mental health in BD by developing interventions focused on increasing characteristic resilience behaviours and attitudes.

## Developing CBT manual for secure services - A pilot randomised controlled trial

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**Gurmit Dhillon, University of Southampton;** Prof David Kingdon, University of Southampton

Over half a century, there have been some improvements in mental health outcomes particularly in individuals with psychosis. This is due to understanding and advances in psychological therapies and medication. These advances have been demonstrated in randomised controlled trials and meta-analyses. Most patient related studies in the literature of severe mental health problems have looked at outpatients and inpatients in mental health institutions however, there has been a dearth of studies conducted in secure services population (Laithwaite et al, 2009). Part 1: A two centre qualitative study consisting of individual semi structured interviews with participants in secure services with a diagnosis of schizophrenia, schizo-affective, delusional disorders or psychosis (n=17); focus groups with mental health professionals (n=23). Data was analysed using two qualitative approaches of grounded theory and thematic analysis. NVivo 8 was used to manage and explore data. Part2: The recommendations were used to inform adaptation of CBT for psychosis in secure services (CBTp-ss). A pilot randomised controlled trial was conducted in two centres in the UK. A total of 12 participants' were recruited. Assessors blind to randomisation and treatment allocation administered outcome measures at two-time points; baseline and post-therapy using the Positive and Negative Syndrome Scale (PANSS), Birchwood insight scale (BIS), AND Social Functioning scale (SFS). Participants in the CBTp-ss arm (n=8) were offered 20 sessions of Therapy and Treatment as usual (TAU: n=4) arm continued with standard treatment. Post-treatment the intervention group showed statistically significant reductions in symptomatology on positive and negative symptoms of PANSS and some of the items on both SFS and BIS. The CBTp-ss adapted from participants and professionals experiences provided a platform to understand participants' views about their treatment and may have contributed to positive outcome. Participants in the CBTp-ss group showed reductions in symptoms and improvement in social functioning compared to TAU. Attrition rates were low and therapy experiences suggest that the newly adapted CBTp-ss is acceptable and may have made impact on participants' experiences.

## Incorporating service users' views in CBT for psychosis in secure services - the adaptation process

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**Gurmit Dhillon, University of Southampton;** Dr Anupam Kishore, Central and Northwest London NHS Trust; Dr Sarah Allen, Central and Northwest London NHS Trust; Prof David Kingdon

Over half a century, there have been some improvements in mental health outcomes particularly in individuals with psychosis. This is due to understanding and advances in psychological therapies. Most patient related studies in the literature of severe mental health problems have looked at outpatients and inpatients in mental health institutions however, there has been a dearth of studies conducted in the secure services population and patients' views have been neglected. (Laithwaite et al, 2009). A qualitative study (Study 1), views were gathered from (n=17) service users and (n=23) mental health professionals in secure services. Themes were analysed using a thematic analysis approach and used in preparing a manual (CBTp-ss) that was trialled in a pilot randomised controlled study (Study 2). A total of 12 service users were recruited, out of which eight received new treatment and four Treatment as Usual (TAU). Following this, a further qualitative study (Study 3) was conducted to refine themes. Important themes surrounding therapeutic processes and environment were gathered and further advanced knowledge in treating this complex population and adaptation of a manual for treatment. Service users views in secure

services are essential and need to be adopted into psychological treatment such as CBTp-ss. Themes will be discussed using case scenarios and the adaptation processes.

## Effects of attentional bias modification on emotion regulation

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Prominent cognitive theories and models of anxiety assume that attentional bias is causally involved in the maintenance of anxiety (for a review, see Van Bockstaele et al., 2014). However, it remains unclear how changes in attentional bias influence anxiety. A possible underlying mechanism of the effect of changes in attentional bias on anxiety is improved emotion regulation, because selective attentional deployment is considered an important emotion regulation strategy (Gross, 2001; Todd et al., 2012). In the present experiments, we attempted to bridge the gap between the attentional bias modification literature and the emotion regulation literature, by investigating whether changes in attentional bias lead to changes in emotion regulation. In two experiments, we trained unselected participants either to avoid or to attend to threatening stimuli. Next, we assessed how well participants could suppress or enhance their emotions while watching negative and positive pictures. In the first experiment, we used the modified dot probe task in the training, while we used a new chase-the-picture paradigm for the training in the second experiment. In Experiment 1, we found no group differences in emotion regulation. However, this lack of group differences is not hard to explain, as our training had also failed to induce changes in attentional bias. That is why we used the new chase-the-picture paradigm in Experiment 2. The data of this experiment are currently being collected and the data collection will be completed in April 2015. Despite the discouraging findings of Experiment 1 and the fact that the results of Experiment 2 are currently unknown, we feel that research on the possible link between attentional bias modification and emotion regulation is important. Many recent studies on attentional bias modification have yielded null-results (see Van Bockstaele et al., 2014), both in terms of changing attentional bias and in terms of reducing anxiety. Therefore, a thorough understanding of the processes underlying attentional bias modification as well as the development of new methods to change attentional bias are imperative. Attentional bias modification has the potential to add to the effects of successful CBT. However, as long as attentional bias modification research yields heterogeneous results, its use in clinical practice will remain controversial. In the present line of research, we aim to improve our understanding of the processes involved in attentional bias modification, thereby attempting to reduce this heterogeneity and increase the effectiveness of attentional bias modification.

## The relevance of professionals' attachment style, expectations and job attitudes for therapeutic relationships with young people who experience psychosis

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**Clio Berry, University of Sussex and Sussex Partnership NHS Foundation Trust;** Kathryn Greenwood, University of Sussex and Sussex Partnership NHS Foundation Trust

Therapeutic relationships are a central component of community treatment for psychosis and thought to influence clinical and social outcomes. However, perhaps due to historical scepticism that people experiencing psychosis could form positive therapeutic relationships, there is a paucity of research regarding which professional characteristics' may be relevant to therapeutic relationships in this context. It was hypothesised that professionals' own relating style and attitudes toward their work (for example, empathy and role security) might be important influences on the development of positive therapeutic relationships. Dyads of professionals and young service users with psychosis rated their therapeutic relationships with each other at one time-point. Professionals also completed measures of attachment style, therapeutic optimism, outcome expectancy, and job attitudes regarding working with psychosis at the same time-point. Associations between variables were modelled using directed path analysis. No significant associations were observed between professional characteristics and service user therapeutic

relationship ratings, with the exception of optimistic professional expectations of outcome. Professionals exhibiting an anxious attachment style rated their relationships with service users as less positive. In directed path analysis, data were consistent with professional anxious attachment directly predicting the perceived quality of the therapeutic relationship. Data were also consistent with this predictive effect being mediated by reduced professional therapeutic optimism and less positive job attitudes. Professionals' own attachment style is associated with the therapeutic relationships formed with young people experiencing psychosis, both directly and indirectly through professionals' therapeutic optimism and job attitudes. Thus it is theoretically possible to limit the impact of professionals' insecure attachment on therapeutic relationships through improving their professional attitudes. Current findings with 'generic' professionals support the relevance of professional characteristics in formation of positive therapeutic relationships in psychosis. These findings prompt professionals to consider their own attachment and relating styles and how these may influence their professional practice. In addition, current findings suggest potential mechanisms by which professionals' own attachment style may be influential, including professionals optimistic beliefs about possible patient outcome and their security within and commitment to their role. Such professional attitudes are amenable to change within brief training and thus should be considered as potential training and education requirements for professionals working therapeutically in psychosis services.