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Keynote Addresses

Compassion Focused Therapy and the Fears of Compassion

Paul Gilbert, University of Derby

This talk will give a brief overview of the origins and nature of Compassion Focused Therapy. One of CFT key aims is to increase affiliative positive emotion to self and others. The talk will outline how these emotions evolved to become powerful regulators of threat processing and emotional reacting, and how affiliative emotion is linked strongly to well-being. However, this talk will also draw attention to recent research that shows that many people with mental health problems can have a fear and resistance to this affiliative and compassion based positive affect. This has major implications for threat regulation. This talk will explore current research on this difficulty and how to address it in therapy.

The Process of Change in Psychotherapy

Adele Hayes, University of Delaware

Key theories of change in cognitive behavioral therapy (CBT) for anxiety disorders and depression focus on changes in pathological associative networks, such as fear networks (Lang, 1984; Foa & Kozak, 1986) and depressive networks, interlocks, or schemata (Beck & Dozois, 2011; Teasdale & Barnard, 1993). Successful therapy is thought to involve the activation of these networks, affective arousal, exposure to corrective information, and a shift in meaning and affective response, often called emotional processing. Recent developments in learning theory also highlight the importance of developing and strengthening new associative networks to reduce the risk of relapse (Bouton, 2004; Foa, Huppert, & Cahill, 2006). A program of research on Exposure-Based Cognitive Therapy for depression will be presented to illustrate how destabilizing pathological networks can facilitate emotional processing and how processing predicts not only improvement in depression, but also the development of more adaptive networks or patterns of functioning. These findings will be discussed in the context of emotional processing theory and principles of therapeutic change that might be common in the treatment of anxiety and depression.

An Emotion Regulation Framework for Emphasizing Commonalities in Cognitive-Behavioural Treatments

Doug Mennin, City University of New York, USA

Cognitive behavioural therapy (CBT) has a rich history of alleviating the suffering associated with mental disorders. Recently, there have been exciting new developments, including multi-componential approaches, incorporated alternative therapies (e.g., meditation), targeted and cost-effective technologies, and integrated biological and behavioural frameworks. These field-wide changes have led some to emphasize the differences among variants of CBT. In this address, I will draw attention to commonalities across cognitive-behavioral therapies, including shared goals, change principles, and therapeutic processes and offer an emotion regulation-based framework for examining common CBT characteristics that emphasize behavioral adaptation as a unifying goal and three core change principles, namely (1) context engagement to promote adaptive imagining and enacting of new experiences; (2) attention change to promote adaptive sustaining, shifting, and broadening of attention; and (3) meta-cognitive change to promote adaptive perspective taking on events so as to alter verbal meanings. Further, I argue that specific intervention components including behavioral exposure/activation, attention training, acceptance/tolerance, decentering/defusion, and cognitive reframing may be emphasized to a greater or lesser degree by different treatment packages but are still fundamentally common therapeutic processes that are present across approaches and are best understood by their relationships to these core CBT change principles. Emotion Regulation Therapy (i.e., ERT) utilizes this principle-based approach by drawing together traditional and contemporary cognitive behavioral treatments with basic and translational findings from affect science to offer a framework for improving intervention for “distress disorders” (i.e., generalized anxiety, depression; Watson, 2005) by targeting dysfunction in core motivational responses (i.e., threat/safety, loss/reward) and corresponding regulatory

characteristics (i.e., worry, rumination). Outcome and mechanism data that provide preliminary support for the use of ERT to treat these distress disorders will be reviewed. I will conclude by arguing for shared methodological and design frameworks for investigating unique and common characteristics to advance a unified and strong voice for CBT in a widening, increasingly multimodal and interdisciplinary, intervention science.

Cognitive Mechanisms Involved in Ruminative Thought

Ernst Koster, Ghent University, Belgium

Extensive research has demonstrated that repetitive negative thinking styles such as rumination and worry can play an important role in the etiology and maintenance of affective disorders such as depression and anxiety. The past decades there has also been remarkable progress in understanding the cognitive mechanisms involved in ruminative thought where different theories emphasize that attentional factors play a key role in the susceptibility to rumination. In this talk I will discuss some of the key models of rumination and discuss the empirical evidence for these models. I highlight that there are interesting insights mainly from studies examining thought processes during rest (e.g., mindwandering). Based on these studies I will discuss both the value of established therapeutic treatments of rumination and I will introduce a number of interesting new avenues to reduce rumination.

Enhancing extinction-based therapies of anxiety disorders: cute dogs and other (unlikely) candidates

Tanja Michael, Saarland University, Germany

CBT is – for sound empirical reasons – widely accepted as the first-line treatment for anxiety disorders. Although it reaches high effect sizes, unfortunately not all participants profit sufficiently. Current psychological and neurophysiological models of anxiety disorders regard CBT as the clinical analogue of extinction learning that results in persistent modifications of the fear memory. This view suggests that CBT may be enhanced through techniques that facilitate the acquisition of a non-fear memory structure during therapy. It suggests equally that the encoding, storage and recall of the corrective therapeutic experience needs to be optimized in order to maximize treatment benefits.

The talk is divided into two parts. In the first part, I will provide an overview of the extinction learning - memory view of anxiety disorders with particular focus on the modulating role of cortisol on these processes. In the second part, I will present data from our group examining various aspects of the derived assumptions. Some of the results may seem intuitive – like those suggesting that the presence of a dog reduces the anxiety response towards a traumatic film or that exposure therapy works better in the morning than in the evening. Others, however, may seem counter-intuitive at first glance – like the result showing that memory control in a Think/No-think Task is associated with less distressing intrusions occurring after an analogue traumatic event.

The past present and future of psychological therapy for insomnia disorder

Colin Espie, The University of Oxford

Insomnia Disorder is extremely common and represents a risk factor for subsequent mental and physical health problems, yet it is poorly managed in practice. CBT has the strongest evidence base for treating persistent insomnia, but historically it has proven difficult to make it available. Digital (web and mobile) therapy offers a personalised behavioural medicine solution, that could stand alone or integrate with face to face therapy. This presentation will summarise the evidence base for various CBT delivery methods and propose a way forward for delivering effective care at population level.

Can school-based CBT programmes prevent anxiety and depression in children?

Paul Stallard, University of Bath

Cognitive Behaviour Therapy has established itself as an effective psychological intervention for children and young people with anxiety and depressive disorders. The positive results from treatment trials has led to interest in whether CBT programmes can be more widely provided in community settings to prevent or ameliorate depressive and anxiety symptoms in children.

The widespread provision of preventive mental health programmes is an appealing concept with schools offering a natural and convenient location to deliver these programmes. However before the widespread use of school based preventive programmes can be advocated methodologically robust evaluations are required to demonstrate that they are effective when transported to everyday settings.

This presentation will provide an overview of school based anxiety and depression programmes and will summarise the results from two large UK randomised controlled trials. PROMISE is a school-based depression prevention trial involving 5030 young adolescents aged 12-16 from 8 secondary schools. Year groups were randomly assigned to a CBT programmes (Resourceful Adolescent Programme), attention control or usual school provision. PACES is a school based anxiety prevention trial involving 1362 children aged 9/10 from 40 schools. School were randomly assigned to either a health or school led CBT programme (FRIENDS) or usual school lessons.

The results from the trials will be presented and the implications of these findings for the future role of school-based anxiety and depression prevention programmes discussed.

Cognitive processes in addiction: new directions and clinical implications

Matt Field, University of Liverpool

Current psychosocial treatments for addiction rest on the assumption that clients are aware (or can be made aware) of the motivational and decision-making processes that cause them to engage in substance use, and that those processes can be modified in order to break the cycle of addiction. Whilst existing treatments are certainly effective, it is also clear that many of the cognitive processes that contribute to addiction are not available to introspection and they may not be amenable to change via conventional techniques. I will discuss evidence from the previous decade which demonstrates subtle biases in automatic cognitive processes and deficits in self-control in addiction, and will take a critical look at the clinical relevance of this work. Implications for treatment will also be discussed, including computerised treatments that target cognitive processes directly, and consideration of how the existing 'gold standard' treatments may exert their effects through the modification of these cognitive processes.

Subterranean Homesick Blues: How do we Improve the Mental Health of People with Intellectual Disabilities?

Chris Hatton, Lancaster University

There are estimated to be over 1 million people with intellectual disabilities in England, with research suggesting higher rates of broadly defined distress amongst both children and adults compared to the general population. This talk will discuss the place of psychological therapies for this population from a public health perspective, given that:

- 1) In terms of the major socio-economic risk factors for distress (e.g. poverty, unemployment, loneliness, physical inactivity) people with intellectual disabilities are likely to be near the bottom of socio economic hierarchies with little prospect of upward social mobility.
- 2) These higher rates of distress are largely a function of people's aversive and disadvantaged circumstances, rather than an inevitable consequence of their intellectual disability.
- 3) The vast majority of adults with intellectual disabilities are not recognised as such within health and social care services, and are unlikely to be accessing effective psychological interventions.
- 4) Psychological therapy services for children and adults with intellectual disabilities known to specialist services are sparse and people with intellectual disabilities known to specialist services are less likely to gain access to mainstream psychological therapy services.
- 5) Inpatient services for the assessment and treatment of distress in people with intellectual disabilities are largely anti-therapeutic.

The talk will finish by discussing how psychological therapies can be aligned with a public health agenda, with the aim of reducing distress and building resilience with a broader population of people with intellectual disabilities

Group Cognitive Behavioural Therapy for People with Asperger Syndrome and Anxiety Disorders: Findings from the PAsSA Trial

Peter Langdon, University of Kent

A number of studies have established that children, adolescents and adults with Asperger Syndrome (AS) and high functioning autism (HFA) have significant problems with anxiety. Cognitive behavioural therapy (CBT) is an effective treatment for anxiety in a variety of clinical populations, and there is a growing interest in exploring the effectiveness of CBT for people with AS who have mental health problems. The current literature regarding the effectiveness of CBT for people with AS who have comorbid anxiety will be presented, along with the findings of the PAsSA Trial, which is a randomised single-blind cross-over trial. Fifty-four participants were randomised into a treatment arm or a waiting-list control arm. During treatment, individuals received 3 sessions of individual CBT, followed by 21 sessions of group CBT. The initial findings from this feasibility trial suggest that group CBT may be helpful for people with AS, and a further definitive trial is warranted.

Behavioural Treatments for Depression: Don't Call it a Comeback

Carl Lejuez, University of Maryland

Behavioural Treatments for Depression have a long and storied history, but largely disappeared from the interventions landscape in the 80's and 90's. I will discuss the nature of these early theories and approaches and what precipitated their falling out of favour, as well as the factors associated with their apparent re-emergence in the past decade. In the context of this discussion, I will argue in many ways that the core of this approach never really went away, and outline the future prospects of behavioural interventions going forward.

Personalized and Embedded Mobile Cognitive Behavioral Therapy for Depression

Heleen Riper, VU University, Amsterdam

Not available

Cognitive and behavioural management of emotional problems after stroke

Ian Kneebone, University of Western Sydney, Australia

Background: Stroke is the greatest cause of disability in the developed world. Emotional problems are common after stroke and impact recovery. The problems encountered include depression, anxiety, anger, PTSD and fear of falling. Recent national and international guidance recommending attention to these difficulties has been added to by stroke survivors themselves demanding greater support.

Content: This address will consider emerging methods of identifying emotional difficulties in stroke survivors, and the evidence base for cognitive and behavioural means of preventing and managing them. It will include articulation of the stepped care approach as applied to stroke and a description of the ASK (Action Success Knowledge) programme, an intervention being trialled by speech and language therapists to prevent depression in survivors with communication disorder. Finally, a transdiagnostic framework for the implementation of CBT for emotional disorders in this population will be presented.

Conclusions: Protocols have been developed to systematically screen for emotional problems after stroke and are being improved via validation of existing instruments in this population and the development of new tools. Evidence suggests a number of approaches may be useful in the prevention and treatment of emotional problems after stroke. The application of these may be informed by a use of a stepped care model and a specific framework for the application of CBT in stroke survivors.

Why CBT Therapists Need to Take a Good Look at Themselves

James Bennett-Levy, University of Sydney

This keynote will address questions such as: How do therapists develop therapy skills? What makes us good or poor therapists? What is reflective practice? What do we mean by 'self-reflection'? What is the value of personal development in therapist training? Do we all need personal therapy, or are there other options?

Drawing on the Declarative Procedural-Reflective (DPR) model of therapist skill development (Bennett-Levy, 2006, Bennett-Levy & Thwaites, 2007; Bennett-Levy et al., 2009)) and research and writing across a number of countries (e.g. UK, Ireland, Germany, Australia, New Zealand, Austria, USA) over the past 15 years, James will argue that self-reflection and self-practice of therapy skills are central to the development of therapist competence and expertise in CBT. The talk will discuss current understandings of reflection, and examine the empirical evidence for the value of self-practice and self-reflection (SP/SR) in therapist training. It will conclude with some ideas about how, as CBT therapists, we can best 'take a good look at ourselves' to enhance our professional, and personal, development.

How to help clients get the most out of therapy

Jasper Smits, The University of Texas at Austin, USA

Exposure therapy is an effective treatment for anxiety disorders, demonstrating outcomes that rival those of established pharmacological interventions. Fear extinction, or the establishment of new "safety" memories, is a putative mechanism of exposure therapy for anxiety disorders. Through repeated contact with feared stimuli, exposure therapy aims to help patients re-establish a sense of safety around these feared cues. Therefore, a successful exposure therapy outcome is directly correlated with (1) the degree to which exposure sessions provide salient information about safety, and (2) whether patients retain information learned in a session. This presentation reviews research on the efficacy of psychosocial and pharmacological strategies that target session success and/or the consolidation of fear extinction memories.

DBT: the perimeters and frontiers

Janet Feigenbaum, University College, London

Dialectical Behavioural Therapy (DBT) was originally developed and evaluated for women with Borderline Personality Disorder at high risk of suicide, self harm, and in-patient admissions. Since the publication of the initial efficacy trial in 1991 (Linehan et al., 1991) 23 subsequent trials and two meta-analyses have been conducted. Many of these trials have examined adaptations of DBT for a range of presenting problems/diagnoses, and clinical settings. On the back of this research, the NICE guidelines for BPD, and the publication of a number of practical manuals, DBT has gained considerable popularity as a 'third wave therapy'. The questions to be addressed are: what are the strengths and limitations of the evidence base for the increasing implementation of DBT? and, where next for DBT?

Do cognitive models of psychosis differentiate individuals with psychotic experiences with and without a 'need-for-care'? Implications for CBT for psychosis

Emmanuelle Peters, King's College, London

The majority of people with psychosis and a substantial minority of the healthy population report psychotic-like anomalous experiences, such as hearing voices. What factors determine whether such experiences lead to a pathological or benign outcome? Are the psychological processes identified by cognitive models involved in leading to a 'need-for-care'? How can research on individuals with psychotic experiences who do not cross the psychosis threshold inform CBT for psychosis?

These questions will be addressed in this keynote. A range of studies on people who experience persistent, full-blown psychotic experiences but are not in need of care, will be presented. These

individuals are an ideal group for identifying both potential risk and protective factors in the development of psychosis. As therapists we have much to learn from this unique group, who can help us to pinpoint what psychological processes are at play in keeping anomalous experiences benign.

The findings of this body of work broadly support the predictions made by cognitive models of psychosis. Specifically, it will be demonstrated that maladaptive appraisals and response styles are key in differentiating individuals displaying psychotic experiences with and without a 'need for care'. The implications for CBT for psychosis will be discussed.

Improving Care for Veterans with PTSD

Josef Rusek, VA Palo Alto Health Care System

To effectively assist individuals experiencing post-traumatic stress disorder (PTSD) and other post-trauma problems, including the large numbers of Veterans returning from Iraq and Afghanistan, it is critical that mental health providers deliver best practices in assessment, prevention, and treatment. There remains, however, a large translational gap between research on evidence-based treatments and standard clinical practices. Moreover, models of individual and small group face-to-face treatment may need to be supplemented by treatment innovations. Several key challenges to improving care include finding ways to effectively train large numbers of mental health providers in evidence-based treatments, engaging individuals in treatment and active self-management of problems, and developing health care systems that are able to more nimbly implement new practices in response to research findings and policy changes. This Keynote describes a series of initiatives designed to explore possible solutions to these challenges, including the implementation of a national training programme in Prolonged Exposure treatment for PTSD, development and evaluation of online training methods and resources for practitioners, incorporation of web interventions and mobile health/smartphone apps into treatment, development of a practice-based implementation network and other aspects of a dissemination infrastructure.

Symposia

The Role of Compassion in Mental Health

Convenor: Anke Karl, University of Exeter

Psychophysiology of self-compassion and the role of individual differences

Hans Kirschner, Willem Kuyken & Anke Karl, University of Exeter

Understanding processes and mechanisms that prevent mental health problems, such as depression, and facilitate wellbeing is of great importance. Recent research has pointed out that the cultivation of self-compassion may be one of these protective mechanisms and seems to moderate the positive effects of Mindfulness-based Cognitive Therapy (MBCT). However, self-compassion is a quite new construct in psychology research and its cognitive and psychophysiological correlates are not well understood. We therefore studied psychophysiological correlates of two meditation exercises (Loving Kindness Meditation and Compassionate Body Scan) designed to cultivate state self-compassion as compared to a rumination, control and positive excitement condition. Heart-Rate (HR), Skin-Conductance-Level (SCL) and prefrontal alpha asymmetry of the electroencephalogram (EEG) during the guided audio exercises were recorded in 135 participants. In addition, changes in positive affiliative affect, state self-compassion and state self-criticism from directly before and after the guided audio exercise were assessed. Both self-compassion inductions and the positive excitement condition increased state self-compassion and affiliative affect and decreased self-criticism whereas the rumination condition triggered opposite pattern. We tested if affect changes in the self-compassion conditions were accompanied by the expected psychophysiological response patterns (i.e., a significantly lower HR, SCL and higher relative left prefrontal activation during the self-compassion conditions as compared to rumination). The results indicate that one possible protective effect of self-compassion lies in the activation of the positive

affiliative affect system which is characterized by a content and calm state of mind with a disposition for kindness, care and social connectedness. Further explorations of these findings suggested that responses to the self-compassion conditions were moderated by participants' tendencies to self-criticize. Individuals high in self-criticism tended to respond to the compassionate body scan (i.e., a more indirect approach to cultivate self-compassion) with higher activation of the positive affiliative affect system but not to the loving kindness meditation (i.e., a more direct approach to cultivate self-compassion), while those participants low in self-criticism showed the opposite pattern. This indicates that both forms of meditation can have beneficial effect on the positive affiliative affect system and point towards differential indications for offering them to individuals based on their tendencies to self-criticize.

Overcoming Self-Critical Attitudes and Promoting Self-Compassion Through Virtual Reality

Caroline J Falconer, Department of Clinical, Educational & Health Psychology, Aitor Rovira, University College London. John A. King, Department of Clinical, Educational & Health Psychology, Paul Gilbert, University of Derby, Angus Antley, University College London, Mel Slater, University College London and Chris R. Brewin, Department of Clinical, Educational & Health Psychology

High self-criticism and low self-compassion are vulnerability factors in the development and maintenance of depression. Self-compassion can be seen as a regulator of mood, shame and feeling of low-self-worth but such self-relating has proven a peculiar experience for Westerners, despite its centuries old use in Far Eastern traditions. Compassion Focused Therapy has been developed to help facilitate self-compassion in healthy and clinical populations, with much success. This therapy uses mental imagery to create affiliative experiences with kind, compassionate beings or a personified compassionate self. Despite the success of this treatment there are some who struggle with imagery, lacking any penetrative impact from the compassionate experience, or have their attempts mitigated by their fear of self-compassion. The aim of the current study was to investigate whether changes in perspective, achieved through virtual reality, could be used to overcome these problems and help facilitate self-compassion and reduce self-criticism. Highly self-critical participants, as an avatar in a virtual room, were required to be compassionate to an upset child. In response to the participant's compassion the child becomes visually and audibly less upset. After their compassion intervention the participant experienced one of two perspective changes. In one condition the participants embodied the child avatar. From this position participants could see their original adult avatar and could re-experience their compassionate intervention through the eyes of the child. This condition was designed to simulate self-compassion. That is, while the participant embodies and self-identifies with the child avatar they still self-identify with their original adult avatar and their compassionate response, ultimately experiencing their own compassion from a first person perspective. In a second condition participants viewed their compassionate intervention from a third person perspective. This condition allows participants to re-experience their compassionate response, confirming their compassion for others, but does not simulate self-compassion. Results revealed a significant reduction in state self-criticism for both perspective conditions after the virtual reality session. However, only for the first person perspective condition was there a significant increase in self-compassion and positive affiliative emotions. Additionally, path analysis revealed that avatar embodiment mediates these results. This further corroborates our hypothesis that embodying the child avatar creates a self-to-self situation that can simulate self-compassion, which ultimately precipitates a reduction in state self-criticism as well as an increase in self-compassion and positive mood. These results provide an initial positive indication that manipulating embodiment through virtual reality could be used as a potential clinical tool to overcome the problems that some patients experience with traditional compassion therapies. Indeed, the results also lend support for the use of virtual reality in the treatment of mental health problems more globally.

Does Self-compassion Attenuate Reactivity in People at Risk for Depression?

Willem Kuyken, University of Exeter; Karl, A, University of Exeter; Williams, M, University of Exeter; Cardy, J, University of Exeter; Hayes, R, University of Exeter and Dalgleish, T, University of Cambridge

Self-compassion may enable people at risk for depression to break the link between cognitive reactivity and a spiral of negative mood and thinking that can trigger depression (Kuyken et al., 2010). This experimental study showed that following a sad mood induction people at risk for depression able to

deploy self-compassion are better able to repair sad mood. This has implications for how to build resilience in people at risk for depressive relapse.

What is Compassion?

Paul Gilbert, University of Derby

This presentation will look at different concepts and definitions of compassion, with a focus on an evolutionary model. Problems in understanding the nature of compassion and how to measure it will be addressed. The presentation will also discuss the fears of compassion which often arise from misunderstandings about what compassion actually is. In addition the presentation will discuss research on core elements of compassion and present data on a new scale called submissive compassion and discuss the distinction between the desire to be helpful and kind to be liked from genuine compassion.

Elucidating the mechanisms and moderators of meditation enriched treatments at the confluence of CBT, affective science, and contemplative practice

Convenor: David Fresco, Kent State University, USA

Decentering from distress: Regulating negative emotion by increasing psychological distance.
Fresco, D.M & Shepherd, K, Kent State University, Kent, OH, USA

Decentering, which represents one's ability to observe thoughts and feelings as temporary, objective events in the mind, as opposed to reflections of the self that are necessarily true, is present-focused and involves taking a nonjudgmental and accepting stance regarding thoughts and feelings. Although the concept of decentering can be found in traditional cognitive therapy (e.g., Beck et al., 1979), Teasdale and colleagues (2002, p. 276) suggest that it was primarily seen as "a means to the end of changing thought content rather than, as ... the primary mechanism of therapeutic change." Increasingly, evidence has validated decentering as a construct important in the acute and enduring treatment of MDD and anxious depression (Fresco, Segal et al., 2007; Mennin & Fresco, 2011), GAD (Hoge, Bui, Goetter, Robinaugh, Ojerskis, Fresco, & Simon, 2013) and in the prevention of MDD relapse following prophylactic treatment with mindfulness based cognitive therapy (MBCT; Bieling et al., 2012). Given these promising findings, research has increasingly sought to elucidate the biobehavioral markers of decentering associated with its salutary benefits. In particular, this work has initially focused on decentering's relationship to negative self-referential processing (Barron et al., 2013; Mennin & Fresco, 2013; Vago & Silbersweig, 2012). A recent study with fMRI assessment and neural correlates of treatment following MBCT revealed that decreased activation in the posterior cingulate cortex (PCC), a region associated with experiential and nonjudgmental self-reflection (Johnson et al., 2006) was associated with high self-report decentering and low relapse (Fresco, Shepherd, Farb, & Segal, 2013). Thus, despite these promising findings, study of decentering has largely been limited to self-report, and the mechanisms through which decentering alleviates and prevents the symptoms of depression remain unexplored.

As a first step to address this gap, we developed and began validating two objective decentering tasks of individuals' ability to create psychological distance (i.e., decenter) in response to negative emotional provocation. Tasks manipulated psychological distance either implicitly or explicitly, and self-reported negative affect and arousal were collected as a function of increasing distance from distressing visual stimuli (e.g. images of poisonous insects or snakes). We examined associations between task performance, in terms of reductions in distress from distancing, and self-report measures of depressive and anxiety symptoms, trait mindfulness, and emotion regulation.

We found that implicitly increasing psychological distance from distressing visual stimuli reduced emotional reactivity to those images, but only in individuals with low levels of self-report depression ($\eta^2 = .08$) and emotional avoidance ($\eta^2 = .05$), and high levels of mindful awareness ($\eta^2 = .1$). Explicitly increasing distance was associated with reduced emotional reactivity in individuals scoring high on cognitive reappraisal ($\eta^2 = .1$). Our data suggest that the capacity to increase psychological distance in response to negative emotional provocation may depend on 1) depressive symptomology and trait emotion regulation styles, and 2) level of awareness (implicit vs. explicit).

Additional experimental and neurobiological studies of decentering may enhance our understanding of its underlying mechanisms while informing clinical efforts to promote decentering in a therapeutic context.

Responding mindfully to depression: does mindfulness-based cognitive therapy reduce the risk for depression to escalate into suicidal thinking

Barnhofer, T., Crane, C., & Williams, J. M. G, Oxford Mindfulness Centre

Training in mindfulness aims to help patients to relate to difficult feelings and thoughts in a way that allows observing the experience of these feelings without getting entangled in the maladaptive patterns of thinking that these feelings often draw for. In patients who have suffered from suicidal depression in the past, depressive moods can easily escalate into suicidal thinking. This talk will present data from a recent clinical trial to investigate the question of whether MBCT can reduce the likelihood of such escalation.

We compared the relation between depressive symptoms and suicidal thinking in previously suicidal patients who had either received MBCT, Cognitive Psycho-Education (CPE), or continued with Treatment-as-Usual (TAU) only.

While depressive symptoms continued to be significantly associated with suicidal thinking in those who had received CPE or continued with TAU only, this relation failed to become significant in those who had received MBCT.

The findings suggest that training in mindfulness can help to break the link between negative mood and suicidal thinking in patients with a history of suicidal depression.

MBCT may have significant preventative effects in patients with suicidal depression.

Intensive Prospective Experience Sampling Study of a Mindfulness Preventive Intervention: Illuminating the Development and Mechanisms of Present Moment Attention and Awareness Over Time

Amit Bernstein; Adi Shoha; Ravit Oren; David Spivak; Yuval Hadash; Reut Plonsker; Galia Tanay; Kim Yuval, University of Haifa

Clinical interest in mindfulness is growing rapidly. Accordingly, scholars are increasingly exploring *why* paying attention is good for us – hoping to empirically elucidate the salutary mechanisms of action of mindfulness. We argue that extant research is limited in large part due to reliance on methodology not suited for study of dynamic prospective developmental processes and related mechanisms of action (e.g., retrospective self-report or cross-sectional neuroimaging data).

Accordingly, the present study employed intensive experience sampling (ES) measurement methods to prospectively evaluate the development of mindfulness, its putative proximal (e.g., decentering, avoidance) and distal (e.g., cognitive over-engagement, negative affect) risk/protective processes and symptoms (e.g., anxiety, depression) over the course of a 1-month mindfulness training intervention among an unselected community sample.

Ninety-two adult participants from the general community received an adapted mindfulness (Mahasi-based) preventive intervention, entailing 3 traditional group sessions, 3 individual home-based video sessions, and (daily) independent home practice. Mindfulness, proximal and distal processes symptoms were assessed at baseline pre-intervention, throughout the intervention 2-3/day via ES, and then at 1-week, 1-month and 4-month post-intervention follow-up assessment sessions.

Data collection was recently completed. Theoretically, we believe this research will make a unique contribution to better understanding the salutary mechanisms of mindfulness. Clinically, we hope it will contribute a novel means by which illuminating mechanisms of mindfulness may help engender innovation in the delivery and thereby efficacy of mindfulness-based prevention and treatment.

The impact of MBCT on positive emotions: the moderating role of genes, childhood adversity and antidepressant medication

Marieke Wichers , Maastricht University

Mindfulness-based Cognitive Therapy (MBCT) has been shown to prevent relapse to major depression and to reduce current depressive symptomatology. Furthermore, a recent study showed that MBCT-induced increase in positive emotional experience is associated with the resulting reduction in depressive symptoms, suggesting a crucial role of positive emotions in the combat against depression. However, considerable individual variation is evident in response to (psychological) interventions. Therefore, an important challenge in psychiatry is to discover what factors influence treatment outcome. In this

presentation I will highlight the role of three factors (genes, childhood adversity and use of antidepressant medication) which may explain some of the inter-individual differences in PA response to MBCT.

Uncovering the role of safety seeking behaviours in anxiety disorders – an update on recent clinical findings and the therapist’s role

Convenor: Fjola Helgadottir, University of Oxford

The lives of therapists: reassurance seeking and giving in the context of emotional problems. Brynjar Halldorsson, The University of Bath

At the heart of the cognitive and behavioural approach is negative meaning, which generates both anxiety and the associated behavioural reactions. These behavioural reactions often involve reassurance seeking. Although seeking reassurance from a trusted person appears to be a normal and often helpful interpersonal reaction to feelings of distress, something different appears to be going on in the context of emotional disorders where reassurance seeking typically has the paradoxical effect of maintaining pathological levels of anxiety or distress rather than reducing it as the person intended; the solution becomes the problem. Reassurance seeking is a form of safety-seeking behaviour which represents a special case of obsessional checking where the individual’s intention is to make sure that he or she has done everything in their power to prevent or diminish harm or blame, and also to disperse responsibility of harm or blame to others.

The current clinical wisdom within the CBT literature is that you should refrain from giving patients’ reassurance and the logical extension from that is that therapists withhold any reassurance giving and simply ban patients from seeking it and their carers from providing it. Although this thinking makes sense theoretically, there are good reasons to question this blanket consideration that reassurance is a ‘bad thing’ that should simply be stopped. It is argued here that reassurance seeking is an extremely complex interpersonal behaviour which is poorly understood; and clinical experience suggests that withholding reassurance from a loved one is something that those who live with and otherwise care for people with emotional problems often describe as finding particularly challenging, if not impossible.

During this presentation findings will be presented from a recent study focusing on therapist beliefs about reassurance seeking in emotional disorders. There are good reasons to believe that clinicians experience difficulties in treating reassurance seeking and not surprisingly there are conflicting views amongst clinicians and theorists about how (and if) to treat this behaviour. Results will be presented from a cross sectional questionnaire study where therapists from different theoretical backgrounds were recruited to: explore their views and understanding of reassurance seeking; and enquire about what treatment techniques therapist find necessary to treat reassurance seeking in emotional problems.

Reassurance seeking in the digital age: Does searching for health information on the Internet fuel health anxiety?

Kate Muse, University of Oxford

The internet offers quick and easy access to a vast wealth of material from a wide variety of sources, making it a popular health information resource. With just a few clicks on a mobile phone you can now diagnose symptoms, select treatment options and access support and advice from others who have experienced similar problems- all within a matter of minutes. For many people the Internet provides a useful source of health information. However, for individuals with health anxiety, repetitive checking of health information online may fuel fears that one has or will develop a serious disease, a phenomenon dubbed ‘cyberchondria’. Indeed, compared to traditional sources of health information (e.g. books, magazines, medical journals), seeking health information on the Internet may increase exposure to conflicting, unreliable, inaccurate or outdated information, as well as to chronic and life-threatening medical explanations for ones symptoms. Thus checking health information online may be a particularly problematic form of reassurance seeking. This talk will present findings from a recent study examining the relationship between health anxiety and seeking health information online. In particular, it will outline differences in the frequency, impact and methods of searching for health information online between those with high and low health anxiety. The implications of these findings for the way in which we assess, understand and target reassurance seeking in health anxiety will also be discussed.

Function over form. Therapists' recommendations can maintain anxiety if the subtle, idiosyncratic theory behind advice is ignored

Fjola Helgadottir, The University of Oxford

Cognitive behaviour therapy treatment strategies need to be understood in theoretical terms in order to be effective. In particular, the role of safety seeking behaviours needs to be targeted to successfully reduce anxiety in the long term. Anxiety in those who stutter is linked to poor maintenance of gains for behaviourally oriented treatments aimed at reducing stuttering. This talk presents surprising findings from a study on whether safety seeking behaviours may be recommended in speech therapy. 160 therapists who treated adult stuttering patients were asked if they advised adults who stutter to use of various safety seeking behaviours, and the results indicated that this happened frequently. For example, only 6% of the therapists surveyed claimed never to recommend the use of safe or easy speaking partners, 81% had recommended the use of safe speaking partners in socially threatening situations, and 92% had recommended rehearsing the opening line of telephone calls prior to making them. However, clearly this was only an investigation of form of behaviour recommended, and future research needs to clarify the idiosyncratic function of these behaviours for adults who stutter. In other words, intention needs to be clarified in order to pinpoint causality for the maintenance in anxiety.

Performance-oriented safety behaviours in social anxiety disrupt coordination between conversation partners

Claire Mein, The University of Oxford

In an attempt to avoid others' disapproval, socially anxious individuals engage in impression-management strategies like preparing conversation topics or jokes advance, mentally rehearsing utterances before speaking aloud, and closely monitoring their own speech and actions for possible errors. Of course, these safety-seeking behaviours maintain anxiety via an important cognitive pathway - the anxious individual emerges from a social encounter convinced she or he has narrowly avoided negative evaluation only by giving a carefully organised 'performance'. This talk presents findings from a study which indicates a second, interpersonal-behavioural pathway by which safety behaviours maintain social anxiety. I present data to show that socially anxious individuals' focus on intrapersonal performance disrupts their capacity to engage in interpersonal behaviour that is synchronised in time and complements or 'comes together' with a partner's coinciding behaviour, and that this leads partners to respond with less interest and liking. It seems that anxious individuals safety-seeking behaviour may help maintain anxiety by attracting the very response from others they wish to avoid.

CBT for complex trauma reactions: a series of case presentations

Convenor: Kerry Young, Forced Migration Trauma Service, CNWL NHS Foundation Trust

Treating PTSD using trauma-focused CBT in the context of very severe dissociation

Millay Vann 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 when the client dissociates during accounts of their trauma. Recently, there have been several encouraging papers suggesting how to work with dissociation in the context of tfCBT (Kennerley, 2009; Hagenars et al., 2010; Schauer & Elbert, 2010). This presentation will describe how these suggestions were put into practice in the treatment of a female refugee presenting with very severe dissociation and PTSD following rape and witnessed murder. The techniques used and her progress in therapy will be discussed. A traditional tfCBT paradigm was adapted to minimise her dissociation (including the use of imagery re-scripting techniques). 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 trauma.

The treatment of PTSD in a victim of Human Trafficking with complex needs

Dr Katy Robjant, Helen Bamber Foundation and Vivo International.

Victims of Human Trafficking have often experienced multiple traumatic events both in their country of origin and upon arrival in the UK, and are potentially at risk of developing PTSD as a result (Zimmerman et al, 2006). In addition to their mental health needs, they encounter many of the same difficulties as asylum seekers arriving in the UK, including a risk of social deprivation and a prolonged and uncertain legal process for immigration status. However as victims of crime in the UK, they face additional stressors including a risk of re-trafficking as well as the legal procedures involved in pursuing possible convictions. There is a scarcity of evidence regarding effective treatments for this population. Research has shown that Narrative Exposure Therapy (NET) (Schauer, Neuner, & Elbert, 2005) is an effective treatment for PTSD in survivors of multiple trauma. This approach was employed in order to treat a victim of trafficking with complex mental health, legal and social needs. The progress in therapy is discussed as well as implications for therapists working with this population, which include the importance of ongoing risk assessment and provision of an integrated model of care.

"The abuse never ends and there's nothing I can do": Using trauma-focused CBT to intervene with post-traumatic stress in psychosis.

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

A growing body of evidence highlights high rates of PTSD in psychosis compared to the general population, and a potential causal role of childhood victimisation in psychosis (Grubaugh et al, 2011; Varese et al., 2012). Despite concerns about using trauma-focused CBT in clients with psychosis, recent findings are promising and PTSD treatment is now recommended by the National Institute for Health and Clinical Excellence (Frueh et al., 2009; Mueser et al., 2008, NICE, 2014; van den Berg and van der Gaag, 2012). This case will highlight how trauma-focused techniques, including psychoeducation, affect regulation, cognitive restructuring and narrative exposure, can be incorporated into CBTp to address symptoms of PTSD and trauma-related psychosis. The progress of and challenges to therapy will be discussed, together with recommendations for intervening with this client group.

Treating complex PTSD with compassion focussed therapy: A phased based treatment approach

Dr Deborah Lee & Dr Carmen Chan, 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 the 12 session group outline used by Berkshire Traumatic Stress Service to develop compassionate resilience as part of a phased based approach to treating complex PTSD.

Basic Processes in Depression

'She Called Her Partner - Hence She Is Needy': Depressed Patients Show Increased Tendencies to Make Spontaneous Trait Inferences

Benjamin Boecking, Institute of Psychiatry, King's College London; Thorsten Barnhofer, Dahlem Institute for Neuroimaging of Emotion, FU Berlin

Interpersonal Stress Generation is known to be an important maintaining factor in depression; however, little is known about the psychological mechanisms that undermine interpersonal functioning. This study investigated the role of deficits in person perception to this regard.

Depressed patients (n = 20) and healthy controls (n = 20) completed a false recognition paradigm to investigate their tendency to make spontaneous trait inferences, i.e. to spontaneously ascribe personality traits to others. They then reported interpersonal daily hassles for one week following the task. Tendencies to make spontaneous trait inferences were significantly higher in depressed patients, particularly in those with a history of childhood trauma. The degree to which participants made spontaneous trait inferences was significantly related to depression severity, and across, but not within groups, predicted the occurrence of interpersonal daily hassles during follow-up. The results suggest that depressed patients show characteristic biases in person perception, which may contribute to the generation of interpersonal stress. Interpersonal therapy approaches for depression may benefit from the inclusion of trainings of social perception, for example through specific computer-based exercises or interpersonal mindfulness training.

Development of a transdiagnostic measure of abstract and concrete repetitive thinking **Suraj Samtani, University of New South Wales; Michelle Moulds, University of New South Wales**

Rumination and worry have been grouped under the transdiagnostic construct of Repetitive Thought. Watkins (2008) proposed the presence of two subtypes: maladaptive abstract and relatively adaptive concrete thinking. Current scales of repetitive thought assess only the maladaptive subtype, and exhibit confounds with depressive symptoms (Treyner et al., 2003). The current project aimed at creating a transdiagnostic measure of abstract and concrete repetitive thinking (the RTS-T). Three online community sample studies (N= 614, N= 595 and N= 860) and one university sample study (N= 410) have been conducted to test the factor structure, reliability, and validity of this measure. An additional community sample with never (n= 61), previously (n=43) and currently depressed (n= 15) individuals was recruited. Factor analyses resulted in a total of 24 items, with 6 first-order and 2 higher-order factors: abstract (causes, implications, behaviour) and concrete repetitive thinking (reliving, physical sensations, emotions). The measure demonstrated good factor structure across samples and excellent reliability (?= .859-.964). It also demonstrated good convergent validity with measures of repetitive thought, meta-cognitive beliefs, negative affect, and psychopathology. In the community depression sample, the abstract thinking subscale was a stronger predictor of depressive symptoms. Both subscales discriminated between healthy and depressed individuals. The scale appears to have good psychometrics in terms of factor structure, reliability, and validity. The RTS-T is a transdiagnostic measure of abstract and concrete repetitive thought with good psychometric properties. The scale's transdiagnostic nature, validity and brevity make it a useful tool to measure repetitive thinking in clinical settings regardless of the nature of the primary diagnosis or the presence of comorbidities.

Observer Vantage Perspective and Positive Autobiographical Memories in Depression **Presenter: Ly Huynh, University of New South Wales, Sydney, Australia; Michelle Moulds, University of New South Wales, Sydney, Australia**

Ruminative processing and recalling emotional memories from a third-person observer vantage perspective both play maladaptive roles in depression. While the literature has focused on negative autobiographical memories, recent research has extended to include imagined future events, and there is growing recognition that depressed individuals' responses to positive experience require further investigation.

An online community sample (N = 342) completed a range of measures and were then randomly allocated to recall or imagine themselves in situations that had either occurred in their recent past or might occur in their foreseeable future, of either a positive or negative valence. Participants reported the perspective from which they recalled/imagined the situation, and also completed a measure of their tendency to engage in repetitive thinking about the specific situation.

We found expected associations between the general tendency to ruminate, depressive symptoms, and repetitive thinking about the specific situation across all groups; that is, amongst participants who recalled negative events, imagined future negative events, recalled positive events, and imagined future

positive events. Interestingly, for positive memories only, there was also a relationship between vantage perspective and measures of psychopathology such that the general tendency to ruminate, level of depressive symptoms, and degree of repetitive thinking about the specific situation were positively associated with recalling the event from an observer perspective.

This finding is consistent with the suggestion that recalling positive autobiographical memories from an observer perspective may play a role in the dysregulation of positive emotion in depression.

Furthermore, it suggests that targeting the processes involved in positive memory recall may be beneficial in the treatment of depression.

Effects of a brief behavioural activation intervention on approach and avoidance tendencies in acute depression

Farjana Nasrin, Institute of Psychiatry, Kings College London; Katherine Rimes, Institute of Psychiatry, Kings College London; Andrea Reinecke, University of Oxford; Rinck Mike, Behavioral Science Institute, Radboud University Nijmegen; Barnhofer Thorsten, Institute of Psychiatry, Kings College London

Recently, research evidence has highlighted the effectiveness of behavioural activation (BA) treatments as a mainline treatment of depression (e.g. Dimidjian et al., 2006; Dobson et al., 2008), with BA interventions as short as one session producing significant changes in symptoms of depression (Gawrysiak et al., 2009). Whilst there is a clear behavioural rationale underlying BA treatments, little research has examined the cognitive mechanisms through which BA leads to reduced depressive symptoms. From a BA perspective one of the key ideas is about replacing depressive avoidance behaviours with healthy non-avoidance behaviours.

This study utilised Gawrysiak et al.'s (2009) study design of one treatment session of Brief Behavioural Activation Treatment for Depression (Lejuez et al., 2001) to explore effects on approach and avoidance behavioural tendencies. A sample of 40 participants from primary care psychological therapies services were randomised to either treatment or control group. Approach and avoidance tendencies were assessed before and after the one-week intervention phase using the Approach Avoidance Task (AAT; Rinck & Becker, 2007), an established implicit measure that uses overt behaviour to index automatic approach and avoidance tendencies. Furthermore, self-reports of symptoms and cognitive factors were assessed before and after the intervention phase, as well as at a 1-week follow-up.

Results showed a significant decrease in depressive symptoms in comparison to the control group after one session of BA. Effects on approach and avoidance tendencies are currently being analysed and will be presented at the conference.

The results indicate that one session of BA leads to significant changes in depressive symptoms with a clinical population.

Knowing about mediating effects is important as results can potentially guide decision making between different therapies e.g. consideration of whether CBT or BA is most appropriate for an individual.

Comparing the Interpretation of Hypothetical Scenarios in Depressed and Non-Depressed Adolescents

Faith Orchard, University of Reading; Shirley Reynolds, University of Reading; Craig Steel, University of Reading

Cognitive Behavioural therapy (CBT) appears to be less effective at treating depression in adolescents compared to adults (e.g. Kennard et al., 2006; Goodyer et al., 2007). It is assumed that the cognitive model of depression is applicable to adolescents but this has rarely been tested. This paper reports on the assessment of interpretation bias in adolescents aged 13-18 using an ambiguous scenarios test (Berna, Lang, Goodwin & Holmes, 2011).

Three groups of adolescents will be compared: 1. Adolescents with a diagnosis of depression (based on K-SADS), 2. Adolescents with elevated symptoms of depression and 3. Adolescents with no symptoms of depression. Groups 2 and 3 are recruited from the community, and group 1 through referrals to the NHS CAMHS. Power analysis requires 42 participants per group and data collection will be complete in June 2014. Adolescents complete the Ambiguous Scenarios Test for Depression (Berna et al., 2011). This includes 20 ambiguous situations. Adolescents are asked to describe what they think will happen and rate the outcome on a 1-9 scale of pleasantness. Responses are coded as negative, positive, mixed or neutral.

Between-group differences in interpretation bias will be analysed using one way ANOVAs and correlations between depression severity and pleasantness ratings will be conducted.

The results will inform the development of CBT for depressed young people.

If depressed young people do have cognitive biases, existing methods can be further adapted. If cognitive biases are not characteristic of depression during adolescence then significant development of novel CBT methods may be necessary.

Re-visiting What Works for Whom: A Work in Progress in a Chronic Pain Service

Convenor: Elenor McLaren, University College London Hospitals

In the beginning.... why integrate?

Kelley Corcoran, University College London Hospitals

UCLH developed multi-disciplinary cognitive behavioural PMPs in 1980's. Despite significant outcomes across a range of measures and the team striving to meet the individual needs of group members, some individuals reported that the PMP did not meet their specific needs particularly those who experienced:

A range of symptoms broader than widespread pain (e.g. autonomic symptoms)

Fears common to those with certain pain conditions, (e.g. of dislocation; managing pregnancy; hereditary aspects)

Unpredictable, non-activity related paroxysmal pain

Allodynia

Pain in a site different from the rest of the group

These experiences related to specific pain conditions including Joint Hypermobility Syndrome (JHS) (a and b above); neuropathic pain (c and d) and any pain condition with a site different from the group 'norm' but particularly abdominal pelvic pain (APP) (e). The literature (Coughlan, 1995) and experience suggest that feeling different increases distress and attrition from PMPs. Led by patient need, between 2002 and 2009, we developed specific PMPs for people with JHS, facial pain and APP. All show significant improvements.

Alongside these developments came the changing landscape of multi-disciplinary chronic pain interventions and the burgeoning of acceptance and commitment therapy (ACT) and mindfulness approaches (Dahl, et al, 2005; Hayes et al., 2011; Wicksell et al., 2012, McCracken et al, 2011; 2012; 2013).

The team at UCLH wish to continue using traditional CBT pain management approaches given our outcomes (most improvements at $p > 0.001$) and ACT outcomes, although similar, are relatively new. We aimed to harness the most effective methods from both approaches, being integrative but not 'eclectic'. We set out to get closer to answering the question "What works for whom?" Can we improve outcomes for individuals by integrating ACT and MBCT with traditional CBT so as to broaden the options available to patients in managing their pain whilst retaining theoretical coherence?

Integrating traditional CBT and ACT: conceptual, clinical and practical issues

Elenor McLaren, University College London Hospitals

We address the challenges of integration both at the level of theory and treatment model (are we focused on distress reduction or psychological flexibility?) and at the level of methods. Can cognitive work include restructuring *and* defusion? Can behavioural experiments incorporate opportunities to practice willingness to have difficult private experiences as well as to gather disconfirmatory evidence? Can we use *both* relaxation and mindfulness practices to increase awareness and develop individuals' ability to develop a present moment focus?

We re-examine 'self-management': is it about living around the edges of pain or life engagement? Rather than reducing contact with pain, can we enable people to embrace pain experiences for purposes: the activities they want their lives to be about?

To create coherence in methods, reduce mixed messages and hone in on what works for whom, we found using individual formulations actively, throughout treatment, to be crucial. This helped the team to keep intervention focused on targeting how it works to help individuals achieve their goals (function) rather than ensuring certain features of the programme are delivered to all (form). Through these processes we aimed to enhance psychological flexibility in both patients and team.

These issues are explored and illustrated through clinical examples. Preliminary data from pilot PMPs using an integrated CBT-ACT approach are presented.

Mindfulness based Cognitive Therapy (MBCT) for Neuropathic Pain

Dairmuid Denney, University College London Hospitals

Comparison of differences between pain of neuropathic and nociceptive origin has shown that although outcomes on major variables are similar (pain, mood, cognition and physical function), there are differences related to patients' beliefs about pain, and its causes, responses to pain and the problems reported as a result of experiencing pain (Daniel et al., 2008). Consequently some patients with neuropathic pain have difficulty applying aspects of traditional cognitive behavioural pain management methods.

Eccelston and Crombez (1999) described how pain grabs attention and interferes with cognitive processes and activity. Clinical experience suggests that this 'grabbing of attention' may be more sudden and unexpected with neuropathic pain leaving no option but to stop activity and for pacing to be interrupted and become pain contingent. Pacing can then act as a means to avoid difficulty with pain. We consequently explored alternative strategies.

With a growing evidence base for MBCT in chronic health conditions, we developed a PMP using an MBCT framework to sensitively address specific challenges faced by those with neuropathic pain; to enable them to develop skills to enhance present awareness and broaden their options in responding to pain which may otherwise interfere with their life goals. We will present outcomes of two pilot studies integrating MBCT for neuropathic pain, reflect on the challenges we faced and offer ideas for future development.

Birmingham and Beyond

Anna Ferguson and Elenor McLaren, University College London Hospitals

We summarise our journey in terms of key learning points, findings and challenges. We address the importance of staff competence and cohesion in developing integrative PMPs and the challenges of achieving this across professions within the multi-disciplinary team in the context of delivering group based treatment.

School based mental health interventions

Convenor: Paul Stallard, University of Bath

The effectiveness of a school based cognitive behaviour therapy programme (FRIENDS) in the reduction of anxiety and improvement in mood in children aged 9/10

Convenor: Paul Stallard, University of Bath

Schools provide a convenient location for widely providing emotional health prevention programmes for children. Although the results from anxiety prevention programmes are promising, large implementation trials evaluating effectiveness when delivered by health and school staff under everyday conditions are lacking.

Preventing Anxiety in Children through Education in Schools (PACES) is a large three armed cluster randomised controlled trial. The study evaluated the effectiveness of a universally provided cognitive behaviour therapy programme (FRIENDS) delivered by school and health staff compared with usual school provision. Children aged 9-10 years from 14 schools (n=497) received the 9 session FRIENDS programme delivered by health leaders from outside the school. Staff from 14 schools were trained to deliver the programme to 509 children, with children (n=442) from a further 12 schools receiving their usual school provision.

Baseline assessments were completed by 1339 children with 1257 (92%) completing follow-up assessment at 12 months. The trial design and results will be summarised and the implications for schools based anxiety prevention programmes discussed.

Evaluating the efficacy of the Promoting Alternative Thinking Strategies (PATHS) curriculum in promoting social and emotional wellbeing among children in primary schools

Neil Humphrey, University of Manchester

'PATH to Success' is a large, cluster randomized trial examining the impact of the Promoting Alternative Thinking Strategies curriculum in Manchester, England. 45 primary schools were randomly allocated to implement PATHS or continue practice as usual over a 2-year period. This paper will use data collected in the first year of the trial. The study sample are c.5,000 children aged 7-9 at baseline. Our outcome assessment protocol spans a range of informants (e.g. children, teachers, parents), domains (e.g. social skills, health-related quality of life, academic attainment) and methods (e.g. survey, standardized assessment). Implementation in the 23 PATHS schools is being examined via both teacher self-report and direct observation, with attention paid to fidelity/adherence, adaptation, dosage, quality, participant responsiveness, reach and programme differentiation. Hierarchical linear modeling of study data will be presented using a staged approach as follows: (i) intention-to-treat analysis (e.g. impact of PATHS on study outcomes), (ii) implementation analysis (e.g. association between different aspects of implementation and study outcomes), and (iii) sub-group analysis (e.g. differential effects of PATHS on children identified as at-risk at baseline)

The effectiveness and cost effectiveness of the incredible years teacher classroom management programme in primary school children. Results from the feasibility work and progress to date

Kate Allen and Anna Price, University of Exeter Medical School

STARS is a large, cluster randomised controlled trial examining the effectiveness of the Incredible Years Teacher Classroom Management (TCM) Programme on primary school children's mental health and behaviour and teachers' stress and burnout levels. One teacher from 80 primary schools across the Southwest England will be randomly allocated to either the intervention (TCM course; n=40) or control (teaching as usual; n=40) groups. The TCM course is delivered in six whole-day sessions spread over a six month period and combines elements of cognitive social learning theory, modelling and self-efficacy and Piaget's developmental interactive learning methods to help teachers enhance their classroom management skills. The primary outcome measure is the total difficulties score from the child Strengths and Difficulties Questionnaire (SDQ) completed by teachers at baseline and 9, 18 and 30 months. Secondary outcome measures include parents' version of the SDQ, children's feelings about school, teachers' self-efficacy, stress and burnout levels and children's academic attainment. We will present information about the TCM course along with the current progress of the RCT

Psychological Care for Older People – Everybody's Business

Convenor: Ken Laidlaw, University of East Anglia

Adapting Therapy for Older People

Wendy Spence, Belfast Health and Social Care Trust

The population of the UK is ageing. Over the last 25 years the percentage of the population aged 65 and over increased from 15 per cent in 1983 to 16 per cent in 2008, an increase of 1.5 million people in this age group. This trend is projected to continue. By 2033 it is estimated that 23 per cent of the population will be aged 65 and over. Ageing can be associated with a number of psychological challenges, including loss, physical illness and changes in role. There is evidence that older people benefit just as much from psychological therapy as younger people do.

There has historically been a tendency, when working with older people, to make adaptations to therapy based purely on someone's age in the absence of any clear theoretical rationale. This presentation will outline some of the reasons, both practical and related to the therapeutic process, adaptations may be made in therapy when working with older people in order to ensure that they can effectively engage with the process and will consider how these factors shape the way we deliver therapy.

Working with Older People who are experiencing long term conditions

Sarah Butchard, Mersey Care NHS Trust

In England, more than 15 million people have a long term condition, defined as a health problem that can't be cured but can be controlled by medication or other therapies. This figure is set to increase over the next 10 years, particularly those people with 3 or more conditions. Examples of long term conditions include high blood pressure, depression, dementia and arthritis (Department of Health, 2013).

Living with a long term condition is associated with increased comorbid mental health difficulties. It has been suggested that “the life of a person with a long-term condition is forever altered – there is no return to ‘normal’” (Department of Health, 2008). Those people with one long-term condition are two to three times more likely to develop depression than the rest of the population (Department of Health, 2011). For those living with three or more physical conditions, the risk of common mental health conditions increases to seven times that of the general population (NICE, 2009). The links between physical and mental health are clear. Despite these obvious connections, many individuals do not receive care that addresses both their physical and psychological needs (NHS Confederation, 2012). Although living with long term physical health conditions is relevant across the entire lifespan the prevalence of many long term conditions increases with age. In line with the NHS Confederation’s (2012) document on emotional and psychological wellbeing for patients with long-term conditions this presentation will focus on the common pathways experienced by people presenting with long term conditions and explore how psychological formulation may assist practitioners in capturing the complex nature of the experiences of those with long term conditions.

Supporting carers

Julia Boot, Cheshire and Wirral Partnership NHS Foundation Trust

1 in 8 adults (around 6.5 million people) are carers. In England and Wales, just under one million (950,000) people over 65 are carers and 65% of older carers (aged 60–94) have long-term health problems or a disability themselves. Carers fulfil an essential role and save the economy £119 billion per year, an average of £18,473 per carer. Being a carer is associated with increased risk of psychological distress and people providing high levels of care are twice as likely to be permanently sick or disabled. This presentation will focus on ways of engaging with carers to promote both their well being and the well being of those they care for.

Widening Delivery: Stepped Care and Occupational Interventions

Provision of 'Stress Control' large group intervention at step 2; evidence of effectiveness

Paul Burns University of Sheffield; Stephen Kellett, University of Sheffield; Gill Donohoe, University of Sheffield

Despite 'Stress Control' as an intervention being commonly delivered across IAPT services at step 2 in the stepped care model for depressed and anxious patients, evaluations of its effectiveness have been limited in this context.

The evaluation methodology adopted a mixed methods approach containing three integrated aspects; (1) clinical outcomes are assessed via calculating moving to recovery and deterioration rates on the IAPT MDS, (2) attendance rates, deprivation, gender of patient and provision of other interventions are connected to general outcomes and also sudden gains and finally (3) the patients experience/satisfaction with the format are evaluated via qualitative analysis of group appraisals.

The results demonstrate that Stress Control is a clinically effective intervention by significant differences being obtained on the PHQ-9 and GAD-7. The shape of change across groups shows that most change occurs early in groups.

The application of a stepped care model means that services need to deliver rapid and comprehensive interventions at step 2; Stress Control appears a useful means of supplementing patient choice at step 2. The evaluation is critiqued and particularly notes the lack of follow-up data.

1. provision of large group low intensity CBT is organizationally and clinically effective at step 2 of IAPT services.
2. teaching in such groups is a skill in and of itself and has different competencies to that of standard clinical one to one low intensity work.

An Evaluation of the Clinical and Occupational Outcomes of a Military Group Behavioural Activation Programme

Matthew Wesson, Ministry of Defence; Dean Whybrow, Ministry of Defence; Matthew Gould, Defence Clinical Psychology Service; Neil Greenberg, Academic Centre for Defence Mental Health, Kings College London

Behavioural Activation (BA) is an evidence-based psychological treatment for depression based on behavioural theory. However, in common with other talking therapies, there is limited evidence about occupational factors related to treatment. This is an important gap in the research given the emphasis placed on employment considerations in recent service initiatives. Aim: A service evaluation to investigate the clinical and fitness to work outcomes of a group BA programme for serving military personnel.

46 patients experiencing moderate to severe depression attended a 12-session Military Behavioural Activation and Rehabilitation Course (MBARC). The primary outcomes were the Patient Health Questionnaire-9 (PHQ-9), a self-report measure of depression and the patient's medical employability category.

Clinical and statistically significant changes were found on the PHQ-9 between pre-course and 3-month follow-up. Pretreatment 3 patients (6.5%) were psychologically fit to deploy on full operational duties in their primary role; this increased to 25 (56.8%) and 29 (65.9%) at 3 and 6-months respectively.

Preliminary findings suggest that MBARC is a clinically and occupationally effective treatment for depression in military personnel. Further research is required to identify if BA delivered in a group setting would be effective in non-military settings and whether treatment benefits are maintained in the longer term.

The potential benefits of utilising group CBT for the treatment of Veterans mental health issues. How Group CBT can be effective within Occupational Health services. Finally, the delivery of group BA for moderate to severe depression as a resource efficient intervention.

Talking Heads: case study of guided self-help CBT adapted for brain injury

Sian Newman, Lancashire Care NHS Foundation Trust; Rebecca Minton, Camden & Islington NHS Foundation Trust

Psychological Wellbeing Practitioners (PWP) often need to adapt guided self-help interventions to treat patients with long-term physical health conditions (LTC). This case study outlines the treatment of a patient presenting with depression resulting from post-concussion syndrome, and offers an insight into the inherent challenges of doing so. Consideration is also given to how PWP could be supported to develop clinical skills in order to work effectively with this patient group.

Behavioural activation was the main intervention used. This focused on scheduling and pacing everyday chores and increasing enjoyment without increasing symptoms of post-concussion syndrome. The patient received 8 guided self-help sessions plus 1 follow-up.

Scores on PHQ-9 and GAD-7 reduced from 24 and 21 to 2 and 1 respectively at the final session.

Treatment was successful and the patient was able to return to previously enjoyed activities such as cooking family meals and going out with friends, albeit with adaptations to prevent cognitive fatigue.

Using supervision, standard PWP protocol was successfully adapted to accommodate the impact of the patient's head injury. This is important, given that 20% of people with a LTC also have depression (NICE, 2009) and IAPT's new remit to work with patients who have LTCs (Talking Therapies: A Four Year Plan of Action, 2011).

This case demonstrates that PWP can be supported to work with patients presenting with LTCs through supervision and targeted additional training. Working with this patient group offers one way to develop the role of the PWP in IAPT.

Expanding the reach of low intensity interventions; the experience of training physical health staff as PWP.

Stephen Kellett, University of Sheffield; Maggie Speake, University of Lancaster

There is a drive in the NHS for the mental health needs of patients to be more effectively recognized and treated at source when that is appropriate - rather than on solely relying on referral to mental health services. This project evaluated the experiences of physical health staff in completing the full 1-year PWP training.

The evaluation methodology adopted a mixed methods approach containing three integrated aspects; (1) clinical outcomes are reported via moving to recovery and deterioration rates, (2) learning outcomes on the training programme via course progression data and (3) the cohort's (N=8) experience of the initiative was evaluated via semi-structured interviews.

Physical health trainees successfully completed all of the required course assessments. Between 1/1/13 and 23/7/13 a total of N=173 patients were assessed by the physical health trainees. In the same time period, the physical health trainees completed a 1:1 intervention with N=27 patients and achieved a moving to recovery rate of 50%. This meets the IAPT KPI for clinical outcomes. Six key themes emerged from interviews: learning experience, high need for support, value of supervision, key challenges, learning journey and looking to the future.

Physical health staff were able to successfully complete the training, valued its high quality and then applied the newly acquired and helpful skills in physical healthcare settings. Effective integration of PWP and physical health skills in the longer term may require the development of new care pathways and new roles within physical health teams. Further research is needed to evaluate the impact of having completed the PWP training on the trainees' clinical outcomes in physical health settings.

1. staff from a variety of backgrounds can compete (and value) the PWP training
2. high levels of organizational support and integration are required to support such initiatives

Too stressed to decide? The evaluation of a CBT self-help programme for dentists.

Helen Chapman, Paul Lowe Dentistry and University of Lincoln; Roger Bretherton, University of Lincoln; Susan Chipchase, University of Lincoln

It has long been recognised that dentists find a wide variety of aspects of their work stressful (eg Gorter et al., 1999) and that this can lead to burnout (Hakanen et al., 2008). There have been 2 significant research projects to try and address this issue; both were highly expert-intensive. (Gorter et al., 2001; Netherlands, Newton et al., 2006; UK) Both studies found improvements at one month follow up, but this was not maintained at one year follow up in the Dutch study. However, self-motivated changes in a group of Dutch dentists were maintained (te Brake et al., 2001).

A self-help CBT-based manual to address stress in dentists and its consequent effects on clinical decision making was written, informed by earlier studies (Chapman et al., in preparation). This was piloted and then offered to 3 groups of volunteer dentists; one group (22) received the manual only and the second received a supplementary 3 hour training session (2 groups of 10 each). Follow ups were conducted at 6 weeks and 6 months. The programme was evaluated by the participants.

Data on the programme acceptability, stress, burnout, decision making styles and anxiety in the dental clinical while working were collected and will be presented.

The implications of the programme for dentists' well-being and patient care will be discussed.

Using Self-Practice/Self-Reflection (SP/SR) Programs to Train CBT Therapists in Low and High Intensity Contexts

Convenor: James Bennett-Levy, University of Sydney

Self-practice/self-reflection (SP/SR): An Introduction

James Bennett-Levy, University of Sydney

This paper will be a short introduction to SP/SR to provide a context for the rest of the papers in the symposium. It will describe what SP/SR is, why SP/SR was developed, and what are the typical components of an SP/SR program.

Developing artistry in low intensity CBT interventions: Implementing a Self-Practice and Self-Reflection program for experienced Psychological Wellbeing Practitioners (PWPs)

Richard Thwaites, Cumbria Partnership NHS Foundation Trust; James Bennett-Levy, Centre for Rural Health, Sydney University; Beverly Haarhoff, Massey University, New Zealand; Mark Freeston, University of Newcastle

There is a growing evidence base for the effectiveness of Self-Practice/Self-Reflection (SP/SR) programs as a learning tool for CBT therapists. This involves practitioners practising specific CBT techniques on themselves and then reflecting on what they have learnt about CBT, themselves and the process of

therapy. To date the evidence has been found that for both therapists-in-training and highly experienced therapists, completion of SP/SR programs have led to a range of valued outcomes e.g. perceived improvement in CBT skills and knowledge (especially relating to interpersonal aspects), belief change about the self (as a therapist and more general).

In the UK, there is a rapidly expanding workforce of Psychological Wellbeing Practitioners who provide low intensity CBT-based interventions (e.g. guided self-help) as part of the Improving Access to Psychological Therapies (IAPT) program. This presentation will provide a brief description of the role of the Psychological Wellbeing Practitioner and then describes the implementation of a 12 module (over 24 week) SP/SR program for experienced PWPs.

The initial findings suggest two main benefits: greatly enhanced artistry in the delivery of LI interventions and significant changes in personal and therapist beliefs.

Enhancing the cognitive behavioural therapist: Is skill acquisition the real benefit of SP/SR?

Craig Chigwedere, St Patrick's University Hospital and Trinity College Dublin; Brian Fitzmaurice, Health Service Executive & Trinity College Dublin; Gary Donohoe, National University of Ireland Galway

CBT training is effective but there is some evidence that it may ineffectively targets particular skills such as conceptualization (Haarhoff, 2011) and the transfer of learning to practice (King et al., 2002). Reflection has been shown to enhance learning and the DPR model (Bennett-Levy, 2006) proposes that reflection may be the engine that drives therapist development, which enhances perceptual and interpersonal skills. The model proposes that applying CBT techniques to the self creates a 'deeper sense of knowing' of those techniques. This enhances their knowledge and application. Previous studies have demonstrated the enhancement of therapeutic skills (Bennett-Levy et al., 2003), therapist attitudes (Chaddock et al., 2006) and beliefs about the self (Davies et al., 2008). The current study aimed to empirically test the impact of the inclusion or not, of SP/SR to CBT training. A retrospective cohort study was performed, comparing the CTS-R scores of 76 trainees that had either received SP/SR (n=51) or not (n=25). Available Revised Cognitive Therapy Rating Scale (CTS-R) scores at three time points (Term 1, Term 2 and Term 3) were compared. Relative risk (RR) analyses were performed on the original 2 factors of the CTS-R and also on four factors from a new principle components analysis. Post hoc analyses were carried out on the individual items of the CTS-R. Results showed that SP/SR impacted on cognitive therapy (CT) specific skills at the term two time point. Post hoc analyses showed that SP/SR significantly impacted on conceptualization and interpersonal skills at the term two time point. Though this study has flaws, it provides evidence that SP/SR enhances CT specific and interpersonal skills. In keeping with education and reflection theory and research, SP/SR may impact on training by providing faster acquisition of clinical skills. Though further research is needed, it is worth considering wider use of CTS-R in CT training.

Relationship between reflective ability and clinical competency: Implications for the role of SP/SR within CBT training

Marie Chellingsworth, University of Exeter; Paul Farrand, University of Exeter

Self Practice/Self Reflection (SP/SR) is identified as a central component to knowledge and skill development of Cognitive Behavioural Therapists. Many benefits of SP/SR associated with enhancing the development of common and specific factors during CBT training, alongside contributions of SP/SR to the learning environment have been well documented. However to date most research demonstrating the benefits of SP/SR has been qualitative and highlighted the benefits of SP/SR as perceived by trainees and educators, rather than identifying the impact of SP/SR on trainee outcomes. This study examines the benefits of SP/SR in developing reflective ability amongst trainee Psychological Wellbeing Practitioners (PWP), and assesses the extent to which reflective capacity is associated with their performance on the simulated competency assessments undertaken as part of the IAPT PWP training programme. Results demonstrate the relationship between reflective ability and assessed competency in clinical skills of 40 PWP trainees. Discussion of the results further establishes the relationship between reflective ability and the competent practitioner. The impact of SP/SR to help develop training outcomes related to reflective ability and enhanced trainee competency during training is further discussed, alongside suggestions regarding ways to integrate SP/SR into CBT training programmes to help develop reflective ability.

Engaging the self in SP/SR: evidence with experienced practitioners

Melanie Davis, County Durham and Darlington NHS Foundation Trust; Mark Freeston, Institute of Neuroscience, Newcastle University; Richard Thwaites, Cumbria Partnership NHS Foundation Trust; James Bennett-Levy, University Centre for Rural Health (North Coast), University of Sydney, Australia

Self-practice/self-reflection (SP/SR) has a growing evidence-base as a training and development approach across a range of CBT practitioner experience. As SP/SR is an experiential CBT training programme, a core focus of the approach is an emphasis on engagement with self; both at a personal level, as well as at a therapist level. Bennett-Levy's (2006) model of therapist skill development predicts that engagement with both levels is required for development in certain areas of therapist skill; particularly those in the interpersonal domain. Whilst previous SP/SR studies to date have reported an enhancement of therapeutic skill across a range of areas, the current study aimed to empirically demonstrate that SP/SR has a measurable impact at the level of beliefs about self. Fourteen experienced CBT therapists participated in a 10-week SP/SR programme that was evaluated using a multiple-baseline single-case experimental design. From the initial 14 therapists recruited (the Intention-to-Treat (ITT) group), three left the study due to reported work and time pressures (the drop-outs), four started SP/SR, but did not complete it within the study's timescale (finishing at Weeks 4, 7, 8 and 8 respectively) (the partial completers), leaving seven participants who completed SP/SR through to follow-up (the full completers). The ITT group had an average of nine years experience post formal CBT training and an average of 18 years experience post professional qualification (Clinical Psychology (n = 7); Nursing (n = 5); and Psychiatry (n = 2)). Individually determined self and therapist related beliefs were rated weekly throughout the baseline, intervention, and follow-up periods. Participants were randomised to baseline length. Data were analysed using a novel non-overlap measure (Tau-U; Parker, Vannest, Davis & Sauber, 2010), which corrects where necessary for baseline trend for each participant. Results show that for all analyses (ITT, partial completers, and full completers) there were significant, positive changes to both types of beliefs in response to the intervention. Effect sizes were benchmarked to other published single-case studies rather than typical Cohen interpretations. This study provides strong evidence that SP/SR can reduce ratings of identified dysfunctional beliefs, both the 'personal self' and 'therapist self' amongst experienced CBT practitioners. While demand characterises cannot be eliminated, participants chose whether to reveal the content of the belief or not, so reducing this possibility. Self-monitoring effects alone cannot account for the change as any baseline trend was removed from cases where this may have been an issue. In line with theoretical proposals, that engaging the self is a key part of therapist development, these data are consistent that SP/SR programmes can engage the self, even amongst experienced therapists.

New Advances in Behavioural Activation

Convenor: Christopher Martell, University of Wisconsin, USA

Adapting BA protocols for use with depressed adolescents: A review

Christopher Martell, University of Wisconsin, USA

Behavioral Activation (BA) is an efficacious treatment for depression that has been successfully used with adults in both high intensity and low intensity treatments. BA is a logical treatment to use with depressed adolescents as well. The straightforward nature of the treatment and the principles of treatment make it a good alternative for those adolescents for whom cognitive concepts prove challenging. Data are beginning to emerge that support the use of an adolescent version of BA. This presentation will address the modifications to the BA protocol that have been suggested by several studies, including a trial being undertaken by the presenter and his colleagues. It will review the published data on BA treatments with depressed adolescents.

A Blended Therapy (BA + telephone support) for Postnatal Depression

Heather O'Mahen; Jo Woodford; Esther Wilkinson; Dave Richards; Julia McGinley; Rod Taylor; Fiona Warren, University of Exeter

Despite the high prevalence of postnatal depression (PND), few women seek help. Internet interventions may overcome many of the barriers to PND treatment use. We report a phase II evaluation of a 12-session, modular, guided Internet behavioural activation (BA) treatment modified to address postnatal-specific concerns [Netmums Helping With Depression (NetmumsHWD)].

To assess feasibility, we measured recruitment and attrition to the trial and examined telephone session support and treatment adherence. We investigated sociodemographic and psychological predictors of treatment adherence. Effectiveness outcomes were estimated with the Edinburgh Postnatal Depression Scale (EPDS), Generalized Anxiety Disorder-7, Work and Social Adjustment Scale, Postnatal Bonding Questionnaire, and Social Provisions Scale.

A total of 249 women were recruited via a UK parenting site, Netmums.com. A total of 83 women meeting DSM-IV criteria for major depressive disorder were randomized to NetmumsHWD (n=41) or treatment-as-usual (TAU; n=42). Of the 83 women, 71 (86%) completed the EPDS at post-treatment, and 71% (59/83) at the 6-month follow-up. Women completed an average of eight out of 12 telephone support sessions and five out of 12 modules. Working women and those with less support completed fewer modules. There was a large effect size favouring women who received NetmumsHWD on depression, work and social impairment, and anxiety scores at post-treatment compared with women in the TAU group, and a large effect size on depression at 6 months post-treatment. There were small effect sizes for postnatal bonding and perceived social support.

A supported, modular, Internet BA programme can be feasibly delivered to postpartum women, offering promise to improve depression, anxiety and functioning.

Cost and Outcome of Behavioural Activation (COBRA). A Randomised Controlled Trial of Behavioural Activation versus Cognitive Behaviour Therapy for Depression

David A Richards, Shelly Rhodes, David Ekers, Dean McMillan, Sarah Byford, Paul Farrand, Simon Gilbody, Stephen Hollon, Willem Kuyken, Christopher Martell, Heather A O'Mahen, Emer O'Neil, Nigel Reed, Rod S Taylor, Ed R Watkins and Kim A Wright

Cognitive behaviour therapy (CBT) is an effective treatment for depression. However, CBT is a complex therapy that requires highly-trained and qualified practitioners, and its scalability is therefore limited by the costs of training and employing sufficient therapists to meet demand. Behavioural Activation (BA) is a psychological treatment for depression that may be an effective alternative to CBT and, because it is simpler, might also be delivered by less highly trained and specialised mental health workers.

COBRA is a two-arm non-inferiority patient level randomised controlled trial, including clinical, economic, and process evaluations comparing CBT delivered by highly trained professional therapists with BA delivered by junior professional or para-professional mental health workers to establish whether the clinical effectiveness of BA is non-inferior to CBT and if BA is cost effective compared to CBT. Therapists to establish whether the clinical effectiveness of BA is non-inferior to CBT. Four hundred and forty patients with major depressive disorder will be recruited through screening in primary care.

We will analyse for non-inferiority in per-protocol and intention to treat populations. Our primary outcome will be severity of depression symptoms (Patient Health Questionnaire-9) at twelve months follow up. Secondary outcomes will be clinically significant change and severity of depression at 18 months, and anxiety (General Anxiety Disorder-7 questionnaire) and health related quality of life (Short-Form Health Survey-36) at twelve and 18 months. Our economic evaluation will take the United Kingdom National Health Service/Personal Social Services perspective to include costs of the interventions, health and social care services used, plus productivity losses. Cost-effectiveness will be explored in terms of quality adjusted life years using the EuroQol-5D measure of health-related quality of life.

The clinical and economic outcomes of this trial will provide the evidence to help policy makers, clinicians and guideline developers decide on the merits of including BA as a first line treatment of depression.

[Advances in the experimental investigation of paranoia](#)

Convenor: Lyn Ellett, Royal Holloway, University of London

A new paradigm for the study of paranoia: The Prisoner's Dilemma Game

Lyn Ellett, Royal Holloway, University of London; Rhani Allen-Crooks, Royal Holloway, University of London; Adele Stevens, Royal Holloway, University of London; Tim Wildschut, University of Southampton; Paul Chadwick, Institute of Psychiatry, King's College London

Three studies are reported that examined the Prisoner's Dilemma Game (PDG) as a paradigm for the evaluation of paranoia. The PDG captures three qualities that are at the heart of paranoia – it is interpersonal, it concerns threat, and it concerns the perception of others' intentions towards the self. Study 1 (n=175) found that state paranoia was positively associated with selection of the competitive PDG choice. Study 2 (n=111) found that this association was significant only when playing the PDG against another person, and not when playing against a computer. This finding underscores the interpersonal nature of paranoia and the concomitant necessity of studying paranoia in interpersonal context. In Study 3 (n=152), we assessed both state and trait paranoia and distinguished between distrust-based and greed-based competition. Both state and trait paranoia were positively associated with distrust-based competition. The PDG is a promising paradigm for the study of paranoia.

Self-Awareness and Nonclinical Paranoia

Jessica Kingston, Royal Holloway, University of London; Olivia Sherlock, Royal Holloway, University of London; Sarah Buchanan, Royal Holloway, University of London; Paul Chadwick, Institute of Psychiatry, King's College London; Lyn Ellett, Royal Holloway, University of London

Self-focused attention is a reliable trigger for paranoid cognitions in healthy students, perhaps by enhancing the perception that one is the target of another's thoughts and actions. This paper presents three experiments that examine aspects of the relationship between self-awareness and paranoid cognitions in college students. Experiment 1 exposed participants to a laboratory environment involving two key elements - task failure, and heightened self-awareness, triggered by the presence of a camera. Both state paranoia and public self-awareness significantly increased following the paranoia induction; change in state paranoia was also associated with change in state self-awareness. Experiment 2 assessed whether high self-awareness mediated increased state paranoia. Participants were randomised to one of two conditions, task failure plus camera, or task failure alone, and again completed measures of state paranoia and public self-awareness. Results suggest that the combination of failure plus camera caused an increase in state paranoia due to public self-awareness. Experiment 3 tested whether a self-affirmation priming task would uncouple the relation between high self-awareness and state paranoia. Participants were randomised to complete a self-affirmation task or a non-affirmation control, prior to experiencing task failure plus camera. Individuals who affirmed a valued domain were significantly less paranoid than controls.

Adult Attachment and Paranoia: An Experimental Investigation

Jane Owens, University of Manchester; Katherine Berry, University of Manchester
Lyn Ellett, Royal Holloway, University of London

Associations between paranoia and insecure attachment have been demonstrated in both clinical and analogue samples. Attachment theory may provide a theoretical framework for understanding the occurrence and maintenance of persecutory delusions. The current study investigates the role of dispositional attachment and contextually primed secure-base attachment representations in the occurrence of paranoid thinking in an analogue sample. Sixty participants were randomly allocated to one of three conditions; a secure attachment priming condition, a positive affect condition or a neutral control condition. Following priming, all participants were exposed to a paranoia induction. State paranoia was measured pre- and post-manipulation. Dispositional levels of insecure attachment were associated with both trait and state paranoid thinking. Contrary to predictions, the secure attachment prime did not appear to buffer paranoid thinking. The secure attachment prime appeared to have a negative impact for participants with high levels of attachment anxiety, who experienced higher levels of paranoia, following the paranoia induction. The study provides further evidence for the association between insecure attachment and paranoia. It demonstrates the potentially aversive effects of exposure to secure attachment material in those with existing insecure attachment styles. Clinical and theoretical implications, limitations and considerations for future research in this area are discussed.

An exploratory investigation of real-world reasoning in paranoia.

Gary Brown, Royal Holloway, University of London; Vyv Huddy, Royal Holloway, University of London; Tom Boyd, Barnet, Enfield & Haringey Mental Health Trust, UK; Til Wykes, Institute of Psychiatry, KCL

Paranoid thinking has been linked to greater availability in memory of past threats to the self. However, remembered experiences may not always closely resemble events that trigger paranoia, so novel explanations must be elaborated for the likelihood of threat to be determined. We investigated the ability of paranoid individuals to construct explanations for everyday situations and whether these modulate their emotional impact. Twenty-one participants experiencing paranoia and 21 healthy controls completed a mental simulation task that yields a measure of the coherence of reasoning in everyday situations. When responses featured positive content, clinical participants produced less coherent narratives in response to paranoid themed scenarios than healthy controls. There was no significant difference between the groups when responses featured negative content. The current study suggests that difficulty in scenario construction may exacerbate paranoia by reducing access to non-threatening explanations for everyday events, and this consequently increases distress.

Advancing Understanding and Management of Insomnia

Convenor: Simon Kyle, University of Manchester and Nicole Tang, University of Warwick
Abstracts not received

Talking the Talk: Ensuring the language of IAPT is accessible for all

Convenor: Pam Myles, University of Reading
Abstracts not received.

Psychological Therapies of Mood Disorder Following Stroke

Convenor: Ken Laidlaw, University of East Anglia

Treating anxiety after stroke using relaxation training

Kneebone, I, University of Western Sydney; Golding K, University of Surrey; Fife-Schaw, University of Surrey

Anxiety is a common problem after stroke. Relaxation training is a proven treatment in non-stroke populations. Autogenic relaxation delivered in a CD format, to stroke survivors with anxiety was evaluated via a randomized two group design (intervention and waiting list control). Twenty community dwelling stroke survivors with significant levels of anxiety were asked to listen to a CD five times a week for at least one month. All participants completed the Hospital Anxiety and Depression Scale (HADS) each month for four months administered by telephone. At 1, 2 and 3 month follow up participants who received the relaxation training were significantly more likely to report reduced anxiety compared to controls. Of those in the intervention group, 78% reported completing the relaxation training as directed and 78% planned to continue using it. The treatment was feasible and acceptable to the majority of the participants. It might be offered as part of a stepped care approach for post-stroke anxiety.

Communication and Low Mood (CALM) study: a randomised controlled trial evaluating behaviour therapy for low mood in people with aphasia after stroke

Shirley Thomas, University of Nottingham; Nadina Lincoln, University of Nottingham; Marion Walker, University of Nottingham; Jamie Macniven, Auckland Hospital, New Zealand; , Helen Haworth, Nottinghamshire Community Health

Low mood is common in people with aphasia yet studies of psychological treatments usually exclude people with aphasia. Behavioural approaches may be appropriate as they do not require intact

communication. The aim of this multicentre randomised controlled trial was to evaluate behavioural therapy for treating low mood in stroke survivors with aphasia. One hundred and five patients with low mood were randomly allocated to receive up to three months of behavioural therapy from an assistant psychologist, or usual care. Participants received a mean of 9.1 therapy sessions (range 3-18, SD 2.6). Outcome assessments of mood (Stroke Aphasic Depression Questionnaire; SADQH-21, Visual Analog Mood Scales sad item; VAMS), self-esteem (Visual Analogue Self-Esteem Scale; VASES) and leisure activities (Nottingham Leisure Questionnaire; NLQ) were completed three and six months after randomisation. At three months, allocation to behavioural therapy was a significant predictor of SADQH-21 (Beta=-0.20, p=0.05), VAMS (Beta=-0.22, p=0.03) and VASES (Beta=0.28, p=0.002). At six months, allocation to behavioural therapy was a significant predictor of SADQH-21 (Beta=-0.12, p=0.045). Group allocation did not significantly predict leisure activities (p=0.275-0.495). Behavioural therapy seemed to improve mood in people with aphasia and is an appropriate approach to use with stroke survivors with communication difficulties.

Psychological Skills Training for Stroke Staff in Oxfordshire

Clare Stafford, **Vivienne Purcell**, Simon Pragnall & Patrick Kennedy-Williams, Oxfordshire NHS Foundation Trust

Emotional distress is common following stroke, with depression and anxiety being particularly common. It is estimated that one third of people will experience depression at some stage following a stroke. This can greatly reduce the quality of life of stroke survivors and their family/carers. It can also impact on their functional recovery, and increase their healthcare use.

We designed and implemented one-off training sessions delivered at two levels to increase psychological awareness, understanding, recognition and treatment of emotional issues following stroke. Level one offers support and listening skills training, and level 2 develops these further.

In total 118 NHS, Social Care and voluntary sector staff participated in psychological skills training for stroke staff. Training sessions lasted three hours, with a total of 9 sessions delivered; seven at level I (junior staff) and two at level II (senior staff). This paper reports on findings and discusses clinical implications.

Optimising Clinical Practice: Engagement, Assessment and Treatment Approaches

Client Perceptions of Helpfulness: A Study of the Therapeutic Relationship

Alexandra Cocklin, University of Manchester; Warren Mansell, University of Manchester; Sara Tai, University of Manchester; Phil McEvoy, Six Degrees Social Enterprise; Jody Comisky, Six Degrees Social Enterprise; Chloe Figg, Six Degrees Social Enterprise

Evidence that suggests alliance and relationship factors make an important contribution to therapeutic outcomes in cognitive-behavioural psychotherapy is well established (Leahy, 2008). However, debate continues regarding the key mechanisms of change that are involved as researchers attempt to identify the 'active ingredients' of the relationship. Recent research has moved away from conceptualising the relationship in terms of static components and is focusing on the dynamic interaction of therapist and client in session. This involves collecting real time feedback and identifying events that are perceived as helpful or hindering for the client in therapy.

This study devised a novel methodology to capture client's perceptions of what was helpful about the therapeutic environment created by the therapist during a single session of Method of Levels Therapy, a transdiagnostic CBT (Mansell, Carey & Tai, 2012).

Twenty three therapy sessions were video recorded and both clients and therapists were asked to rate a twenty minute section at two minute intervals using repeated measures. Process measures of the client/therapist experience and standardised measures of the therapeutic relationship were included.

This study is ongoing and the results of this study will be made available from April this year.

Full conclusions to the study will be made when the results become available in April.

The authors hypothesise that the most therapeutic or helpful aspect of the relationship is 'the establishment of an environment that promotes the unfiltered exploration of the client's internal experience' (Carey et al, 2012). The study therefore includes process measures to track the client's

perception of what was helpful, the extent to which they felt in control, their ability to experience emotion and to talk freely about their problem across a single session of therapy.

Session by session monitoring in CAMHS: What are Clinicians thoughts?

Kirsty James, University of Bath; Sarah Elgie, South Gloucestershire CAMHS; Joanna Adams, University of Bath; Tracey Henderson, South Gloucestershire CAMHS; Paul Salkovskis, University of Bath

The CYP-IAPT programme emphasises the meaningful contribution session-by-session routine outcome monitoring (ROM) can make to clinical practice and its importance in highlighting services' effectiveness. Two studies on the implementation of ROM in children's services were conducted.

In study one twelve CAMHS professionals participated in focus groups to identify thoughts about this clinical practice. Themes from the focus group led to the development of a questionnaire about professional's views on session-by-session ROM. In study two, 59 professionals from four CAMHS teams completed the questionnaire.

Study one suggested themes including this way of working providing objectivity, being collaborative and empowering, but also illustrated concerns over how measures may influence therapeutic sessions and the information may be used. Study two found that only 6.8% reported "almost always" utilising session-by-session ROM, and only 7% had received CYP-IAPT training. Exploratory factor analysis of questionnaire responses suggested two factors reflecting the perceived negative and positive impact of session-by-session ROM. Results suggested clinicians who currently use session-by-session ROM hold stronger positive and negative beliefs than clinicians who do not.

Whilst considering its limitations, this study suggests that session-by-session ROM is not currently routine practice within CAMHS and highlights the importance of considering how this practice can be best implemented within this setting.

Within CBT, the influence of thoughts and beliefs is assumed to apply as much to therapists as to clients. With the expanding implementation of CYP-IAPT, exploring clinician's views on session-by-session routine outcome monitoring (ROM) is important as this is expected by both IAPT and non-IAPT trained professionals. The results demonstrate that session-by-session ROM is not currently routine practice within CAMHS and therefore highlight the importance of considering how this can be best implemented within this setting. Identifying both positive and negative thoughts is important to enable and support CAMHS teams to develop the most effective ways of using this clinical practice. This can also facilitate understanding clinicians concerns further, which can inform the on-going development and implementation of training and support systems.

An investigation into non-attendance at psychological therapy appointments

James Binnie, Bromley Healthcare

Research demonstrates that non-attendance at healthcare appointments is a waste of scarce resources; leading to reduced productivity, increased costs, disadvantaged patients through increased waiting times, and demoralised staff. Ensuring attendance at appointments is therefore vital for meeting Department of Health recommendations. Although the subject of non-attendance is relatively well researched, there are often problems with the methodology and generalizability of the studies.

This service audit took place in a metropolitan borough's primary care psychological therapies (IAPT) service. The aims were to determine the rates of non-attendance, the circumstances under which they occurred and measures taken to reduce non-attendance. As a result of this process recommendations to improve attendance would be generated and implemented.

A mixed methods approach was used. Firstly, existing service guidelines and reporting systems were reviewed. A year's cohort of patients was then examined to investigate where in the care pathway non-attendance was most frequent. A cross-sectional quantitative design was used to compare completers of cognitive behavioural therapy (N=140) to drop-outs (N=61). Two separate questionnaires were sent, one to patients that did not attend (DNA) an appointment and the other to therapy drop-outs. Discussions were then held within the service to identify current strategies to reduce non-attendance.

Findings suggested contrasting guidelines and clinically inaccurate reporting systems. The overall service DNA rate was found to be 8.9%; well below rates suggested from the literature review. The drop-out rate from CBT was found to be 17%; lower than findings from similar studies. The most influential factor

associated with CBT drop-out was the patient's level of depression. The level of anxiety, risk ratings and deprivation scores were also found to be different between completers and drop-outs. This was consistent with prior research. The main reasons given for non-attendance were forgetting, being too unwell to attend, having other priorities, or dissatisfaction with the service; again these findings were consistent with prior research. Several strategies to reduce non-attendance were currently being used by the service.

As a result of the investigation several recommendations were made to reduce non-attendance. To date many have been implemented and the DNA rate has reduced as a result. Despite limitations, such as data quality issues in the patient records system, the study has helped the IAPT service become more efficient and has helped future auditing on the subject of non-attendance to occur.

CBT for Hoarding Disorder in people with Intellectual Disabilities

Stephen Kellett, University of Sheffield; Chandanee Kotecha, University of Sheffield; Heather Matuozzo, Independent Practice

There is no current evidence base for treating hoarding in people with learning disabilities.

In a pre-post and follow-up design, N=14 hoarders were treated with CBT in their homes. Outcomes were assessed in terms of the Clutter Image Rating Scale, the Savings Inventory-Revised and the Glasgow Anxiety and Depression Scales.

There were significant reductions hoarding, with a significant reduction in environmental clutter in the homes. Participants were significantly less depressed at completion of treatment and maintained these reductions over the follow-up period.

The methodology is critiqued and amendments to the treatment of hoarding in participants with learning disabilities are made based on the results.

1. encouragement to use CBT for hoarding with this population
2. an example of generating practice based evidence

NICE Guidelines for Mental Health: Evidence Updates

Convenor: Anna Coughtrey, University of Reading

NICE Evidence Update for Alcohol Use Disorders

Colin Drummond, King's College London

Evidence Updates provide a summary of selected new evidence published since the literature search was last conducted for the accredited guidance to which they relate. A search was conducted for new evidence from 1 January 2008 to 9 July 2013. A total of 21,207 pieces of evidence were initially identified. After removal of duplicates, a series of automated and manual sifts were conducted to produce a list of the most relevant references. The remaining 79 references underwent a rapid critical appraisal process and then were reviewed by an Evidence Update Advisory Group, which advised on the final list of 40 items selected for the Evidence Update. The update conclusions include (1) the evidence base generally shows that harm from alcohol-use disorders costs a substantial amount of money and that increases in prices of alcoholic drinks may be associated with reductions in drinking and in harms, including deaths, associated with drinking, (2) healthcare professionals seem to have a generally negative attitude towards people with alcohol-use disorders but this perception may be improved with education and training and (3) multicontact interventions delivered in primary care may be effective in reducing alcohol consumption.

NICE Evidence Update for OCD

David Veale, South London and Maudsley NHS Foundation Trust and Institute of Psychiatry, Kings College London

A search was conducted for new evidence from 30 October 2003 to 2 April 2013. A total of 1909 pieces of evidence were initially identified. Following removal of duplicates and a series of automated and manual sifts, 16 items were selected for the Evidence Update. New evidence reviewed included (1) an RCT finding that acceptance and commitment therapy may improve symptoms of OCD to a greater extent than progressive relaxation training, (2) studies showing family-based CBT may be associated with higher rates

of response to treatment than psychoeducation plus relaxation training and may yield long-term benefits, (3) transcranial magnetic stimulation may not be an effective treatment for people with OCD.

NICE Evidence Update for PTSD.

Jennifer Wild, University of Oxford

We conducted a search for new evidence available from 1 July 2011 to 12 July 2013. A total of 2061 pieces of evidence were initially identified. Following removal of duplicates and a series of automated and manual sifts, 19 items were selected for the Evidence Update. An Evidence Update Advisory Group, comprising of topic experts, reviewed the prioritised evidence and provided a commentary. New evidence included (1) a study demonstrating that involving the intimate partner in treatment may help improve the patient's PTSD symptoms and relationship satisfaction, (2) that research may be warranted into the delivery of trauma-based therapy within refugee communities in the UK using trained lay workers from the ethnic group, (3) a range of studies add to the evidence base showing the efficacy of trauma-focused psychological interventions for PTSD consistent with NICE CG26.

Intrusive Memories in PTSD: Formation, Prevention, and Treatment

Convenor: Tanja Michael, Saarland University, Germany

Experimental induction of intrusions of warning signals

Juliane Sachschal, University of Oxford; Oliver Sündermann, King's College London and Anke Ehlers, University of Oxford

Clinical observations suggest that re-experiencing in posttraumatic stress disorder (PTSD) can be triggered by stimuli that have a temporal, but no meaningful, association with the trauma, suggesting a role of associative learning in re-experiencing. Ehlers et al. (2002) further observed that the content of intrusive memories in PTSD also appears to fit with associative learning: Intrusions were often of stimuli that signalled either the trauma onset or one of its worst moments. This included stimuli that had a temporal rather than meaningful association with the trauma.

Two experiments used a picture story paradigm to investigate whether intrusions of "warning signals" can be induced experimentally. Healthy participants were exposed to neutral and traumatic picture stories (as in Sündermann et al., 2013). Neutral objects were interspersed in-between the story slides. Participants reported any intrusions they experienced in the following week. Experiment 2 also assessed heart rate responses to the neutral objects at one-week follow-up.

Participants reported more intrusions of, and showed a stronger heart rate decrease in response to, objects seen in the context of traumatic stories, compared to objects seen in the context of neutral stories. The studies demonstrate that it is possible to induce intrusions of warning signals after a single pairing with trauma.

Forget about it: Interindividual differences in memory control predict PTSD-like memories after an analogue trauma

Markus Streb, Axel Mecklinger, Michael C. Anderson, Johanna Lass-Hennemann, & Tanja Michael, Saarland University, Germany

Most trauma survivors suffer from intrusive re-experiencing in the immediate aftermath of a traumatic event. As such intrusions are immensely distressing, survivors wish to gain control over these unwanted memories. In point of fact, basic memory research shows that memory control can be exerted through a process called retrieval suppression. Retrieval suppression means that unwanted memories are excluded from consciousness, thereby reducing accessibility to these memories. Persistent intrusions and chronic posttraumatic stress disorder (PTSD) might thus, inter alia, be due to deficient memory control. In the current study, we examine whether individuals with low memory control are more likely to develop distressing intrusions after a "traumatic" experience.

Memory control was examined with a standard retrieval suppression task, the think/no-think paradigm (TNT). Retrieval suppression was indexed by behavioral data (below-baseline forgetting scores for to-be-suppressed items) and event-related potentials (ERP; i.e. enhanced N2 component for to-be-suppressed items). Twenty-four healthy participants watched a traumatic and a neutral film clip after having

performed the TNT. Intrusions in response to the film-clips were measured with an electronic diary (5 days) and a modified version of the Impact of Event Scale.

In line with our hypothesis, the behavioral data of memory control show a negative association with distress ratings of intrusions of the traumatic film-clip ($r=-.53$, $p<.01$). Accordingly, the ERP estimates of memory control are negatively correlated with intrusion distress ($r=-.45$, $p<.05$) and the Impact of Event Scale score ($r=-.49$, $p<.01$).

Low memory control predicts PTSD-like symptoms after an analogue traumatic event. Thus, deficient memory control may be a risk factor for developing PTSD after traumatic life experiences. Future research should establish whether memory control can be enhanced through training and be used as an adjunctive therapeutic tool.

“Mindreading” flashback formation: Using neuroimaging to predict flashbacks

Ian A. Clark, University of Oxford; Katherine Niehaus, University of Oxford; Eugene P. Duff, University of Oxford; Clare E. Macka, University of Oxford; Stephen M. Smith, University of Oxford; Mark W. Woolrich, University of Oxford and Emily A. Holmes, MRC Cognition and Brain Sciences Unit, Cambridge

Vivid, sensory-perceptual (predominantly visual images), emotional of a traumatic event that intrude involuntarily into consciousness, herewith “flashbacks”, are a hallmark symptom of post-traumatic stress disorder (PTSD). However, why only some moments of a traumatic event return as a flashback remains unclear. We recently conducted two separate studies combining an analogue trauma, the trauma film paradigm, with neuroimaging. Results suggest differential brain activation at the time of viewing traumatic film scenes that induce flashbacks in comparison to scenes that do not. However, these analyses can not determine whether this activation is consistent enough for accurate prediction of a flashback. Machine learning overcomes this, highlighting key regions that are likely to be involved in flashback development. We therefore re-examined our previous results with a machine-learning approach. Algorithms were trained using a leave one out methodology on one of the datasets: first, within individual participants who experienced four or more flashbacks, with a pair of flashback/non-flashback events left out for each participant; and second, across participants, with one participant left out. The algorithm was then tested across participants on the separate dataset. Within participants, flashback prediction accuracy was close to 100%. Across participants, flashback prediction accuracy remained high but to a lesser extent. Analysis across participants in the separate dataset replicated this result. Results suggest that patterns of brain activation during flashback encoding are widespread and vary by individual. They also illustrate that it is possible to predict whether an individual will flashback to a particular scene. Understanding the neural basis of flashbacks may help develop preventative treatments against their formation.

Intrusive memories and fear conditionability: Investigation of their relationship using a novel conditioned-intrusion paradigm in women

Wegerer, M; Blechert, J; Kerschbaum, H; Wilhelm, F. H, Salzburg University, Austria

Intrusive memories constitute a hallmark symptom of posttraumatic stress disorder (PTSD) and are often triggered by stimuli possessing similarity with cues that predicted or accompanied the traumatic event. According to cognitive-behavioral accounts, intrusive memories can be seen as a conditioned responses to trauma reminders. However, direct laboratory evidence for the link between fear conditionability and intrusive memories is missing. Fear conditioning studies have predominantly relied on different kinds of basic aversive stimulation (e.g. electric stimulation) that bear little resemblance to typical traumatic events and are unlikely to generate the kind of complex memories that could later give rise to intrusive recollection. To investigate the general relationship between fear conditionability and intrusive memories, we tested 66 mentally healthy women in a novel conditioned-intrusion paradigm designed to model real-life traumatic experiences. The paradigm included a differential fear conditioning procedure with neutral sounds as conditioned stimuli and short violent film clips as unconditioned stimuli. Subsequent intrusive memories were assessed through a memory triggering task (in the laboratory) and ambulatory assessment (involuntary intrusive memories in the two days following the experiment). Skin conductance responses and subjective ratings demonstrated successful differential conditioning in our

film-based fear conditioning paradigm. Furthermore, intrusive memories were elicited in response to the conditioned stimuli during the memory triggering task and also occurred in the two days following the experiment. Importantly, participants who displayed higher conditionability showed more intrusive memories during the memory triggering task and during ambulatory assessment. This suggests that fear conditioning constitutes an important source of persistent intrusive memories. Further results of our study implicate a role of the female gonadal hormone estradiol in these processes. Implications for PTSD and the treatment of intrusive memories are discussed.

Understanding and treating disturbances in positive mood in mood disorders: From basic science to clinical intervention

Convenor: Barney Dunn, University of Exeter

The relationship between mindfulness and positive emotional experience.

Barney Dunn, Mood Disorders Centre, University of Exeter

Anhedonia – a loss of interest and pleasure – is a cardinal symptom of depression that predicts a poor prognosis and yet is relatively neglected in many existing gold standard psychological treatments (see Dunn, 2012). However, there is emerging interest in the idea that mindfulness based approaches may be effective at bolstering positive emotion experience in depression vulnerable individuals and that this may be associated with reduced relapse rates following meditation practice. This talk will present recent data from my laboratory evaluating this claim. First, data examining links between different facets of trait mindfulness, depression and positive emotion experience will be presented. Second, studies evaluating the impact of short- and longer- term meditation practice on positive emotion experience will be described. Third, studies in the laboratory that measure the impact on positive emotion experience of manipulating underlying mechanisms linked to mindfulness will be discussed. Clinical implications of weaving mindfulness based approaches into the targeted treatment of anhedonia will be considered.

The regulation of positive emotion in depression

Grace Fisher, Aliza Werner-Seidler & Barney Dunn, University of Exeter

While it is widely accepted that depression is associated with difficulty in regulating negative emotion, much less is known about how depressed individuals regulate positive emotion. It is plausible that depressed individuals make reduced use of regulation strategies that amplify positive emotion and greater use of regulation strategies that dampen positive emotion, and that this contributes to reductions in pleasure from everyday events (anhedonia). If this is the case, targeting these amplifying and dampening strategies in therapy may help resolve anhedonic symptoms. Three studies will be presented examining this hypothesis, measuring dampening and amplifying strategies with the Response to Positive Affect Scale (RPA; Feldman et al., 2008). Study One examines if the anhedonic symptoms of depression are cross-sectionally related to use of dampening and amplifying strategies in currently depressed and remitted depressed individuals. Study Two examines if instructing individuals to use dampening strategies reduces positive emotion experience and if instructing individuals to use amplifying strategies increase positive emotion experience during positive memory recall in an unselected sample. Study Three presents preliminary data examining if dampening and amplifying strategies longitudinally predict anhedonic symptoms.

Do wanting, liking and learning predict psychopathology in a community sample?

Henrietta Roberts, Mood Disorders Centre, University of Exeter; Barnaby Dunn, Natalia Lawrence, Henrietta Roberts, Nicholas Moberly, Kimberly Wright, and Mahmood Javaid, Mood Disorders Centre, University of Exeter, Adam Hampshire, Imperial College London, Jonathon Mill, University of Exeter Medical School, Gillian Baker, Exeter Clinical Research Facility.

Transdiagnostic investigations are a valuable means to identify underlying functional dimensions that cut across traditional diagnostic boundaries and can account for the considerable comorbidity amongst many psychological disorders. One such core dimension is the positive valence system (PVS), which regulates feelings of pleasure, motivation, and reward. Disturbances in the PVS have been found to be associated

with mood disorders and certain unhelpful lifestyle behaviours that are frequently co-morbid with them (for example overeating, alcohol or drug use). However, the extent to which disturbances in the PVS predict the onset and course of psychopathology has yet to be established. The present study examines the relationship between distinct aspects of PVS functioning and measures of psychopathology and unhelpful lifestyle behaviours in a community sample. Specifically, the associations between three critical components of reward sensitivity (wanting, liking, and learning) and mood disorder symptoms and the unhelpful consumption of food, alcohol, or drugs, are examined using an internet-based experimental research platform. The present research examines the temporal associations between these relationships in order to clarify whether PVS dysfunction might be an important causal mechanism underpinning psychopathology. Clarifying this issue is clinically important in improving understanding of which, if any, aspects of PVS functioning hold potential as areas to target in the treatment of mood disorders.

Person-tailored insights into positive affective experience in depressed patients: a RCT **Marieke Wichers, Maastrich University**

Previous studies showed that positive emotions in particular are important in preventing and recovering from depressive symptoms. New strategies -that can be easily implemented in mental health care- are needed focused at increasing positive emotional experience in individuals with depression.

A randomised controlled trial (RCTs; n=102) was conducted examining a new 6-week training which aimed to provide patients with insight into their real-life patterns of behaviour and positive emotional experience. This may help patients to learn in which contexts they will experience most positive emotions and adapt their behaviour accordingly. Ecologically valid real-life measurements of emotional experience, daily activities and situations were obtained using experience sampling techniques (ESM) over the course of the intervention period. In addition, a pseudo-intervention and a control intervention arm were included in the study.

Providing feedback on patients' measured levels of daily life positive emotions and the daily life contexts in which these were experienced was beneficial. The training was associated with a long-term (24 weeks) statistically and clinically significant reduction in depressive symptoms which was not the case in the other two intervention arms.

A new focus in therapy on positive emotions combined with person-tailored real-life information may help to combat depression.

Bringing positive imagery online: a randomized controlled trial of internet-delivered imagery cognitive bias modification in depression

Simon E. Blackwell, MRC Cognition and Brain Sciences Unit, Cambridge; Michael Browning, University of Oxford; Arnaud Pictet, University of Oxford; John R. Geddes, University of Oxford; Andrew Mathews, Institute of Psychiatry, King's College London and University of California, Davis; Emily A. Holmes, MRC Cognition and Brain Sciences Unit, Cambridge.

Depression is characterized not only by preferential processing for negative information, such as a negative interpretive bias, but also by deficits in positive information-processing. For example, depressed mood and major depression are associated with deficits in positive future imagery (Holmes et al., 2008; Morina et al. 2011), such that when people who are depressed think about the future, they may struggle to imagine anything other than negative events lying ahead. Such cognitive biases may be amenable to change via simple computerized training, known as cognitive bias modification (CBM), and there is preliminary evidence that one week of a CBM program targeting positive imagery and interpretation delivered via computer can lead to significant reductions in symptoms of depression (Blackwell & Holmes, 2010; Lang et al., 2012; Williams et al., 2013; Torkan et al., in press). In the current randomized controlled trial, 150 participants with current depression were randomized to either a 4-week imagery CBM intervention or a closely-matched control condition, completed at home via the internet. Participants were assessed at pre and post-treatment, and then 1, 3 and 6-month follow-up. The trial is discussed in relation to its part in the clinical translational process of developing novel cognitive interventions for depression.

New developments in Intolerance of Uncertainty - Part 1: Children, young people, and development

Convenor: Mark Freeston, Newcastle University

A randomized controlled trial of cognitive therapy for Generalized Anxiety Disorder in youth: The role of intolerance of uncertainty in symptom change.

Sean Perrin, University of Lund, Sweeden and King's College London; Denise Bevan, South London and Maudsley NHS Foundation Trust; Susanna Payne, South London and Maudsley NHS Foundation Trust; Derek Bolton, King's College London

Generalized Anxiety Disorder (GAD) is among the most commonly occurring anxiety disorders among youth referred for treatment of anxiety. Cognitive Behavioural Therapy (CBT) designed to improve coping skills and to encourage exposure to fear eliciting-situations/thoughts has proven effective for children and adolescents who have multiple anxiety disorders including GAD. However very little data is available for the effectiveness of CBT for GAD specifically in youth. The present study extends previous work testing a theoretical model that specifies four cognitive processes (Intolerance of Uncertainty, Cognitive Avoidance, Negative Problem Orientation, and Positive Beliefs About Worries) as relevant to the development and maintenance of excessive worry and anxiety - and by extension GAD. This is the first randomized controlled trial to date to test the effectiveness of a disorder-specific treatment for GAD in youth and the first to report treatment outcome for CBT in children with a primary diagnosis of GAD. In the present RCT, 40 children (aged 10-18 years) with a primary diagnosis of GAD, and who were seeking treatment for anxiety from child and adolescent mental health services across South London, were randomized to either 10 weeks of individual cognitive therapy or 10 weeks of a supported wait-list. Treatment targeted the four cognitive processes involved in worry and GAD (as above) through a combination of cognitive restructuring, imaginal and in vivo exposure exercises. Participants were not given any training in arousal reduction or other traditional coping skills. Parental involvement was limited with no formal parent training in management of their child's anxiety. Results indicate that treatment participants experienced significant and marked reductions not only in their primary diagnosis of GAD but in their comorbid (untreated) anxiety disorders (as measured by blind raters at post-treatment and 3-month follow-up). Significant and marked reductions in worry, anxiety, and depression as measured by child and parent-report were also observed. No improvement was observed in the wait-list group. Planned mediation analyses strongly suggest that clinical improvement in the treated group was mediated by changes in intolerance of uncertainty and cognitive avoidance in partial support of the theoretical model. The implications of this trial for future research on GAD and other anxiety disorders in children will be discussed.

Intolerance of Uncertainty as a Framework for Understanding Anxiety in Children and Adolescents with Autism Spectrum Disorders

Christina Boulter, Newcastle University and NTW NHS Trust Jacqui Rodgers, Newcastle University; Mickle South, Brigham Young University; Mark Freeston, Newcastle University and NTW NHS Trust

Anxiety is a problem for many children diagnosed with Autism Spectrum Disorders (ASDs) with up to 40% showing clinically significant levels. There is a paucity of models of the cognitive processes underlying this. Intolerance of Uncertainty (IU) has utility in explaining anxiety in neurotypical populations but has only recently received attention in ASD. We sought first to replicate previous findings of higher levels of anxiety in children with ASD. Second, we sought to replicate the relationship between IU and anxiety in TD children and adolescents, establish whether this relationship is also in evidence in children with ASD, and to compare the relationship between IU and anxiety in the ASD and TD samples.

We modelled the relationship between anxiety and IU in ASD (N = 119) and a typically developing comparison group (N = 110). The groups were matched on age and IQ. IU and anxiety were measured with parent and child self-report versions of IU (IUS-12) and anxiety (Spence Child Anxiety Scale: Spence, 1998; Spence, Barrett & Turner, 2003.).

Results showed significantly higher levels of anxiety in the ASD group, similar positive relationships between IU and anxiety in both groups, and no difference between the relationships. Using a causal steps approach, results were consistent with a causal model suggesting that IU mediates the relationship

between ASD and anxiety so that differences in IU can account for the differences in anxiety between the groups.

The findings confirm IU as a relevant construct in ASD and that the relationship between IU and anxiety in children with ASD appears to function similarly in children with and without ASD. This study opens the way for identifying an appropriate model of anxiety which is relevant to individuals with ASD. In doing so we need to consider the contribution of a range of autism related characteristics to the presence of anxiety, including ASD characteristics as well as the significant social and environmental challenges faced by young people with ASD, including loneliness, peer rejection and bullying. Our proposal is that IU may have a key role within this model and tentatively propose an integrated cognitive model of anxiety for ASD for further evaluation and refinement.

Coping with Uncertainty in Everyday Situations (CUES): a parent based group intervention for children with Autism Spectrum Disorder

Jacqui Rodgers, Newcastle University Anna Hodgson, Newcastle University; Mark Freeston, Newcastle University/NTW NHS Trust; Emma Honey, Newcastle University/NTW NHS Trust

Anxiety is a significant problem for many individuals with an Autism Spectrum Disorder (ASD). For some children with ASD anxiety includes intolerance of uncertainty (IU). Advances have been made in the development of interventions to tackle anxiety in ASD. However none of these interventions focus specifically on IU. This study evaluated the acceptability and feasibility of a novel parent group based intervention targeting IU for young people with ASD (CUES: Coping with Anxiety in Everyday Situations). 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 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 acceptability and feasibility, attendance and drop-out were also recorded.

These findings indicate that parents of young people with ASD view an intervention which focusses on intolerance of uncertainty to be 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 responses to uncertainty. Implications for future research and further development of the package will be considered.

The Role of Childhood Attachment and Behavioural Inhibition in Predicting Intolerance of Uncertainty in Adulthood

Magdalena Zdebik, Université du Québec à Montréal; Ellen Moss, Université du Québec à Montréal; Jean-François Bureau, Université du Québec à Montréal

Anxiety disorders are both extremely prevalent and debilitating psychopathologies. Insecure childhood attachment is proposed as a risk factor for generalized anxiety disorder because it may promote the development of intolerance of uncertainty, the tendency to react negatively to uncertain situations. Similarly, child temperament, particularly behavioural inhibition, characterized by fearful reactions to the unfamiliar, has consistently been identified as a risk factor for anxiety disorders; however, it has not been examined in relation to intolerance of uncertainty. The present study longitudinally tested the predictive effects of childhood attachment and behavioural inhibition on the development of intolerance of uncertainty in young adulthood. Sixty children were observed in a separation-reunion procedure at age 6 and classified as either having a 'secure', 'avoidant', 'ambivalent', 'disorganized controlling' or 'behaviourally disorganized' attachment to their caregiver. Behavioural inhibition was also assessed with an observational measure at age 6, while maternal anxiety was assessed with the Symptoms Checklist 90-Revised (Derogatis, 1994) when the children were 14 years old. Neuroticism and intolerance of uncertainty were measured when participants were 21 years old using the Revised NEO Personality Inventory (Costa & McCrae, 1992) and the Intolerance of Uncertainty scale short form (Carleton, Norton & Asmundson, 2007) respectively. Childhood attachment and behavioural inhibition independently predicted intolerance of uncertainty in adults, a finding that remained after controlling for maternal anxiety and neuroticism. High intolerance to uncertainty was associated with ambivalent and disorganized controlling attachment and high behavioural inhibition. This study is the first to empirically confirm a link between both ambivalent and disorganized controlling attachment patterns, as well as

behavioural inhibition, in children to the development of intolerance of uncertainty in adulthood 15 years later. Thus these results have not only aetiological and preventative implications for generalized anxiety disorder but also for other disorders related to intolerance of uncertainty. Moreover, they underline the need for both individual and family based early interventions.

New Directions in Attentional Bias Research

Convenor: Ernst Koster, Ghent University, Belgium

Attention Feedback Awareness and Control Training (A-FACT): Experimental test of a novel intervention paradigm targeting attentional bias

Amit Bernstein, University of Haifa, Israel

We present an experimental investigation of a novel intervention paradigm targeting attentional bias – Attention Feedback Awareness and Control Training (A-FACT). A-FACT is grounded in the hypothesis that training awareness of (biased) attentional allocation will lead to greater self-regulatory control of attention and thereby ameliorate attentional bias and its maladaptive sequelae. To do so, A-FACT delivers computerized, personalized, real-time feedback regarding a person's (biased) allocation of attention concurrent with its expression. In a randomized control experimental design, we tested A-FACT relative to an active placebo control condition among anxious adults (N = 40, 52.5% women, M(SD) = 24.3(4) years old). We found that relative to the placebo control condition, A-FACT led to: (a) reduced levels of attentional bias to threat; (b) (non-significantly) lower rates of behavioral avoidance of exposure to an anxiogenic stressor; and (c) greater rates of emotional recovery following the stressor. The approach and findings will be discussed with respect to their potential implications for basic and clinical research.

The Effect of Sad Mood on Engagement and Disengagement of Angry Faces

Lonneke van Tuijl, University of Groningen, The Netherlands

The mood-congruency effect in attentional bias has often been used to refer to congruency between attentional processes and stimuli that relate to the mood disorder of a given clinical population. However, what remains relatively less clear is the role of mood states on attentional bias. In the present study, undergraduate students (n= 105) completed a visual dot-probe task following a negative mood induction. In order to highlight potential test-retest effects, only half of the participants completed a baseline measure of the dot-probe task. It is hypothesized that attentional bias measured during sad mood exacerbates the relationship between attentional bias scores and symptoms of depression. This may highlight that an attentional bias is a vulnerability factor particularly when participants are in a sad mood. However, it remains unknown as to whether a sad mood has equal effects on both the engagement and disengagement of angry faces.

New directions in Attentional bias modification

Ernst Koster, Ghent University, Belgium

Extensive evidence shows that depression and anxiety disorders place a large burden on individuals and are an important challenge for mental health providers. Cognitive factors play a crucial role in the etiology and maintenance of these disorders which has given rise to the successful development of cognitive therapy. Cognitive bias modification (CBM) has been presented as a usual technique to improve cognitive processes such as attention and memory. Yet so far clinical results have been mixed. I will argue that current application of CBM could be improved through combining CBM with cognitive case conceptualization.

Cognitive case conceptualization - where an individual's automatic thoughts are identified and related to core beliefs - is a crucial part of conducting cognitive therapy in identifying targets for therapeutic interventions. Despite remarkable progress in our understanding of cognitive processes involved in affective disorders, cognitive case conceptualization in clinical practice is not informed by recent insights in CBM and vice versa. As cognitive case conceptualization is an important part of cognitive (behavioral) therapy I will propose new ways in which therapy can be informed by cognitive science. I will argue that

an integration of cognitive case conceptualization and cognitive science at an individual level is feasible in order to facilitate treatment of affective disorders.

Cognitive Mechanisms in Anxiety and Somatic Complaints

How does exposure work? The role of overprediction of fear and underprediction of coping

Anouk Vanden Bogaerde, Ghent University; Rudi De Raedt, Ghent University

Exposure has been shown to be the most effective treatment intervention for phobias (Merkelbach, 1996), while its specific mechanisms remain unclear. Central to fear and phobias are the overestimation of fear and the underestimation of coping (Rachman, 1994). In line with Rachman's Match/Mismatch model, the current study investigates whether correcting the overestimation of expected fear and underestimation of coping could be essential to exposure treatment for flight phobia.

The current sample consists of 54 individuals with flight phobia who took part in a two-day CBT program with two exposure flights as the core component. Before both and after both flights participants indicated their expected and actual levels of fear and coping.

Most participants overpredicted their level of fear and underpredicted their coping. An initial overprediction of fear led to a decrease in predicted fear for the second flight. Conversely, an initial underprediction of coping was followed by an increase in predicted coping. Interestingly, only the adjustment in coping predictions were associated with treatment outcome.

The findings of the current study are mostly in line with the Match/Mismatch model of fear. However, a reduction of fear during exposure happened independent of the predictions made. The adjustment in coping predictions, however, was related to fear reduction during exposure: the more accurate participants became in predicting their coping, the larger the decrease in fear during exposure.

Based on these results, the reappraisal of coping skills during exposure seems to be a key ingredient for an effective exposure.

Catastrophizing misinterpretations of physical symptoms are predictive of new onsets of somatoform disorder: a potential target for early cognitive intervention?

Marcella Woud, Ruhr University Bochum; Xiao Chi Zhang, Ruhr University Bochum; Eni Becker, Behavioural Science Institute, Radboud University Nijmegen; Jürgen Margraf, Ruhr University Bochum

Somatoform disorders are characterized by multiple and reoccurring symptoms that resemble physical illness but defy physiological explanation. Cognitive models of the disorders suggest that catastrophizing misinterpretations of harmless physical symptoms play a key role. For example, patients suffering from a somatoform disorder may interpret (harmless) physical symptoms as a sign of a severe illness. If such misinterpretations contribute to the development of somatoform disorders then they may offer a target for early intervention. However, this developmental role had yet to be investigated.

In the present study we tested whether catastrophizing misinterpretations are in fact predictive of new onsets of somatoform disorders using a longitudinal design. We used data from the Dresden Prediction Study, in which an epidemiological sample of young German women was tested at two time points approximately 17 months apart. Assessments included a diagnostic interview, an interpretation questionnaire for somatoform disorders and hypochondria, a measure of hypochondria symptoms (Whiteley Index), the somatoform scale of the Symptom Checklist – 90 (SCL-90) and the Body Sensation Questionnaire (BSQ).

Results of single as well multiple regressions showed that catastrophizing misinterpretations of physical symptoms predicted new onsets of somatoform disorder approximately 17 months later. Moreover, analyses also revealed predictive validity for the Whiteley Index and the somatoform scale of the SCL-90. This is the first prospective study demonstrating the incremental validity of catastrophizing misinterpretations as a predictor of somatoform disorder. These results not only emphasize the need for early identification of at-risk individuals, but also suggest a potential target for preventative cognitive interventions.

The present findings provide a strong rationale for early interventions to prevent development of somatoform disorders. Hence, clinical practice could focus on the screening and identification of

potentially vulnerable individuals, and if the bias does in fact play a causal role, may offer a target for focused preventative cognitive interventions.

Brief biopsychosocial treatment for non-cardiac chest pain: a pilot evaluation of a stepped-care approach

Elizabeth Marks, University College London Hospitals; Elizabeth Chambers, University College London Hospitals; John Chambers, Guy's & St Thomas' NHS Foundation Trust; Victoria Russell, Guy's & St Thomas' NHS Foundation Trust; Myra Hunter, Institute of Psychiatry, King's College London
Non-cardiac chest pain (NCCP) affects up to 80% of patients attending chest pain clinics. Treatment of NCCP is suboptimal. This study describes the outcomes of a pilot, stepped-care, biopsychosocial management programme.

All patients received a biopsychosocial assessment and were offered stepped care (assessment only, low intensity Cognitive Behaviour Therapy (CBT), or high intensity CBT). The primary outcomes were chest pain frequency and pain interference scores at 3 months.

The new approach will be described and preliminary results reported on the 77 patients who completed the intervention. The proportion of patients with pain occurring more than once a month fell from 100% at baseline to 61% at 3 months ($p < 0.001$). Pain interference reduced significantly, as did scores on measures of psychological well-being and quality of life. Improvements were maintained or improved upon by the 6-month follow-up.

A stepped-care biopsychosocial approach to NCCP is effective in reducing chest pain frequency and improving behaviour and wellbeing. By involving cardiac nurses in the delivery of treatment, this approach can be integrated into any chest pain clinic

The preliminary findings suggest that CBT is an effective treatment for Non-Cardiac Chest Pain, and that it can be delivered using a stepped-care approach, integrated into any chest pain clinic.

Behavioural experiments in the treatment of intolerance of uncertainty

Elizabeth A. Hebert, Concordia University; Michel J. Dugas, Concordia University, Université du Québec en Outaouais, Hôpital du Sacré-Coeur de Montréal; Isabelle Geninet, Hôpital du Sacré-Coeur de Montréal; Julie Turcotte, Hôpital du Sacré-Coeur de Montréal; Pierre Savard, Hôpital du Sacré-Coeur de Montréal; Thu-Van Dao, Hôpital du Sacré-Coeur de Montréal

Generalized anxiety disorder (GAD) is characterized by excessive and uncontrollable worry, anxiety, and somatic symptoms (DSM-5, American Psychiatric Association, 2013). Several cognitive-behavioural treatment (CBT) protocols have been developed for GAD, including one centered upon intolerance of uncertainty (IU). IU is a dispositional characteristic that arises from a set of negative beliefs about uncertainty and its consequences (Dugas & Robichaud, 2007). Although this CBT-IU protocol has demonstrated impressive efficacy across four randomized clinical trials, 20-30% of participants do not attain diagnostic remission by post-treatment. Many individuals who do not achieve remission of GAD continue to endorse elevated levels of IU, suggesting that the current CBT protocol does not effectively reduce IU in some treated individuals. Established CBT protocols for GAD are also complex, utilizing multiple cognitive and behavioural techniques, and typically take between 12-16 sessions to administer. Recently, some authors (e.g., Cogle et al., 2011) have suggested that there is increased need for parsimony and efficiency in CBT protocols.

In an effort to streamline and strengthen GAD treatment, we have developed a new CBT protocol targeting IU directly and exclusively via behavioural experiments. Behavioural experiments are an efficacious way to target the emotional, cognitive, and behavioural components of anxiety disorders and may be superior to habituation-based exposure paradigms (McMillan & Lee, 2010; Salkovskis et al., 2007).

We will present preliminary data from an ongoing clinical case replication series (N = 5) testing the pre- to posttreatment efficacy of this newly developed CBT protocol.

The findings and clinical implications will be discussed.

Cognitive therapy for people with psychosis who choose not to take antipsychotics: Findings from a randomised controlled trial

Convenor: Tony Morrison, University of Manchester

Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic medication: A randomised controlled trial

Tony Morrison, University of Manchester

Our trial aimed to determine whether cognitive therapy (CT) is effective in reducing psychiatric symptoms experienced by people with schizophrenia spectrum disorders that have chosen not to take antipsychotic medication. We conducted a two-site single-blind randomised controlled trial comparing CT plus treatment as usual (TAU) with TAU only. Participants were followed-up for a minimum of 9 and a maximum of 18 months. 74 participants with schizophrenia spectrum disorders who had chosen not to take antipsychotic medication psychosis (aged 16-65 years; mean 31.47; SD 12.27) were recruited. 37 were assigned to CT and 37 to TAU. Our primary outcome was the Positive and Negative Syndrome Scale (PANSS) total score, which provides a continuous measure of psychiatric symptoms associated with schizophrenia spectrum disorders on the basis of a commonly used structured psychiatric interview. Changes in outcomes were analysed following the intention-to-treat principle, using random effects regression (a repeated-measures ANCOVA) adjusted for site, age, gender and baseline symptoms. Psychiatric symptoms were significantly reduced in the group assigned to CT, in comparison with TAU, with an estimated between-group effect size of -6.52 (95% CI -10.79 to -2.25, $p = 0.003$). CT significantly reduced psychiatric symptoms and appears safe and acceptable in people with schizophrenia spectrum disorders who have chosen not to take antipsychotic medication. The results have important implications for the provision of mental health services for people with schizophrenia spectrum disorders.

Components of therapy as mechanisms of change in cognitive therapy for people with psychosis who choose not to take antipsychotics

Helen Spencer and Douglas Turkington, University of Newcastle

In the ACTION trial of CBT vs. TAU for patients with a schizophrenia spectrum disorder who choose not to take antipsychotic medication, all therapists completed a template for each session to record the main therapeutic components. These included normalising, development of a case formulation, completion of homework tasks, behavioural experiments, metacognitive techniques and belief change strategies. A mediational analysis was performed to identify those CBT techniques that were associated with good clinical outcomes. The findings will be presented in this presentation.

Suicide risk factors in people who choose not to take antipsychotics: findings from the ACTION trial

Paul Hutton, University of Edinburgh

Almost 1 in 20 people who receive a diagnosis of schizophrenia will commit suicide (lifetime risk; 4.9%) ([Palmer et al., 2005](#)). A systematic review and meta-analysis in 2005 suggested that several factors linked to increased suicide risk in the general population are also important in psychosis ([Hawton et al., 2005](#)). Psychosis-specific risk factors included fear of mental disintegration, agitation, restlessness and suspiciousness. However there is little data on suicide risk factors in those refusing antipsychotic treatment. Although large-scale epidemiological studies have found an association between not taking antipsychotics and increased mortality through suicide, it is unclear whether the increased risk and non-use of antipsychotics were attributable to a third variable, such as increased illness severity or disengagement from services. We will present data from the ACTION cohort, taking the opportunity to see whether the risk factors identified through previous research are also important in relation to those who have not taken antipsychotics for at least 6 months, yet wish to engage in psychological therapy.

Internalised stereotypes of psychosis, emotional dysfunction and the effects of cognitive therapy on internalised stigma in people with psychosis not taking antipsychotic medication

Melissa Pyle, Greater Manchester West Mental Health NHS Foundation Trust

This study explores internalised stereotypes in people with psychosis who are not taking antipsychotic medication and tests for possible relationships between internalised stereotypes and emotional dysfunction. Data from sixty-six participants who participated in the Assessment of Cognitive Therapy Instead of Neuroleptics (ACTION) Trial and who completed measures of internalised stereotypes and emotion at baseline and three month assessment was analysed. Cross section and longitudinal data was

used to test for relationships between internalised stereotypes, emotional dysfunction and insight at baseline and three months. Levels of internalised stereotypes and clinical insight were compared at baseline between participants with psychological or other causal model of their psychotic experiences. Greater levels of internalised stereotypes of psychosis were associated with depression and social anxiety at baseline and internalised stereotypes contributed to the variance in depression over time. At baseline those with social anxiety had significantly greater levels of stigma. Participants who reported a psychological causal model for their psychotic experiences had significantly lower levels of stigma. Findings support a stigma model of emotional dysfunction in people with psychosis replicating previous findings in an anti-psychotic medication free group. Further research is required to demonstrate effective interventions for internalised stigma in those with psychosis to prevent further psychological difficulties. The effects of Cognitive Behavioural Therapy on internalised stigma in this group will also be presented.

A qualitative study of participants' experiences of CBT in the ACTION trial Rory Byrne, Greater Manchester West Mental Health NHS Foundation Trust

A recent randomised controlled trial ('ACTION') evaluated the effectiveness of Cognitive Behavioural Therapy (CBT) for reducing psychiatric symptoms associated with schizophrenia spectrum disorders among people not taking antipsychotic medication. The present study is a qualitative exploration of subjective experiences of CBT among a sample of those randomised to the treatment condition of the trial. This study aimed to explore subjective experiences of CBT in order to identify commonly valued elements of CBT experience, difficult or negative experiences of CBT, and participant-defined outcomes of therapy. Individual semi-structured interviews were conducted with ten individuals who had undertaken CBT in the ACTION trial. Participants' mean age was 37.2; five participants were female and five male; six participants identified as white British, one as black African, one Chinese British, one white and black African, one white and Asian. Interviews lasted between 40 and 100 minutes, and were analysed using Thematic Analysis. Findings drawn from analysis of interviews include the following thematic areas: engagement; CBT practice; challenges and negative experiences; outcomes and recovery. Further sub-thematic findings will be discussed, along with suggested conclusions and clinical implications.

Intrusive Memories in PTSD: Formation, Prevention, and Treatment Part II: Prevention and Treatment Strategies for Intrusive Imagery After Traumatic Experiences

Convenor: Tanja Michael, Saarland University, Germany

Developing Preventative Strategies to Reduce Flashback Development Following Psychological Trauma: From Memory Consolidation to Reconsolidation

Ella L. James, MRC Cognition and Brain Sciences Unit, Cambridge; Catherine Deeprise, MRC Cognition and Brain Sciences Unit, Cambridge; Thomas Coode-Bate, MRC Cognition and Brain Sciences Unit, Cambridge; Emma J. Kilford, MRC Cognition and Brain Sciences Unit, Cambridge; Elizabeth Tunbridge, MRC Cognition and Brain Sciences Unit, Cambridge; John R. Geddes, MRC Cognition and Brain Sciences Unit, Cambridge; Laura Hoppitt, MRC Cognition and Brain Sciences Unit, Cambridge & Emily A. Holmes, MRC Cognition and Brain Sciences Unit, Cambridge

Haunting memories of a traumatic event in the form of intrusive mental imagery (e.g. flashbacks) are a hallmark symptom of posttraumatic stress disorder (PTSD).

Newly acquired memories for an event are transiently labile before becoming increasingly resistant to interference over time, a process termed consolidation. During this time period it has been demonstrated that flashback memories can be modified; for example, by completing specific cognitive tasks which compete with the resources necessary for the flashbacks to develop [1, 2]. More recently, studies of human memory have found that the recall of a stabilised, consolidated memory may 'reactivate' that specific memory rendering it once again transiently labile and vulnerable to modification. This process, referred to as memory reconsolidation, may offer a window of opportunity for novel treatment interventions that can be administered following a longer period subsequent to experiencing a traumatic event.

We present a summary of the literature on memory reactivation and subsequent reconsolidation and discuss how this may be able to inform early stage design treatment innovations. We briefly look at the effect of competing tasks on flashback memory development during the memory consolidation phase, i.e. within 6 hours of an analogue traumatic event [1, 2] as well as during the memory *re*consolidation phase when memory for an event has stabilised, i.e. at 24 hours following a (analogue) trauma.

Can cognitive science research on imagery help women traumatized by an emergency cesarean section?

Antje Horsch, University of Lausanne; Patrick Hohlfeld, University of Lausanne; Mathilde Morisod-Harari, University of Lausanne; Emily Holmes, MRC Cognition & Brain Sciences Unit, Cambridge
Prevalence rates of posttraumatic stress disorder (PTSD) are higher after emergency cesarean section than other modes of delivery (Ayers, 2004). For example, a ‘flashback’ might include intrusive visual images to the moment when the baby might have died (Horsch, 2009). Focusing on the psychological impact of postnatal PTSD is important because such problems not only impact on the well-being of the woman and her partner, but may also significantly interfere with the attachment relationships with the baby, potentially leading to severe and long-term consequences for the development of the child. Although there are evidence-based psychological treatments available to treat PTSD in the adult population, these are only recommended to start after at least one month has passed following the traumatic event. To date, no evidence-based early intervention to *prevent* the development of postnatal PTSD has been published. At the heart of PTSD are distressing flashbacks, nightmares, and intrusive images/thoughts in which the person re-experiences aspects of the traumatic event. Cognitive science studies in analogue populations by Holmes and colleagues (2009, 2010) have demonstrated that a visuospatial task, such as playing the computer game Tetris, can significantly reduce the frequency of traumatic intrusive images (analogue flashbacks) following the experimental exposure to traumatic film material. To date, these findings have not been translated into clinical practice. A pilot study investigating the effectiveness and acceptability of a cognitive task for the prevention of traumatic intrusions in women following emergency caesarean section and will be presented. Clinical implications will be discussed.

Effects of acute cortisol administration on perceptual priming of trauma-related material **Elena Holz, Saarland University, Germany;** Johanna Lass-Hennemann, Saarland University, Germany; Markus Streb, Saarland University, Germany & Tanja Michael, Saarland University, Germany

Intrusive memories are the hallmark symptom of posttraumatic stress disorder (PTSD). PTSD is often associated with low cortisol levels. Acute elevations of cortisol are known to impair the retrieval of already stored memory information. Thus, cortisol administration might help in reducing intrusive memories. Strong perceptual priming for neutral stimuli associated with a traumatic context has been shown to be one important learning mechanism that leads to intrusive memories. However, the memory modulating effects of cortisol have only been shown for explicit declarative memory processes. In our study we aimed to examine whether cortisol influences perceptual priming of neutral stimuli appearing in a traumatic context. Healthy volunteers (N = 160) watched either neutral or “traumatic” picture stories. Neutral objects were presented in between the pictures. Memory for these neutral objects was tested on the next day with a perceptual priming task. Prior to it half of the participants in each group received 25 mg of cortisol, the other half received placebo. Participants in the traumatic stories/placebo condition showed more perceptual priming for the neutral objects than participants in the neutral stories/placebo condition. In the cortisol-condition this effect was not present: Participants in the neutral stories/cortisol condition and participants in the traumatic stories/cortisol condition showed about the same amount of priming for the neutral objects. These findings indicate that cortisol also influences PTSD-relevant memory processes and thus further support the idea that administration of cortisol might be an effective treatment strategy in reducing intrusive reexperiencing.

An experimental study of the effects of stimulus discrimination training on intrusive memories

Jennifer Wild, University of Oxford; Maia Byrne, University of Oxford; Anke Ehlers, University of Oxford

Trauma-focused cognitive therapy for PTSD is recommended for the treatment of PTSD and includes stimulus discrimination, a technique that targets intrusive memories. Little is known about the relative effectiveness of stimulus discrimination on reducing intrusive memories in comparison to what people may normally do when they experience unwanted memories linked to trauma. This study compares stimulus discrimination to thought suppression, a commonly used strategy after trauma, and also to a control condition to investigate whether the technique could be used to reduce the number of intrusions that people may experience after trauma. Healthy volunteers ($N = 68$) watched a series of 7 distressing films known to induce intrusive memories in the subsequent week. They were then randomly allocated to: stimulus discrimination, thought suppression, or a control training procedure. Participants were required to apply their training whenever they had an intrusive memory and to record any intrusive memories in an online diary in the week following the films. Participants trained to respond to intrusive memories with stimulus discrimination experienced significantly fewer intrusive memories compared to participants who were trained in thought suppression or in the control procedure. They also employed fewer maladaptive coping strategies in response to their unwanted memories. Contrary to prediction, there were no differences on a post-trauma measure of PTSD severity at one-week follow-up. This study is the first to demonstrate that a specific cognitive technique derived from cognitive therapy for PTSD (i.e., Ehlers & Clark, 2000) can reduce the frequency of intrusive memories following exposure to analogue trauma. The results are discussed in terms of their implications for developing early interventions for at-risk occupational groups regularly exposed to trauma.

New developments in Intolerance of Uncertainty - Part II: Processes and applications among adults

Convenor: Mark Freeston, Newcastle University and NTW NHS Trust

A Closer Look at the Construct of Intolerance of Uncertainty and Its Relation with Generalized Anxiety Disorder

Naomi Koerner, Ryerson University; Teresa Mejia, Ryerson University; Andrea Kusec, Ryerson University

A number of studies have examined the association of intolerance of uncertainty to worry and generalized anxiety disorder (GAD). However, few studies have examined the extent of overlap between IU and other psychological constructs that bear conceptual resemblance to IU. The present study examined (1) the associations of IU and GAD diagnostic status to a negative risk orientation, low trait curiosity, high trait indecisiveness, low perceived control, perfectionism, intolerance of ambiguity, the need for predictability, and the need for order and structure and (2) the degree to which IU predicts GAD status over and above these individual difference constructs. $N = 205$ adults completed self-report measures of the aforementioned constructs. Each of the constructs was significantly associated with IU, but only IU, indecisiveness, self-oriented perfectionism, socially-prescribed perfectionism, perceived constraints and the need for order and structure distinguished people with probable GAD from people without GAD.

When IU was entered in the first step of a logistic regression, the addition of the other uncertainty-relevant constructs did not make a significant contribution to the prediction of the presence or absence of GAD. However, when these other uncertainty-relevant constructs were entered in the first step, the addition of IU to the equation did result in a significant improvement in the prediction of GAD status. Finally, IU was the sole unique predictor of the presence of GAD when accounting for statistical overlap with the other uncertainty-relevant constructs. Theoretical implications of the findings are discussed, in particular as they pertain to ongoing discussions regarding the definition and meaning of "intolerance of uncertainty".

Testing the psychometric and conceptual validity of the IUM in the Italian context: preliminary findings

Gioia Bottesi, University of Padova, Italy; Ilaria De Dominicis, University of Padova; Samantha Man, Northumberland, Tyne and Wear NHS Foundation Trust; Caterina Novara, University of Padova; Mark Freeston, Newcastle University and NTW NHS Trust

In Italy the one-year prevalence of Generalized Anxiety Disorder (GAD) is 0.5% and its lifetime prevalence is 1.9%; furthermore, many people do not meet the diagnostic criteria for GAD but experience worries in a subclinical form.

The Intolerance of Uncertainty Model (IUM) is one of the most experimentally and clinically validated theoretical approaches targeting GAD. According to the IUM, four main components are associated with the development and maintenance of worry: Intolerance of Uncertainty (IU), Negative Problem Orientation (NPO), Positive Beliefs about Worry (PBW) and Cognitive Avoidance (CA). Several randomized control trials have demonstrated the effectiveness of therapeutic interventions based on the IUM in reducing GAD symptoms. Nonetheless, such a theoretical framework is not so well established in Italian clinical practice and to date worry and anxiety symptoms are managed through the implementation of traditional and more generic theoretical models of anxiety.

The main aim of the present study was to provide preliminary validation of the IUM in the Italian context, by testing both the psychometric and conceptual validity of the model. One hundred and eighty-five undergraduate students (58.9% males) aged between 19 and 29 ($M=21.94$; $SD=1.87$) attending Psychology and Engineering courses were recruited. They completed the following self report measures, administered in a rotated sequence to control for order effects: Intolerance of Uncertainty Scale-12 (IUS-12), Why Worry III (WW-III), Revised Cognitive Avoidance Questionnaire (R-CAQ), Negative Problem Orientation Questionnaire (NPOQ), Penn State Worry Questionnaire (PSWQ). Except for the PSWQ these self-report measures had not previously been validated in Italian so a forward-back translation procedure was employed. To assess the psychometric properties of the questionnaires internal consistency, correlations between measures and gender differences were tested. Then moderated mediation analysis was performed to assess the construct validity of the model.

The four self-report measures preliminary showed good psychometric properties: analyses revealed high internal consistency ($0.77 < \alpha < 0.94$), small-medium range correlations between constructs ($0.15 < r < 0.47$), and absence of gender differences. Mediation analysis revealed that NPO and PBW, but not CA, mediate the association between IU and worry. Moreover, moderated mediation analysis showed that IU moderates the effects of the indirect path through NPO and PBW on worry.

These preliminary findings are the first to support the validity of the model in an Italian sample. Future studies aiming to validate such measures in the Italian context (e.g. community and clinical samples) are needed. Furthermore, present results also support the conceptual validity of the IUM and are in line with those previously found by Bottesi et al. (2012) among British undergraduates. The moderated mediation analysis highlights a specific mediational role played by NPO, PBW and CA in the path between IU and worry and it suggest that IU also acts as a moderator, thus outlining the key role played by current levels of IU on the degree of reported worry.

The Intolerable Uncertainty of Anxiety

Nicholas Carleton, University of Regina, Canada

Intolerance of uncertainty (IU) – a dispositional characteristic resulting from negative beliefs about uncertainty and its implications – began as a key area of study for patients experiencing generalized anxiety disorder; however, developments in the measurement of the construct have supported a surge in studies exploring the relationship between IU and several anxiety and related disorders. Most anxiety disorder models have implicitly included IU, but only recently have researchers focused specifically on whether the IU construct is broadly associated with anxiety. To date, the results have indeed supported IU as a broad transdiagnostic construct associated with generalized anxiety disorder, obsessive compulsive disorder, social anxiety disorder, panic disorder, posttraumatic stress disorder, and depression. Successful IU-specific treatments employed in prospective studies have provided initial evidence for IU as a causal or maintaining mechanism for several anxiety and related disorders. Furthermore, there is now evidence of a generalized neurobiological relationship between IU and anxiety that supports preliminary biological and evolutionary postulates involving uncertainty. The current presentation will present and synthesize the current transdiagnostic IU research, offer a coherent but

generalized model for the contribution of IU to other disorders, contextualize IU within the broader domain of current research, and provide specific directions for future research.

A little more certain about what intolerance of uncertainty really means? Intolerance of uncertainty in everyday life

Mark Freeston, Newcastle University, NTW NHS Foundation Trust; Ravi Sankar, Newcastle University; NTW NHS Foundation Trust; Sophie Sultana, Newcastle University; NTW NHS Foundation Trust; Emma Honey, Newcastle University; NTW NHS Foundation Trust; Claire Lomax, University of Bath; Kevin Meares, NTW NHS Foundation Trust

After 20 years of research with the Intolerance of Uncertainty Scale there is convincing evidence of the role of IU in GAD, increasing evidence of its role in other anxiety disorders and depression, and intriguing extensions into health anxiety, eating disorders and psychosis, and the first studies have now emerged linking IU to Autism Spectrum disorders. Most of these studies establish relationships between IU and symptom measures. However, we know relatively little about how IU manifests in everyday life. This presentation summarizes some initial findings from our ongoing research programme that seeks to elucidate how IU affects appraisals of situations, decision making and patterns of behaviour. In particular we are interested in the following questions: Do people who report being intolerant of uncertainty show narrow/situation-specific intolerance or do they show broad generalized IU across domains? What are the typical repertoires of behaviours that people who are high in IU use to cope with or manage uncertainty? What are the consequences of these strategies? Do people who are intolerant of uncertainty show a similar dislike of uncertain situations when only positive outcomes are possible? How much will people who are intolerant of uncertainty “give up” or discount things of value for increased certainty? These studies have been conducted with healthy participants, both student and community samples, using a variety of methods ranging from standardized measures, decision making tasks, novel vignette methods, through semi-idiographic approaches, to semi-structured interviews. The key feature of this series of studies is the attempt to separate out threat/danger and uncertainty and so understand how IU can in and of itself lead to potentially unhelpful patterns of thinking, responding, and acting. We believe this is the way to develop a transdiagnostic approach as we already know much about the key dangers or concerns in various disorders but relatively less about transdiagnostic factors or processes. Through an enhanced understanding of IU and its effects, disorder-specific concerns, and interactions between the two, it is hoped that better formulations and more focused and parsimonious interventions may then be developed.

Mental Imagery Across Disorders: Phenomenology and Treatment

Convenor: Charlotte Weßlau, University of Frankfurt, Germany

The role of visual mental imagery in depressed mood

Charlotte Weßlau, University of Frankfurt, Germany; Marie Cloos, University of Frankfurt, Germany; Volkmar Höfling, University of Frankfurt, Germany; Regina Steil, University of Frankfurt, Germany

Negative mental images are a common phenomenon in clinical and non-clinical populations (Newby & Moulds, 2011). Often, only minor differences regarding quantitative and qualitative characteristics between different disorders can be found (Birrer, Michael, & Munsch, 2007; Reynolds & Brewin, 1999). Depressed individuals frequently suffer from distressing and very vivid visual intrusions (Newby & Moulds, 2011; Weßlau & Steil, 2014), which can be present in acute as well as remitted phases (Brewin, Hunter, Carroll, & Tata, 1996; Reynolds & Brewin, 1999). In addition to negative imagery, research has lately also focused on positive mental images and it has been found that the recall of positive memories can be used to repair sad mood in non-depressed individuals but often deteriorates mood in those who are currently depressed (Joormann, Siemer, & Gotlib, 2007). Specific mechanisms of the influence of mental imagery on depression are, however, still unclear.

We conducted a large-scale ($N = 912$ at t_1 and $N = 174$ at t_2) web-based study of adults aged 18 to 65 to assess the influence of positive and negative visual mental images in a diverse sample regarding the severity of depressive symptoms, measured with the BDI-II (Hautzinger, Keller, & Kühner, 2006). 87% of

the sample reported having positive images and 77% experienced negative mental images in the past two weeks. The presence of distressing visual images was connected to significantly higher depression scores, as compared to when negative images were absent. In 17% of the cases, positive images led to a mood deterioration, which was accompanied by higher depression scores in general ($d = 0.92$).

The number of positive and negative images in the past two weeks contributed significantly to depression scores at the cross-sectional as well as the longitudinal level, 8 weeks later. The lack of pleasantness of positive images additionally contributed to depression severity, over and above imagery distress caused by negative images.

Our results indicate that mental imagery can play an important role in the maintenance of depressive symptoms.

Changing negative self-images in patients with PTSD

Meike Müller-Engelmann, Goethe University Frankfurt and Regina Steil, Goethe University Frankfurt

For the development and maintenance of posttraumatic stress disorders negative self-images are an important factor. This pilot study uses a combination of cognitive restructuring and imagery modification (CRIM) to change negative self-images in PTSD patients. A combination of the two methods has already been used successfully to reduce the feeling of being contaminated in sexual abuse victims (Steil et al., 2011).

The intervention consists of three sessions. In the first session cognitive techniques like Colombo technique and *Advocatus diaboli* are used to restructure the negative self-image. In the second session the negative self-image is changed into a positive image by imagery modification. The last session is a buster session that addresses integrating the learned techniques into daily routine. 9 patients with PTSD after different types of trauma were treated. The Clinical-Administered PTSD Scale (CAPS) was administered prior to and four weeks after treatment. Self-ratings were administered prior to, post and four weeks after treatment.

The mean PDS scores were reduced from 25 to 12 and the CAPS scores declined from 70 to 33. 5 patients recovered for PTSD. When comparing CAPS scores from t0 and t2 differences are highly significant ($t = 6.26$; $p < .001$; $\text{cohens } d = 2.09$) Depressive symptoms also declined significantly.

Results show that addressing the negative self-image in PTSD by a combination of cognitive techniques and imagery modification can reduce psychic symptoms effectively.

Imagery rescripting with flashforwards

Marisol J. Voncken, Maastricht University, the Netherlands; Iris Engelhard, Utrecht University, the Netherlands; Pauline Dibbets, Maastricht University, the Netherlands; Elisabeth Dittmar, Maastricht University, the Netherlands; Arnoud Arntz, University of Amsterdam, the Netherlands Social anxiety disorder patients experience recurrent, vivid, negative images of how they come across to other people (Wild and Clark, 2011). Hackmann et al. (2000) showed that these images are linked to early, social traumatic experiences. Imagery rescripting (ImRs), frequently used in schematherapy for personality disorders, is an experiential treatment method used to update and reinterpret such negative childhood memories (Arntz & Weertman, 1999). Recently ImRs is successfully used to update social traumatic experiences in social anxiety disorder (Wild & Clark, 2011; Nilsson, Lundh & Viborg, 2012; Lee & Kwon, 2013; Frets, Kevenaar & van der Heiden, 2014). Interestingly, in research on the working mechanism of EMDR Engelhard et al. (2012) describe negative imagery as “flashforwards” (Engelhard et al., 2012). They showed that instead of focusing on underlying early childhood memories EMDR is successful in *directly* reducing the vividness and distress of such flashforwards (Engelhard et al., 2012; Engelhard et al., 2011; Engelhard et al., 2010). The current study investigates whether the ImRs procedure with a *direct* focus on the flashforward image instead of the underlying childhood memory can be an effective procedure. For sake of homogeneity of the sample we recruited students with public speaking anxiety. In a pilot ($n=14$) study we concluded that the flashforward focus could be useful implemented and was accepted by the participants. In the main study in which the last participants are currently included, participants are randomized over two sessions traditional ImRs focused on a linked childhood memory ($n=15$), on a flashforward image ($n=15$) or placebo sessions ($n=15$). Participants were assessed prior to treatment and at one-week follow-up. These assessments consisted of questionnaires

assessing general and speech anxiety symptoms and an impromptu speech in front of two confederates. Results of this study will be presented.

Imagery-focused cognitive therapy (ImCT) in a small sample of patients with bipolar disorder: a pilot clinical audit

Martina Di Simplicio, MRC Cognition and Brain Sciences Unit, Cambridge; Susie Hales, MRC Cognition and Brain Sciences Unit, Cambridge; Simon Blackwell, MRC Cognition and Brain Sciences Unit, Cambridge and Emily Holmes, MRC Cognition and Brain Sciences Unit, Cambridge

Bipolar disorder is a chronic and complex disorder characterised by mood instability, periods of depression and of (hypo)mania, and anxiety. Recent evidence suggests that patients with bipolar disorder experience intrusive, real-like and compelling mental imagery (Hales et al., 2011, Ivins et al., 2014) and it has been proposed that this may act as an emotional 'amplifier' contributing to the mood instability and high levels of comorbid anxiety (Holmes et al., 2008). However, symptoms in the form of problematic images remain neglected in this population, with the risk of missing out on crucial psychopathological experiences (Di Simplicio et al., 2011). CBT interventions targeting intrusive negative mental imagery have been shown to be efficacious in the treatment of anxiety disorders. It remains to be tested whether the same could be applied to the bipolar population.

A case series of 11 outpatients with bipolar disorder were given an average of 15 sessions of imagery-focused cognitive therapy (ImCT) as a stand-alone treatment, via the Oxford Mood Action Psychology Programme (OxMAPP).

Mood stability was monitored during and post treatment through weekly self-report of depression and mania symptoms. Patients presented significant reduction in anxiety levels measured by the Beck Anxiety Inventory during 1 month following the end of treatment compared to anxiety levels over the assessment period. The duration of depressive episodes relapses based on ratings on the Quick Inventory for Depressive Symptoms (QIDS) was also significantly reduced over 6 month follow up compared to 6 months pre-treatment. Post-treatment, patients also completed a patient experience questionnaire and a service user lead interview which revealed high levels of satisfaction with ImCT and OxMAPP. All respondents stated that the imagery-focus in treatment had been important. These preliminary data offer positive indications for the development of a formal case series evaluation of ImCT for bipolar disorder.

The Economics of Improving Access to Psychological Therapies

Convenor: Pam Myles, University of Reading
Abstracts not received

Autism Spectrum Disorders

Convenor: Peter Langdon, University of Kent

Group cognitive behavioural therapy for people with Asperger Syndrome who have problems with anxiety: views of the people with Asperger Syndrome

PE Langdon, University of Kent; GH Murphy, University of Kent ; E Wilson, University of Kent; L Shepstone, University of Kent; D Fowler, University of Kent; D Heavens, University of Kent ; A Malovic, University of Kent; A Rose, University of Kent ; L Mullineaux, University of Kent

A number of studies have established that people with Asperger Syndrome (AS) have significant problems with anxiety. This talk will focus on the subjective experiences of people with AS who took part in the PAsSA Trial. This trial was a randomised single-blind cross-over trial of group CBT with 54 participants. During treatment, individuals received 3 sessions of individual CBT, followed by 21 sessions of group CBT. All participants were invited to take part in a semi structured interview at the end of the trial. The results indicated that the views of the people with AS were variable: some found the group extremely helpful but some did not. A number said they would have preferred individual treatment. Participants also had strong views on the parts of the programme that were helpful and the parts that were not. This relatively small trial suggest that aspects of the treatment were helpful for people with AS and anxiety, but that

further adaptations to the CBT would be advisable. A larger RCT is now required with an adapted programme to properly test its efficacy.

Behavioural and cognitive behavioural approaches to severe feeding difficulties in the context of ASD

Fay Murphy, Great Ormond Street Hospital

Many children on the autism spectrum have diets that are severely restricted (in some cases to one or two foods or liquid diets) (Schreck, Williams & Smith, 2004). In autism the most commonly occurring feeding problem is selectivity by type, which is defined as eating a narrow range of food that is nutritionally inappropriate (Field et al., 2003). These difficulties are most commonly associated with sensory sensitivities (e.g. heightened sensitivity to smell, taste and texture) as well as difficulties with change (e.g. moving on from bottle feeding to solids). Children get stuck on restricted diets and consequently have poor nutrition, which can impact on their growth, development and behaviour (Ahearn et al., 2001). Specialist behavioural and cognitive behavioural treatments for children with these difficulties represent an area of unmet need in the NHS. This presentation will outline treatment approaches underpinned by the existing evidence base, being developed in the Feeding and Eating Disorders Service at Great Ormond Street Hospital, including video footage and case examples.

Aspergers syndrome, alexithymia and schizotypy

Dougal Hare, University of Manchester and Nicole Pacchiarini, University of Manchester
Schizotypy and Aspergers syndrome share a number of apparent phenomenological similarities, including being on continua and being associated with other traits, including alexithymia. This paper will outline what is known about the apparent relationship between schizotypy, alexithymia and Aspergers syndrome, including reporting on data from two empirical studies, and discuss the implications for both research and clinical practice.

Mindfulness-based cognitive therapy: new applications and alternative means of delivery

Convenor: Fergal Jones, Canterbury Christ Church University, Sussex Partnership NHS Foundation Trust & Sussex Mindfulness Centre

Self-help Mindfulness-Based Cognitive Therapy (MBCT): Evidence from two randomised controlled trials

Clara Strauss, University of Sussex, Sussex Partnership NHS Foundation Trust & Sussex Mindfulness Centre; Billie Lever Taylor, University of Surrey; Kate Cavanagh, University of Sussex & Sussex Mindfulness Centre; Laura Lea, Sussex Partnership NHS Foundation Trust & Canterbury Christ Church University; Fergal Jones, Canterbury Christ Church University, Sussex Partnership NHS Foundation Trust & Sussex Mindfulness Centre

Mindfulness-based cognitive therapy (MBCT) is recommended by NICE as a relapse prevention intervention for people who are currently well but who have a history of three or more episodes of depression. There is also growing evidence that MBCT is an effective intervention for people experiencing a current episode of a depressive or anxiety disorder. However, MBCT involves approximately 20 hours of therapist contact time and it is not universally available. Self-help MBCT may help to widen access but little is known about its effectiveness. We have conducted a randomised controlled trial (RCT) of self-help MBCT for students experiencing mental health difficulties.

80 students experiencing mental health difficulties were randomly assigned to an eight-week self-help MBCT condition or to a no-intervention control condition.

There were significant group x time interactions in favour of self-help MBCT on the short form of the Depression Anxiety and Stress Scales, Satisfaction with Life Scale, Five Facet Mindfulness Questionnaire and on the Self-Compassion Scale Short-Form. Engagement with self-help MBCT was high with 85 percent of participants reading at least half the book and engaging in mindfulness practice a median of 2 to 3 times a week. Only 5 percent of participants dropped out.

This is the first RCT, to our knowledge, of self-help MBCT and benefits relative to control were found for measures of depression, anxiety, stress, life satisfaction, mindfulness and self-compassion. The self-help

MBCT intervention has the potential to be a low-cost, readily available and highly acceptable self-help intervention. Future research should explore if findings extend to clinical populations and we are currently conducting an RCT of self-help MBCT for mental health service users experiencing symptoms of depression; we'll report progress on this.

A randomised controlled trial of a brief online mindfulness-based intervention: Replication and extension

Kate Cavanagh, University of Sussex & Sussex Mindfulness Centre ; Clara Strauss, University of Sussex, Sussex Partnership NHS Foundation Trust & Sussex Mindfulness Centre; Fergal Jones, Canterbury Christ Church University, Sussex Partnership NHS Foundation Trust & Sussex Mindfulness Centre

There is growing evidence that mindfulness has positive consequences for both psychological and physical health in both clinical and non-clinical populations. Self-guided mindfulness-based interventions may be a way to increase access to the benefits of mindfulness. Building on previous research, this study explored whether two brief, online, mindfulness-based interventions (mindfulness psychoeducation only, mindfulness psychoeducation plus and invitation to mindfulness meditation) could increase mindfulness and reduce perceived stress, perseverative thinking and anxiety/depression symptoms within a University population.

One hundred and fifty-four University staff and students were randomly allocated to either immediately start one of two, two-week, self-guided, online, mindfulness-based intervention or a wait-list control.

Measures of mindfulness, perceived stress, anxiety/depression and perseverative thinking were administered before and after the intervention period.

Intention to treat analysis identified significant group by time interactions for mindfulness skills, perceived stress, anxiety/depression symptoms and perseverative thinking. Participation in the intervention was associated with significant improvements in all measured domains, where no significant changes on these measures were found for the control group. No differences between the intervention conditions were found.

This provides further evidence in support of the feasibility and effectiveness of shorter self-guided mindfulness-based interventions in non-clinical contexts. The limitations and implications of this study for clinical practice are discussed.

A pilot study of mindfulness training compared to psycho-education for perfectionism

Kirsty James, University of Bath; Katharine Rimes, Institute of Psychiatry

Perfectionism has long been considered to be linked to distress and has been highlighted as both a risk and maintaining factor across a range of psychological difficulties. Preliminary evidence suggests that perfectionist individuals tend to show higher levels of rumination and perfectionist beliefs about emotions, and lower levels of mindfulness and self-compassion. Addressing these and other cognitive and behavioural processes may help reduce distress and impairments associated with unhealthy perfectionism. This pilot study was designed to compare a mindfulness-based cognitive therapy (MBCT) intervention adapted for students experiencing difficulties as a result of perfectionism with written psycho-education. The study aimed to explore the acceptability of this new intervention and the feasibility of conducting a larger-scale randomized trial in the future. Preliminary investigation of the impact of both interventions was also undertaken.

Participants were randomised to either MBCT or written psycho-education materials about perfectionism. Questionnaires were completed before the intervention, eight weeks later (corresponding to the end of the MBCT course) and at ten week follow-up.

Results regarding feasibility, acceptability and the impact of both interventions on perfectionism and associated psychological processes will be presented.

Whilst preliminary, the implications of this pilot trial for the acceptability and impact of mindfulness-based interventions for perfectionism will be discussed.

Offering mindfulness to trainee therapists and NHS staff

Fergal Jones, Canterbury Christ Church University, Sussex Partnership NHS Foundation Trust & Sussex Mindfulness Centre; Emma Justice, Canterbury Christ Church University; Clara Strauss,

University of Sussex, Sussex Partnership NHS Foundation Trust & Sussex Mindfulness Centre; Puffin O'Hanlon, Sussex Partnership NHS Foundation Trust; Kate Cavanagh, University of Sussex & Sussex Mindfulness Centre

There is increasing interest in offering mindfulness-based approaches to therapists and other health care staff. Findings from two studies on this issue are presented. The first study aimed to explore whether a brief mindfulness practice can have an immediate, beneficial effect on trainee clinical psychologists' and trainee psychotherapists' generic therapeutic competencies; such an effect might be expected if mindfulness practice improves attention, compassion and openness to experience, as some theories suggest. The study employed an experimental design, with trainees in the intervention group being guided through a 15-minute mindfulness of breathing practice, while control participants undertook a mind wandering exercise for the same amount of time. The relative impact of the mindfulness practice on measures of empathy, compassion, memory and emotional tolerance will be outlined and the implications of this, for trainee and qualified therapists, discussed. In the second study, the feasibility of offering mindfulness-based self-help interventions to NHS staff, and the feasibility of evaluating the impact of this, are explored. Self-selecting participants were invited to choose between book-based and online mindfulness-based self-help interventions. Quantitative data were collected on participant preference, as well as regarding the feasibility of participant recruitment, retention, and outcome measure completion. Qualitative data were collected on participants' views of the interventions and potential areas for improvement. These data should provide a useful guide to the feasibility of, and best parameters for, future randomized controlled trials in this area.

A Multicentre, Randomised Controlled Trial of Cognitive Therapy to Prevent Harmful Compliance with Command Hallucinations ('COMMAND')

Convenor: Emmanuelle Peters, Institute of Psychiatry, King's College London

CTCH (Cognitive therapy for Command Hallucinations): An overview of the therapy with an illustrative case example

Alan Meaden, Birmingham & Solihull Mental Health NHS Foundation Trust and Nadine Keen, South London & Maudsley NHS Foundation Trust; Robert Aston, Birmingham University; Karen Barton, Birmingham & Solihull Mental Health NHS Foundation Trust; Sandra Bucci, University of Manchester; Max Birchwood, Warwick University

Cognitive therapy for Command Hallucinations (CTCH) draws heavily upon an amalgamation between Cognitive Behavioural Therapy for Psychosis (CBTp) and Rational Emotive Behaviour Therapy (REBT). It was Chadwick and colleagues (Chadwick & Birchwood, 1994) who first highlighted the key role of beliefs in cognitive therapy for voices. They used the ABC model adapted from REBT, where A is the activating event (e.g. the voice), B the beliefs about that voice, and C the emotional and behavioural consequences of the beliefs.

Utilising this model enables us to remain clear about the targets of our therapeutic efforts. The problems that clients present are located firmly at 'C'. The aim of CTCH is not to reduce symptoms, since these are the 'A' in cognitive terms. In CTCH terms, voice related distress and compliance or safety behaviours are viewed as posing a risk to others or the person themselves. Our central notion, 'power', concerns the voices' ability to harm (ie omnipotence) but is also a broader concept, incorporating other voice beliefs (control, omniscience, compliance, identity and purpose) which imply power. For this reason we have adopted the term 'voice-power schema'. The perceived need to comply with seemingly powerful voices is crystallised in this power schema. A key target of therapy is to deconstruct it through relocating the problem at B.

Central to CTCH is also the notion of social rank theory (Gilbert, 1992). In response to their perceived weakened social position, voice-hearers develop beliefs about their voices that can be understood in terms of an interpersonal relationship. Often this subordinate-dominant relation is rooted in early experiences and is mirrored in other social relationships. CTCH involves addressing such relationships as well as the schema that underpin them.

While CTCH was protocol based in the COMMAND RCT, it remains a pragmatic intervention and recognises individual differences in voice content, beliefs about voices and compliance. In COMMAND

CTCH was delivered in NHS clinics with outreach to participants' homes by a total of 9 cognitive therapists supervised in each centre by a lead clinician with expertise in CBT for psychosis. CTCH was administered over a maximum period of 9 months, which included a therapeutic window of approximately 25 sessions. The current presentation will provide an overview of the therapy, illustrated by a case-study from the trial.

A multi-centre randomised controlled trial (RCT) of cognitive therapy to prevent harmful compliance with command hallucinations

Emmanuelle Peters, Institute of Psychiatry, King's College London; Maria Michail, University of Nottingham; Nicholas Tarrow, Institute of Psychiatry, King's College London; Til Wykes, Institute of Psychiatry, King's College London; Graham Dunn, University of Manchester; Max Birchwood, Warwick University; Alan Meaden, Birmingham & Solihull Mental Health NHS Foundation Trust;

A pilot RCT (Trower et al, 2004) showed that Cognitive Therapy for Command Hallucinations (CTCH); Meaden et al, 2012) could reduce harmful compliance with command hallucinations in a small sample (N=38). The gains were maintained at 12 months follow-up, and were accompanied by a reduction in power beliefs. A full-scale multi-centre RCT ('COMMAND'; ISRCTN 62304114) was subsequently funded by the Medical Research Council to investigate the effectiveness of CTCH in reducing compliance in a larger sample.

COMMAND is a pragmatic, single blind, intention-to-treat, randomized controlled trial comparing CTCH + Treatment as Usual (TAU) with TAU alone. The trial recruited eligible participants from Birmingham (including Leicester), London and Manchester. Recruitment to the trial began in February 2008 and was completed in July 2010. Outcome was assessed at 9 and 18 months post-randomization. The trial received ethical approval from the West Midlands Research Ethics Committee (06/MRE07/71).

The level of compliance/resistance (primary outcome) with each command was assessed using the Voice Compliance Scale. This primary outcome assessed the presence of any episode of full compliance in the follow-up period, and was therefore a stringent test of the hypothesis. Secondary outcomes included the perceived power differential between voice and voice hearer; the voice hearer's beliefs about the voice's omnipotence, intentions, and omniscience; and participants' emotional and behavioural reactions towards their voices. Affective outcomes included voice distress; depression; hopelessness; and suicidal ideation. Psychotic symptoms were assessed using the Positive and Negative Symptoms for Schizophrenia, and experiences of early abuse and neglect were recorded. A health economic evaluation was also conducted. All prescribed antipsychotic medication at baseline and 18 months was recorded. The inclusion and exclusion criteria, randomisation procedures, strategies to assure blinding and reliability monitoring of the measures will be presented. 197 individuals consented to randomisation with only 12% refusing. Over 83.5% completed the intervention and 83.2% were followed up at 18 months. The high rate of consent to randomisation and level of follow-up assures the validity and generalizability of the findings, and the high rates of completion indicate that the therapy was acceptable to this high risk and distressed group of individuals.

Command hallucinations are among the most distressing, high risk and treatment resistant symptoms for people with psychosis; however, currently, there are no evidence-based treatment options available for this group. The COMMAND trial evaluated the effectiveness of Cognitive Therapy for Command Hallucinations (CTCH; Meaden et al, 2012), a type of CBT grounded in the principles of the Social Rank Theory.

COMMAND is a pragmatic, single blind, intention-to-treat, multi-centre, RCT comparing CTCH + Treatment as Usual (TAU) with TAU alone. Eligible participants had to have command hallucinations for at least 6 months leading to risk of harm to self or others. Following the completion of baseline assessments, eligible participants were randomly allocated to either CTCH + TAU group or the TAU group. Outcome was assessed at 9 and 18 months post randomization with assessors blind to treatment allocation. The primary outcome was compliance behaviour and secondary outcomes include beliefs about voices' power, distress, and psychotic symptoms.

The cognitive therapy significantly reduced the perceived power of the persecuting voice to do harm to the individual which was linked to a halving of the rate of serious compliance (odds ratio= 0.45, 95% confidence interval 0.23 to 0.88, p=0.021).

The results were in line with the pilot trial (Trower et al, 2004) and demonstrate the largest effect size of CBT for psychosis to date. We believe the outcome of this trial marks a significant breakthrough in the evidence base for this most severe group of patients, and will provide a treatment option for this group where none currently exist.

Upscaling and Implementation of Online CBT in Routine Practice

Convenor: Heleen Riper, VU University Amsterdam, the Netherlands

Blending iCBT into routine practice

Heleen Riper, VU University Amsterdam, the Netherlands

The results of a feasibility study that was focussed on the development of a blended treatment protocol for depressed patients will be presented. Subsequently the feasibility and acceptability by patients and professionals in specialized outpatient mental healthcare services will be discussed and an indication of potential clinical effectiveness will be presented. Online self-report measurements took place at baseline and after 10 weeks. Assessments measured symptoms of depression (IDS-SR) and anxiety (BAI), mastery, pre-treatment expectations (CEQ-9) and post-treatment satisfaction (SUS). This will be followed by an outline of the European MasterMind project in which iCBT treatment interventions for depression will be implemented in routine practice. The MasterMind project will target at 5,230 patients and 120 professionals in 14 European regions. The upscaling will be evaluated by making use of the MAST Model (Model for Assessment of Telemedicine. In this model 7 interrelated domains of interest to implementation will be applied (client and care profiles; safety of treatment; clinical and cost-effectiveness; patient and professional perspectives; organisational aspects and the broader social, legal and ethical issues). Data will be retrieved from routine outcome measurements, medical patient data files, online qualitative surveys and organizational level data. Transferability of findings will be assessed through two-step approach in which first regions with more experience will implement iCBT in routine practice. A second implementation wave will follow, in which regions with less experience in iCBT will implement iCBT in routine practice by making use of lessons learned in the first wave of upscaling.

Untapped potential? The implementation of online CBT in routine practice

Kate Cavanagh, University of Sussex

Ten years since NICE (2004) first recommended Computerised Cognitive Behavioural Therapy (CCBT) as a treatment choice for depression, the systematic, large-scale implementation of these services within the NHS remains limited. Whilst this decade has seen a rapid expansion of low intensity service provision for common mental health problems the emphasis has remained on supporting the use of paper-and-pen self-help. Now recommended across a wide range of common mental health problems (NICE, 2009; 2011) the potential for online CBT to extend the reach of psychological therapies remains only partially exploited in routine care.

Recent reviews and meta-analyses continue to produce promising findings with regard to online CBT's effectiveness and acceptability, but developing and supporting effective and sustainable models of online CBT service implementation presents a challenge – not least due to barriers to uptake and engagement from both clients and providers. This presentation considers online CBT usage and explores the challenges to the wide scale implementation of online CBT. I propose a simple model of engagement factors associated with the program, the problem, the person and the provider and highlight some actions that service developers and providers can take that might increase the use of online CBT. Policy and politics will also be considered. Managing expectations and promoting hope in both service users and providers is emphasised.

The MasterMind EU trial – cCBT at scale

Stella Anne Clark, University of Edinburgh

Stella Clark is the Clinical Lead for Mental Health in NHS 24, a Scotland wide tele-health organisation which triages all out of hours requests advice and assessment from Primary care in the out of hours period and which supports the development on tele-health and tele-care services in Scotland.

NHS 24 is part of an EU consortium known as “MasterMind” which aims to make high quality treatment for depression more widely available for adults suffering from the illness by the use of ICT.

The project will identify barriers and success factors to implement the two services on a large scale in different political, social, economic and technical health care contexts and from the perspective of different stakeholders such as patients, professionals and health insurances.

The project runs from the 1st of March 2014 to the 28th of February 2017 and has a total budget of €14m.

This presentation will describe the MasterMind project to date and draw on experience to date of deploying cCBT across 2 health board areas in Scotland covering a population of approximately 670,000.

New advances in CBT for OCD: A focus on single cases

Convenor: Adam Radomsky, Concordia University

A single case design of cognitive treatment for obsessions

Maureen Whittal, Vancouver CBT Centre

The efficacy of cognitively focused treatment for OCD and primary obsessions in particular is well established through randomized controlled trials (RCTs). Although RCTs are the gold standard for determining efficacy, it is difficult to properly explore mediators in the absence of a large sample size. Single case methodology is one way to facilitate a detailed examination and explore factors related to change. An individual who received cognitive treatment for primary obsessions will be the focus of the presentation. In keeping with the cognitive model for OCD, the meaning of the intrusions was measured weekly along with severity of obsessions and extent of avoidance. These data will be superimposed on the various treatment strategies to determine if a relationship can be established between components of treatment (e.g., differentiating desire from fear of desire), meaning of the intrusion (i.e., mad, bad or dangerous) as measured by the personal significance scale (PSS) and self-reported severity of obsessions and avoidance. The potential of establishing a relationship between components of treatment and outcome is promising in that it may further increase efficacy rates which have reached a plateau in the past 20 years.

Imagery re-scripting for body dysmorphic disorder (BDD)

Rob Wilson, Institute of Psychiatry; David Veale, Institute of Psychiatry, KCL; Mark Freeston, University of Newcastle

Individuals with Body Dysmorphic Disorder (BDD) are preoccupied with the idea that they are ugly and defective. The problem results in significant levels of distress and impairment in social, occupational or some other important area of functioning. BDD affects around one percent of the population, yet research in understanding and treating this problem is still very much in its infancy. Given that BDD is inherently a body image problem it seems logical that imagery related interventions would be worthy of investigation. Furthermore, there is evidence that imagery re-scripting may benefit individuals with social phobia (Wild & Clark, 2011) which shares a number of features with BDD. Data on a single case series with an experimental design of using 1-2 sessions of imagery re-scripting preceded by a talking control with individuals who have treatment refractory BDD will be presented, and the indications of the mechanisms of change will be discussed.

Cognitive therapy for compulsive checking: Single cases and treatment development

Adam Radomsky, Concordia University; Jessica Senn, Concordia University; Sarah Schell, Concordia University; Laurie Gelfand, Concordia University

Abstract: Effective interventions for obsessive-compulsive disorder (OCD) have changed little since the advent of exposure and response prevention in the 1960's. Recent advances in our understanding of the phenomenology of OCD have led to the development of new theories and associated OCD treatments which are more specific, and more cognitive in nature. We will report on a single case design methodology applied to a highly novel, cognitively-based intervention for an individual struggling with compulsive checking. The participant engaged in daily monitoring of multiple variables associated with the treatment (e.g., time spent checking, responsibility, probability of harm, confidence in memory), as well as the weekly completion of the Personal Significance Scale – Compulsive Checking Version from a

period beginning three weeks before session one through to one month following the end of the 12-session intervention. Results show dramatic improvements across all monitored variables, as well as marked reductions in diagnostic and symptom severity ratings over the course of the treatment. Interestingly, many of the monitored variables show their greatest changes immediately following sessions which focused on relevant content. Results will be discussed in terms of the value of single case design methodology, and of the development of specific treatments for specific manifestations of OCD.

“I feel dirty right under my skin”: The treatment of Mental Contamination in OCD

Anna Coughtrey, University of Reading; Roz Shafran, University College London; Stanley Rachman, University of British Columbia

Patients with Obsessive Compulsive Disorder (OCD) often describe a fear of contamination that arises in the absence of physical contact with a contaminant. This experience of mental contamination leads to intense feelings of dirtiness and results in a number of compulsive behaviours including washing to neutralise the negative feelings and prevent future contamination. This presentation will describe a case of mental contamination in a young woman with OCD who experienced feeling dirty under her skin when she spoke to people she considered immoral. Treatment involved 12 sessions of cognitive behavioural therapy (CBT) following which the woman no longer met the diagnostic criteria for mental contamination or any mental health problem. These gains were maintained at 3 and 6 month follow-up. The implications of these findings for the treatment of mental contamination in OCD will be discussed.

Understanding and preventing adverse effects of psychological therapy

Convenor: Glenys Parry, University of Sheffield

Learning from therapists' and patients' experience of failed therapy

Gillian Hardy, University of Sheffield

Aims: a) to investigate the accounts of service users and therapists who have reported failed therapies or adverse effects of therapy; b) to explore what they would have found helpful in preventing the adverse outcome; c) to inform a specification of potential tools for clients and therapists and direct how these tools may be used most effectively.

We used a two-stage mixed method design. A survey of therapists and service users was undertaken, identified through service user organisations and professional bodies. This yielded 193 client questionnaires and 322 therapist questionnaires. This was followed by a qualitative study of participants' perceptions of failed therapies (including accounts of what went wrong and how this might have been prevented). The survey sample was opportunistic, followed by purposive sampling to achieve maximum variation in the age, sex, ethnicity and sexual orientation of patients and the type of therapy, drawing on survey participants who had volunteered to be interviewed. Face-to-face (n=10) and telephone interviews (n=30) were conducted, audio-recorded and transcribed for 20 therapists and 20 clients.

Eighteen themes were identified and elaborated from the therapist survey, including client factors, therapist competence, service pressures and constraints, and problems in the therapeutic relationship. Other data are currently being analysed; results will be available from February 2014.

These results enable a rich understanding of the factors which signal risks of adverse effects or harm from therapy, and directly inform tools to support both therapists and clients in achieving safer therapy.

Risk factors for reliable deterioration during therapy and unplanned therapy endings

Dave Saxon, University of Sheffield

To assess the rate and predictors of client deterioration and unplanned endings in psychological therapies, using large datasets from routine practice.

The UK CORE National Database consists of nine years of CORE outcome measure data (1999 – 2008), from psychotherapists and counsellors in differing sites and settings across the UK. Reliable deterioration was defined as a pre-post increase in CORE-OM score of 5 points or more. Hierarchical linear modelling enabled data to be analysed by site and therapist.

Of the 26,130 completer clients in the dataset, 335 (1.3%, 95% CI: 1.2, 1.4) experienced statistically reliable deterioration. The proportion of clients per therapist showing reliable deterioration ranged from

0.24% -15.8%. Being unemployed or on welfare benefits was a strong predictor of reliable deterioration. Other predictors of reliable deterioration were chronicity (problems for over a year), caseload and Black or Minority Ethnic status. Approximately 25% of clients who received two or more sessions of treatment had an unplanned ending (N=41,342). There was considerable variability between therapists in rates of unplanned endings (range 0% to 71.2%). Unemployment, ethnic minority status, younger age, and client complexity were predictive of unplanned endings. Smaller change from first to last session may also be a factor.

The wide variation between sites and therapists is striking. It demands greater awareness in service managers and therapists of risk factors for deterioration or dropout, including service factors, e.g. caseloads, client complexity, which signal need for therapist support.

Risk of harm in psychological therapies: a re-analysis of deterioration data from randomised controlled trials.

Glenys Parry, University of Sheffield

To investigate the risk of harm in psychological therapies by comparing deterioration rates in randomised controlled trials of psychological treatments with control groups receiving no psychological treatment. Inclusion criteria were a) randomised trials of psychological treatment; b) analysed by the UK National Institute for Health and Care Excellence (NICE) as the basis for their clinical guidelines; c) in depression, anxiety or PTSD; c) which included a comparison with a 'no psychological treatment' control group. Principal Investigators of these trials were approached and asked to provide their full dataset for re-analysis as part of the AdEPT project. This yielded 16 study datasets (11 Depression, 3 GAD, 2 PTSD; total N= 992), which were assembled into a single dataset and analysed using STATA.

For each included study the proportion of people who deteriorate in the treatment arm was compared to the proportion which deteriorates in the control arm. These and their confidence intervals were then combined using meta-analytic techniques, to produce an overall relative risk of deterioration from treatment. A number of analyses were undertaken to accommodate the diversity of populations, treatments, measures and measurement points, and a pre-post deterioration 0.5 SD was defined as reliable.

Of the 16 studies, seven showed a higher rate of reliable deterioration in the active treatment group, but 95% confidence intervals included a 'no difference' result in all but one study. Overall, meta-analyses found no evidence that deterioration rates systematically differ between treatment and control groups.

Basic Processes in Child and Adolescent Anxiety

Attentional bias in anxious preschool children: an eye-tracking study

Helen Dodd, University of Reading; Jennifer Hudson, Macquarie University; Tracey Williams, Macquarie University; Talia Morris, Macquarie University; Rebecca Lazarus, Macquarie University; Yulisha Byrow, Macquarie University

Extensive research has documented an attentional bias for threat in anxious adults and school-aged children but it is unclear when this anxiety-related bias is first established. Despite increasing recognition of anxiety disorders in preschool-aged children, little is understood about attentional bias and anxiety in this age group. This evidence-base is vital before any consideration is given to using bias modification techniques with younger children.

The present study uses eye-tracking technology to assess attentional bias in a sample of 37 children who met criteria for an anxiety disorder and 46 non-anxious children. Participants were aged 3 or 4 years. Gaze was recorded during a free-viewing task with angry-neutral face pairs presented for 1250ms. There was no indication of between-group differences in bias for angry over neutral faces, with both anxious and non-anxious groups showing a bias in vigilance and maintained attention favouring angry faces. Importantly, however, the anxious participants spent significantly less time looking at the faces overall, when compared to the non-anxious group.

The results suggest that both anxious and non-anxious preschool-aged children have a threat-related attentional bias such that more attention is paid to angry faces over neutral faces. However, anxious children differ in their overall attention to faces, with this study providing the first evidence of avoidance

of faces in anxious preschool-aged children. As the sample were high in behavioural inhibition and social anxiety, this pattern of attention may be specific to this subgroup of anxious children.

There is increasing interest in the extent to which cognitive biases can themselves be targeted in treatment using modification protocols. Before we consider using these techniques, we must have an evidence-base from which to make decisions about the nature of the modification as well as appropriate methods of assessing bias. This study provides a first step towards this; in indicating that anxious preschool children might avoid faces generally, the research raises questions about the logic of training avoidance.

Towards the Development of an Interpersonal Model of OCD: Assessment of the role of attachment style in the development of reassurance-seeking behaviours in adolescents with OCD.

Sasha Walters, University of Bath; Paul Salkovskis, University of Bath; Sarah Elgie, CAMHS, NBT; Brynjar Halldorsson, University of Bath

OCD is a common mental health disorder occurring between 1% and 4% of the child and adolescent population (Lewin et al., 2005), yet the efficacy of current treatment protocols remains limited (e.g. March, Mulle, & Herbel, 1994; Whittal & McLean, 1999). In an attempt to better understand the aetiology, and by extension effective treatment, of OCD, there has been increasing interest in the role of excessive reassurance-seeking behaviours in its maintenance (e.g. Kobori & Salkovskis, 2013; Kobori, Salkovskis, Read, Lounes, & Wong, 2012) with studies indicating that it is 'the most frequent interpersonal manifestation of OCD' (p. 25, Kobori et al., 2012). In other disorders excessive reassurance-seeking has been found to interact with an insecure attachment style to predict a greater severity and duration of symptoms in young people (e.g. depression; Abela et al, 2005). Despite findings that insecure attachment and excessive reassurance-seeking are common among sufferers of OCD (e.g. Ivarsson, Granqvist, Gillberg, & Broberg, 2010; Yabro, Mahaffey, Abramowitz, & Kashdan, 2013) empirical studies exploring the interactive effects of them for the onset and maintenance of OCD in adolescents are yet to be conducted.

Participants were recruited to 1 of three groups. Young people aged 11-18 with OCD, or with any other anxiety disorder, or healthy control. Young people and their carers completed a series of questionnaires enquiring about general mental health, OCD, reassurance seeking, responsibility attributions and schemas prior to completing a video-taped interaction coded in line with the Goal-Corrected Partnership in Adolescence-Coding System (Hennighausen et al., 2011) to assess adolescent attachment stance. Preliminary data of recruited participants will be presented demonstrating initial findings of associations between attachment stance and reassurance seeking behaviours in adolescents with OCD compared to those with an anxiety disorder or not attending CAMHS. This will be further illustrated with the case presentation detailing the delivery of CBT for OCD with a targeted parent-child component to successfully reduce reassurance-seeking behaviours in addition to symptoms measured on the child OCI (washing, checking, doubting, ordering and obsessions).

CBT for young people with OCD is an effective method of treatment but attachment and parent-child interaction difficulties act as a vulnerability factor and may maintain symptoms if not specifically targeted.

CBT is currently effective for around 40% of young people with OCD at follow up. It is proposed that more fully understanding the impact of attachment in the aetiology of one of the key maintenance factors of this disorder may help develop more targeted CBT interventions to enhance the results achieved with standard CBT for OCD to support young people to overcome, and remain free of symptoms in the long term.

Prevention of Vicarious Learning via Latent Inhibition and Immunisation

Gemma Reynolds, Kingston University; Andy Field, Sussex University; Chris Askew, Kingston
Learning through observing others (vicarious learning) is an established pathway through which childhood fears develop. However, the mechanisms underpinning this learning and the nature of the learnt responses are not yet fully understood. Accordingly, the current research investigates how vicarious fear learning can be prevented. Prior positive modelling ('immunisation') has been found to inhibit the effects of subsequent vicarious fear learning in monkeys; however, pre-exposure only ('latent

inhibition') had no effect despite a robust finding in the conditioning literature that pre-exposure inhibits learning. These findings have also been replicated in 12-21 month old toddlers. The researchers suggested that latent inhibition may not have been found because of the young age of the children or low statistical power.

Using a large enough sample of older children (7-9 years) to guarantee sufficient power, this experiment explores whether latent inhibition and / or positive modelling reduce fear learning. Before a vicarious fear learning procedure with two novel animals whereby one animal is paired with scared faces (scared-paired) and a second animal is presented alone (unpaired), one group of children were given a positive vicarious learning experience with the scared-paired animal (positive modelling), a second group were simply exposed to the scared-paired animal (latent inhibition) and a third acted as a control group. Findings will be discussed along with the potential to inform parents, teachers and prevention programs. The results help us to better understand how children's fears develop and could therefore lead to the development of more effective treatment interventions.

Trying to fall asleep while catastrophising: What sleep disordered adolescents think and feel
Rachel Hiller, University of Bath and Flinders University of South Australia; Nicole Lovato, Flinders University of South Australia; Michael Gradisar, Flinders University of South Australia; Michael Oliver, Flinders University of South Australia; Amy Slater, Flinders University of South Australia

Catastrophising is a repetitive cognitive process related to sleep disturbance in adult insomnia patients. More recently catastrophising has been associated with increased sleep disturbances in community samples of children and adolescents; with this association mediated by anxiety and depression. However, there is currently no evidence of these processes outside of community samples of children; impeding our ability to draw clinical conclusions. Knowledge on such dysfunctional cognitive processes in adolescents experiencing sleep disturbance would be clinically beneficial in terms of aetiology and intervention. Our research examined the link between catastrophising, anxiety, depression and sleep latency in a sample of sleep disordered adolescents. We also explored specific catastrophising themes which may impact the sleep latency of these adolescents.

Forty adolescents (age = 15.1±1.5yrs, 53% male) diagnosed with Delayed Sleep Phase Disorder completed a 7-day sleep diary, along with measures of anxiety and depression, and a Catastrophising Interview with a trained sleep therapist.

Several catastrophisation themes were generated, the most common concerning interpersonal and performance aspects of school. Bootstrapping analyses showed depression did not mediate the relationship between catastrophising and sleep, however, an indirect relationship was found between catastrophising, anticipatory anxiety, and sleep latency.

These findings have implications for the role of dysfunctional thinking in prolonging sleep onset for adolescents, as well as providing a clinical framework for health professionals when assessing and treating adolescents with delayed sleep timing.

To date, much of the literature on the association between childhood sleep problems and dysfunctional cognitions has come from community samples; limiting our ability to draw clinical conclusions. In this study we explored the association between catastrophising, anxiety and sleep problems, in a clinical sample of teens diagnosed with delayed sleep phase disorder. Results suggest teens' catastrophising and anxiety are associated with an increased difficulty falling asleep. Consequently, these results support the use of cognitive and behavioural strategies (e.g., thought challenging, behaviour experiments) as part of the treatment program for delayed sleep phase disorder. Moreover, we have identified those catastrophising and anxiety themes most strongly associated with difficulty initiating sleep, highlighting those cognitions which may be of particular importance for clinicians to address during the CBT program.

Reasoning and memory biases in psychosis; Recent advances and clinical applications

Convenor: Pamela Jacobson, King's College London

Overgeneral autobiographical memory bias in healthy and clinical voice-hearers

Pamela Jacobsen, Kings College London; Paul Chadwick, Kings College London; Emmanuelle Peters, Kings College London

Hearing voices is a positive experience for some people (e.g. spiritual experiences), and does not automatically lead to a 'need for care' from psychiatric services. Cognitive models of voices in psychosis indicate that beliefs about voices are an important determinant of whether voices are associated with distress and disability. Beliefs that voices are omnipotent, omniscient and uncontrollable are characteristic of voice hearers that are distressed by their experiences. Memory and reasoning biases may be important in maintaining such beliefs about voices, and once identified, may be open to modification within cognitive-behavioural therapies for psychosis. In particular, people with distressing voices often struggle to recall specific memories from their daily experience which might be helpful in challenging some of their unhelpful beliefs about their voices (e.g. I always have to obey the voices). This could be attributed to an overgeneral autobiographical memory bias, which is already well-established within the depression literature.

To investigate the role of the overgeneral autobiographical memory bias in maintaining distress associated with hearing voices in psychosis.

Performance on a standard autobiographical memory task (AMT) was compared between three groups 1) healthy controls, 2) people who hear voices in the context of a mental health problem (clinical group) and 3) people who hear voices but are not distressed and do not require mental health care (healthy voice-hearers). In addition, groups 2) and 3) also completed an adapted version of the AMT, using the same prompt words, but asking people to recall only memories relating to their voices.

Preliminary findings indicate that the clinical group displayed an overgeneral memory bias compared to both the healthy controls and the healthy voice-hearers. On the voices-specific AMT adapted task, both voice-hearing groups were more overgeneral in their responses compared to the standard AMT task; however this relative difference in performance was significantly more marked in the clinical group compared to the healthy voice-hearers.

The overgeneral autobiographical memory bias is associated with distressing voices in psychosis.

Targeting the overgeneral autobiographical memory bias within psychological interventions for psychosis may help people to gain better access to information which can help challenge beliefs which perpetuate distress.

Overgeneral autobiographical memory and social problem solving in people with persecutory delusions

Natasha Vorontsova, University of London; Daniel Freeman, University of Oxford; Philippa Garety, Kings College London

Depression has been proposed to maintain positive symptoms of psychosis, including persecutory delusions. Empirical studies have supported a specific association between depression and paranoia. Cognitive aspects of depression, such as memory biases, are of interest in improving our understanding of the persistence of persecutory beliefs.

An over-general bias in autobiographical memory (OGM) has repeatedly been found in depressed groups, and this bias has been shown to predict the persistence of depression over time. A theoretical account proposed that OGM originates from avoidance of contact with concrete negative memories, eventually spreading to pervasive overgeneralisation across the autobiographical memory network. OGM may maintain emotional problems by interfering with problem solving, leading individuals into unhelpful situations.

The present study examined OGM and social problem solving in 60 participants with persecutory delusions, of whom half had concurrent major depression, alongside 30 participants with non-psychotic depression and 30 non-clinical controls. It was hypothesised that OGM and problem-solving deficits would characterise groups with depression, irrespective of the presence of absence of delusions. The results, however, indicated no association of depression with either OGM or problem solving scores. Instead, participants with persecutory delusions showed OGM and problem solving deficits, relative to the non-psychotic depressed and non-clinical control groups. OGM and problem solving deficits were significantly intercorrelated in the delusions group, and both were particularly elevated in those participants who showed a "jumping to conclusions" (JTC) data gathering bias. Problem solving deficits predicted the persistence of paranoia and depression over six months in the group with delusions.

Our findings indicate significant prevalence of OGM and problem-solving deficits in people with persecutory delusions, but not by association with depression, as had been expected. A role for social problem-solving deficits in the maintenance of persecutory delusions is suggested, which could mediate the effects of biases such as JTC and OGM.

Examining the stability of the jumping to conclusions bias over time using an American community sample

Michelle Lim, Swinburne University of Technology, Australia ; John Gleeson, Australian Catholic University, Australia; Thomas Rodebaugh, Washington University in St Louis, USA

The jumping to conclusions (JTC) bias is a well-known reasoning bias associated with the severity of abnormal beliefs such as delusions (So et al., 2012). It refers to a tendency to gather less evidence before reaching a decision (Van Dael et al., 2006). Although the reasoning bias is well-demonstrated in individuals with psychotic disorders, the bias can also occur in nonclinical samples (Freeman et al., 2008). Most of the studies in the JTC bias have been cross-sectional, and the stability of the reasoning style over time has been under examined. In a recent study, people with first-episode psychosis generally became less hasty with their decisions over time when given an abstract reasoning task but those who were less hasty also reported fewer psychotic symptoms (Dudley et al., 2013).

We administered a newly developed emotionally-salient task known as the Social Probabilistic Inference Task (SPIT) to measure the JTC bias across time in an American community sample. In the SPIT, participants are told that they were being introduced to someone in a social situation. The new person will show the participant a series of positive and negative facial expressions during a conversation. The participant is asked to decide if the new person likes or dislikes them based on the facial expressions shown.

Participants completed the SPIT together with paranoia measures online. They were randomized into one of two SPIT conditions at each timepoint. A liked condition where the participant was shown more positive than negative facial expressions, and a disliked condition where the participant was shown more negative than positive facial expressions. The main index drawn from the SPIT is the number of facial expressions, a participant requests before reaching a decision of whether he or she was liked or disliked by another person.

Initial results indicated that the two conditions of the SPIT task appear to be stable over time (3 time points over 3 months). However, it appears that the relationship between the SPIT and paranoid dimensions may not necessarily be related over time, at least in a healthy community sample. Further prospective studies are needed to provide evidence a causal relationship between the JTC bias and psychotic symptoms (specifically those related to persecutory delusions). And although the SPIT may be a new experimental reasoning task that measures the JTC bias, further validation in a clinically diagnosed group with psychotic disorders is required.

Targeting reasoning biases in delusions; A Pilot Study of the Thinking Well Group

Alison Jones, Kings College London, Helen Waller, Kings College London; Amy Hardy, Kings College London

Delusions are considered a significant diagnostic marker in psychosis (DSM-IV-TR, American Psychiatric Association, 2000) and are a symptom present in approximately 75% of those with a diagnosis (Freeman et al, 2007). Delusions often persist despite antipsychotic medication and Cognitive Behavioural Therapy and are a symptom which can significantly affect wellbeing and quality of life (Norman et al, 2000).

Research has shown that 'jumping to conclusions' (JTC) and 'belief flexibility' (BF) are reasoning biases implicated in the formation and maintenance of delusions (Garety and Freeman, 1999; Garety et al, 2001). Previous studies have targeted these reasoning biases and have shown a computerised reasoning programme has improved JTC, belief flexibility and conviction in delusions (Ross et al, 2009; Waller et al, 2011; Garety and colleagues in press). The present study is the first to adapt and pilot the intervention in a group format.

The group format included the computerised tasks and information, alongside interactive exercises, aimed at enhancing participants' abilities to apply their new skills to their own experiences and work towards the completion of a personal goal which they previously found difficult due to their delusional beliefs. There are several factors which support the rationale for adapting the individual computerised

reasoning programme to a group format, which broadly fall into two additional benefits; normalisation and cost effectiveness. It was hoped that the group context would allow greater normalising in a non-threatening or challenging context and participants may find ideas more acceptable and viable if generated by peers than ideas coming from a health professional.

17 participants with a diagnosis of psychosis and above 50% conviction in a distressing delusion were recruited from community mental health teams in the South London and Maudsley NHS Foundation trust. Participants were randomised in a 2:1 ratio to either the group intervention or a waitlist. Three groups were run over an 8 month period. Groups had approximately 6 participants, which included waitlist controls from the previous group. The group involved six weekly 1.5 hour sessions including group discussion, use of CBT-based techniques aimed at introducing and discussing key training tips (e.g. to 'gather more information before coming to a conclusion', 'remember your mood can affect how you see things'; 'could there be a less upsetting explanation'; 'look for evidence your first thought may not be true at least on this occasion'.)

Modules contained interactive components and real life examples designed to illustrate JTC leading to negative or paranoid conclusions. Outcomes, including delusions, reasoning style and mood were assessed at baseline, post-intervention (a week after completing the group) and at 1 month follow-up. Results of the statistical analysis on key outcomes will be presented. A thematic analysis of participants' qualitative feedback on the group, including its acceptability and helpfulness will also be given. The implications of the results on possible future service provision and research will be discussed.

Exploring psychotic experiences in non-need for care populations: Findings from the UNIQUE study (UNusual Experiences enQUIry Study)

Convenor: Emmanuelle Peters, Institute of Psychiatry, King's College London

Appraisals of experimental analogues of psychotic symptoms in individuals with psychotic experiences with and without a 'need for care'

Emmanuelle Peters, Institute of Psychiatry, King's College London; Thomas Ward, Institute of Psychiatry, King's College London; Mike Jackson, Bangor University; Craig Morgan, Institute of Psychiatry, King's College London; Philippa Garety, Institute of Psychiatry, King's College London

There is a high incidence of seemingly benign psychotic symptoms, such as hearing voices, in the general population, in accordance with the continuum view of psychosis. Cognitive models of psychosis propose that interpretations ('appraisals') of these experiences are key to determining the transition from anomalous experience to psychotic symptom. Our previous pilot studies (Brett et al, 2007; Ward et al, 2013) show that psychotic patients are more likely to think their experiences are caused by someone else ('personalising' appraisals), and less likely to have 'normalising' or 'psychological' appraisals (eg that they are part of the normal range of human experience), than individuals displaying psychotic-like experiences without a 'need for care'. We have also found that these appraisals are linked to distress, with personalising appraisals predicting more distress, and normalising and psychological appraisals predicting less distress (Brett, Heriot-Maitland et al, 2014).

210 individuals were recruited (70 'need-for-care; 70 non-need for care; and 70 controls) from two sites, one urban (South East London) and one rural (North Wales). The three groups' appraisals were compared following experimental tasks inducing anomalous experiences. The Cards Task and the Telepath were used as analogues of thought interference symptoms, and the Virtual Acoustic Paradigm (VAP) as an analogue of auditory hallucinations.

It was predicted that the clinical group would endorse more maladaptive appraisals than the non-need for care group, who would not differ from the controls. A similar pattern was predicted for salience, distress and threat ratings of the experimentally-induced anomalous experiences, and likelihood to incorporate the experimental set-up into their ongoing experiences.

The study findings will be discussed within the context of cognitive models of psychosis.

Embracing uncertainty- The role played by Belief Flexibility in responding adaptively to psychosis-like experiences

Thomas Ward, Institute of Psychiatry, King's College London; Philippa Garety, Institute of Psychiatry, King's College London; Mike Jackson, Bangor University; Craig Morgan, Institute of Psychiatry, King's College London; Emmanuelle Peters, Institute of Psychiatry, King's College London

The role played by belief flexibility and reasoning style in maintaining distressing delusional beliefs can be elucidated by comparing individuals with psychotic-like experiences with and without a need for care. Qualitative differences between the groups may not be picked up within standard (dichotomous) ratings, highlighting the risk that more nuanced aspects of belief flexibility that could act as protective factors for those in the non-need for care group may be neglected.

Two groups of individuals with persistent anomalous experiences with and without need for care (n=20 per group) will be compared on their reasoning and belief flexibility about their unusual experiences.

Content analysis will be conducted on transcriptions of responses to:

- 1) The specific belief flexibility questions (taken from the Maudsley Assessment of Delusions; (MADS; Wesseley et al, 1993)
- 2) The appraisal question asking "what sense do you make of your experiences?" (AANEX; Brett et al, 2007).

Group differences in the following areas will be presented:

- 1) The nature of the individual's belief about their unusual experiences
- 2) The way in which the individual construes the role of evidence in understanding their experiences.
- 3) The style of reasoning employed when discussing beliefs and evidence, with reference to
 - a. Experiential versus rational type reasoning
 - b. Presence of reasoning/ cognitive biases
- 4) The relevance of Existential Quest to the comparison of reasoning across the two groups.

Potential clinical implications that may follow from how belief flexibility manifests in the 'non-need for care' group will be discussed. The relevance of a broader conceptualisation of Belief Flexibility will also be discussed.

Victimisation in people with psychotic experiences with and without a 'need for care'

Monica Charalambides, South London and Maudsley NHS Foundation Trust; Thomas Ward, Institute of Psychiatry, King's College London; Philippa Garety, Institute of Psychiatry, King's College London; Mike Jackson, Bangor University; Craig Morgan, Institute of Psychiatry, King's College London; Emmanuelle Peters, Institute of Psychiatry, King's College London

Psychotic-like experiences are commonly found in the general population; this raises the question as to why some individuals are in 'need for care' whilst others are not adversely impacted by such experiences. Recent meta-analyses have established strong evidence of increased rates of stressful adverse experiences across the life span, particularly those of a victimising or intrusive nature, in individuals endorsing psychotic symptoms (Varese et al., 2012). The current study aimed to design a more comprehensive interview to assess and compare victimisation in clinical and non-clinical populations with psychotic-like experiences, incorporating a wider range of experiences and factors that may serve as specific risk indicators for psychosis.

The Victimisation Experiences Schedule (VES) was developed using established interviews and questionnaires to assess the two categories of: (a) interpersonal trauma and (b) perceived discrimination across the lifespan. A measure of duration, severity, frequency, positive and negative social support, impact, and powerlessness in relation to these experiences were also included. Victimisation experiences of individuals currently endorsing psychotic-like experiences in 'need for care' (N = 25) and 'not in need for care' (N = 25) were compared. Inter-rater reliability (IRR) was obtained to measure the degree of consistency in scoring between raters.

IRR completed on 20% of the sample (N = 10; 5 clinical, 5 non-clinical) was excellent. There were no significant differences in number of lifetime victimisation experiences between groups; however the 'need for care' group reported higher rates of adulthood discrimination. The non-clinical group were significantly more likely than the clinical group to have received higher levels of positive support for overall adulthood victimisation. Current impact of total victimisation experiences was higher in the clinical than the non-clinical group, with trends in a similar direction for total adulthood experiences,

lifetime discrimination, and lifetime interpersonal trauma independently. Similar findings in relation to current levels of powerlessness were yielded; the clinical group were more likely to report higher levels of powerlessness for total victimisation experiences.

Similar rates of total victimisation experiences across the lifespan in both groups suggest that victimisation may be implicated in the formation of anomalous experiences, but not in determining 'need for care' status. Factors such as social support and on-going impact and powerlessness in relation to the victimisation experiences, may be more relevant to the transition to 'need for care'. Through the use of a more comprehensive victimisation interview, the study's attempt to address methodological shortcomings of previous research has proved useful in uncovering not only differences at a discrimination level, but other potential variables of importance in the relationship between victimisation and need for care.

What is benign about benign psychotic experiences?

Mike Jackson, Bangor University Louise Brookwell, Bangor University; Thomas Ward, Institute of Psychiatry, King's College London; Philippa Garety, Institute of Psychiatry, King's College London; Emmanuelle Peters, Institute of Psychiatry, King's College London

Psychotic like anomalous experiences in the normal population (PLEs) are the most common form of psychotic experience, and they are often viewed as 'sub-clinical' or indicative of an underlying pathology which does not reach clinical levels. However, some previous research has indicated that PLEs are often viewed by the experient as being positively helpful, meaningful, constructive or transformational. From a clinical perspective, the idea that psychotic experience can be constructive is a paradoxical and challenging concept. Current explanatory models of psychotic experience tend to focus on dysfunction and distress, and do not readily account for benign consequences.

The present study aimed to examine in more detail the ways in which people without a need for care find their PLEs helpful to them, and to explore how far these themes emerge in the experiences of need for care participants, and how they differ.

Interpretative Phenomenological Analysis was used to explore the lived experience of 6 individuals reporting benign psychosis, with a particular focus on the function the experiences have in the participant's lives. Emerging themes were then explored and contrasted in the accounts of 6 individuals with diagnoses of psychotic disorders. These themes will be reported and discussed within the context of whether PLEs can serve a positive function for the individual. The implications for the development of our cognitive models of psychosis to account for benign psychotic function will be explored.

Mindfulness: New Developments

The genetic and environmental influences on mindfulness and its aetiological associations with depression symptoms and anxiety sensitivity.

Monika Waszczuk, SGDP, Institute of Psychiatry, King's College London; Antonova, Department of Psychology, Institute of Psychiatry, King's College London; Claire Haworth, SGDP, Institute of Psychiatry, King's College London; Robert Plomin, SGDP, Institute of Psychiatry, King's College London; Helena Zavos, SGDP, Institute of Psychiatry, King's College London; Thalia Eley, SGDP, Institute of Psychiatry, King's College London

Mindfulness-based therapies have been shown to be effective in treating internalizing psychopathology. There is a growing interest in the application of mindfulness-based approaches in adolescence, a developmental period when depression prevalence increases. However, little is known about the aetiology of the associations between mindfulness disposition, emotional problems and cognitive biases associated with internalising problems. The aim of this study was to examine the role of genetic and environmental factors in mindfulness, and its aetiological overlap with depression and anxiety sensitivity, a cognitive bias associated with anxiety and depression which refers to an enhanced sensitivity towards symptoms of anxiety, with a belief that these are harmful.

Over 2,200 16-year-old twins from a population-based study (TEDS) rated their mindfulness disposition, depression symptoms and anxiety sensitivity.

Twin modelling analyses revealed that mindfulness disposition is 34% heritable and 66% due to non-shared environmental factors. Common genetic influences were found to explain over half of the

moderate phenotypic association between low mindfulness, depression and anxiety sensitivity. However, there was also evidence of significant genetic effects on mindfulness independent of internalizing psychopathology.

The present study is the first to show that both genes and environment play an important role in the aetiology of mindfulness in adolescence. Common genetic liability underpins the co-occurrence of low mindfulness, depression and anxiety sensitivity. The common genetic pathway suggests that these problems may share a neurological perturbation and that mindfulness-based therapies may work by modifying a genetically predisposed susceptibility factor for cognitive biases and depression. Although an increasing number of practitioners engage in various forms of mindfulness-based therapies, the biological and psychological mechanisms behind this practice remain unclear. The current study provides a preliminary insight into how the positive impact of mindfulness-based interventions may come about.

Engagement in Mindfulness-Based Interventions

Moitree Banerjee, University of Sussex; Kate Cavanagh, University of Sussex; Dr Clara Strauss, Sussex Partnership NHS Foundation Trust

Mindfulness based interventions (MBIs) have developed status as effective and popular interventions in mental health care, but limited research has explored participant engagement and retention in MBIs. Engaging with mindfulness interventions and practice may be particularly challenging. The main reasons may be people with mental health problems such as depression or anxiety are likely to experience negative thoughts and feelings. Mindfulness practice, which encourages noticing of current experiences, may be difficult to tolerate in this context. Second, becoming preoccupied with negative thoughts and feelings is characteristic of depression and anxiety, for example in the form of rumination, worry and catastrophizing. Such repetitive thinking styles are in conflict with the “being mode” of mindfulness, potentially making the skill more challenging to accomplish and leading to disengagement from MBIs. The present meta-analysis examined the relative risk of dropout from MBIs and factors associated with this. Electronic databases were searched systematically to obtain data from randomized control trials (RCT) comparing mindfulness with an inactive control or an active treatment intervention that reported sufficient information on drop-out. The studies were coded and meta-analyses were conducted using of the Cochrane Collaboration Review Manager 5.2. Mean dropout rates and risk ratios were computed and the extent to which these effects were a function of measured moderators was explored. The qualitative data on dropout was also explored.

23 RCTs with a total of 1678 participants were included. The mean dropout rate from the MBIs was 13.79%. Participants in the MBI arm were at a higher risk of dropping out compared to those in the inactive controls with a risk ratio 1.68 ($p=.01$). Dropout risk was lower in MBIs compared to other active interventions; however, the comparison between these conditions was not statistically significant. Dissatisfaction with MBIs was the major cause of dropping out from the intervention.

These findings indicate that participants in research trials are at a significantly greater risk of dropping out from MBIs compared to inactive, but not active control conditions. Further research is needed to establish the processes which facilitate engagement in MBIs for people who may benefit from these interventions. Suggestions are made on ways to improve engagement in MBIs in the outpatient setting. To the best of our knowledge, this is the first ever meta-analysis looking into engagement in MBIs. This meta-analysis found relatively low rates of drop out from the MBIs in RCT studies compared to other psychotherapies such as cognitive-behavioural therapy (CBT). This indicates that MBIs are engaging. However, from the qualitative data available, dissatisfaction with the intervention is a key reason for dropping out from MBIs as opposed to the logistic reasons for dropping out in CBT. It might be important to explore which aspects of the MBIs are dis-satisfactory. The data available suggested that longer scheduled class sessions may be associated with lower dropout rates. Suggestions are made on improving engagement of MBIs and increasing the understanding of mindfulness principles.

The effects of mindfulness and relaxation training in reducing vulnerability for depression

Ana Costa, Institute of Psychiatry, King's College London; Paul Chadwick, Institute of Psychiatry, King's College London; Thorsten Barnhofer, Institute of Psychiatry, King's College London

This study aimed to elucidate the effects of mindfulness training in depression by comparing its effects against relaxation, and by exploring the relation between treatment-related changes in cognitive functioning and changes in symptoms at different stages of the recovery process.

Currently depressed patients were randomly allocated to receive either a brief mindfulness training (N = 20) or a relaxation training using guided imagery (N = 20). Participants were introduced to the respective techniques in a single session, and practiced daily over a 2-week period using audio recordings of guided practices. Self-reported levels of depressive symptoms, difficulties in emotion-regulation, attentional control, ability to decenter, and mindfulness were assessed pre- and post-intervention, and at a 1-week follow-up.

From pre- to post-intervention, symptoms of depression significantly decreased and cognitive functioning significantly increased in both groups. Changes were maintained at follow-up. When controlling for depressive symptoms, results showed significantly higher improvements in emotion regulation and mindfulness skills in the mindfulness group. The ability to decenter predicted change of symptoms from pre- to post-intervention, whilst mindfulness skills significantly predicted symptoms during the maintenance phase.

The findings show that brief interventions can significantly reduce symptoms and enhance cognitive functioning in depression. However, in order to improve emotion regulation above levels explained by reductions in symptoms more systematic mental training seems necessary. Furthermore, whilst the ability to disengage from negative patterns of thinking seems crucial for reduction of acute symptoms, maintenance of gains seems to critically rely on broader skills in mindfulness.

Brief mindfulness and relaxation interventions are effective in reducing depressive symptoms among clinically depressed individuals and can be integrated into CBT for depression. Improvement in emotion regulation skills, beyond reductions in depressive symptoms, are better achieved through mindfulness than through relaxation.

A meta-analysis examining the psychological benefits of mindfulness-based interventions (MBIs) for healthcare practitioners

Clara Strauss, University of Sussex; Kate Cavanagh, University of Sussex; Thomas Mundy, University of Sussex; Fergal Jones, University of Sussex; Puffin O'Hanlon, University of Sussex

The demanding nature of working in healthcare settings confers a particular vulnerability to stress among healthcare practitioners, has been shown to impair employee performance and to contribute to staff sickness absence. There is evidently a need for effective interventions to enhance the psychological wellbeing of health care professionals (Shapiro, Shapiro & Schwartz, 2000). This paper presents a meta-analysis of studies that have examined the psychological benefits of mindfulness-based interventions (MBIs) for healthcare practitioners.

The authors searched Web of Knowledge, Psycinfo and Scopus from the first available year to November 2013. Studies were included if they contained validated outcome measures, mindfulness meditation practice, a randomized control design with extractable data and health care staff/trainees.

462 articles were obtained from literature searches, only twelve met our rigorous inclusion criteria and were included in the final review. Overall, relative to control conditions, MBIs were associated with significantly lower levels of staff stress/distress at post-intervention.

This meta-analysis of methodologically sound RCTs provides credible evidence to support the benefits to emotional wellbeing for healthcare practitioners undertaking MBIs. Limitations of studies include a reliance on inactive control conditions, making the specific benefits of mindfulness practice and principles difficult to ascertain. Potential secondary benefits of staff mindfulness training for health care services and service users are also discussed.

MBIs may be one alternative way to promote healthcare practitioner wellbeing and potential secondary benefits to health care services and service users warrants further research.

Mindfulness as a novel approach to eating disorder prevention: A preliminary controlled evaluation

Melissa Atkinson, University of the West of England

This preliminary randomised controlled trial assessed the efficacy and acceptability of a mindfulness-based intervention with respect to reducing the risk of eating disorders in young women.

Forty-four young adult females with body image concerns ($M = 20.57$, $SD = 3.22$) were randomly allocated to a mindfulness-based or a dissonance-based intervention (3 x 1 hour weekly sessions), or to assessment-only control. Self-report measures of eating disorder risk factors, symptoms, and related psychosocial impairment were compared at baseline, post-intervention, 1-month, and 6-month follow-up.

At post-intervention, acceptability ratings for both interventions were high. Mindfulness participants demonstrated statistically significant improvements relative to control at post-intervention for weight and shape concern, dietary restraint, thin-ideal internalisation, eating disorder symptoms and related psychosocial impairment; however, these gains were largely lost over follow-up. Dissonance participants did not show statistically significant improvements relative to control on any outcomes, despite small to moderate effect sizes.

These findings demonstrate the acceptability and short-term efficacy of a mindfulness-based approach to reducing the risk of disordered eating in young women. This provides support for the continued evaluation of mindfulness in the prevention and early intervention of eating disorders, with increased efforts to produce maintenance of intervention gains.

This research represents an important step in the evaluation of mindfulness as a strategy for ameliorating body image concerns and eating problems.

Training and Evaluation: Tools for the Road Ahead

Convenor: Sarah Rakovshik, Oxford Cognitive Therapy Centre and University of Oxford

Expert insight into the assessment of CBT competence: A qualitative exploration of experts' experiences, opinions and recommendations

Freda McManus, Oxford Cognitive Therapy Centre; University of Oxford

To offer insight into how CBT competence is currently measured and evaluated, and to highlight ways in which the assessment of CBT competence could be further improved.

The current study utilises qualitative methodology to examine CBT experts' ($N = 19$) experiences of assessing CBT competence. Semi-structured interviews were used to explore participants' experiences of, opinions about and recommendations for assessing the competence of CBT therapists. Interview transcripts were then analysed using Interpretative Phenomenological Analysis in order to identify commonalities and differences in the way CBT competence is evaluated.

Four super-ordinate themes were identified: (i) what to assess: the complex and fuzzy concept of CBT competence; (ii) how to assess CBT competence: selecting from the toolbox of assessment methods; (iii) who is best placed to assess CBT competence: expertise and independence; and (iv) pitfalls: identifying and overcoming assessment biases.

Priorities for future research and ways in which the assessment of CBT competence could be further improved are discussed in light of these findings.

The Supervisor Competency Scale

Helen Kennerley, Oxford Cognitive Therapy Centre; 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. This presentation describes the evolution of a tool for assessing the quality of CBT supervision. 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. It is now in the final stage of validation.

The Assessment of Core CBT Skills (ACCS) – a new tool for assessing CBT competence

Kate Muse, University of Oxford

Assessing the competence with which CBT is delivered is crucial to the success of the current drive to expand CBT training and service provision, and to the widespread dissemination of CBT into routine clinical practice settings. This is because effective measures provide a means of assessing the training of

new CBT therapists and ensuring the quality of treatment provision within routine clinical practice. In addition, competence assessments that provide detailed corrective feedback and promote self-reflection play an important role in guiding therapists' ongoing learning and development. Thus, it is essential for training providers and clinical services to have access to reliable, valid and feasible tools to assess the competence of CBT therapists. As the assessment measures which are currently available have been widely criticised, there is an urgent need for improved measures for assessing CBT competence, particularly those that assess whether therapists can demonstrate the skills necessary to effectively deliver CBT. This talk will present a novel CBT competence rating scale – the Assessment of Core CBT Skills (ACCS) - which aims to build upon currently available measures in order provide a tool with improved validity, reliability and usability. The primary intention of the ACCS is to provide a framework which assessors can use to deliver formative and summative feedback about a therapist's performance within an observed treatment session and which therapists can use as a tool for self-reflection. This talk will briefly describe the ACCS scale and its development and will present initial data examining its reliability and validity.

Training in action: effects of Internet-based CBT training on therapists' competence and patients' outcomes in a three-armed RCT

Sarah Rakovshik, Oxford Cognitive Therapy Centre; University of Oxford

This study's primary aim was to investigate the effect on therapists' competence ($N = 61$) of an online training package consisting of Internet-based training with either reflection or supervision by Skype from an accredited CBT therapist. Clinical outcomes for patients ($N = 177$) treated by these therapists during the online training were also compared.

Participants were randomized into three groups: (1) 'delayed-training' control, (2) Internet-based training with reflection (IBT-R), and (3) Internet-based training with CBT supervision via Skype (IBT-S).

For therapist competence, there was a significant effect of both online training and Skype supervision.

Patients' clinical outcomes did not show significant effects of therapists' training condition when

controlled for therapists; however, sensitivity analyses did show some variation between conditions.

IBT programs may be a scalable and effective method of disseminating CBT into routine clinical practice,

particularly for populations without ready access to more traditional 'live' methods of training. The

positive effects of IBT, particularly when accompanied by supervision, demonstrate that IBT can remain

effective even when therapists must generalize and maintain skills in RCP across a variety of clinical

presentations. There may also be some evidence that supervision adds additional benefit during IBT

training; however, further investigation is needed to clarify the effects of training modality on patients'

clinical outcomes.

Panel Discussions

Despite the Evidence, Why are we not Creating More Trauma Informed Mental Health Services?

Convenor: Suzanna Rose, Berkshire Healthcare Foundation Trust

Panelists Farooq Ahmad, Berkshire Healthcare Foundation Trust; Gwen Bonner, Berkshire Healthcare Foundation Trust; Sue MacLaughlin, Berkshire Healthcare Foundation Trust; Simon Proudlock, Berkshire Healthcare Foundation Trust

It is known that exposure to a traumatic event (whether developmental/adult or both) can lead to a range of subsequent serious and sometimes chronic range of psychopathology such as post-traumatic stress disorder (PTSD) (DSM 5 APA 2013), depression, substance misuse, anxiety disorders, personality distortions and psychosis (Herman 1992; Van der Kolk 2005; Read, Fink, Rudegeair, Felitti & Whitfield 2008; Mueser, Salyers, Rosenberg, Goodman 2004, Read 2013).

Current British Position

Given these data it is somewhat surprising that, until relatively recently, this issue was not specifically addressed within the British NHS mental health services. However, two policy papers published in 2008 appeared set to change this. 'Refocusing the Care Programme: Approach and Practice Guidelines' was

published by the Department of Health in March 2008 and became policy in October 2008. It is worth quoting the relevant section in full (page 28) 'Childhood experience of sexual and other abuse is known to be more frequent in the histories of individuals with both mental illness and personality disorders (MNMSF 1999). Research indicates that around 50% of women service users have been sexually victimised as children, notwithstanding further abuse in adulthood and a significant number of men service users have also experienced abuse. It is now DH policy that, following appropriate training for staff, exploration of violence and abuse is routinely undertaken in all mental health assessments. Questions should be asked by suitably trained staff at assessment about the experience of physical, sexual or emotional abuse at any time in the service user's life. The response, with brief details, should be recorded in the case records/care plans. If the specific question is not asked, the reason (s) for not doing so should be recorded.'

Secondly, again in 2008 the NHS Confederation (in conjunction with CSIP and the DH) published a briefing paper entitled 'Implementing National Policy on Violence and Abuse' (Issue 162). The key points in this document again highlight the prevalence of violence and abuse histories in mental health service users and again it mentions DH policy of asking questions around traumatic exposure as part of routine mental health assessment. Additional information is around embedding this question within the clinical audit process, ensuring sexual safety within inpatient units, actively involving service users in this process, enabling staff who are survivors of abuse themselves to access confidential counselling and developing appropriate services for those service users who wish to work with their abuse issues by providing appropriate interventions. From this work training was designed and delivered and an evaluation of that training was published (Donohoe 2010). This review (Donohoe 2010) highlighted increased confidence in clinicians asking about abuse and that relevant questions were now being asked as a routine part of assessment. However, it is currently not clear how widespread that training has been available within the NHS and other relevant services in England.

Meanwhile within the British mental health system there appears only to be some fragmentary acknowledgement of this. And while the barriers to, for instance, asking questions about past abuse are well known (Read et al. 2008), the fact remains that currently many of our mental health services are not designed to be trauma informed. While the research evidence in this arena remains persuasive it does not appear to have translated to clinical practice in many areas of mental health service provision.

The Panel Discussion

Why is this? This panel discussion will focus on various views. It will discuss the view that discussing traumatic exposure is 'a can of worms' and should not be addressed. It will also set out the case for creating more trauma informed mental health services and welcome discussion from the floor around possible issues and barriers to implementing this.

Behind the Curtain: The Impact of Involvement of Being a Therapist in a Research Trial

Convenor: Christopher Martell University of Wisconsin - Milwaukee USA

Panelists: Sandra Coffman Private Practice and University of Washington Seattle; Zafra Cooper Oxford University; Heather O'Mahen University of Exeter

Acquiring the evidence for evidence-based treatments requires the participation of therapists in research trials. While we know a great deal about the efficacy of many behavioral and cognitive behavioral treatments, less is known about the effectiveness of these treatments in actual clinical settings. The often-touted gap between clinical practice and research has been navigated in randomized clinical trials by research therapists who often maintain active clinical practices as well. Therapists who have actually contributed to the research base do not share the common assumption that research therapy is done in a nearly sterile environment with therapists following a lock-step protocol that allows no flexibility and minimal clinical judgment is not shared by. This panel discussion will examine the similarities and dissimilarities between conducting therapy as part of a research trial and conducting therapy in a regular clinical service. Clearly the more similar the treatment in the research lab is with treatment in an actual service, the more likely the effectiveness of the therapy. Therapists from the UK and North America will explore the behind-the-scenes experience of doing therapy in research. Some of the issues involved include: differences in time allotted for treatment between the research and clinical setting; adapting

one's personal style to a protocol; concluding therapy at required, often arbitrarily determined, times; the on-going impact of participating in research and maintaining strict adherence to a study protocol on the clinician's general practice. This panel provides unique perspective of research therapists who are typically silently in the background of research teams. The panel will discuss criticism of randomized trials such as the frequent complaint that research clients are carefully screened and therefore not like actual clinical clients, or that research therapists have an abundance of training and supervision opportunities to insure that treatment is conducted faithfully. The truth behind some of these criticisms will be considered, as well as a discussion of the lack of validity to some of these complaints. The panel will also discuss the possible parameters of modifying treatments in clinical settings: when is it acceptable to apply the treatment flexibly versus losing fidelity to the treatment protocol and/or principles. There are also differences between highly structured protocol driven treatments, and those treatments that are principle driven but provide a degree of inherent flexibility for therapists. This panel will consist of active audience participation and audience members who have also worked as research therapists will be encouraged contribute to the conversation and provide their perspectives. While the participants have not all been determined, Sandra Coffman, Ph.D., Clinical Faculty in the Department of Psychology – University of Washington – Seattle, Washington USA will serve as one of the panelists. Implications: CBT therapists are expected to become proficient in utilizing empirically-based treatments in their practices. This panel discussion will help therapists tackle questions such as how flexible one can be and still be doing a treatment faithfully?

Is The Scientist-Practitioner Model Still Relevant in the 21st Century?

Conveor: Steve Flatt, Psychological Therapies Unit, Liverpool

Panelists; Paul Gilbert, University of Derby; Steve Flatt, Psychological Therapies Unit, Liverpool; Paul Salkovskis, University of Bath, Michael Scott, Sheffield Hallam University

The scientist-practitioner model has been regarded as integral to the delivery of psychological services for over 60 years. This symposium addresses the strengths and weaknesses of the model and considers whether it is still 'fit for purpose'. Alternative conceptualisations of the CBT practitioners role will be elaborated.

Prof Paul Salkovskis argues that the model has been and is likely to continue to be very productive and that it has evolved in ways that have made it even more fit for present purposes. Dr Mike Scott suggests that the major issue facing CBT is dissemination and that this is ill-served by the scientist- practitioner model and recommends an 'engineering' metaphor to better encapsulate the work of the vast majority of practitioners. Steve Flatt emphasises the need to objectively reconsider all aspects of both roles and suggests that oftentimes the current model is a hindrance to this. Prof Paul Gilbert as the discussant will weigh the different contributions from his evolutionary/ social/ compassion focussed perspective.

Implications: Depending upon which perspective is adopted there could be a shift from an almost wholly intrapsychic CBT, to one that can also better address the social context in which treatment occurs e.g. social problems, managerial targets. Practitioners would also be better equipped to address the external validity of randomised controlled trials and enabled to adapt findings to their social context.

Cognitive Behavioural Therapy Approaches to Working with Distressed Couples

Convenor: Michael Worrell, Central & North West London NHS Foundation Trust

Panellists: Christopher Martell, University of Wisconsin, USA; Michael Worrell, Central & North West London NHS Foundation Trust; Sarah Corrie, Central & North West London NHS Foundation Trust; Marion Cuddy, South London and Maudsley NHS Foundation Trust
Andre Geel, Central & North West London NHS Foundation Trust

There has been a recent growth of interest in, and training focussed upon, cognitive behavioural therapy for couple distress. There is in fact a long history of empirically driven work on couple distress within the behavioural and cognitive psychotherapies and CBT approaches to couple therapy represent one of only a handful of evidence based approaches. At the present time there exist a number of distinct but also overlapping Cognitive Behavioural Approaches to work with couples. These include Traditional

Behavioural Couples Therapy (BCT), Integrative Behavioural Couple Therapy (IBCT), Cognitive Behavioural Couples Therapy (CBCT) as well as some newer Acceptance and Commitment Therapy based approaches that as yet have not been subject to the same level of empirical investigation. This clinical roundtable will focus upon clarifying the points of convergence and divergence between the main CBT approaches to couple therapy at the level of both theory and clinical practice. Delegates will gain an understanding and appreciation for the richness and diversity of Cognitive Behavioural work with couples as well as an understanding of the main areas of debate and challenges for future growth in this field.

Clinical Roundtables

Using Supervision to Improve Clinical Services for Individuals with Eating Problems

Convenor: Glenn Waller, University of Sheffield

Discussants Denise Ratcliffe, Central and North West London NHS Trust; Madeleine Tatham, Norfolk Community Eating Disorders Service; Hannah Turner, Southern Health NHS Foundation Trust

This session will address the role of supervision in developing and maintaining high quality clinical services for individuals with eating problems. This can include changing the practice of supervisees, changing a broader culture, addressing physical and psychiatric risk, and ensuring that health service requirements and professional development are not incompatible. Each presenter will outline an experience of their own where supervision identified, raised or addressed difficulties in clinical practice. These cases will be used to prompt discussion among the attendees of best supervisory practice in clinical settings where eating disorders are treated.

Working with Distressing Voices: New Developments and Future Directions

Convenor: Craig Steel, University of Reading

Discussants: Katherine Berry, University of Manchester; Alan Meaden, University of Birmingham; Dirk Corstens, RIAGG group, Maastricht, Netherlands; Mark Hayward, Sussex Partnership NHS Foundation Trust and University of Sussex; Charles Heriot-Maitland, Kings College London; Rufus May, Bradford Hearing Voices Group

Most clinical trials within the area of CBT for psychosis report outcomes in relation to psychotic symptoms as a whole. The evidence base for cognitive therapy specifically targeting distressing voices is relatively minimal. However, several distinct clinical perspectives are emerging within the clinical literature. Whilst these perspectives overlap within some of their core assumptions, they vary in key areas, such as how to understand the voice-hearers relationship with the voice.

The discussion will start with an introduction and brief description of a clinical case (Craig Steel). This will be followed by each speaker outlining the key features of their clinical perspective in relation to this case. The perspectives put forward will be based on attachment and voices (Katherine Berry), cognitive therapy for command hallucinations (Max Birchwood), the work of Intervoice (Dirk Corstens), relating therapy for voices (Mark Hayward), compassion focussed therapy for voices (Charles Heriot-Maitland) and the work of the Hearing Voices Network including Voices Dialogue Approaches (Rufus May). This will be followed by a discussion on which distinct elements of these approaches may make them appropriate for specific types of clinical presentation.

Skills Classes

Cognitive Therapy for Social Anxiety Disorder in Adolescents

David M Clark, University of Oxford and Eleanor Leigh, King's College, London

Social anxiety disorder (SAD) is a common and disabling anxiety disorder that has a particularly low natural recovery rate, so there is a real need for effective treatments.

Randomized controlled trials have shown that individual cognitive therapy (based on the Clark & Wells 1995 model) is highly effective in adults and compares favourably with other treatments (exposure therapy, group CBT, IPT, psychodynamic psychotherapy, SSRI's, and pill placebo). However, SAD invariably starts in childhood or adolescence, and can severely interfere with school performance and social development. Ideally, effective treatment should therefore start in childhood, rather than waiting until adulthood. Unfortunately, the evidence base for adolescent treatments is weak (NICE, 2013) and there is some evidence that existing child focused CBT programmes benefit children with social anxiety disorder less than children with other anxiety disorders.

In response to this problem, we have experimented with adapting individual cognitive therapy (based on the Clark & Wells model) for use with adolescents. We have obtained excellent results in a small case series and will be exploring the approach further.

This clinical skills session will outline the Clark & Wells model and illustrate the key treatment procedures that have been developed from the model. These include: the self-focused attention and safety behaviours experiential exercise, video-feedback, externally-focused attention training, behavioural experiments, and procedures (discrimination training and memory re-scripting) for addressing early experiences that influence patients' current behaviour in social situations. Particular emphasis will be placed on how the techniques can be applied with adolescents and the key adaptations that are needed.

Learning Objectives:

1. To be able to identify key processes in maintaining social anxiety disorder
2. To be familiar with the main procedures in cognitive therapy for social anxiety disorder
3. To learn about the key adaptations of cognitive therapy for social anxiety disorder with adolescents

David M Clark is Professor of Experimental Psychology at the University of Oxford. He is well-known for his pioneering work on the understanding and treatment of anxiety disorders. With colleagues, he has developed effective cognitive-behaviour therapy programmes for four different anxiety disorders: panic disorder, social anxiety disorder, post-traumatic stress disorder and health anxiety (hypochondriasis). He has also played a key role in disseminating evidence-based psychological treatments, including the IAPT programme.

Eleanor Leigh is a Senior Clinical Psychologist at the Anxiety & Traumatic Stress Clinic, National & Specialist CAMHS. She provides teaching, training and supervision in cognitive-behaviour therapy with children and adolescents, including the Children & Young People's IAPT initiative.

Skills for working with compulsive checking and/or pathological doubt

Adam Radomsky, Concordia University, Canada

Compulsive checking is one of the most common symptoms of obsessive-compulsive disorder (OCD), and both checking behaviour and pathological doubt are also prominent in a number of other anxiety and related disorders. We will begin with a review of the theoretical and empirical work conducted on the phenomenology of compulsive checking and pathological doubting. The skills session will continue with practical instruction on the cognitive case conceptualization and treatment strategies that can be successfully employed with clients who are plagued by doubt and who check repeatedly in an attempt to increase certainty and/or reduce distress. The applicability of these strategies to reassurance seeking will also be addressed. Attendees should leave the workshop with some new ideas about how to work with their clients struggling with doubting and checking. Although OCD remains a serious and often debilitating disorder, our ability to substantially improve the lives of those suffering from the problem has dramatically increased in recent years. This workshop will capitalize on these recent improvements through the emphasis of new cognitively-based treatment strategies for this challenging aspect of the disorder.

Learning Objectives

1. To learn about theoretical and background research related to compulsive checking and pathological doubting in OCD.

2. To learn cognitive case conceptualization skills for use in guiding the treatment of doubting and checking behaviour.
3. To acquire treatment skills to be employed with clients who doubt, check and/or seek reassurance.

Modalities: Didactic, experiential, role play, case review.

References: Radomsky, A.S., Shafran, R., Coughtrey, A.E., & Rachman, S. (2010). Cognitive-behavior therapy for compulsive checking in OCD. *Cognitive and Behavioral Practice*, 17(2), 119-131.

Radomsky, A.S., & Alcolado, G. (2010). Don't even think about checking: Mental checking causes memory distrust. *Journal of Behavior Therapy and Experimental Psychiatry*, 41(4), 345-351.

Rachman, S. (2002). A cognitive theory of compulsive checking. *Behaviour Research and Therapy*, 40, 625-639.

Implications: Participants will learn effective and acceptable strategies for helping people struggling with compulsive checking, pathological doubt and excessive reassurance seeking.

Dr. Radomsky is Professor of Psychology at Concordia University and Co-Editor-In-Chief of *Journal of Behavior Therapy and Experimental Psychiatry*. His research investigates cognitive, behavioural and emotional aspects of OCD and a number of other anxiety disorders, as well as ways to enhance the effectiveness and acceptability of cognitive-behaviour therapy (CBT) for anxiety disorders and related problems. In his clinical practice he specializes in Cognitive Behaviour Therapy (CBT) for adult OCD and other anxiety disorders.

Optimising Video Feedback for Social Anxiety Disorder: Face-to-Face and Virtual Techniques

Jennifer Wild, University of Oxford

Awaiting abstract

How to Engage Young People with Mental Health Problems in Mindfulness

Brenda Davis, Sussex Partnership NHS Foundation Trust

This experiential workshop will provide practical skills and information on how to adapt and deliver an MBCT course to adolescents in a way that is both accessible and acceptable to them, as well as being effective in addressing their mental health needs. Drawing on the combined qualitative and quantitative data gathered from three years of experience of running groups with over 70 young people, we will be exploring the whole process of engagement, sufficient to be able to convey basic course themes. We will be looking at the process of initial engagement, how to maintain their engagement and cooperation and hence continued attendance for the duration of the group, how to encourage them to practice the skills between sessions, and, most importantly, how to enable the young people to apply the skills they have learnt in an ongoing way that fits into the reality of their everyday lives.

The data on which this workshop will be based forms part of an ongoing research project at Sussex Mindfulness Centre, recently linking with Exeter Mindfulness Centre, looking at the mechanisms of change involved in Mindfulness with young people, as distinct from adult populations, - what works and why.

Supplementing Brief Behavioral Activation with Functional Analysis

Carl Lejuez, University of Maryland, USA

Functional analysis (FA) is an individualized assessment used to understand contextualized factors that underlie or maintain behavior. FA is a core building block of assessment for behavioral and cognitive clinicians, but most available resources on FA are highly technical and largely focused on theoretical issues with less attention to implementation. This skills class provides a practical guide to the nature and implementation of FA, including step-by-step descriptions of key components with examples applying the approach across a range of psychological conditions including mood, substance use, and personality disorders. This skills class can be useful for clinicians less familiar with the basic behavioral and cognitive

principles underlying BA who want to understand FA and implement it effectively, as well as those who already use FA but want to develop their skill in teaching and supervising trainees using this approach.

Group Cognitive Behavioural Therapy for People with Asperger Syndrome

Peter Langdon, University of Kent

Awaiting abstract

Parenting for Anxious Parents

Sam Cartwright Hatton, University of Sussex, UK

Awaiting abstract

Beating the Biases - Real Life Demonstrations

Ernst Koster, Ghent University, Belgium

Anxiety and major depression are among the most frequently encountered in mental health settings. Although important advances have been made in improving the effectiveness and efficacy of psychological treatments for these disorders, major challenges remain. Although psychological treatments are quite effective in treating certain affective disorders, such as phobia and panic disorder other disorders such as generalized anxiety disorders and major depression are less easy to treat. In the latter disorders there is a substantial portion of patients who do not respond to psychological treatments (see Hofmann & Smits, 2008). Moreover, even when treatment has been successful initially, there is a problem of recurrence in many of these patients (Solomon et al. 2000). Hence, there is an strong impetus to further improve the effectiveness and efficacy of treatments to these patients.

The past years there has been an increased push towards translational and personalized medicine for psychiatric disorders where the idea is that our increased understanding of the genetic and neurobiological mechanisms of psychopathology may assist in targeting specific etiological and maintaining factors of these disorders. The assessment of specific biomarkers allows to individually diagnose specific factors which can subsequently be modified using a wide variety of available techniques (e.g., pharmacological, neurostimulation, etc.). This approach has the strong advantage that it directly aims to influence the causal mechanisms associated with psychopathology as well that it takes into account the substantial heterogeneity observed in groups of patients with a shared diagnosis. Interestingly, many of these ideas are also of interest to translating findings from cognitive psychopathology research into clinical practice. That is, the past decade there has been a marked change in understanding the causal contribution of cognitive processes at the level of attention, memory and interpretation to symptoms of psychopathology. Based on influential cognitive models of anxiety and depression empirical research has demonstrated convincingly that cognitive processes contribute to hallmark symptoms of anxiety and depression such as enhanced emotional reactivity, recurrent negative thoughts, and impaired emotion regulation. A wealth of research has embarked on developing methods to specifically target and improve the cognitive processes that are associated with psychopathology. Such research has been termed “cognitive bias modification (CBM)” where pathological ways of processing neutral or affective information are modified through repeated practice of more adaptive processing (Koster, Fox, & MacLeod, 2009). In the context of depression other authors have proposed that neurocognitive training could be beneficial (Siegle et al., 2007).

In this workshop I will demonstrate a tapestry of available training programs that could have interesting potential in treatment or prevention of affective disorders. These include attentional, interpretive and cognitive control training. I will discuss the current state-of-the-art critically and will propose crucial ways forward for the integration of computerized training programs in clinical practice.

Key learning objectives

- Having a clear understanding and overview of available computerized training programs for affective disorders

-Understanding ways to integrate cognitive training programs in clinical practice

Training modalities

The workshop will consist of a combination of a presentation with demonstrations of computer programs to train cognitive processes. Moreover, through interactive discussion potential integration of training in clinical practice will be considered with the workshop participants.

Ernst Koster is associated professor in experimental psychopathology. He is affiliated at the Psychopathology and Affective Neuroscience Lab at Ghent University. Moreover, he is a behavior therapist. He has published extensively on cognitive processes associated with psychopathology and their modification

Implications for everyday clinical practice of CBT

The current workshop will provide the clinician with an idea when cognitive training would be interesting to add to treatment. This could facilitate treatment of affective disorders.

Thinking About Including Self-practice/Self-reflection (SP/SR) in Your CBT Training Programme? Guidelines for Trainers

James Bennett-Levy, University of Sydney, Australia

Self-practice/self-reflection (SP/SR) is an experiential training technique for CBT therapists, in which they practice CBT techniques on themselves in a structured way (usually via a workbook), and then reflect on their experience in a group context via online discussion forums or group emails. Over the past 12 years, evidence has accumulated to suggest the value of SP/SR with different groups, including clinical psychology trainees, CBT trainees, low intensity Psychological Wellbeing Practitioners, and experienced CBT therapists and supervisors.

The purpose of this skills class is to provide guidelines for trainers thinking about including SP/SR in their training programs. These guidelines are derived from theoretical considerations, practical experience, and empirical data. It is hoped that James and Richard might be joined by other trainers who have run SP/SR programs, thus providing participants with a wide-ranging blend of SP/SR experience from a variety of contexts.

Objectives:

1. Acquisition of skills to run an SP/SR CBT training program
2. Knowledge about how to obtain SP/SR training resources

Modalities: The principal training modalities will be didactic, dialogical and consultative. After initial presentations, there will be plenty of time for questions, comments, and consultation

References: Bennett-Levy, J. & Lee, N. (2014). Self-practice and self-reflection (SP/SR) in cognitive-behaviour therapy training: What factors influence trainees' engagement and experience of benefit? *Behavioural and Cognitive Psychotherapy*, 42, 48-64.

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Thwaites, R., Bennett-Levy, J., Davis, M. & Chaddock, A. (2014). Using self-practice and self-reflection (SP/SR) to enhance CBT competence and meta-competence. In: A. Whittington & N. Grey (eds) *The cognitive behavioural therapist: From theory to clinical practice*. Routledge, London.

Implications

1. Evidence suggests that SP/SR enhances CBT therapists' confidence and skills, and may be beneficial both professionally and personally.
2. Facilitating the dissemination of SP/SR training has the potential to enhance levels of therapist competence in both high and low intensity CBT services

Leaders: James Bennett-Levy developed the first SP/SR programs in the late 90s, and began publishing SP/SR papers in 2001. SP/SR sparked his broader interest in the role of experiential methods and self-reflection in therapist skill development, and the development of his declarative-procedural-reflective (DPR) model. Richard Thwaites has wide-ranging experience in running and supervising SP/SR programs with high and low intensity therapists at different levels of experience. Richard and James have collaborated in a number of SP/SR projects including their recent book 'CBT from the inside out: A self-

practice/self-reflection workbook for therapists' (Bennett-Levy, Thwaites, Haarhoff & Perry, Guilford Press, due Nov 2014).

Can Principles of Exposure and Emotional Processing from the Treatment of Anxiety Disorders Apply to the Treatment of Depression?

Adele Hayes, University of Delaware, USA

Pharmacological and psychosocial treatments for Major Depressive Disorder have efficacy rates of approximately 60%. Although these findings are promising, relapse rates are still high across treatments, and risk increases dramatically with each subsequent episode. These data highlight the need to improve treatments for depression and reduce the substantial risk of relapse. Exposure-Based Cognitive Therapy (EBCT; Hayes et al., 2005, 2007) is a multimodal approach that integrates components of current psychotherapies for depression, principles of exposure from the treatment of anxiety disorders, and principles of wellness and resilience. Within this framework, EBCT aims to reduce relapse by targeting three specific risk factors: 1) the avoidance-intrusion-rumination cycle, which involves avoidance of emotions, a rebound or flood of the avoided material, chronic unproductive processing of emotional experiences, and further avoidance (Brewin, Gregory, Lipton, & Burgess, 2010); 2) depressive attentional biases, which are characterized by an orientation toward and difficulty disengaging from negative emotion stimuli (Gotlib & Joorman, 2010); and 3) a positive blockade (Disner, Beevers, Haigh, & Beck, 2012), which includes an attentional bias away from positive emotion stimuli, a tendency to dampen or avoid positive emotion, and decreased sensitivity to reward. Cognitive, behavioral, and exposure techniques are used to target these attentional and processing dysfunctions. Together these techniques can increase flexibility and openness to new information, facilitate healthy processing of emotional experiences, and increase resilience. This skills class will briefly review the principles of exposure and emotional processing from treatments for anxiety disorders and then illustrate how these principles can be applied to the treatment of depression and the adaptations that are required. In addition, participants will learn how exposure techniques can be combined with CBT techniques to activate and strengthen the positive emotion system.

Objectives:

To gain a brief introduction to principles of exposure and emotional processing in the treatment of anxiety disorders

To learn how these principles can be adapted and applied to the treatment of depression to facilitate emotional processing

To learn how to engage and strengthen the positive emotion system in depression

Modalities: Powerpoint, experiential, video

Implications: Therapists will learn principles of therapeutic change from the treatment of anxiety disorders that can be translated into specific techniques and incorporated into a CBT framework for treating depression.

Adele Hayes is a Professor at the University of Delaware in the United States. She developed Exposure-Based Cognitive Therapy and is the Director of the Depression and Wellness Program. She has conducted two small clinical trials on EBCT and is collaborating with Martin Grosse Holtforth on a randomized controlled trial in Switzerland that compares EBCT with Cognitive Therapy. Her research focuses on identifying principles and mechanisms of change in treatments for mood and anxiety disorders. She is a former Associate Editor of *Journal of Consulting and Clinical Psychology* and *Cognitive Therapy and Research* and is currently on the editorial board of *Clinical Psychology: Science and Practice*.

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Learning How to Feel Good: How to Build Positivity in Depressed Clients

Barney Dunn, University of Exeter and Richard Moore, Cambridge and Peterborough NHS Foundation Trust

Background: The primary focus in CBT for depression has been on down-regulating negative thinking and feeling. However, it is increasingly realised that anhedonia, a reduction in the ability to experience pleasure, is also central to the onset and maintenance of depression, particularly more chronic presentations. Augmenting positive emotional experience and positive information processing has received less attention in the CBT literature to date. There is increasing interest in the idea that anhedonia is central to mood disorders and should be more of a focus in treatment. This skills workshop will focus on ways to build positivity in CBT treatment, whilst minimising the possibility that a positive focus is perceived by clients as “PollyAnna-ish”. A mixture of training modalities will be used, including reviewing session tapes and role-play practice

Learning Objectives: By the end of the class, participants will have learnt how to:

Identify and formulate mechanisms that maintain anhedonia

Identify and target ‘positive dampening’ appraisals and counterproductive emotion regulation strategies that block pleasure experience

Optimise use of existing CBT techniques (e.g. activity scheduling, positivity data logs) to build positivity

Minimise the likelihood that a positivity focus is perceived by clients as “PollyAnna-ish”

References

Dunn, B.D. (2012). Helping depressed clients reconnect to positive emotion experience: Current insights and future directions. *Clinical Psychology & Psychotherapy*, 19, 326-340.

Werner-Seidler, A., Banks, R., Dunn, B. D. & Moulds, M. L. (2013). An investigation of the relationship between positive affect regulation and depression. *Behaviour Research and Therapy*, 51, 46-56.

Moore, R. G. & Garland, A (2003). *Cognitive Therapy for chronic and persistent depression*. Wiley

Barnaby Dunn is a research and clinical psychologist, currently employed as an Associate Professor at the University of Exeter Mood Disorders Centre. He leads a research programme characterising positivity deficits in depression and developing novel ways to build positivity in CBT. He has recently completed the Beck Scholar programme at the Beck Cognitive Therapy Institute in Philadelphia and was awarded diplomate membership of the Academy of Cognitive Therapy in 2013 and in his ongoing clinical practice treats anhedonic depressed clients (see:

http://psychology.exeter.ac.uk/staff/index.php?web_id=Barney_Dunn). Richard Moore is a clinical psychologist in Cambridge & Peterborough NHS Foundation Trust. He trained in Cognitive Therapy at the Center for Cognitive Therapy in Philadelphia and has been the therapist in a number of successful outcome trials of therapy for persistent depressive disorders. He has extensive experience in providing CBT for treatment resistant depression in the NHS, and co-authored “Cognitive Therapy for Chronic and Persistent Depression” with Anne Garland.

Implications for everyday CBT practice: Better targetting anhedonia is likely to lead to improved treatment outcomes when using CBT to treat depression.

CBT for Command Hallucinations

Alan Meaden, University of Birmingham

Command hallucinations are amongst the most distressing of all symptoms experienced by people affected by psychosis and frequently lead to harmful even fatal acts. This evidence-based therapy is aimed at reducing distress and harmful compliance. It is a collaborative approach which targets the power balance between the person and their voices enabling them to resist powerful commands and take control back over their voices and their own lives. Cognitive Therapy for Command Hallucinations (CTCH) involves 8 levels of therapy offered flexibly over 25 sessions. Independent reviews and recent trial results (Wykes *et al.*, 2007; Birchwood *et al.*, In Press) confirm it to be a particularly effective form of

cognitive therapy. It is the only therapy to date developed specifically for this most treatment resistant of all psychotic symptoms. This half day workshop addresses both theory and practice.

Objectives: To provide delegates with an understanding and knowledge of assessment, formulation and engagement issues when working with people with command hallucinations. To gain an understanding and experience of strategies and techniques to promote control over powerful voices and dispute and reframe power beliefs

Modalities: Powerpoint slides/presentation, video and structured role plays

References:

Meaden, A., Keen, N., Aston, R., Barton, K., & Bucci, S., (2012) Cognitive therapy for command hallucinations: An advanced practical companion. Brunner-Routledge.

Birchwood, M., & Meaden (2012). Cognitive therapy for reducing distress and harmful compliance with command hallucinations. In C. Steel (Ed.). Evidence based interventions for psychosis: Current evidence and future direction. John Wiley & Sons.

Meaden, A., Birchwood, M., & Trower, P. (2010) Cognitive therapy for command hallucinations. In R. Larøi & A. Aleman (Eds.). Hallucinations: A practical guide to treatment. Oxford University Press.

Trower, P., Birchwood, M., Meaden, A., Byrne, S., Nelson, A., & Ross, K. (2004) Cognitive therapy for command hallucinations: A randomised controlled trial. *British Journal of Psychiatry*, 184, 312-320.

Implications: This workshop is intended to familiarise delegates with the cognitive model of command hallucinations and the key strategies for working with this difficult to treat problem.

Dr Alan Meaden is a Consultant Clinical Psychologist working for Birmingham and Solihull Mental Health NHS Foundation Trust and is the lead for the Trust's Assertive Outreach and Non-Acute Inpatient Services. He has been involved in research on command hallucinations and the development of theory and practice for their treatment for nearly two decades. Most recently he has been the supervisor and trainer for therapists on COMMAND: the recent multicentre randomised controlled trial. His other clinical and research interests include working teams and individuals with complex mental health and behavioural needs.

Narrative and Metaphor in CBT: Tools for Therapeutic Change

Paul Blenkiron, Leeds and York Partnership NHS Foundation Trust

Narrative is a powerful tool that blends the science with the art of therapy. By using a story, analogy or metaphor in CBT, we can heighten the impact for our clients - by engaging with the 'heart' as well as the 'head'. Evidence shows that this approach can help build bridges between thoughts, feelings and behaviour, heighten a person's recall of learning and improve the outcome. This skills class will help therapists to introduce short stories and analogies into the session when it is appropriate to do so, and to develop the clients' own ideas into personalised metaphors for change. The goal of this workshop is to enable clinicians to develop practical tools that can engage, inspire, and motivate clients towards meaningful therapeutic change.

Objectives: 1) Understand how a narrative approach may be used in CBT when assessing suitability, explaining basic principles and planning specific interventions (eg behavioural experiments)

2) Begin to work with practical stories and analogies for specific disorders (eg anxiety, pain and depression) and psychological processes (eg avoidance and rumination)

Modalities: Interactive Presentation

Audio clip demonstration/modelling of techniques

Use of Visual metaphors

Role play and small group discussion - examining use of stories and metaphor from a variety of literary and contemporary sources. Attendees will also be invited to describe their own experience and use of examples

Use of humour

References: Blenkiron, P. (2010) *Stories and Analogies in Cognitive Behaviour Therapy*. Oxford: Wiley-Blackwell, ISBN 978-0-4700-5896-1

Blenkiron, P. (2011) *Analogy Therapy*. In: *Encyclopaedia of the Sciences of Learning*. Ed: Seel, NM New York: Springer. ISBN 978-1-4419-1427-9

Stott, R, Mansell, M, Salkovskis, P, Lavendar, A & Cartwright Hatton, S (2010). Oxford Guide to Metaphors in CBT: Building Cognitive Bridges. Oxford University Press.

Implications: This workshop is intended to help CBT practitioners improve their communication of key ideas and techniques so that the emotional impact for their clients is heightened. The session will also allow therapists to listen out for, and unpack, a client's own 'story' and consolidate the therapeutic relationship.

Paul Blenkiron is a national trainer in CBT and an accredited member of the BABCP. He currently acts as an advisor to England's first National Books on Prescription Scheme, launched in public libraries in 2013. He is an NHS consultant psychiatrist in York with 15 years' experience of integrating therapy into daily practice. Paul is also CBT Tutor for the North Yorkshire Psychiatry Training Scheme and a 'NICE Fellow', facilitating the practical implementation of several clinical guidelines. He authored the innovative 'how to do it' book *Stories and Analogies in CBT* (Wiley-Blackwell, 2010), now translated into Chinese.

Poster Presentations 1

Wednesday 23rd July

The Effectiveness of the STEPPS Group Within a UK Secondary Care Setting: A Case Study

Sinead Lambe, University of Bath

Borderline Personality Disorder (BPD) is a serious and prevalent condition. However available interventions are often long and costly, providing a challenge for services with limited resources. The Systems Training for Emotional Predictability and Problem Solving (STEPPS) programme is a 20 week Cognitive Behaviour Therapy based intervention aimed at providing a cost effective alternative. However evidence for its use in the UK is scant. This case study aims to address this. Five service users were referred to the community mental health team. Each presented with a diagnosis of BPD and a history of self-harm, predominantly cutting and overdosing behaviours, which had escalated over the past two months.

The STEPPS program views BPD as arising due to deficits in the person's internal ability to regulate emotional intensity. Hence the first twelve sessions focused on psychoeducation and emotional management skills, where service users learn to predict the course of emotional states, anticipate stressful situations and develop functional coping strategies. The last eight sessions then focused on behaviour management skills, which include goal-setting, sleep hygiene, physical health, abuse avoidance and interpersonal relationship management.

By the end of treatment there was a 32% reduction in self-reported impairment resulting from BPD symptoms. Scores on the Becks Depression Inventory (BDI) also reduced by 30% from the baseline range of 26-55 (M=43.7, SD=12.3) to a range of 9 to 35 (M=30.5, SD=18.8) at end of treatment.

These results are comparable with randomized controlled trials with American samples and indicate the potential utility of this intervention within the UK.

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Cognitive Behaviour Therapy: A South Asian service users' perspective

Richard Bennett, University of Birmingham; Parveen Kaur, University of Derby

This study looks at South Asian service users' experiences of cognitive behavioural therapy for low mood and/or anxiety.

Five South Asian participants were recruited to take part in a qualitative study to explore their experience of accessing CBT for low mood and/or anxiety in a primary care setting. Participants were interviewed using a semi structured interview and the resultant data was analysed using hermeneutic interpretative phenomenology.

The data analysis identified certain key themes. The first theme was that CBT was experienced by the service users as helpful in the short term, although not in the long term. Additionally, the supportive aspect of the therapeutic relationship was experienced as more helpful than implementation of specific CBT techniques. A degree of conflict between cultural issues and CBT was reported. Finally, CBT was experienced as more helpful for anxiety than it was for low mood.

The findings are consistent with the notion of Asian culture emphasising a more collectivist, supportive nature, in contrast with the more individualistic and challenging emphasis of CBT. As a predominantly Western model developed mainly with a white, middle class population, CBT may require some adaptation in order to maximise its effectiveness with an Asian client group. An integration of CBT and counselling might be helpful in treating a minority group whose cultural values and history identifies more readily with a supportive counselling type framework. This notion is consistent with previous literature in this area.

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"All these negative thoughts come flooding in": the phenomenology of rumination in young people with depression

Jeremy Oliver, Royal Holloway, University of London; Patrick Smith, Institute of Psychiatry, King's College London; Eleanor Leigh, Institute of Psychiatry, King's College London

Individuals with depression describe repetitively thinking about their depressive symptoms, the cause of these symptoms and their consequences. This rumination includes many 'why' questions about self-worth and negative comparisons with others. Rumination has already been associated with adolescent depression in quantitative studies. This study was the first to use qualitative methodology to find out how rumination is actually experienced by young people with depression.

Seven young people with depression attending a Child and Adolescent Mood Disorder Service were interviewed about their experience of rumination. The semi-structured interview included questions about content, associated emotions and start and stop triggers. Transcripts were analysed using interpretative phenomenological analysis (IPA), to capture the richness and diversity of their experience of rumination. Emergent themes were verified by participants.

The young people with depression in this study described experienced rumination as a disorientating cognitive battle, in which they felt under attack. "It's trying to get out of its little drawer in your head and it's really, like, disruptive" (Bryony). Rumination was said to elicit sadness predominantly, but also anger and anxiety, with mood and rumination often maintaining each other. "I'm thinking about more and more things, so it's like piling on top, so, the mood just kind of keeps going down" (Liz). Finally, interpersonal interaction was reported to play a key role in starting and stopping rumination episodes. "And then we both just kind of carried on talking about the past and feeling bad about it" (Tim).

Certain elements of young people's experience of rumination emerged as distinct from adults. There was a particularly vivid sense of being attacked by rumination, with a strong negative emotional impact. Addressing the experience of being overwhelmed by rumination may be particularly important when

working with depressed young people, particularly if it has some bearing on the irritability and anxiety associated with depression in this age group. The influence of other people on rumination behaviour also seemed more prominent for young people in this study than for adults (Pearson et al., 2008). These aspects now warrant further quantitative investigation with larger samples. The young people with depression in this study described experienced rumination as a disorientating cognitive battle, in which they felt under attack. "It's trying to get out of its little drawer in your head and it's really, like, disruptive" (Bryony). Rumination was said to elicit sadness predominantly, but also anger and anxiety, with mood and rumination often maintaining each other. "I'm thinking about more and more things, so it's like piling on top, so, the mood just kind of keeps going down" (Liz). Finally, interpersonal interaction was reported to play a key role in starting and stopping rumination episodes. "And then we both just kind of carried on talking about the past and feeling bad about it" (Tim).

Effectiveness of CBT for Obsessive Compulsive Disorder (OCD) in a young person with PANDAS

Sarah Mills, University of Bath; Susannah Lloyd, Oxford Health NHS Trust

A case report outlining protocol driven Cognitive Behaviour Therapy (CBT) for Obsessive Compulsive Disorder in a young man with comorbid tic disorder and a diagnosis of PANDAS (Paediatric Autoimmune Neuropsychiatric Disorders associated with Streptococcal infection)

The young man's difficulties appeared to have developed at an early age with obsessional thoughts relating to safety and responsibility. These had continued to the present day and behavioural avoidance appeared to play a significant role in maintaining the problems. He expressed a preference for addressing the obsessions and compulsions before his tics so it was agreed that he would be offered CBT for OCD based on the protocol outlined by Bolton, Williams, Perrin, Atkinson, Gallop, Waite & Salkovskis (2011). Improvement in OCD symptoms was achieved in 12 sessions of CBT delivered through a community CAMHS clinic.

The Child Obsessive Compulsive Inventory was used as the primary outcome measure. The Outcome Rating Scale (ORS) and Session Rating Scale (SRS) were used to measure change over time and patient satisfaction with treatment.

Improvement in OCD symptoms was achieved in 12 sessions of CBT delivered through a community CAMHS clinic.

The impact of secure electronic video submissions for students undertaking CBT training

Megan Edwards, University of York; Byron George, University of York; Lynn Burnell, University of York

The viewing of CBT practice allows students to gain specific feedback and identify areas for development from the commencement of CBT training. It is known that interactive methods including viewing actual practice enhance clinical supervision effectiveness (Milne 2009). The importance of operating in accordance with data protection law poses increasing challenges for students and practitioners alike leading to delays in receiving regular valuable feedback and in students submitting their DVD on time.

A new policy and procedure were developed with support from key departments (IT and the Student assessment office) detailing the processes and security required for students to share with their information governance departments. The new approach will be adopted alongside current process for the first year, in order to pilot it with students who agreed to submit in this manner.

Results will be presented in a qualitative manner, with feedback from all parties involved and with clarity as to the specific processes that were developed and their impact on both students and markers.

The implications of this new approach for students in training will be considered as well as the wider implications of ensuring that not only students but all CBT practitioners are able to use a secure method for not only submitting their work, but also in an ongoing manner for ensuring that the most effective use

is made of clinical supervision in order to maintain best practice. Differing approaches to achieve this will be examined and related to practice.

Results will be presented in a qualitative manner, with feedback from all parties involved and with clarity as to the specific processes that were developed and their impact on both students and markers.

Treatment of Post Traumatic Stress Disorder in a person with Autism Spectrum Disorder and a Learning Disability: a Case Study

Neil Carrigan, Univeristy of Bath; Kate Allez, 2gether NHS Foundation Trust; Lorna Hogg, Univeristy of Bath

One of the difficulties in assessing and treating post traumatic stress disorder (PTSD) in people with a learning disability (LD) is that it may not present with the typical symptoms associated with the disorder. The problem may be compounded if the patient also has Autism given they may struggle to describe their inner mental life. This may be why there is a dearth of literature on the treatment of PTSD using cognitive behavioural approaches for people with autism and a LD; especially one that relies heavily on cognitive reappraisal of the meanings associated with the trauma memories (e.g., Ehlers, Clark, Hackmann, McManus, & Fennell, 2005).

The case reported here is of the successful treatment of a young man diagnosed with autism and a mild LD. Three years prior to seeking treatment he was the victim of a violent sexual assault. This led to symptoms that included flashbacks, nightmares, anger outbursts and avoidance of places that reminded him of the attack. Treatment involved 12 sessions of cognitive therapy for PTSD using the approach developed by Ehlers et al (ibid).

Treatment led to a reduction in symptoms and scores on a self report measure (CRIES) as well as self reported elevation in mood.

Careful questioning, adaptation of language and elucidation of concepts, allowed the patient to fully engage in therapy. Even with a diagnosis of autism and mild LD, he was able to engage in reappraisal of the meanings associated with his assault which in turn led to reductions in his symptoms of PTSD.

Treatment led to a reduction in symptoms and scores on a self report measure (CRIES) as well as self reported elevation in mood.

The impact of victims' responses to bullying on the attitudes and behaviours of peer bystanders

Nicole Sokol, Macquarie University; Kay Bussey, Macquarie University; Ronald Rapee, Macquarie University

School bullying is increasingly being recognised as a group phenomenon, which both affects and is affected by bullies, victims, and bystanders alike. Through their attitudes towards the victim and behavioural reactions, peer bystanders have the potential to influence bullying situations and to reduce the negative consequences experienced by victims. While various individual and situational factors have been found to influence the attitudes and behaviours of peer bystanders, the effect of the victim's response to being bullied has yet to be clarified. This study examined how different victim responses influence peer liking and bystanders' behavioural intentions when witnessing physical and verbal bullying.

Australian fifth- and seventh-grade students (Mage = 11.13 and 13.18 years, respectively; N=206; predominantly Caucasian) completed online questionnaires about hypothetical videotaped bullying scenarios in which the victims' responses (angry, sad, confident, ignoring) were experimentally manipulated.

Peer liking was found to be the lowest for angry victims, especially among females and students who themselves experienced more victimisation. Bystanders were most likely to report intentions to assist sad victims by adopting defender behaviours or informing a teacher. By contrast, more active victim responses (i.e., angry and confident) increased reported intentions to adopt outsider behaviours. These findings suggest that a victim's emotional and behavioural response to bullying is a salient situational factor affecting peer bystanders' attitudes and behaviours.

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Differences in physical sensation reporting following mood induction in relation to alexithymia and medically unexplained symptoms

Faith Martin, Univeristy of Bath; Jeremy Gauntlett-Gilbert, Royal National Hospital for Rheumatic Diseases; Paul Salkovskis, University of Bath

The role of affect in the cause of “medically unexplained symptoms” is unclear. It has been suggested that an inability to recognise emotions, known as alexithymia, plays a causal role in generating medically unexplained symptoms. It is thought that a failure to attribute physical changes to emotional state leads instead to their attribution to an underlying physical problem and the experience of physical sensations including pain.

Participants with medically unexplained symptoms, including chronic fatigue syndrome and fibromyalgia, completed physical state measure (visual analogue scale) before and after induction of a low mood.

Alexithymia was measured using the Toronto-Alexithymia scale (Bagby, Parker & Taylor, 1994).

Interim analysis in this ongoing study has revealed no correlation between alexithymia and reporting of physical states before or after the mood induction. No significant differences were observed in physical sensation reporting between baseline and post-mood induction. Current achieved power (with n=17) would be sufficient to detect a large correlation of 0.6 or a large effect (d=0.8 or greater) for t-tests.

Early results suggest that if there is any relationship between alexithymia and the impact of mood change on physical or psychological state, this is not a large relationship. Results suggest that a failure to attribute physical sensations to mood state is not a large causal factor in medically unexplained symptoms.

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ACT & Adoption: Application of the Acceptance and Commitment Therapy model to support adoptive parents pre- and post-placement

Stephanie Hutton, Staffordshire University

Adoption preparation groups and parenting programmes for adoptive parents tend to focus on using attachment theory to understand the needs and behaviours of children who are placed for adoption, alongside behavioural techniques to manage children’s behaviour once they are placed. The focus of training is usually on the history, needs and difficulties of the children with little consideration of the internal world of the adopters. However, research suggests that the progress made by children in adoptive families is influenced by adoptive parent factors as well as child factors.

ACT has been applied to parenting interventions in general as well as with specific populations such as parents of children with developmental disabilities, autism, and acquired brain injury, with some promising results. A literature search failed to find any evidence of ACT being applied within pre- or post-adoption training and support.

This paper aims to summarise how an ACT approach could be beneficial to adopters from both a professional and personal perspective. It assumes that there are differences between birth parents’ and adopters’ journeys to parenthood, and the presentation of birth compared to adopted children, which make a specific adoption-focused use of ACT valuable.

Each of the six elements within the ACT model of psychopathology will be considered in light of a typical adopters’ journey from loss, to assessment and eventual matching and placement of children. Typical ways that adopters respond to adopted children’s needs will be described within these patterns. The six

core therapeutic processes will be explored in terms of what could be offered to adoptive parents both in preparation for and after adoption.

It is anticipated that incorporating an ACT perspective alongside the use of attachment theory in both prospective adopter group work and post-adoption parent support would add value and increase placement stability.

The author is currently developing a reflective workbook for prospective adopters which includes some elements from ACT.

Those practitioners supporting adoptive families through training, support or direct therapeutic work could usefully apply an ACT perspective. Gathering data on the efficacy of this will be vital to inform wider practice and help services involved in assessment and support (typically in social care or adoptive agencies) move away from focusing solely on child factors.

Fighting Fear: A preliminary evaluation of a novel trans-diagnostic CBT and mindfulness group treatment for anxiety disorders

Saqib Ahmad, West London Mental Health Trust - Hounslow IAPT

Anxiety disorders can be highly disabling to individuals and are the most economically costly. CBT protocols have shown efficacy for the treatment of most anxiety disorders. There is also growing evidence to support group treatment for individual anxiety disorders. However the evidence base for treating a range of anxiety presentations in a group setting is in its infancy.

Due to increased demands on services to treat a larger number of patients who often have complex presentation, where co-morbidities are the norm and not the exception and time is of an essence, some services are offering as little as 6 sessions to treat a presentation which would ideally be treated using up to 20 sessions. The need for a group interventions which is not only cost effective but also clinically efficacious has become necessary. Fighting fear; a group treatment option for treating anxiety was based on these very needs.

Patients were recruited through routine clinical practice following referral from GPs. The patients were assessed and screened for appropriateness to a group intervention for anxiety. The model used was a trans-diagnostic model of anxiety which could be applied to various anxiety disorders. The protocol combined CBT with mindfulness to treat anxiety in 10 sessions where each session was 2 hours long. We recruited 6 patients; 3 social anxiety disorder, 1 GAD and 2 panic disorders (1 of which also had PTSD). Of the 6 that started the group 4 completed treatment. Intention to treat analysis showed that 5/6 patients improved on the IAPT MDS (includes PHQ9, GAD and WSAS) which was administered at every session. 3/4 improved on their anxiety disorder specific measures (ADSMs) by the end of treatment in relation to their initial scores. 3/4 patients showed improvements on the PHQ9, 1 did not, however they remained subclinical from beginning to end. 3/4 improved on the GAD7 and all patients improved on the WSAS from beginning to end. The 2 patients that withdrew also showed improvements on all MDS questionnaires however we were unable to attain their end of treatment ADSMs. A patient experience survey was administered at the end of treatment which demonstrated that those who engaged in all aspects of the intervention made the largest improvements and these gains were maintained at the 1 month follow-up.

The results demonstrate that this model and treatment approach is effective at reducing the symptoms of panic, social anxiety and GAD; however improvements are relative to their level of engagement in treatment. Furthermore it also demonstrates that addressing general principles of anxiety can be used to treat various anxiety disorders in a group setting and in the case of one patient it can subsequently also reduced the symptoms of a co-morbid condition without a direct intervention.

Further research is required with a much larger sample size and controlled groups; however at present these results are promising and demonstrate the effectiveness of a trans-diagnostic group intervention for anxiety disorders which is also cost effective.

PTSD in sub-Saharan Africa: Reviewing the Applicability and Success of Cognitive Models and Interventions

Faith Martin, Univeristy of Bath; Claire Bourne, Coventry University; Ailsa Russell, University of Bath

Post-traumatic stress disorder (PTSD) is an important issue in sub-Saharan African countries where violent conflict and natural disaster are frequently reported. The cognitive model of PTSD (Ehlers and Clark, 2000), has received substantial support. However its applicability to a sub-Saharan Africa context is unclear. Various interventions exist to target PTSD. Their use and cultural adaptations require synthesis. Cognitive-behavioural therapy (CBT) has been found effective for treating PTSD but its effectiveness in this context requires analysis.

To address these three issues, Medline, PsycInfo, EMBASE and CINAHL were searched for sub-Saharan African nations names and trauma terms. Studies providing novel data relating to the model were included. Intervention studies using a control group were identified, from which CBT effect data were extracted.

18 studies addressed elements of the model, providing support for it, particularly relating to appraisals of threat and evidence for use of avoidance and rumination strategies as attempts to manage trauma memory. Fourteen intervention studies were identified, revealing use of a wide range of psychological interventions and inclusion of participants without PTSD diagnosis. Cultural adaptations focused on culturally relevant content. Eight CBT studies were identified. Meta-analysis revealed "Narrative Exposure Therapy" (NET) not to be effective, whilst more standard CBT appears effective.

Overall, the lack of focused model-related research and heterogeneity in intervention studies highlights the need for further theory based, high-quality research.

Adaptations to render CBT culturally appropriate can be drawn out for wider practice, highlighting the importance of considering mode of delivery and using culturally relevant content in metaphors.

Psychological interventions for children with long-term physical conditions and psychiatric comorbidities

Sophie Bennett, UCL Institute of Child Health; Anna Coughtrey, Great Ormond Street Hospital; Roz Shafran, UCL Institute of Child Health; Tara Murphy, Great Ormond Street Hospital

Children with long-term physical illnesses are significantly more likely to develop common mental health disorders than otherwise healthy children (e.g. Green et al., 2005; Reilly et al., 2013). Cognitive behavioural interventions are recommended for the treatment of psychiatric morbidity in children, but there is no guidance for their treatment in children with long-term physical illness, and there remains an unmet need in this population (e.g. Ott et al., 2003).

Green, H., et al., Mental health of children and adolescents in Great Britain, 2004. ONS. The Stationery Office, London, 2005.

Ott, D., Siddarth, P., Gurbani, S., Koh, S., Tournay, A., Shields, W. D., & Caplan, R. (2003). Behavioral disorders in pediatric epilepsy: unmet psychiatric need. *Epilepsia*, 44(4), 591-597.

Reilly, C., Atkinson, P., Gillberg, C., Scott, R., Das K., Chin, R., Aylett, S., Burch, V. & Neville, B. (2013). The CHES study: A population-based study of behaviour and cognition in school-aged children with 'active' epilepsy. Poster Presentation. American Epilepsy Society Annual Conference, Washington, USA 8th to 10th December.

This paper first presents the results of a recent systematic review of 10 studies examining the effectiveness of psychological interventions, mainly CBT, aimed at treating psychiatric morbidity in children with long-term physical illness.

It then goes on to describe the cognitive behavioural treatment of a young person with depression/anxiety in the context of epilepsy.

The intervention was not adapted specifically for young people with a physical illness.

The systematic review demonstrates that cognitive behavioural interventions can be successfully used to treat anxiety and depression in the context of long term physical illness. The case illustration of a young person who received such an intervention found significant reductions in symptoms of depression and anxiety across the course of intervention.

There is some preliminary evidence that Cognitive Behavioural Therapy has positive effects in the treatment of depression and anxiety in children with long-term physical health conditions. However, the

current evidence base is weak, and there is a necessity for fully powered Randomised Controlled Trials to establish the efficacy of psychological treatments in this vulnerable population. Results from the systematic review, and clinical evidence such as this case illustration, suggest that it is possible to use standard evidence-based treatments for psychiatric morbidity in young people who also have a physical health condition.

CBT for common mental health problems in children with neurological and cognitive difficulties

Daniel Stark, Great Ormond Street Hospital; Fiona McFarlane, Great Ormond Street Hospital; Isobel Heyman, Great Ormond Street Hospital; Roz Shafran, Institute of Child Health; Tara Murphy, Great Ormond Street Hospital;

Neurological / neurodevelopmental disorders increase the likelihood of mental health difficulties in children. This population often have cognitive difficulties. Similarly, population rates of cognitive problems in children with mental health disorders are approximately nine times higher than the background population. It therefore appears that weaknesses with language, attention, memory and executive skills may be a risk-factor for mental health difficulties. Cognitive deficits can also significantly impede traditional evidence based treatments, so their assessment and integration into case formulation is key to successful treatment planning and delivery.

In the absence of specific randomised controlled trials, we propose that the current best approach involves accounting for cognitive difficulties and tailoring traditional evidence based treatments. This approach will be described, including examples using case studies.

In all cases, significant adaptations were required to evidence based treatments, whilst retaining the key principles. Delivery of these modified protocols in a case series led to improvements in anxiety and depression on standardised measures.

Whilst there is a strong evidence base for cognitive-behavioural therapy for children with common mental health difficulties, it is often unclear how to implement this in children who have co-occurring neurological and cognitive difficulties. The cases discussed required significant adaptations, designed to facilitate child and family access to existing evidence based treatment protocols.

Taking account of children's individual cognitive profiles, in conjunction with cognitive-behavioural theory allows adaptation of existing evidence based treatment protocols. Preliminary clinical evidence indicates that clinical effectiveness can be maintained with theory consistent adaptations to treatment. Evidence based treatments can thus be more fully accessed by children and families who have historically may have had difficulty accessing evidence based treatments.

The role of Self-Practice/Self-Reflection (SP/SR) in the training of Psychological Wellbeing Practitioners (PWPs)

Allán Laville, Charlie Waller Institute, University of Reading

Experiential learning can take many forms but one method within clinical training programmes is the use of Self-Practice/Self-Reflection (SP/SR; Bennett-Levy, Turner, Beaty, Smith, Paterson, and Farmer (2001). This involves participants to practice therapeutic techniques on themselves and then write a reflective blog based on their experiences.

Participants completed a pre-questionnaire detailing their expectations of SP/SR and then a post-questionnaire reviewing their experience of SP/SR.

Results were that students found using SP/SR led to a better understanding of the interventions from a patient perspective, contributed to general skill development and supported a deeper level of understanding of the treatment interventions.

The findings of this study highlight how the benefits of using SP/SR within a clinical training programme far outweigh the cons (i.e., staff time required in initially delivering the training, reviewing blogs and facilitating supervision sessions).

It is hoped more PWP programmes will adopt the SP/SR approach and by doing so, allow participants to develop their reflective writing and clinical practice within a supportive and structured experiential learning environment.

Is offering choice over treatment a realistic option for early intervention service? Views from service users and an early intervention for psychosis staff team

Felicity Cowdrey, University of Bath; Kate Chapman, Avon and Wiltshire NHS Trust (AWP); Lorna Hogg

National guidelines and policy promote collaborative decision-making and choice. For psychosis, the duration of untreated illness is operationalized in terms of administering antipsychotic medication establishing it as the 'front-line' treatment. This makes it harder to offer choice over treatment despite the fact that individuals with psychosis often chose not to take medication and emerging evidence suggests that cognitive behaviour therapy may be an effective first line intervention. The aim of this study was to investigate staff and service-user perspectives on choice over treatment for psychosis.

Service-users and staff from an EI for psychosis team completed a survey. The survey items consisted of multiple-choice questions as well as rating scales used to measure the direction and intensity of attitudes regarding choice over treatment. Participants were encouraged to provide extra comments after each question. Qualitative and quantitative analyses were employed.

Staff felt most confident about not prescribing antipsychotics if the service-user had engaged well in psychological therapy or if they were still engaging in routine activities. Conversely, if the service-user was not engaging well with the service and had a more severe symptom profile, staff would find it harder to offer choice. There was huge variability in responses when staff endorsed statements regarding choice over treatment. Specific themes extracted from the staff responses included factors influencing prescribing, decision-making around treatments and attitudes towards interventions. Data collected from service-users is currently underway. Full results will be reported.

Staff identified ways in which they facilitated informed choice and joint decision-making regarding treatments for psychosis. However, a number of barriers to truly offering choice were identified including individual attitudes, service-level influences and the nature of psychosis.

There is emerging evidence that CBT may be effective for people with psychosis who choose not to take antipsychotic medication. This paper identified some of the potential barriers to translating this research into practice. Service-user views on CBT for psychosis will also be elicited.

Service user perspectives on the use of outcome measures in psychological therapy

Graham Thew, University of Bath; Louise Fountain, Avon and Wiltshire Mental Health Partnership NHS Trust; Paul Salkovskis, University of Bath

Despite much research into the benefits of outcome measurement, service user opinions on this as part of the therapy process have surprisingly not been investigated. This study aimed to assess service users' experiences of completing measures during psychological therapy, with a view to exploring how therapists can maximise how helpful measures are in therapy.

Fifteen service users of a secondary care adult mental health service completed surveys about the use of measures in their current episode of care, and ten clinicians within the service provided information about their use of, and attitudes towards, measures.

Despite mixed experiences in how measures were explained and used, service users showed generally favourable attitudes towards their use in therapy, with them being perceived as most helpful when well integrated into sessions by their therapists. Service users highlighted a clear need for therapists to consistently discuss the results of measures and their responses, feeling this does not always occur.

Although small-scale, this study highlights various clinical, service-level, and research implications. While there are well-documented benefits of using measures in therapy, greater attention should be being paid to service users' experiences of this, with a specific focus on how, rather than simply if measures are used. With services aiming to increase the use of measures, it is important this occurs in a way that maximises their perceived helpfulness for those completing them.

Therapists should consider how they introduce, explain, and integrate measures within sessions, whether this occurs consistently, and how this could be improved.

Polyvagal Theory: practical implications for CBT practice

Brian Pope, University of Derby

The Autonomic Nervous System has played a major role in our understanding of an individual's reactions to themselves and the world around them, especially with regard to threat detection, and this is a basic foundation for therapeutic intervention. Recent theoretical and phylogenetic developments led by Stephen Porges (Porges 1995) have identified a much more complicated system which interacts with our social functioning

A literature review specifically focused on the implications for CBT practice and to identify specific areas for research opportunities

identified six major themes where CBT practice and research would benefit from the integration and exploration of the application of Polyvagal Theory.

These areas included: identification of which level of phylogenetic function is operating in the individual as this seems to have a profound impact on individual cognitive ability and response to trauma; vagal tone as a physiological marker of stress; heart rate variability as a measure of psychophysiological variability; respiratory sinus arrhythmia as a positive index of social and emotional regulation; the relationship between behaviour and the social engagement system and neuroception, how individuals shift between defensive and social engagement strategies.

These insights open up the opportunities for new innovative ways of working especially at the interface between physical and psychological factors and especially at the possibility of an exciting new range of tools and interactions which can provide the measurement of physiological areas of psychological experience. Polyvagal theory is beginning to have a profound impact on practice in a wide range of areas including anxiety, emotional regulation and trauma.

Poster Presentations 2

Thursday 24th July

Community Engagement - Eis Ledaber

Presenter: Raphael Kada, Six Degrees Social Enterprise; Debra Frazer, Six Degrees Social Enterprise

Salford population stands at 216,127 with 5,187 being Jewish. IAPT expect 15% of the population to be seen yet just two patients from the Jewish community were referred in 2011. Continued investigation into causes for low uptake from the BME Jewish community in Salford identified patients unwilling to trust generic mental health services and afraid of being misunderstood.

The organisation set out to employ and train a workforce from the Jewish community to serve that population which is culturally and religiously acceptable to that community.

Community engagement through consulting local Rabbis, communal leaders, third sector agencies and providing one to one psychological therapy based on CBT principles together with educational wellbeing groups. Self referrals were accepted at flexible venues, times and gender with religious and cultural needs met.

An equivalent referral rate from the Jewish community to the wider generic population with nationally acceptable recovery rates achieved.

Results noted that outcome measures are not an accurate assessment of distress and alternative measures deserve consideration.

Some clients specifically requested a non-Jewish worker.

Psychological practitioners have voiced the need for specific BME supervision, currently provided to address difficulties such as living and working in the same community and to increase cultural competence throughout the team.

What emerges is not how culturally competent practitioners are but rather how culturally competent they are perceived to be by the BME community. The tighter knit a community is the greater the need to be working from within and not outside that particular community.

Observer Vantage Perspective and Rumination: Understanding their Relationship in Depression

Ly Huynh, University of New South Wales, Sydney, Australia; Authors: Michelle Moulds, University of New South Wales, Sydney, Australia

Rumination and recalling emotional memories from a third-person observer vantage perspective both play maladaptive roles in depression. While there is correlational evidence linking rumination, observer vantage perspective, and abstract processing, there is little experimental investigation into the nature of this relationship. The current project aims to further investigate this relationship in order to identify potential targets for the treatment of depression.

The two studies replicated the methodology of Libby, Shaeffer, and Eibach (2009), and investigated the relationship between vantage perspective and mode of processing bidirectionally with regard to neutral actions in high and low dysphoric participants.

When perspective was manipulated and mode of processing was measured, high dysphoric participants showed a greater tendency toward abstract processing than low dysphoric participants (Study 1; N = 112). When level of processing was manipulated and perspective was measured, high dysphoric participants showed a greater tendency to adopt an observer perspective than low dysphoric participants. Additionally, relative to concrete processing, participants in the abstract processing condition had a greater tendency to adopt an observer perspective, irrespective of dysphoria status (Study 2; N = 186).

Together, these results indicate a unidirectional causal relationship, whereby processing mode causally influences vantage perspective.

Thus, these findings support targeting abstract processing in the treatment of depression in order to address the negative consequences associated with both abstract processing and recalling/imagining events from an observer vantage perspective.

Behaviour Change in the presence of Fusion with Catastrophic, Pain-Related Cognitions in Acceptance and Commitment Therapy

Lottie Morris, University of Bath; Dimitri Gavriloff, University of Bath; Axel Vitterso, Royal National Hospital for Rheumatic Disease

Cognitive behavioural therapies are widely used in the treatment of people suffering with chronic pain. Acceptance and Commitment Therapy seeks to enhance psychological flexibility through increasing acceptance, present-moment awareness, and committed action/behavioural change, reducing cognitive fusion, and developing a sense of self-as-context, or meta-cognition. The present study sought to investigate, using single case design, the relationship between fusion with pain catastrophizing cognitions, and behavioural change. Service users experience exposure, behaviour change, and defusion exercises from day one of the programme. While behavioural change and defusion are likely to have a symbiotic relationship, it was hypothesised that behavioural change would precede defusion.

10 participants in a pain management programme completed the Pain Catastrophising Scale (PCS), revised to measure fusion with cognitions in addition to the extent to which these cognitions are experienced. Participants also reported their level of behaviour change on a Likert scale. Scores were triangulated with clinician ratings of participants' levels of committed action. Measures were taken at six baseline time-points, 12 time-points during treatment, and at three follow-up time-points.

Most participants showed reductions in pain catastrophizing and fusion, and increases in behavioural change throughout treatment, and at follow-up. There were no temporal differences in changes in catastrophizing, fusion, or behavioural change.

These results have important implications for treatment: patients were able to implement behavioural change immediately in treatment, in the presence of high levels of fusion with catastrophic beliefs. Theoretical implications of this are discussed, from both ACT and traditional cognitive behavioural perspectives.

This study suggests that therapist concerns about encouraging behaviour change and exposure early in therapy may be unfounded.

Treating childhood fears in children on the higher end of the autism spectrum through drama

Haris Karnezi, Trinity College Dublin; Kevin Tierney, Trinity College Dublin

Childhood fears that persist over time and interfere with the children's normal functioning may have detrimental effects on their social and emotional development (1). It has been well documented in the literature that children with autism suffer from intense fears more than their typically developing peers (2). Yet, research on the treatment of fears in this population is scarce. Cognitive behaviour therapy is considered highly effective in treating fears and anxieties (3). However, given that many childhood fears are based on fantasy, the applicability of CBT may be hindered by cognitive immaturity. Furthermore, lack of motivation to engage in therapy is another commonly encountered obstacle.

The purpose of this study was to introduce and evaluate a more developmentally appropriate intervention model, specifically designed to provide phobic children with the motivation to address their fears. To this end, principles and techniques from cognitive and behaviour therapies are incorporated into the 'Drama in Education' model. The method involves using the phobic children's own creativity to involve them in the therapeutic process. The children are invited to engage in exciting fictional scenarios tailored around their strengths and special interests. Once their commitment in the drama is established, a problem that they will feel motivated to solve is introduced. To resolve it, the children will have to overcome a number of obstacles culminating in an in vivo confrontation with the fear stimulus.

The study examined the application of the model in three single cases. Results in all three cases shown complete elimination of all fear related symptoms.

Preliminary results justify further evaluation of the Cognitive Behaviour Drama model.

It is time and cost effective ensuring the clients immediate engagement in the therapeutic process.

Treatment Progress in Medium Secure Settings for Women: Changes in Symptomatology, Personality and Need from Admission to Discharge

Clive Long, St Andrew's; Olga Dolley, St Andrew's; Clive Hollin, St Andrew's

Service evaluations of medium secure facilities for women are underrepresented in the extant literature.

Rates of treatment completion are poor and services have not been geared to gender specific needs.

Analysis of women admitted to secure forensic services indicates the need for specialist therapeutic regimes particularly for those with borderline personality disorder and for those with convictions for arson and a history of alcohol dependence/ misuse. Based on the characteristics of the patient population admitted and the development of a gender specific, 'best practice' service it was hypothesized that positive changes in symptomatology, personality and need would be evident from admission to discharge from a women's medium secure service.

A single pre-post test design was used with comparisons made between admission and pre-discharge points on a variety of psychometric measures.

Pre-post measures show significant changes in terms of symptomatology (Brief Psychiatric Rating Scale; Beck Depression Inventory; Modified Post Traumatic Stress Disorder Symptom Scale); personality (Millon Multiaxial Inventory III); and need (Camberwell Assessment of Need Forensic Version).

Significant within treatment change in key clinical areas is encouraging given poor outcomes for women reported in other research. Findings cannot be unequivocally attributed to treatment interventions employed and further work is needed to address the issue of early engagement and the effective tailoring of treatment to the needs of a heterogeneous population.

Team formulation: A literature review exploring the practice and evidence base

Valentina Short, Durham University and Tees Esk and Wear Valleys NHS Foundation Trust

Helen Stain, Durham University; Lauren Mawn, Durham University

Team formulation is a growing practice in mental health and learning disability services. It is proposed that it helps the teams' knowledge and understanding of clients' difficulties, maintenance factors and interventions required to alleviate problems. This paper reports on an extensive literature review on team formulation that was conducted to examine the process, outcome and client experience of team formulation.

An initial scoping search identified definitions of team formulation and was followed by a systematic search of all relevant major databases. Inclusion and exclusion criteria were applied and no literature was excluded based on quality. Thematic analysis identified key and recurrent themes in the literature.

Seven qualitative studies, one quantitative study, four pilot studies of mixed methods, three service evaluations and two audits were identified. A further 19 studies included practice accounts, guidelines, opinion papers and reports. Themes identified included: team functioning, treatment planning, understanding the client, promoting hope and recovery, implementation, training, client involvement, staff experience, reliability and validity.

The themed synthesis of existing literature identified perceived benefits to team formulation. However, the review highlighted that there is a scarcity of high quality research, little emphasis on clearly defining 'formulation' or 'team formulation', and a predominant focus on qualitative data collection. Indeed, there is a dearth of research that confirms team formulation as an evidence based practice, and a lack of examination of links to treatment planning or clinical outcomes.

Studies report that team formulation promotes psychological understanding of complex mental health problems and behaviours. The majority of literature supports the use of a CBT model to underpin this understanding. Qualitative studies of staff experience report that it is generally found to be a helpful activity. However, formulations developed by teams may not be created collaboratively with clients and the implications of this are not understood. Furthermore, team formulations undertaken by teams with little or no CBT training may impact on the fidelity of the CBT model as described by Beck.

Is 16 the magic number? A meta-analysis of low intensity CBT for psychosis

Cassie Hazell, University of Sussex; Clara Strauss, Sussex Partnership NHS Trust; Mark Hayward, Sussex Partnership NHS Trust; Kate Cavanagh, University of Sussex

Please note that the meta-analysis is currently being conducted and will be finalised by the end of March 2014, in time for preparing the poster for the conference.

NICE guidelines recommend 16 sessions of CBT for people with psychosis. While a number of meta-analyses have found CBT for psychosis (CBTp) to be an effective intervention, it is still not widely available in the UK. One way of addressing this problem is through offering fewer than 16 sessions. However, the effectiveness of briefer forms of CBTp is not well established. The present meta-analysis reviews the effectiveness of brief CBTp for a range of outcomes, and the potential moderators at play.

A search of PsycInfo, Web of Knowledge and Scopus was conducted using the key terms: (COGNITIVE BEHAVIO* or COGNITIVE THERAPY or CBT) and (PSYCHOSIS or PSYCHOTIC or SCHIZO*). A total of 8,613 papers were identified, with 16 meeting the meta-analysis eligibility criteria e.g. CBTp is less than 16 sessions or delivered by a non-therapist.

Both pre-post and between-group effect sizes will be presented for a range of clinical outcomes.

Moderator analyses are being conducted in order to explore if the number of direct therapist contact hours, the number of therapy sessions and therapist training are moderators of outcome.

Results will be discussed in relation to NICE treatment guidelines for psychosis. Limitations of the included studies and of the meta-analysis will be discussed. Implications of findings for increasing access to CBTp will be explored and suggestions for future research will be made.

This research questions the NICE guidelines currently stated for those with psychosis. Low intensity CBT is not currently available for those with psychosis - this meta-analysis is the first step to questioning this empirically.

Cognitive Behavioural Therapy for Emetophobia and The Role of Negative Beliefs about Emotional Expression

Rosanna Chapman, Department of Clinical Psychology; Morwenna Roberts, Department of Clinical Psychology

Miss D was a thirty one year old single female who had no previous contact with mental health services. She had been referred to an Improving Access to Psychological Therapies (IAPT) service following an assessment with the Primary Care Liaison Service. She had suffered from emetophobia for four years but had previously utilised relaxation, mindfulness and self-help information to manage anxiety. At assessment, Miss D's depression and anxiety symptomology fell in the severe range and her scores on the emetophobia questionnaires were above the clinical mean.

It was hypothesised that whenever Miss D experienced physiological sensations of anxiety, such as becoming hot or experiencing butterflies in the stomach, she would misinterpret them as being a sign of impending vomit. In response to this, Miss D experienced negative cognitions about what would happen if she vomited, believing that she would lose control of her emotions and act in a way that was unacceptable, such as crying and screaming. She also had an image of being carried away in an ambulance due to the severity of her behaviour. These cognitions would inadvertently increase feelings of anxiety and therefore increase the accompanied physiological changes, some of which were experienced as gastrointestinal, such as feeling sick in the stomach. In response to anxiety, Miss D would engage in an array of behaviours to minimise the likelihood of vomiting. She would selectively attend to any changes in physiology, checking feelings in her stomach or checking to see if she was getting hot. She would also monitor the environment for people who may be ill. Selectively attending to vomit related stimuli was hypothesised to increase anxiety by repeatedly activating negative cognitions. She would engage in safety behaviours, such as washing her hands in very hot water and checking expiry dates on food. It was hypothesised that these behaviours prevented her from finding out that she could not eliminate the possibility of vomiting. She avoided many things such as eating any food that was undercooked or out of date and talking about vomit. Avoidance of feared situations meant that she failed to habituate to anxiety or gather evidence about coping ability, which was hypothesised to increase anxiety.

Twelve sessions were offered in accordance with the service requirements, including two assessment sessions and ten intervention sessions. Assessment involved the use of a semi-structured interview used by the service, covering the individual's background history, description of the presenting problem, goals, medication, occupation and strengths. In addition, a more detailed assessment of the presenting problem was conducted. The GAD-7 and PHQ-9 were administered on a weekly basis in accordance with service requirements and outcome data was recorded every two weeks, as the questionnaires used were developed for fortnightly use. Two vomit related questionnaires (Specific Phobia of Vomiting Inventory, SPOVI; Veale, Ellison, et al., 2012 and Emetophobia Questionnaire, Emet-Q; Boschen & Riddell, 2005) were administered on the first and last intervention sessions.

Following assessment, an idiosyncratic CBT formulation was collaboratively devised. The intervention was based upon this formulation and involved a combination of psycho-education, in vivo exposure to vomit related material, verbal discussions, surveys and behavioural experiments involving dropping safety behaviours.

Miss D's scores on both emetophobia questionnaires had reduced over the course of therapy and her post-treatment on the SPOVI had fallen below the clinical mean (Veale et al., 2012). Her self-reported coping ability had also increased and by session eleven and she had been able to stay in the room when a friend was sick without feeling anxious. She also had not taken anti-emetic medication since the fifth session and had also gone two working days without Propranolol.

Miss D's general anxiety had decreased over the course of therapy, with scores moving from the severe range to the moderate range. Miss D's depressive symptoms had also shown a decline over the course of therapy until the final session, moving from the severe to the moderate range.

This case study demonstrates some evidence for the effectiveness of using a cognitive behavioural approach for emetophobia, using symptom specific outcome measures. As suggested by Davidson et al. (2008), beliefs about loss of control were central to understanding emetophobia in this case. Miss D's assumptions about having to keep control of her emotions due to others' inability to cope with her

distress was thought to be maintaining the anxiety about vomiting. This suggests that, although the continuation of exposure work may have been useful, further work on altering these assumptions may have been more beneficial. Also, given that Miss D's phobia was of vomiting, rather than vomit alone, in session exposure using fake vomit may have been of limited utility. As it is both impractical and unethical to induce vomiting (Veale, 2009), it was not possible for therapy to facilitate exposure to Miss D's phobia, in the same way that is possible for other specific phobias, such as animal phobia.

This case study has demonstrated the importance of beliefs about emotional control in emetophobia. For this case, vomiting was anxiety provoking as it was thought to precede a loss of emotional control, which was believed to be unacceptable. It also highlighted that the perceived coping ability of others in response to vomiting is important. Therefore, future conceptualisations of emetophobia may consider how beliefs about emotional control and about the reactions of both self and others relate to the development and maintenance of anxiety about vomiting.

The Treatment of Compulsive Checking in an Older Gentleman with Cognitive Impairment: A Case Presentation

Vera Hughes, University of Bath

OCD in later-life is a largely neglected area (see Calamari, Janeck, & Deer, 2002). Little is known about the phenomenology of late-onset OCD and whether the cognitive behavioural model (Salkovskis, Forrester & Richards, 1998) applies in its standard form to older populations.

This paper will aim to explore the phenomenology of later-life OCD utilising the case example of Mr C, a 72 year old gentleman referred with a history of compulsive checking and short-term memory problems. Mr C reported that the onset of compulsive checking followed a perceived decline in his short-term memory. At the time of initial assessment, Mr C engaged in a checking ritual every night before bed, noting that this had become more rigid over time. He also reported intrusive thoughts and images pertaining to his family being attacked in the night by an intruder. He reported feeling responsible for ensuring their safety. An idiosyncratic formulation was developed, drawing on the cognitive behavioural model of OCD (Salkovskis, Forrester & Richards, 1998). Treatment modifications were made in response to information obtained from neuropsychological assessment.

Measures assessing OCD (Obsessive Compulsive Inventory, OCI), anxiety (Beck Anxiety Inventory; BAI) and depression (Beck Depression Inventory; BDI-II) were obtained at baseline and on a weekly basis throughout therapy.

Following seven sessions of CBT, compulsive checking behaviours and associated self-doubt had reduced to non-clinical levels. Improvements in OCD behaviours were associated with a reduction in anxiety and depression symptoms.

This case provides an illustration of the usefulness of CBT for late-onset OCD and suggests insight into the potential phenomenology of OCD in later life.

Assessing event-specific repetitive thought: A subtype-level, transdiagnostic measure

Suraj Samtani, University of New South Wales; Michelle Moulds, University of New South Wales

The construct of Repetitive Thought has come about recently in the literature as rumination, worry, and similar constructs have been grouped under this broader umbrella term (Watkins, 2008). Examining repetitive thinking in a transdiagnostic manner allows us to examine the causes and consequences of this cognitive process beyond the boundaries of major depression and the anxiety disorders (e.g., in eating disorders, Axis II disorders). Current models of Repetitive Thought divide the construct into two subtypes: an analytical (maladaptive) subtype and an experiential (relatively adaptive) subtype. Existing scales of Repetitive Thought only assess the analytical subtype, and also confound repetitive thinking with symptoms of various disorders. This project is aimed at creating a self-report measure (the RTS) that is transdiagnostic, assesses both subtypes, and is content valid.

Two parallel versions of this scale have been developed: a trait- and a state-version. The state-version has been developed given the potential clinical utility of a scale that assesses repetitive thinking in relation to a past or upcoming traumatic or stressful event.

Exploratory Factor Analyses (N = 595) of the state-version revealed that a seven-factor solution resulted in a model with good fit. The seven subscales extracted were: Analysing Behaviour, Experiencing Emotions, Experiential Vivid Recall; Experiential Reliving; Experiencing Physical Sensations; Analysing Implications; and Analysing Causes. A confirmatory factor analysis (N = 410) revealed that the subscales could be grouped under higher-order Analytical and Experiential Repetitive Thought factors.

The scale measures the two subtypes suggested by current models of repetitive thought.

This scale will allow clinicians to assess repetitive thinking in relation to a particular (traumatic/difficult) event, such as in the case of PTSD or depression, and to track its frequency on a regular basis. It will also provide information about the type of repetitive thinking clients engage in.

Developmental trajectories of childhood internalizing symptoms from 17 months to 8 years of age: Early risk and protective factors for adolescent internalizing problems.

Magdalena Zdebik, Université de Montréal; Sylvana Côté, Université de Montréal

Mental health disorders are a major cause of suffering in many young people. The risk of having at least one mental health disorder by age 16 years has been reported to be as high as 36.7% (Costello et al., 2005). Although research on externalizing disorders has steadily grown, there is much left to learn about the development and the aetiology of internalizing disorders, as well as their risk and protective factors. It is vital that we understand how internalizing problems arise, and develop effective treatment and interventions. This study prospectively describes longitudinal trajectories of internalizing symptoms, a major risk factor for later internalizing disorders such as anxiety and depression. Our main objective was to identify group-based developmental trajectories of internalizing symptoms from early childhood (1.5 years) to middle childhood (8 years) and examine how the different trajectories predict later self-reported internalizing problems at 13-14 years old.

The Québec Longitudinal Study of Child Development (QLSCD), consisting of an initial sample of 2123 children born from 1997-8 and their parents, was used for this study. Measures were collected when children were 5, 17, 29, 41, 53 and 60 months-old and 6, 7, 8 and 13-14 years-old and the response rate of the cohort has been excellent. Child internalizing symptoms were measured from 17 months to 8 years using parental reports on the Behaviour Questionnaire (BQ; Tremblay et al., 1991) and were used to create developmental trajectories. Composite scores of risk and resilience factors were constructed for the early childhood and mid-childhood period using variables from different domains (parental mental health: e.g.: depression and anxiety; parenting practices: e.g.: positive vs. coercive or controlling parenting; child care environment; e.g.: age of entry, quality of care) and pre and peri-natal variables (collected at 5 month) were also analyzed. Self-reported anxious and depressive symptoms were assessed using the BQ when participants were 13-14 years-old.

Preliminary analysis identified two types of internalizing factors present across childhood: the first related to an inhibited temperament and the second to anxious and depressed symptomatology. By identifying independent and joint group-based developmental trajectories of these two factors, estimated in SAS, we predict later self-reported internalizing problems at 13-14 years-old and the protective and risk factors related to internalizing problems in adolescence.

This work will move forward our understanding of the individual, family and environmental factors that may promote mental health among children at-risk for internalizing disorders. The strength of this project reside in the longitudinal methodology covering over 14 years, the large sample size of the cohort, and the innovative research questions that can be asked with the newly available adolescent assessments. Identifying specific vulnerabilities at different stages of development can help customize cognitive behaviour therapy not only at the individual/child level, but also at the family-functioning level. The effects of preventive intervention are often modest, but they may be improved if interventions are personalized according to identified protective and risk factors over the course of childhood.

Development and validation of the Japanese version of Responsibility Attitude Scale and Responsibility Interpretations Questionnaire.

Ryotaro Ishikawa, Chiba University, Japan; Authors: Osamu Kobori, Chiba University, Japan; Eiji Shimizu, Research Centre for Child Mental Development, Graduate School of Medicine, Chiba University, Japan

Distorted beliefs about responsibility attitude and interpretation are a central theme in cognitive models of Obsessive-Compulsive Disorder (OCD). This study aimed to develop Japanese versions of the Responsibility Attitude Scale (RAS-J) and Responsibility Interpretation Questionnaire (RIQ-J).

Participants in Study 1 were 118 non-clinical Japanese students who completed the RAS-J and RIQ-J to confirm the test-retest reliability of these scales. In Study 2, 98 participants (OCD group = 37; anxiety control group = 24; healthy control group = 37) completed the RAS-J, RIQ-J, and other measures to assess the validity of the RAS-J and RIQ-J.

Both scales had adequate concurrent validity, demonstrated by significant correlations with other measures of OCD, anxiety, and depression. Group comparison data using ANOVA indicated that RAS-J and RIQ-J scores for the OCD group not only differed from the non-clinical group, but also from the clinically anxious comparison group.

This study demonstrated that the newly developed RAS-J and RIQ-J effectively measure responsibility attitude and responsibility interpretation in Japanese OCD patients.

This is the first report on responsibility attitudes and interpretations in a Japanese sample of OCD patients. These findings have implications for clinical work, especially in cognitive behavioural therapy (CBT) with obsessive-compulsive clients.

Comparing Immediate Recall Memory Biases in Depressed and Non-Depressed Adolescents

Presenter: Faith Orchard, University of Reading; Shirley Reynolds, University of Reading; Craig Steel, University of Reading

Cognitive Behavioural therapy (CBT) appears to be less effective at treating depression in adolescents compared to adults (e.g. Kennard et al., 2006; Goodyer et al., 2007). It is assumed that the cognitive model of depression is applicable to adolescents but this has rarely been tested. This paper reports on the assessment of recall memory bias in adolescents aged 13-18 years.

Three groups of adolescents will be compared; 1. Adolescents with a diagnosis of depression (based on K-SADS), 2. Adolescents with elevated symptoms of depression and 3. Adolescents with no symptoms of depression. Groups 2 and 3 are being recruited from the community, and group 1 is being recruited from the NHS CAMHS. Based on current recruitment rates we anticipate that we will report data on 42 participants per group. Adolescents complete a self-description questionnaire and rate themselves on a mixture of positive and negative adjectives. They are then given a surprise recall task and are asked to recall as many of the words as possible (Kelvin, Goodyear & Teasdale, 1999).

Total positive and negative word recall will be calculated. Between-group differences in responses will be analysed using one way ANOVAs and correlations between depression severity and positive and negative word recall.

The results will inform the development of CBT for depressed young people.

If depressed young people do have memory biases, existing methods can be further adapted. If cognitive biases are not characteristic of depression during adolescence then significant development of novel CBT methods may be necessary.

Treating Social Anxiety: A 70 year-old Grandmother Meets a New Social World

Ann O'Hanlon, Queens University Belfast; Gerard McAleer, Queens University Belfast; Joanne Younge, Queens University Belfast

Margaret is a reserved 70-year old Christian mother and grandmother who lives with her husband of 47 years in a small rural village. She was very unhappy in her marriage and attributed her low mood to her husband's drinking and his extended stays in public houses. Margaret's way to cope was to spend hours most days on bus journeys just to get out-of-the-house. On these trips however, Margaret actively avoided meeting or engaging with others, fearing that she would make mistakes socially and be judged harshly. Margaret experienced both a significant fear and a marked avoidance of social situations where she might feel embarrassed or be judged for her mistakes. This fear interfered significantly with her daily routine, and meant she was isolated socially. Margaret was ultimately given a diagnosis of social anxiety with depression.

Margaret grew up in a busy household of eleven children. Feeling overlooked and inferior, it is hypothesised that Margaret developed core beliefs: "I am not important" and 'I make mistakes easily'. It is further hypothesised that Margaret developed 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". The first four of fifteen sessions addressed Margaret's low mood, while the remaining sessions addressed her worries about making mistakes socially and being judged negatively. Drawing on Clark & Wells social anxiety model Margaret gained insights into her anxiety. A wide range of interventions were used, including thought records to enable Margaret to consider her assumptions and worries. Behavioural experiments also provided really great ways to enable Margaret to check out her worries that others would be nasty or judgemental around mistakes. In one such experiment, Margaret observed reactions when the therapist deliberately made a 'mistake' in playing the piano as badly as possible in a public area. In another experiment Margaret deliberately let go one side of a tray, so that cutlery would fall noisily to the floor in a busy restaurant. Despite a lifetime of anxiety, Margaret observed that people were not critical in these instances.

In fifteen sessions Margaret made full recovery; all her goals were met, she is engaging confidently with others, she no longer fears making mistakes, and her scores on a range of measures have improved significantly (e.g. pre and post SPIN of 45 and 0 respectively). Through this time Margaret also gained confidence and awareness for her own unique strengths in social interactions, including her innate intelligence, her exceptionally strong people skills and her considerable life experience. Margaret's life has now changed unrecognisably as she reports excitement and enjoyment in a new social world that has now opened up to her. In a six month follow-up these results were being maintained.

Time was taken to build trust with Margaret, and to elicit her exact concerns socially though a range of techniques including downward arrowing. Taking time to build trust was especially important given Margaret's awareness of the potential for embarrassment when discussing deeply personal concerns. In drawing out the model, Margaret began to understand the factors that were inadvertently contributing to her anxiety, particularly her negative thinking, and her extensive array of safety behaviours; the latter included using her phone to pretend to be busy, keeping her eyes down to avoid eye contact, and standing a distance away from the bus stop. Unwittingly, these safety behaviours had also denied Margaret opportunities to test her appraisals of danger so that these then persisted unchecked, despite repeated non-occurrence. In the final videoed experiment, Margaret was videoed giving an informal speech to a small group of older adults in the Republic of Ireland about retirement in Ireland. Even at the times when she was most anxious, or worried about her mind going blank, Margaret could see that this anxiety was not apparent in the video. To the contrary, Margaret reported that she looked relaxed, confident and comfortable with others. Margaret spent many decades with a paralyzing social anxiety, that had caused her significant distress, disruption and confusion. Margaret's life has now changed unrecognisably as she reports excitement and enjoyment for a new social world that has now opened up to her.

- Older people with social anxiety can make a full recovery with CBT, even when that anxiety has been present for around 70 years

Panic attacks or intrusive memories: an easy diagnostic error?

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Posttraumatic stress disorder (PTSD) is an adverse reaction to traumatic events. Symptoms include repeated re-experiencing of the event, hyper-arousal, emotional numbing and avoidance (Ehlers & Clark,

2000). In a select number of cases, an individual may re-experience intense physical and emotional sensations associated with a traumatic event, without simultaneous recollection of the event (affect without recollection; Ehlers & Clark, 2000). This paper will describe the case of JE, a 30 year old women referred to IAPT for support in managing persistent 'panic attacks' and low mood. JE completed two 6-week low-intensity IAPT anxiety management courses but reported no reduction in her symptoms. JE was subsequently stepped up to high-intensity IAPT for a more detailed assessment. Recurrent 'panic attacks' were conceptualised as intrusive memories stemming from a traumatic event that occurred several years previously. This was based on two key observations 1) the quality and characteristics of the 'panic attacks' were comparable to those of traumatic intrusions and 2) initial scores on the measure of trauma symptomology fell within the clinical range. Treatment followed Ehlers and Clark's (2000) Cognitive Therapy for PTSD. JE received eight weekly 90 minutes sessions. JE completed measures of trauma symptomology (Impact of Events Scale-Revised; IES-R), depression (Patient Health Questionnaire; PHQ-9) and anxiety (Generalised Anxiety Disorder Scale; GAD-7). A VAS was used to measure the frequency of 'panic attacks' (intrusive memories). Measures were administered at baseline and on a weekly basis throughout therapy. At the end of therapy, JE reported a complete cessation in 'panic attacks' (intrusive memories). Trauma scores reduced to non-clinical levels and JE reported that memories regarding the traumatic event felt more coherent, resolved and less emotionally salient. JE did not initially present with complaints relating to past traumas, rather, persistent panic attacks. Indeed, patients may not always disclose past traumas or identify the link between prior traumatic events and current symptoms. This presentation therefore raises the potential usefulness of assessing trauma in patients presenting with panic disorder type symptoms. This may be particularly the case if previous CBT treatments for panic disorder have proven ineffective and/or symptoms have a 'trauma flavour'.

An exploration of the construct of bitterness in adults

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The concept of bitterness was first introduced to the academic literature by Linden (2003). Through his clinical practice he identified a group of individuals who continued to be affected by negative life events far beyond what might be considered a 'normal' response timeframe. Linden conceptualised bitterness (or 'embitterment') as a complex emotion and described it as "...[a] feeling of having been let down, of injustice and helplessness together with the urge to fight back and the inability to identify a proper goal." (Linden, Baumann, Rotter & Schippan, 2007 p. 160). He suggested that an embittered response is one of many possible psychological reactions to an "exceptional, though normal negative life event such as unemployment [or] divorce" (Linden, Baumann, Lieberei & Rotter, 2009 p. 140). There is little empirical evidence thus far to support the existence of bitterness as a valid construct and there is little published material from anyone outside Linden's own research group in Germany. However, the three previous studies that do exist in this area (Linden, 2003; Linden et al., 2007, Linden et al., 2008) provide promising findings which merit further study. The exploratory nature of this study therefore builds on the emerging literature in this field. The development of an English language measure of the construct and then piloting this measure within a small clinical group are the focus of this study. A new measure of bitterness has been developed and data gathered from approximately 300 non-clinical participants. Factor analysis will be conducted using this data. The measure has also been piloted within a small clinical group of participants accessing secondary mental health services. Results will be presented. Data has been gathered and is being analysed currently. The implications of the results will be discussed in terms of our understanding of adult mental health and factors which may influence therapy outcomes. If bitterness is shown to be a construct separate to others such as low mood and anger then this has implications for CBT practice. The development of a measure of bitterness may help therapists to identify such difficulties in their clients and to account appropriately for these within their formulation and when building an alliance.

Social Inclusion – Recognising the needs of the Polish Community

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The UK has the highest number of Polish migrants in Europe (Central Statistical Office, 2013). The evidence suggests that while the level of stress within this group is estimated to be higher than in any other ethnic group in England and depressive symptoms are quite common (Kucharska, 2012), few Polish people reported seeking any form of professional support (Kozłowska, Sallah & Galisińska, 2008). Reports highlight that this might be due to the language difficulties, poor understanding of the NHS and confusion regarding their entitlement to healthcare (Patel, 2010).

The aim of our project is to create a co-produced and language appropriate psychological service for the Polish community in Salford in which they feel supported and can establish contact with fellow Poles. The objectives are to investigate the psychological needs of the Polish community, review current service provision and liaise with the Polish authorities such as churches and schools to improve engagement with the Polish community. Method used is the implementation of an online survey, researching online forums and liaising with the Polish authorities.

Though the research is still ongoing, current results suggest a lack of culturally and language-appropriate psychological services, social support and a demand for such services.

To engage the Polish community and develop co-produced services which can improve access to psychological support and community engagement.

Effectiveness of Group CBT in Routine Clinical Practice in a South London IAPT Service

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Since 2008, the Improving Access to Psychological Therapies (IAPT) programme has been running within the NHS for the general population who may be encountering difficulties in their lives in matters such as depression and other mental health conditions such as anxiety or low self-esteem. Within IAPT, individual Cognitive Behavioural Therapy (CBT) is the most commonly provided therapy, however meta-analyses and randomised controlled trials have shown that group CBT can be as effective as individual 1-2-1 therapy (Cuijpers, van Straten, & Warmerdam, 2008; Brown et al., 2011; Horrell et al., 2013). It has been suggested that group CBT may be more cost effective to provide than individual CBT (Brown et al., 2011). The Wandsworth Psychological Therapies & Wellbeing Service (Wandsworth IAPT) has been running CBT groups for a range of mental health difficulties since gaining IAPT funding in 2009. A retrospective audit of the groups run in this service between 2009 and 2014 was conducted; from this recovery and retention rates were calculated by each group type. The group interventions developed by the service include six to eight session CBT groups for managing anger, anxiety, depression, low self-esteem, and improving Wellbeing in Later Life. Wandsworth IAPT also provides Self-Confidence Workshops based on the June Brown model (Brown, Elliott, Boardman, Ferns & Morrison, 2004). The service also developed an idiosyncratic 10 session self-confidence building course for women who have experienced domestic violence, the New Horizons Course.

Throughout the running of these different 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). Using 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 (IAPT, 2008), i.e. a 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 outcome scores and calculate “movement to recovery”. Additionally, in line with guidelines produced by IAPT central (IAPT, 2011), 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”.

(These results are from a preliminary data analysis and may be refined before the poster presentation) 157 people were booked on Anger Management Courses in the service, of which 64 attended at least one session and 92 did not attend the course at all; this equates to a 41% attendance rate and 59% non-attendance rate. Of the 64 that attended at least one or more sessions, 14 were at “non-caseness” at their first data point and so were excluded, leaving a total of 50 where 34 achieved a “moved to recovery” in their outcome scores (68% “moving to recovery” rate).

128 people were booked on to Anxiety Management Courses in the service, of which 66 attended at least one session and 62 did not attend the course at all; this equates to a 52% attendance rate and 48% non-attendance rate. Of the 66 that attended at least one or more sessions, 11 were at “non-caseness” at their first data point and so were excluded, leaving a total of 55 where 33 achieved a “moved to recovery” in their outcome scores (60% “moving to recovery” rate).

141 people were booked onto Managing Moods Courses in the service, of which 72 attended at least one session and 69 did not attend the course at all; this equates to a 51% attendance rate and 49% non-attendance rate. Of the 72 that attended at least one or more sessions, 3 were at “non-caseness” at their first data point and so were excluded, leaving a total of 69 where 30 achieved a “moved to recovery” in their outcome scores (43% “moving to recovery” rate).

20 people were booked onto New Horizons Courses in the service, of which 14 attended at least one session and 6 did not attend the course at all; this equates to a 70% attendance rate and 30% non-attendance rate. Of the 14 that attended at least one or more sessions, 2 were at “non-caseness” at their first data point and so were excluded, leaving a total of 12 where 8 achieved a “moved to recovery” in their outcome scores (67% “moving to recovery” rate).

96 people were booked onto Self-Confidence Workshops in the service, of which 41 attended at least one session and 55 did not attend the course at all; this equates to a 43% attendance rate and 57% non-attendance rate. Of the 41 that attended at least one or more sessions, 8 were at “non-caseness” at their first data point and so were excluded, leaving a total of 33 where 23 achieved a “moved to recovery” in their outcome scores (70% “moving to recovery” rate).

188 people were booked onto Self-Esteem Courses in the service, of which 91 attended at least one session and 97 did not attend the course at all; this equates to a 48% attendance rate and 52% non-attendance rate. Of the 91 that attended at least one or more sessions, 19 were at “non-caseness” at their first data point and so were excluded, leaving a total of 72 where 33 achieved a “moved to recovery” in their outcome scores (46% “moving to recovery” rate).

18 people were booked onto Wellbeing in Later Life Courses in the service, of which 17 attended at least one session and 1 did not attend the course at all; this equates to a 94% attendance rate and 6% non-attendance rate. Of the 17 that attended at least one or more sessions, 5 were at “non-caseness” at their first data point and so were excluded, leaving a total of 12 where 4 achieved a “moved to recovery” in their outcome scores (33% “moving to recovery” rate).

The above results compare favourably with IAPT’s target of 50% of clients “moving to recovery” between first and last contact. The results also compare favourably with the “moving to recovery” rate of Wandsworth IAPT service as a whole, where the overall “moving to recovery” rate is estimated at 50% for 2013. These results are of significant value where funding is limited, as group CBT seems to demonstrate comparable clinical effectiveness to, but may be more cost effective, than individual CBT (Brown et al., 2011). However further cost effectiveness analysis by health economists would have to be conducted to understand where the savings actually are, for example even though groups can provide more capacity for service user uptake is there a knock on effect of increased administration costs?

As an area for future development, it would be essential to explore reasons for the high drop-out rates from these groups, as this may help services improve their retention rates. It would be important within this analysis to separate out the difference in drop-out figures for those with high non-attendance (i.e. they attended less than half their sessions but more than two) and those with complete non-engagement

(i.e. they were signed up to participate in a group but never attended any sessions other than their initial screening assessment at entry to the service).

Finally, it would be of use to the service to investigate dynamics involved in group sessions that may have a contributing effect to recovery rates that are not present in individual CBT, such as group process factors like universality and group cohesiveness (Yalom, 1970).

The main implication of these findings is that the symptoms of a range of different mental health difficulties can be effectively treated in routine clinical practice using group CBT interventions, which potentially operate at a lower cost than individual CBT (Bonin, Beecham & Brown, 2012) and that additionally more services users can be accommodated in group CBT without increasing service users' waiting times or the service's client uptake.

Can people with anxiety and depression learn mindfulness? A Meta-Analysis

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There is growing evidence demonstrating mindfulness-based interventions (MBIs) are associated with improved psychological health and wellbeing. Although MBIs are currently used with patients with anxiety and depression, it is not clear whether these effects are underpinned by changes in mindfulness in this group. The meta-analysis evaluated the effects of MBIs on mindfulness skills, compared to control conditions, for people currently experiencing anxiety or depression. The relationship between increased mindfulness skills and symptom improvement was also investigated.

Four electronic databases were systematically searched for papers meeting study eligibility criteria. Meta-analyses were performed using Review Manager 5.2 and SPSS 20.0.

Eight RCTs, including 396 participants were eligible. Compared to control conditions, MBIs were associated with higher mindfulness skills, $g = 0.49$, and lower symptom scores, $g = -0.46$ post-intervention. Amongst MBI participants, as mindfulness improved, symptoms reduced, $r_s = .82$, $p = .01$. Participants with anxiety and depression in MBIs were more mindful post-intervention than control groups. Furthermore in MBI participants, improved mindfulness shared 67% of the variance with symptom improvement. These findings support the proposed mechanisms underlying MBIs and promote clinical usage of these interventions. However, there may be alternative explanations for these findings and further research is required.

The results of the current meta-analysis provide tentative evidence suggesting that MBIs may be beneficial for people with anxiety or depressive disorders. Therefore we suggest in the future MBIs may be considered for inclusion in treatment guidelines. However, first we would recommend further research is conducted assessing the relative benefits of MBIs in comparison to other currently recommended interventions (e.g. CBT for depression and anxiety) before MBIs are incorporated into health care guides.

Are elevated manic symptoms in children related to disorder diagnoses? Preliminary results from the Longitudinal Assessment of Manic Symptoms (LAMS) Study

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Understanding the link between symptom clusters and diagnoses is pertinent due to the delay to diagnosis that many experiencing mental health problems report, particularly in relation to Bipolar Disorder (BP, Baldessarini et al. 2007). The Longitudinal Assessment of Manic Symptoms (LAMS) study, which began in the U.S.A (Findling et. al. 2010) is now running in the U.K. enables such a comparison, which is consistent with the recent research proposal - Research Domains Criteria (RDoC – Cuthbert & Kozak 2013). Elevated symptoms of mania (ESM) are a core feature of BP and are also related to other disorders such as Attention Deficit Hyperactive Disorder (ADHD), making diagnosis complex. Therefore assessing the developmental relationship between symptom dimensions e.g. ESM, and diagnosis is important.

Children (6-12yr olds) seeing generic mental health services are screened using the Parent General Behaviour Inventory 10 item Mania scale (P-GBI-10M), which infers emotion regulation ability. Children scoring ≥ 12 on the P-GBI-10M create the ESM+ group, and below the ESM- group. A baseline assessment, including psychiatric interview (using the K-SADS-PL-W, Findling et. al. 2010), self-report questionnaires and WASI is completed and families are followed every 6months.

Ongoing U.K. recruitment has identified 714 eligible children, 118 have been screened and 78 baselines completed (62 ESM+ and 16 ESM-). Preliminary results show higher rates of ADHD and Disruptive Disorders (particularly Oppositional Defiant Disorder, ODD) within the ESM+ compared to EMS- group ($\chi^2(1, N = 69) = 11.15, p < 0.003$) and ($\chi^2(1, N = 69) = 7.572, p < 0.01$) respectively.

Results from the U.K. study indicate ESM are related to ADHD and disruptive disorder, but not to mood disorder, diagnoses at baseline. This is likely to be due to the preliminary nature of the results. Continued recruitment and future analysis will shed light on this, as well as investigate the possible link between baseline symptoms and disorder development.

Although this study does not directly assess the use of therapy, including CBT, it does study the progression of childhood mental health disorders over time, from a young age. This is vital in order to improve our understanding of mental health difficulties and disorders in young people and therefore enhance the development of novel treatment approaches in the future.