



**MANCHESTER 2010**

38th Annual Conference

21st-23rd July 2010 | University of Manchester

# Abstracts

British Association for Behavioural and Cognitive Psychotherapies

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## Adult Mental Health

### Keynote Addresses

#### Schema Therapy for Personality Disorders

Professor Arnoud Arntz, Maastricht University, The Netherlands

Schema Therapy developed from CBT as it is applied to axis-I disorders. In trying to apply ordinary CBT techniques to axis-II disorders, clinicians experienced limited effects and therefore started to integrate techniques derived from other models and to develop new methods. Schema Therapy integrates insights and techniques derived from CBT, experiential methods (notably Gestalt Therapy), psychodynamic therapy, and developmental theories, esp. attachment theory. Instead of being an eclectic approach, Schema Therapy aims to offer an integrated method based on the cognitive (schema) model of psychopathology. Like the early learning theories, Schema Therapy assumes that people, more specifically children, have basic needs, which drive their behaviour, and that when these needs are not adequately met, dysfunctional schemas and coping strategies develop. Early childhood experiences are assumed to underlie personality disorder problems. A new development in Schema Therapy is the concept of schema modes, which refer to the moment-to-moment state of the individual, characterized by typical combinations of emotions, cognitions (schema content), and behaviour. Schema Mode models have now been developed and tested for almost every personality disorder, and help patient and therapist to understand the strong moment-to-moment changes personality disorder patients often experience, and to choose for the appropriate technique to address the modes that are activated during the session. Schema Therapy has now been tested as a treatment for cluster-C, cluster-B, and paranoid personality disorder, and effects are often very favourable compared to other approaches. New applications include personality disordered patients in high security forensic hospitals, and group-ST which seems to be especially effective in Borderline PD. Evidence from recently completed and preliminary evidence from running trials will be presented. The results indicate that Schema Therapy is an effective and cost-effective treatment. Neuroscience studies suggest that Schema Therapy not only leads to symptomatic change, but also to changes at deep brain levels, where emotional responsivity is regulated.

#### New Developments in Understanding the Psychology of Bipolar Disorder: Implications for Research and Therapy

Professor Steven Jones, Lancaster University

Bipolar disorder is typically characterised as having a lifelong relapsing course with significant negative impacts on the individual, their family and wider society. However this picture is largely informed by research which has concentrated on the study of psychological, social and biological deficits in patients in receipt of ongoing care through mental health services. In reality many people with bipolar experiences receive their support in primary care, through the third sector and through informal sources. Outcomes for individuals whose problems are not sufficiently visible and persistent to bring them to the attention of mental health continuing care services may well be different. If we are going to provide accurate information to people with bipolar disorder it is crucial that we study individuals across this full range of settings. It is also crucial that we understand more about what goes well for people with bipolar disorder in addition to identifying deficits. Learning more from people who live well with their bipolar disorder can provide important information for developing strengths-based intervention approaches for people whose bipolar disorder is more problematic. Such approaches might also have significant benefits in engaging individuals who value aspects of their bipolar disorder highly and are reluctant to engage with traditional therapy approaches. Another key feature of bipolar disorder is its variability over time within the individual and across individuals. This means that people's needs for intervention and support will also vary. Services have traditionally struggled to meet needs in a flexible way and have offered a limited range of support. A range of interventions need to be developed from unsupported self help to face to face individual cognitive therapy approaches if we are going to begin to meet the needs of reasonable numbers of people with bipolar disorder. This talk will review current research into the psychology and psychological treatment of bipolar disorder in the context of the issues above.

#### Treating without Knowing: Should Cognitive Therapy Lighten-Up?

Professor David A Clark, University of New Brunswick, Canada

Since their emergence in the 1970's and 80's, empirical research has been a cornerstone of cognitive therapy (CT) and cognitive behaviour therapy (CBT). Theory development and evaluation through experimentally based studies in psychopathology were considered crucial to innovation and refinement in psychotherapy. Cognitive-behavioural treatment regimes were themselves subjected to rigorous empirical evaluation. The net result of this scientific enterprise has been CBT's recognition as an empirically supported treatment for various psychological disorders and its recommendation as a first-line treatment of choice in various mental health practice guidelines. Recently, however, there has been considerable debate over the necessity and sufficiency of this empirical basis, with recognition of a dissemination gap between research and practice. This presentation focuses on the science/practice debate with particular reference to Beck's cognitive therapy for depression and anxiety disorders. Evidence is reviewed for the efficacy and effectiveness of CT for emotional disorders but its relatively low penetration into clinical practice. Reasons for the CT dissemination gap are considered including the possibility that CT has overemphasized its commitment to scientific methodology. Examples are drawn from the information processing research on emotional disorders to illustrate both the contribution and apparent irrelevance of experimental research in psychopathology to the effectiveness of CT. The treatment implications of more recent research findings in thought suppression and emotional regulation are considered for CT of anxiety and depression. The presentation concludes with the challenges faced by continued commitment to an empirically based CBT as well as some of the more promising signs of treatment innovation, application and refinement rooted in empirically based research methodology.

### **Managing the Mental Health Consequences of Disasters: What Every Clinician Should Know**

Professor Chris Brewin, University College London

Mental health services have not been well integrated into emergency planning for major incidents, but following the 2005 London Bombings the Department of Health have given this greater priority. Mental health clinicians need to be aware of and represented on local emergency planning bodies, so that there are existing cooperative relationships with other providers such as local authorities and all psychosocial interventions are informed by the current evidence base. Short-term interventions have now largely abandoned the debriefing model and rely on the concept of psychological first aid. One of the aims of early intervention should be to prepare for the identification and treatment of the minority of survivors and bereaved relatives for whom symptoms of psychological disorder do not remit naturally. Planning for screening and outreach may be required in the immediate aftermath of major incidents in order to ensure that affected individuals are identified and treated in a timely manner. Liaison with Strategic Health Authorities is critical to obtain funding for unbudgeted-for emergencies as well as to ensure equality of access to evidence-based treatment regardless of geographical location.

### **Empirical Tests and (The Debunking of) Intuitively Appealing Hypotheses about Depression and its Treatment**

Professor Robert DeRubeis, University of Pennsylvania, USA

Progress in research on mental disorders is limited not only by the inherent complexities of the subject, but also by the attractive features of certain hypotheses that render them resistant to disconfirmation. Some features of hypotheses about psychopathology and its treatment that appear to sustain them, despite non-existent empirical support, or a pattern of weak or even negative findings, include their ironic qualities, their representativeness, and their connection to the interests of guild members. My colleagues and I have investigated a variety of popular claims which have enjoyed, in our estimation, weak empirical support at best. An example of an ironic claim is the idea that depressed people are more realistic than their nondepressed counterparts (the “depressive realism” hypothesis), a claim we and others have tested and found wanting. Representativeness, fuelled by guild interests, might explain the durability of the assertion, not supported by the evidence, that somatic treatments are required to reverse severe depressive symptoms. Finally, guild interests have limited the quality of the debates about the evidentiary value of findings from randomized controlled trials of psychotherapies, and of the relative importance of the therapeutic relationship and therapy technique. Relevant research findings from our laboratory will be highlighted, in the context of the respective literatures. The presentation concludes with a plea for “adversarial collaboration,” coined and described in 2001 by Mellers, Hertwig, and Kahneman, to advance debates between groups of scientists who interpret the same set of empirical facts as supporting opposing viewpoints.

### **What does Metacognitive Therapy do and how effective is it?**

Professor Adrian Wells, University of Manchester

Metacognitive therapy (MCT) is based on the principle that most psychological disorders are caused by the activation of a specific pattern of extended thinking. This toxic pattern consists of worry, rumination, threat monitoring, and coping behaviours that restrict adaptive learning. It is called the Cognitive Attentional Syndrome (CAS). According to this approach metacognition and the CAS must change in order for recovery to occur.

Treatment aims to remove the CAS and in so doing modify the erroneous metacognitions that give rise to it. In this keynote the way in which metacognition and the CAS are formulated and modified will be briefly described. A wide range of studies have been conducted on the effectiveness of MCT across disorders. These data will be summarised. They suggest that MCT is highly effective and significant changes in metacognition and the CAS have been achieved. The importance of metacognitive change in recovery is supported in recent studies that show that metacognition predicts outcome following behavioural or cognitive treatment modalities.

Solem, S. et al (2009). Change in metacognitions predicts outcome in obsessive-compulsive disorder patients undergoing treatment with exposure and response prevention. *Behaviour Research and Therapy*, 47, 301-307.

Spada, M.M., Caselli, G & Wells, A. (2009). Metacognitions as a predictor of drinking status and level of alcohol use following CBT in problem drinkers: A prospective study. *Behaviour Research and Therapy*, 47, 882-886.

Wells, A. (2008). *Metacognitive Therapy for Anxiety and Depression*. New York: Guilford Press.

Wells, A. et al. (2010). A pilot randomized trial of metacognitive therapy vs. applied relaxation in the treatment of adults with generalized anxiety disorder. *Behaviour Research and Therapy*, doi: 10.1016/j.brat.2009.11.013

## **Symposia**

### **Understanding Positive Outcomes in Bipolar Disorder**

Convenor and Chair: Steve Jones, Lancaster University

#### **Recovery Experiences in Bipolar Disorder**

Steve Jones, Lancaster University, Sally Higginson, GMW NHS Trust, Craig Murray, Lancaster University & Tony Morrison, University of Manchester

Little is known about experiences in bipolar disorder. Interesting work has exploring ‘staying well’ but this has assumed that relapse and symptom reduction are key to recovery. This talk presents the results of two studies of recovery which are free of these assumptions. We have recently investigated recovery experiences in individuals with recent onset of bipolar disorder (less than 5 years) and individuals with an established bipolar course (more than 5 years). Semi-structured interviews were employed to elicit information on recovery which was then subjected to interpretative phenomenological analyses. These results indicate firstly that recovery experiences are clearly identifiable early in bipolar disorder. Both groups shared themes around the important of meaningful activity in relation to recovery. The recent onset group also reported a strong focus on understanding mood and increasing self management of health. In contrast the established group placed greater emphasis on interpersonal relationships and were more wary about challenges to recovery. Implications of these findings for research and therapy are discussed.

### **A qualitative study of the positive aspects of bipolar experiences**

Fiona Lobban, K Taylor, Craig Murray & Steve Jones, Lancaster University

Bipolar Disorder (BD) is generally considered to be a disabling mental health problem which has a negative impact on many areas of peoples' lives and is associated with high health and social costs. However, anecdotal evidence suggests that many people highly value the experiences they associate with having bipolar disorder and refuse to engage in treatment that would reduce these. Research to date has overwhelmingly focussed on the negative consequences of bipolar experiences for people recruited through mental health services. In this study we used a qualitative methodology to explore the positive aspects of bipolar experiences in people meeting diagnostic criteria for Bipolar Disorder recruited from the general population. Key themes are identified and clinical implications will be highlighted.

### **Hypomanic personality and the student experience**

Alyson Dodd, Lancaster University

Bipolar disorder affects around 1% of the population in its most severe form. When accounting for the 'milder' forms encompassed by the bipolar spectrum, prevalence rates increase. Undergraduate students are passing through the peak age of onset for developing bipolar disorder. In the current study, we aim to investigate what factors are associated with positive and negative outcomes among undergraduates at risk of bipolar disorder. Students at Lancaster University ( $n = 413$ ) were recruited and asked to complete the Hypomanic Personality Scale, a measure commonly used to evaluate bipolar risk. Participants ( $n = 57$ ) were then followed up to complete a series of risk and resilience measures online. Preliminary analyses indicate that hypomanic personality is associated with both positive and negative outcomes, namely more hypomanic experiences, positive mood, engaging in danger activities, positive rumination, and experience, frequency and intensity of inspiration. We will evaluate the relative contributions of these risk and resilience factors to provide an integrative account. Participants' academic achievements will be followed up. This will allow us to investigate which factors are associated with flourishing and which factors are associated with experiencing difficulties while individuals at risk of developing bipolar disorder navigate their university experience. Findings could have important implications for student mental health, and could inform both preventative and post-diagnostic interventions.

### **"The e-psychologist will see you now..." Bipolar Disorder, Psychological Therapy and the Internet**

Nick Todd, Lancaster University

Computerised psychological therapeutic interventions have been hailed as one of the most important advances in the treatment of anxiety and depression in the last 50 years. They have significantly improved access to psychological therapy for millions of people and have a proven track record of clinical effectiveness. There is now increasing evidence that people with Bipolar Disorder (BD) also respond well to psychological interventions, and pharmacotherapy alone has limited effectiveness. Unfortunately the same inequalities in access to face-to-face psychological therapy that plagued anxiety and depression remain. The Living with Bipolar project aims to develop a new free to access web-based self management intervention for BD based on psychological evidence, and evaluate its feasibility and acceptability among BD service users. This intervention will not only increase access to psychological interventions for people with BD, but will increase the spectrum of choice they have in their treatment. This presentation will set out the rationale and structure of the project and review the progress to date. This will include systematic and literature review findings, initial focus group results and the foundations of the web based intervention construction.

### **Psychological Processes in Suicidal Behaviour**

Convener and Chair: Rory O'Connor, University of Stirling

### **Effects of Mindfulness on Meta-Awareness and Specificity of Describing Prodromal Symptoms in Suicidal Depression**

Barnhofer Thorsten, Hargus Emily, Crane Catherine, & Williams J. Mark G., University of Oxford

We will report a study that examined the effects of mindfulness training on 2 aspects of mode of processing in depressed participants: degree of meta-awareness and specificity of memory. Each of these has been suggested as a maladaptive aspect of a mode of processing linked to persistence and recurrence of symptoms. Twenty-seven depressed participants, all of whom had experienced suicidal crises, described warning signs for their last crisis. These descriptions were blind-rated independently for meta-awareness and specificity. Participants were then randomly allocated to receive mindfulness-based cognitive therapy (MBCT) plus treatment as usual (TAU) or TAU alone, and retested after 3 months. Results showed that, although comparable at baseline, patients randomized to MBCT displayed significant posttreatment differences in meta-awareness and specificity compared with TAU patients. These results suggest that mindfulness training may enable patients to reflect on memories of previous crises in a detailed and decentered way, allowing them to relate to such experiences in a way that is likely to be helpful in preventing future relapses.

### **Factors Associated with Attrition from Mindfulness Based Cognitive Therapy in Patients with a History of Suicidal Depression**

Danielle Duggan, Catherine Crane & Mark Williams, University of Oxford

This paper reports data from a randomised controlled trial of Mindfulness Based Cognitive Therapy for people with a history of suicidal ideation or behaviour, focusing in particular on the variables that distinguish those who complete an adequate 'dose' of treatment, from those who drop out. Sixty eight participants were randomised to either immediate treatment with MBCT ( $n = 33$ ) or to the waitlist ( $n = 36$ ) arm of the trial. In addition to collecting demographic and clinical information participants' cognitive reactivity was assessed using the Means End Problem-solving Task (MEPS), completed before and after a mood induction procedure. Ten participants dropped out of treatment and 8 dropped out of the waitlist condition. Those who dropped out of MBCT were significantly younger than those who completed treatment, less likely to be on antidepressants, had higher levels of depressive rumination and brooding and showed significantly greater levels of problem solving deterioration following mood challenge. None of these factors distinguished participants in the waiting list condition who remained in the study

from those who dropped out. These results suggest that individuals with high levels of cognitive reactivity, brooding and depressive rumination may find it particularly difficult to engage with MBCT, although paradoxically they are likely to have the most to gain from the development of mindfulness skills if they remain in class. Addressing how such patients can be best prepared for treatment and supported to remain in treatment when difficulties arise is an important challenge.

#### **Resilience to suicidality: the role of positive self-appraisals**

Judith Johnson, Patricia Gooding, Alex Wood & Nicholas Tarrrier, University of Manchester

Recent years have seen a growing interest into concepts of suicide resilience (eg. Osman et al., 2004). Resilience approaches emphasize the importance of understanding positive coping strategies and emotions and may be of key significance to informing suicide interventions, but research in this area is currently limited. The present paper will discuss findings from two recent studies investigating whether positive self-appraisals as described by the Schematic Appraisals Model of Suicide (SAMS; Johnson et al. 2008) buffered individuals from risk, and may therefore constitute a resilience factor. The first of these studies aimed to examine whether positive self-appraisals buffered the association between stressful life events and suicidality amongst a group of students (n=78) who reported some degree of suicidal ideation. Results suggested that positive self-appraisals moderated the association between life stress and suicidality, such that for those reporting high levels of positive self-appraisals, raised incidence of stressors did not lead to increases in suicidality. The second investigated whether positive self-appraisals could buffer the association between hopelessness and suicidality in a sample of individuals with a diagnosis of a schizophrenia-spectrum disorder (n=77). It was found that positive self-appraisals interacted with hopelessness to predict suicidality, such that for those with high levels of positive self-appraisals, raised levels of hopelessness were significantly less likely to lead to suicidality. These studies suggest that positive self-appraisals confer resilience amongst both clinical and non-clinical populations. Studying the interaction between risk and positive self-appraisals may help to both improve identification of individuals at high risk from suicide and also inform interventions designed to target this problem.

#### **Relationships between psychological factors and suicide risk among repeat self-harm patients**

Caoimhe Ryan, University of Stirling, Mark Williams, University of Oxford, Roger Smyth, Royal Infirmary of Edinburgh & Rory O'Connor, University of Stirling

**Introduction:** The best predictor of completed suicide is a history of self-harm and individuals engaging in repeat self-harm are thus among those at highest risk of suicide. This study investigates suicide risk among repeat self-harmers. A range of psychological factors are known to be associated with suicide risk and this study aims to identify the mechanisms by which a number of these factors are related to each other and to suicide risk. **Method:** Participants were 411 patients (246 female, 165 male; mean age 35.11 years, SD 13.89) admitted to hospital following an episode of self-harm. All reported at least one previous self-harm episode. Participants completed measures of suicide risk (ideation, suicide intent) and a number of psychological factors (future-thinking, social problem-solving, rumination, self-criticism, socially prescribed perfectionism) within 48 hours of admission. Mediating pathways between psychological factors and suicide ideation were explored using regression analysis, controlling for age, gender and depression scores. **Results:** Results indicated that the effects of low social problem-solving scores on suicide risk are mediated by low positive future-thinking, and that the effects of socially prescribed perfectionism and rumination are mediated by self-criticism. The former holds true when control variables are included in analysis, the latter does not. **Discussion:** This evidence has implications for theory and the treatment of repeat self-harmers. For instance where attempts to improve social problem-solving are not effective, clinicians may instead focus on improving positive future-thinking which mediates the effects of social problem-solving on suicide risk.

#### **Personality, Cognition and Suicidal Behaviour**

Rory O'Connor, University of Stirling

**Objectives.** There is a growing literature which suggests that social and self-oriented vulnerabilities (e.g., perfectionism, rumination), future thinking (in particular future positive cognitions) and goal adjustment (in terms of goal reengagement/disengagement) are implicated in suicide risk. However, to our knowledge, until recently, no published research has investigated the relationship between these variables. Consequently, in this presentation, I will summarise some of our recent work to investigate how these factors relate to suicide risk in terms of moderating and mediating pathways. **Methods.** A range of studies of suicidal and healthy participants will be presented. **Results.** There is clear evidence to support the role of social and self-oriented vulnerabilities, goal adjustment and future thinking in suicide risk. Indeed, the deleterious effects of social perfectionism are exacerbated by future thinking and goal adjustment. Lack of goal reengagement is a potent predictor of repetition of self-harm. **Conclusions.** These studies support self-regulatory and diathesis-stress models of suicidal behaviour including entrapment models of suicidality. Implications for theory and practice are described.

#### **Defeat and entrapment in suicide**

Peter Taylor, Patricia Gooding, Alex Wood & Nicholas Tarrrier, The University of Manchester

Suicide is a major public health concern, responsible for over 160,000 deaths in Europe in 2002 alone (World Health Organization). Understanding the psychological factors that precipitate suicide is therefore a priority. A number of models have implicated perceptions of defeat and entrapment in the psychological mechanisms underlying suicide. Despite a strong theoretical basis, empirical investigation of these concepts remains limited in the field of suicide. The current presentation reviews a series of studies investigating defeat and entrapment and their role in suicidal ideation and behaviour. Study one provides an investigation into the factor structure of these variables in a non-clinical student sample (n = 305). The results strongly supported a single factor underlying both defeat and entrapment. Studies two and three provide a cross-sectional test of the association between defeat, entrapment and suicidality. These studies recruited a non-clinical student sample (n = 93) and a sample of individuals diagnosed with schizophrenia spectrum disorders (n = 78), respectively. The results supported a relationship between defeat, entrapment and suicidality. These studies also indicated that defeat and entrapment mediated the impact of other clinical (psychotic symptoms) and cognitive (self-appraisals) variables on suicidality.

Study four reports on a prospective investigation of defeat and entrapment as a predictor of suicidal ideation over a 12 month period. This study recruited a non-clinical student sample (n = 150). It was found that defeat and entrapment predicted changes in levels of suicidal ideation. Conclusions are drawn with respect to a recent socio-cognitive model of suicide, the Schematic Appraisals Model of Suicide (SAMS). The clinical implications of these results are discussed.

#### **Bipolar disorders: From Motivational Processes to Psychological Interventions**

Convenor: Thomas D Meyer, Newcastle University

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##### **Explicit and implicit achievement motivation and its relation to risk for mania**

Lucy Finucane, Psychology in Healthcare, Newcastle upon Tyne, Gabriele Jordan, School of Psychology, Newcastle University & Thomas Meyer, Institute of Neurosciences, Newcastle University

Background: There is substantial evidence that bipolar disorders (BD) are related to achievement-related cognitive characteristics such as perfectionism and setting high goals. An early psychodynamic conception of mania - the manic defense hypothesis - asserts that mania is a psychological defense against unacceptable feelings of depression and unstable self esteem. A key implication of the manic defense hypothesis is that implicit and explicit motives in those vulnerable to BD will therefore be in conflict, necessitating the grandiose 'defense' of mania. In terms of achievement motivation, this explicit confidence or 'hope for success' could mask an underlying lack of confidence about achieving, which may be indirectly identified using an implicit, semi-projective measure of achievement motivation. This study tested the hypotheses that vulnerability for BD positively predicts hope for success motives on an explicit measure but that this relationship will not be apparent on an implicit measure. Method: 318 non-clinical participants were recruited via an online study examining implicit and explicit hope for success achievement motives, vulnerability for BD, and current depression. Results: Partial correlation supported the association between explicit hope for success and vulnerability for BD. Hierarchical regression analyses showed a positive but non-significant trend that risk for BD uniquely accounted for variance in hope for success achievement motives on an explicit measure. Contrary to the main hypothesis, however, vulnerability for BD was also significantly and positively related to implicit hope for success motives. Therefore, those at risk for BD were not motive incongruent in the predicted fashion. Conclusions: These results suggest a more complex interaction of achievement motivation processes and risk for BD than originally conceived. Defensive processing may be externally-driven, requiring specific threats in order to activate. This study places high implicit and explicit approach achievement motivation at the core of vulnerability for BD, suggesting some important future directions for research.

##### **Why and how much alcohol do individuals with bipolar disorders drink in different mood states**

Jennifer McDonald, Jan Scott, Jessica Douglas & Thomas D. Meyer, Institute of Neuroscience, Newcastle University

High rates of alcohol use and abuse are consistently reported for bipolar disorders across clinical and community-based studies (e.g. Cerullo & Strakowski, 2007; Goodwin & Jamison, 2007). Furthermore, alcohol may have a significant detrimental impact on the course and treatment of bipolar disorders, even when consumed in moderate amounts (e.g. Goldstein et al., 2006). Despite this, we have a limited understanding of why individuals with a diagnosis of bipolar disorder drink alcohol. Also, of the few existing studies, none has considered the role of mood state and whether people's reasons for drinking are different depending on their mood. This seemed lacking given that extremes of mood are a central feature of bipolar disorders. The aim of this study, therefore, was to systematically examine a range of motives for alcohol use in different mood states of bipolar disorder. 22 participants with bipolar I or II disorder were individually interviewed using the Modified Drinking Motives Questionnaire - Revised (Modified DMQ-R; Blackwell & Conrod, 2003; Cooper, 1994). This questionnaire is based on a cognitive motivational model of alcohol use originally developed by Cooper and colleagues (1994; 1995), which posits that people are motivated to drink alcohol in order to serve different functions and that motives for drinking can be mood driven (i.e. to cope with negative mood, or enhance pleasurable mood) or externally reinforced (i.e. to obtain social rewards, or respond to negative peer pressure). Each participant in this present study reported their motives for drinking alcohol for the 30 days of euthymic mood prior to the research interview, one past depressive episode, and one past manic or hypomanic episode. A calendar based measure of alcohol consumption - the FORM90 (Miller, 1990) - was also used first to prime participant's recall for drinking related behaviours at each episode. This measure also provided detailed information on the quantity and frequency of alcohol consumed. The results will be analysed using univariate repeated measures analysis of variance, and will be presented along with discussion of any clinical implications and areas for further research.

##### **Extreme and conflicted beliefs about activated mood states: Evidence for an integrative, cognitive model of bipolar disorder**

Rebecca Kelly, Warren Mansell, Alex Wood, University of Manchester

The present research aimed to test an integrative-cognitive model of mood swings and establish whether extreme positive, negative, or conflicting appraisals about activated mood states predict bipolar vulnerability. For study 1, 323 undergraduates completed the HAPPI, which assesses these appraisals, and the Internal States Scale measure of hypomanic symptoms. For study 2, 301 individuals with bipolar disorder I (134), bipolar II (39), unipolar depression (64), or no diagnosis (64) completed the HAPPI. Individuals who endorsed more extreme appraisals about activated mood states had elevated hypomania symptoms, and individuals with bipolar disorder also endorsed more of these extreme positive and negative appraisals than the other groups. Extreme negative appraisals about activated states were the most consistent predictor of bipolar disorder and hypomanic symptoms. In addition, an index of conflict between individuals' positive and negative appraisals differentiated individuals with bipolar disorder from individuals with unipolar depression. The results support the integrative-cognitive model of mood swings, and provide the first empirical evidence that conflicting appraisals about mood states are important for predicting bipolar vulnerability. Keywords: bipolar disorder, hypomania, activation, appraisals, conflict

### **CBT for bipolar disorders: any effects on variables such as self-efficacy? Results from a randomised controlled trial**

Thomas Daniel Meyer, Newcastle University & Martin Hautzinger, University of Tuebingen, Germany  
 Introduction: Despite the fact that a mood stabilizing medication remains the first choice in treating bipolar affective disorders, the relevance of additional psychosocial interventions is, however, more and more recognized. Looking at the empirical evidence, the efficacy of adjunctive psychotherapy has been shown in uncontrolled and controlled studies. Several controlled studies explicitly tested the efficacy of Cognitive Behavior Therapy (CBT), and CBT proved to be effective compared to standard medical treatment with respect to relapse prevention, especially in those with fewer lifetime episodes and when compared to treatment-as-usual (e.g. Lam et al., 2003; Scott et al., 2006) But we do not know, if the effect of CBT goes beyond the effects of supportive therapy (ST) of equal intensity and frequency and if it positively affects variables such as self efficacy or locus of control .  
 Methods: We planned a randomized controlled trial. Each therapy condition consisted of 20 sessions (lasting about 50 minutes) within nine months. Both treatments involve psychoeducation and a monitoring of symptoms. While CBT focuses on the identification of warning signs for episodes and on cognitive and behavioral factors individually involved in relapse, the ST focuses on coping and crises intervention with current issues the patient reports. We randomized 38 patients. 65 patients can be considered "completers" (> 15 sessions). Eleven subjects dropped out. The primary efficacy assessment is symptomatic and functional status in the 12-month-follow-up period (e.g. SCID I). Results: Prior analyses showed that relapse rates did not differ between treatment conditions, so the results to be presented at the meeting will focus on psychological variables such locus of control and self efficacy.

### **Effectiveness and efficacy of psychological intervention in an adolescent onset first episode bipolar sample**

Matthias Schwannauer, Rebecca Ludford & Abbi Green, University of Edinburgh  
 Recent studies in the efficacy and effectiveness of cognitive behavioural treatments in bipolar disorders show mixed results in terms of essential indicators of clinical outcomes and differential effects for different subgroups within this disorder group. These developments clearly emphasise the need for robust and convincing psychological models for bipolar disorders and their underlying mechanisms in order to further the enhancement of effective clinical management of bipolar disorders. In particular the apparent differential response rates to psychological intervention in early onset and recurrent bipolar disorder merits attention. Risk and impulsivity are key themes in the clinical management and psychological treatment of bipolar disorders and readmissions and relapse are often driven by an amplification of these factors. Recent clinical trials indicate that early intervention in Bipolar Disorder could lead to positive clinical outcomes. There is a need to develop a better understanding of the early phase of bipolar disorder, and to develop and evaluate effective psychosocial treatments and interventions that assist people in this phase. In this paper we want to present some current work on affect regulation, risk taking, impulsivity and behavioural activation in a group of adolescents with bipolar disorder. Early results of a pilot study of CBT treatment of adolescent onset bipolar disorder are presented in the context of possible adolescent specific risk factors. The trialed treatment approach shows promising results in terms of reduced mood episodes and perceived quality of life for this group of first episode adolescent onset bipolar disorder.

### **Beyond Checking and Washing: OCD in Other Guises**

Convenor: Alice Kerr, Centre of Anxiety Disorders and Trauma, South London and Maudsley NHS Trust and Institute of Psychiatry, King's College London

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### **Contamination concerns in OCD: when do we need to look beneath the surface?**

Emma Warnock-Parkes, Centre of Anxiety Disorders and Trauma, South London and Maudsley NHS Trust and Institute of Psychiatry, King's College London  
 Obsessional cleaning/washing is one of the most common forms of compulsions in Obsessive Compulsive Disorder (OCD; Rachman & Hodgson, 1980). Cognitive behavioural treatments and exposure response prevention have been found to be effective treatments for OCD, but nevertheless a substantial proportion of people do not recover (Freeston et al., 1997; McLean et al., 2001; Fisher & Wells, 2005). More recently a new type of contamination, coined "mental contamination", has been identified (Rachman, 2004). Mental contamination is a term used to define feelings of contamination and an urge to wash triggered without physical contact with a contaminant. Rachman defines it as a "feeling of dirtiness/pollution/danger provoked by direct or indirect contact with an impure, soiled, harmful, contagious, immoral human source" (2006:19). In people who suffer with mental contamination repeatedly washing the outer parts of the body is misdirected because the source of contamination is often internal (for example, traumatic memories). Similarly, traditional treatment approaches may also be misdirected: it has been proposed that the failure to identify mental contamination in treatment may in part be responsible for poor treatment outcomes (Elliott & Radomsky, 2009). However, identifying when we need to look beneath the surface and address mental contamination can be difficult since patients are not always aware of the sources of contamination, and it is often not picked up by routine assessment questionnaires. This talk will highlight the differences between contact and mental contamination. Specific methods and techniques we have found useful in identifying and treating mental contamination will also be discussed using case examples from the clinic.

### **Scrupulosity: Religious Obsessions and Compulsions**

Alice Kerr, Centre of Anxiety Disorders and Trauma, South London and Maudsley NHS Trust and Institute of Psychiatry, King's College London  
 Religious and blasphemous obsessions are the third most common type of classical obsessions seen in obsessive compulsive disorder after sexual and aggressive obsessions (Rachman, 2009). Religious obsessions are dominated by three themes: a fear that the individual has or will commit a sin, intrusive sacrilegious thoughts or images and fears of being punished by God (Abramowitz, Huppert, Cohen, Tolin, & Cahill, 2002). Related compulsions include excessive questioning of clergy members or significant others, repeated praying and focusing on the details of religious practice rather than broader themes (Abramowitz et al., 2002). This talk will explore the literature regarding religious obsessions and compulsions and the relationship with religiosity and culture. It will then briefly

review audit data from the clinic regarding the incidence of religious obsessions and compulsions. It will lastly attempt to outline the particular issues around formulation and treatment within CBT for religious obsessions and compulsions, using a case example from the clinic.

#### **Striving for Perfection**

Asmita Patel, Centre of Anxiety Disorders and Trauma, South London and Maudsley NHS Trust and Institute of Psychiatry, King's College London

Perfectionism appears to have a strong connection to obsessional experiences in some cases and has been identified as one of six domains of obsessional beliefs (Obsessive Compulsive Cognitions Working Group, 1997, 2001). Clinically significant perfectionism may involve the determined pursuit of self-imposed personally demanding standards and may contribute to the maintenance of Axis I disorders when the domain in which perfectionism is expressed overlaps with the domain affected by the disorder (Shafran, Cooper & Fairburn, 2002). A cognitive-behavioural intervention for obsessive-compulsive disorder (OCD) will be described in relation to a client whose obsessional difficulties were maintained by perfectionistic beliefs. A formulation of the client's difficulties that encompassed the role of perfectionistic beliefs was central to addressing the client's OCD, which was maintained by a fear of never being content until her perfectionistic standards were attained. The impact of perfectionism on the therapeutic process will also be discussed.

#### **Comorbid OCD and Autism - What do you do differently?**

Amita Jassi, Institute of Psychiatry, King's College London

Obsessive Compulsive Disorder (OCD) is very common in people with Autism Spectrum Disorders (ASD), with studies suggesting rates as high as 25% (e.g. Russell et al, 2005). Similar frequencies of obsessions and compulsions have been observed when comparing groups with OCD only and ASD plus OCD. Somatic obsessions have been found to be more frequent in the OCD only group and sexual obsessions in the ASD plus OCD group (Russell et al, 2005). At present, a randomised controlled trial is being conducted to examine the effectiveness of Cognitive Behaviour Therapy for OCD in this population. Several modifications to the assessment and treatment of OCD in this group have been suggested. This talk will focus on the assessment and treatment of OCD in people with ASD, using case examples. The cases will illustrate how to disentangle repetitive behaviours from compulsions, the importance of extended psycho-education on emotions in treatment and differences in the content and structure of the sessions.

#### **Innovations in the Delivery of Cognitive Therapy for Anxiety Disorders**

Convenor: David M Clark, Institute of Psychiatry, King's College London

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#### **One-week intensive cognitive therapy for PTSD**

Nick Grey, South London & Maudsley NHS Foundation Trust & Jennifer Wild, Institute of Psychiatry, King's College London

This presentation will cover our recently completed randomized controlled trial which compared a one-week intensive version of cognitive therapy with the usual fourteen weekly sessions version, both compared to supportive psychotherapy and a no treatment control condition. The basic results are that the two cognitive therapy interventions are superior to supportive psychotherapy and no treatment and do not differ from each other at three months. However, at three weeks, the one-week intensive treatment has already achieved all of its gains and so is a much faster way of achieving recovery. After presenting the main results, we would give some illustrations of how the one-week treatment differs from the weekly treatment, including key clinical tips.

#### **Self-study assisted cognitive therapy for social phobia**

David M Clark & Sheena Liness, Institute of Psychiatry, King's College London

This presentation would start by presenting our recently completed randomized controlled trial of self-study assisted cognitive therapy versus our usual full cognitive therapy programme. The basic results of the trial are that using self-study modules between therapy sessions allows one to achieve twice as much improvement per hour of therapy and results in overall recovery rates after seven sessions which are as high as those normally obtained with our fourteen weekly sessions treatment. At the moment, most of the literature on self-study modules is coming from the IAPT low intensity perspective. What seems to have been missed in the literature is how high intensity therapists can utilize self-study materials in order to make high intensity therapies more effective even with the most severe of patients. This talk addresses this issue. We will conclude with details of how to do the self-study assisted therapy, highlighting all the key do's and don'ts, as well as providing clinical illustrations.

#### **Initial explorations of internet based cognitive therapy for social phobia**

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

Much of our current research effort in social phobia focuses on developing an internet version of the treatment that was used in our self-study assisted trial. Richard Stott will summarize the group's work so far with illustrations of some of the key novel developments that we think are important for the internet programme.

#### **Mediators of change in cognitive therapy for PTSD and social phobia**

Birgit Kleim & Benjamin Boecking, University of Basle

Steven Hayes and colleagues have criticized the CBT literature for its absence of rigorous tests of cognitive mediation. Recently we have conducted a substantial number of mediation analyses using process data that we have collected in several PTSD and social phobia trials. Birgit and Benjamin will present these analyses which strongly support the argument that cognitive therapy works by changing the process targets specified in cognitive models of these two disorders (dysfunctional beliefs, safety behaviours, attentional strategies, etc). The analyses cover both between treatment comparisons (CT versus an alternative psychosocial treatment or medication) and within CT comparisons (the latter are able to do a fine grained analysis of temporal sequencing by looking at cognitive change in session x as a predictor of symptom change in session x+1). These studies nicely complement the first three papers by illustrating why it is so crucial for efficient treatments to focus on the key, theory derived, therapy targets.

## Advances in the Understanding and Treatment of OCD

Convenor: Anna Coughtry, University of Reading

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### Mental Contamination in Obsessive Compulsive Disorder

Anna Coughtry, Roz Shafran, Michelle Lee, University of Reading, Debbie Knibbs, Berkshire Healthcare NHS Foundation Trust, UK & Stanley Rachman, Department of Psychology, University of British Columbia, Canada  
It has recently been proposed that it is possible to feel dirty, polluted, infected or endangered in the absence of physical contact with a contaminant (Rachman, 2006). This so called 'mental contamination' has particular relevance to Obsessive Compulsive Disorder (OCD), where compulsive washing is reported in approximately 38 % of patients. The presence of mental contamination in OCD was examined in a questionnaire study of 177 people with obsessive compulsive symptoms. Significant levels of mental contamination were reported by 43.1 % of participants. Mental contamination was highly correlated with measures of physical contamination concerns, general OCD symptomatology and thought-action fusion. A further study induced feelings of mental contamination in 75 students, using a variety of methods including recall of negative autobiographical memories. Participants reported significant increases in anxiety, feelings of dirtiness and urge to wash (all  $p$ 's < .05) following the various induction tasks. The transience of this effect was examined. It is concluded that consistent with new theories of the fear of contamination, feelings of pollution can arise without physical contact and in some cases can be self generated, arising in direct response to remembering an unpleasant event.

### Exploring Morphing: The Fear of Transformation

Eva Zysk, Roz Shafran, University of Reading & Stanley Rachman, Department of Psychology, University of British Columbia, Canada

Morphing, or 'transformation obsessions', is a relatively unexplored phenomenon that exists in some patients with OCD. It involves fears or beliefs that the person can acquire the negative characteristics of someone undesirable, or can be transformed into that person. Morphing is one of the 5 subtypes of mental contamination. Mental contamination can be defined as feelings of dirtiness without any physical contact with a perceived contaminant. (Rachman, 2006) A 36 item questionnaire to assess for morphing was developed based on the clinical phenomenon and reviewing case studies in the limited available literature. The questionnaire was given to N = 303 clinical controls and 14 OCD patients. It had good internal consistency ( $\alpha = 0.864$ ), and a 2 factor solution accounted for 22.8% amount of the variance. The presentation will describe the measure, its psychometric properties, and its clinical relevance.

### Treating Mental Contamination

Roz Shafran, Anna Coughtry, University of Reading & Stanley Rachman, Department of Psychology, University of British Columbia, Canada

Our group has been treating cases with mental contamination for the past two years. We have accumulated over 20 cases and are in the process of developing a treatment manual. This paper will present the principles of the treatment of mental contamination and will focus on the modifications required for this particular form of OCD. The treatment implications vary according to the particular form of mental contamination. Three particular adaptations will be emphasized. The first concerns the addressing of moral standards which can be excessively high and an important maintaining factor. The second concerns disgust which, for some individuals is highly idiosyncratic and contributes to the persistence of contamination. The third adaptation is the incorporation of work on self-esteem within the CBT protocol. The treatment will be illustrated with DVD vignettes. The pre- and post- treatment outcome data for each group (UK and Canada) will be presented separately and the implications for further research discussed.

### Do GPs Follow NICE Guidelines for OCD?

Alex Gyani, Roz Shafran & Suzanna Rose University of Reading

Since their introduction in 2000, the National Institute of Health and Clinical Excellence (NICE) clinical guidelines have been met with controversy and varying degrees of implementation. Whilst some guidelines are being followed, recent research shows that guidelines are not being followed after a patient has been diagnosed with Post Traumatic Stress Disorder (Ehlers et al, 2009) and Eating Disorders (Currin et al, 2007) in primary care. To understand whether or not there is a prejudice against mental health disorders in primary care more data about NICE guideline usage for other mental health disorders needs to be collected. In this presentation data from a recent questionnaire study shall be presented in which General Practitioners in Buckinghamshire and Berkshire were asked about their views regarding the NICE guidelines for Obsessive Compulsive Disorder (OCD). The questionnaire sought to investigate respondents' views regarding the NICE guidelines for OCD and in general, and their treatment decisions when faced with a patient with OCD. This presentation shall discuss the relationship between GPs' views regarding the NICE guidelines and the treatment they offer their patients, as well as the wider implications of a prejudice against mental health in primary care.

### The OCD Bully

David Veale & Simon Darnley, NIHR Specialist Biomedical Research Centre for Mental Health at the South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry, King's College London

At this symposium, we will unveil our installation "The OCD Bully". It is displayed in the entrance to the Anxiety Disorders Residential Unit at the Bethlem Royal Hospital. The unit provides a national specialist service for the treatment of severe Obsessive Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD). People with OCD often consider their OCD to be like a bully or a demon that has to be obeyed. During the process of cognitive behaviour therapy, they may be encouraged to "externalise" their bully and to act against it by doing the opposite to what the bully demands by graded exposure and behavioural experiments. We decided to enhance the environment at our unit by making a humanoid version of an OCD bully or monster. On the outside of the bully are various manifestations of OCD - for example a clock that represents the wasted time of compulsions; a toilet seat



that is full of “germs”; knives for fears of being violent; words such as “Paedophile” and numbers such as “666”. The bully has several eyes to depict hypervigilance for threat. A door in its chest opens to reveal a heart of stone. The humanoid has a more important therapeutic role. It holds a transparent receptacle in which residents are encouraged to give up their various “safety objects” to the humanoid as a commitment to change. Safety objects are defined here as those that are instrumental to aid safety seeking or avoidance behaviours (Salkovskis, 1991) and therefore maintain a person’s obsessional beliefs, doubts and fears. The installation is interactive and evolves over time as each a resident makes a donation of a new safety object. Each donation has its own story and provides encouragement for a new resident to change by following the example of previous residents who have made the commitment to change. Initial donations have included a pair of handcuffs from a man who was afraid he might be violent to others; rubber gloves and alcohol wet wipes used by a woman to prevent contact with contaminants; a mobile telephone used for seeking reassurance; a mirror and implements for skin-picking used by a woman with BDD. The receptacle is very long and so it is difficult to retrieve items once they have been deposited. It therefore depicts another aspect of OCD - hoarding. When the receptacle is full, another will replace it so that unit will eventually be full of clutter.

## Clinical Roundtable

### Treatment Resistant Depression: When the Going gets Tough, the Tough get Going

Convenor: Anne Garland, Nottinghamshire Healthcare NHS Trust

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Speakers: Anne Garland, Nottinghamshire Healthcare NHS Trust  
 Paul Gilbert, University of Derby  
 Richard Morriss, University of Nottingham and Nottinghamshire Healthcare NHS Trust  
 Thorsten Barnhofer, University of Oxford

The results from the Newcastle-Cambridge randomised controlled trial of CT (Paykel, et al 1999) demonstrated at one year follow up a relapse rate of 47% in the clinical management group and 29% in the CT group. CT is effective in reducing depressive relapse with greater improvements in levels of self-esteem, hopelessness and pessimism and clients’ ability to manage or influence these (Paykel, et al 2000). However, at three years follow-up the relapse rates in both groups were shown to be similar (Paykel, et al 2005). Meanwhile, research in cognitive science has identified two processing biases implicated in the persistence of depression, Over General Memory (OGM) (Watkins et al 2000) and Depressive Rumination (Nolen-Hoeksema et al 1993). Watkins et al (2000) propose that OGM and rumination operate in unison as an avoidant mode of information processing which results from a style of processing information in a verbally analytical way. This clinically manifests itself as self-critical and self-blaming depressive ruminative cycles, which are negatively reinforced by the affect regulation they permit. This method of affect regulation prolongs depressive episodes and predicts the persistence of depression. Moreover, Watkins et al (2000) observe that OGM is not necessarily a direct form of cognitive or emotional avoidance, as OGM does not appear to be under conscious control but is instead a tacit form of emotional processing. Therefore, treatment interventions need to take into consideration the interrelationship between content and process of cognition, and to enable people to use conscious awareness to facilitate rather than hinder emotional processing of unpleasant emotion both in and outside therapy sessions. Compassionate Mind Training (Gilbert 2006) and Mindfulness based Cognitive Therapy are examples of newly emerging clinical interventions that seek to facilitate such emotional processing. This roundtable brings together a panel of clinical and research expertise to discuss the challenges that arise in using standard Beckian CT to work with this population and to examine how to optimise the benefits of existing interventions and the promise of these newly emerging interventions currently under evaluation. The roundtable will commence with a brief case presentation from Anne Garland, illustrating the challenges that arise in using standard Beckian CT with this client group. This will be followed by a presentation from Professor Morriss who will, with reference to the case example, discuss the use of medication in the management of treatment resistant depression and its role in optimising the benefits of CT treatments. Professor Gilbert will then discuss his Compassionate Mind Training for tackling shame related problems in depression and its application to the case presented. Finally Dr Barnhofer will present his work in the area of Mindfulness based Cognitive Therapy with this client group and consider its relevance to the case described. This will be followed by an interactive question and answer session with the audience, based on the material presented by the expert panel and the audience’s own clinical experience of working with this client group. The panel members aim to debate these challenges with reference to NICE Guidance for Depression and current research evidence and how these are applied in clinical practice. Consideration will also be given to service delivery within a stepped care model; the interface between IAPT services and secondary care and the training and clinical supervision issues that arise in the process of developing clinical skills in newly emerging interventions.

## Panel Discussion

### What should we use? NICE Recommended Treatments for Depression

Convenor: Heather O’Mahen, University of Exeter

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Speakers: Robert DeRubeis, University of Pennsylvania, USA  
 Mark Williams, University of Oxford  
 Heather Flynn, University of Michigan, USA  
 Kurt Hahlweg, University of Braunschweig, Germany

The new NICE guidelines recommend four primary treatments for depression: Cognitive Behavioural Therapy, Behavioural Marital Therapy, Interpersonal Psychotherapy, and Mindfulness Based Cognitive Therapy. What are the differences between these treatments? What are their strengths? Do we know who they work best for and when we should use one treatment versus another? What factors produce the best treatment outcomes in any of the treatment modalities, and how do these factors compare across treatments? Experts in each treatment modality will discuss these questions, focusing on current research evidence guiding critical clinical decisions. Professor Rob

DeRubeis, recognized as an international expert on CBT, has conducted a definitive multi-site trial of CBT for depression, and has published widely on CBT. Professor Hahlweg, a leader in BMT, has published extensively on BMT for depression. Dr. Heather Flynn conducts clinical research trials on depression and has training, supervision and clinical expertise in IPT for depression. Professor Mark Williams is the founding director of the Centre for Suicide Research at the University of Oxford and an innovator in MBCT.

## Skills Classes

### Emotion Regulation in Cognitive Therapy for Depression

Richard Moore, Cambridgeshire and Peterborough NHS Foundation Trust

In many cases of depression, helpful emotion regulation is achieved through the use of standard cognitive therapy procedures. Eliciting relevant problems and automatic thoughts is accompanied by distressing emotions, which are then addressed through re-evaluating negative thoughts and developing coping strategies. In cases of persistent depression, this helpful regulation of emotion frequently does not occur without some adaptation of therapy style and procedures. This class will consider clinical presentations where insufficient or excessive emotional arousal impedes working on therapy goals. The problems this presents to the therapy process will be illustrated through clinical examples. Formulation of patients' unhelpful emotion regulation strategies will explore how these strategies may be linked to dysfunctional assumptions and beliefs. Adaptations of the therapeutic style to help to foster helpful levels of emotional arousal will be suggested and practiced through role play exercises. This class will combine didactic teaching with clinical examples and role play exercises.

Learning Objectives:

Through attending this class, participants will learn to:

1. Recognise the effect of difficulties in emotion regulation on presentations of patients with persistent depression and the problems this presents in therapy
2. Formulate difficulties in emotion regulation in terms of the cognitive model of depression
3. Consider and practice how to adapt the style of therapy to manage levels of affect in the session

References:

McCullough, J.P. (2000). *Treatment for Chronic Depression: Cognitive Behavioural Analysis System of Psychotherapy*. New York: Guilford Press.

Moore, R., & Garland, A. (2003). *Cognitive Therapy for Chronic and Persistent Depression*. John Wiley: Chichester, West Sussex.

Skills Class Presenter:

Richard Moore is a clinical psychologist working in adult mental health services in Cambridge. After training in Cognitive Therapy in Philadelphia, he was a research therapist in two major UK outcome trials of CT in recurrent and persistent depression. He has published a book and a number of papers and presented numerous workshops on cognitive therapy for depression.

### Working with Dissociation: from PTSD through BPD to DID

Fiona Kennedy, Private Practitioner

Dissociation is a little understood phenomenon, related to trauma history and with the function of preventing awareness. It is a psychological process underlying many presentations (PTSD, BPD, DID) and is clinically important because if dissociation is unaddressed the client's ability to process therapeutic interaction is impaired. In the extreme this can make therapy a waste of time and resources. Learning objectives: understand the CBT approach to dissociation: theory and application; be able to recognise dissociation; understand its role in common presentations; learn key skills to work with dissociation in a clinical setting. Training will be didactic in the presentation of basic theory then become experiential and interactive as clinical techniques are presented and tried out in learning pairs. To practice CBT (or any other therapy) with a client who experiences significant dissociative symptoms can be ineffective, unless the dissociative aspects are addressed. Because dissociation serves to reduce awareness, the client can become 'unavailable' during and between sessions. The therapist may feel helpless and frustrated. This skills class should help therapists feel more oriented within a CBT framework, and competent when faced with dissociative phenomena. Fiona Kennedy was head of psychology services on the Isle of Wight until leaving for private practice in 2006. Her research interest in dissociation grew from extensive clinical experience with severe trauma survivors. She found a lack of coherent accounts of dissociation from a CBT point of view. Her research is in partnership with the University of Southampton. She has presented at EABCT and other international and national conferences.

Kennedy F C et al (2004) Towards a cognitive model and measure of dissociation. *Journal of Behaviour Therapy and Experimental Psychiatry*. 35 25-48.

Kennerley H (1996) Cognitive therapy of dissociative symptoms associated with trauma. *British Journal of Clinical Psychology*. 35 325-340

Nijenhuis, E R (2000) Somatoform dissociation: major symptoms of dissociative disorders. *Journal of Trauma and Dissociation* 1(4) 7-29.

### Using Imagery Rescripting to treat PTSD and Traumatic Bereavement

Jennifer Wild, Institute of Psychiatry, King's College London

Posttraumatic stress disorder (PTSD) following traumatic bereavement is common, and difficult to treat. Following spousal bereavement by illness, PTSD rates are as high as 10% (Zisook, Chentsova-Dutton, & Shuchter, 2004). Following traumatic loss, PTSD can be as high as 39%. The National Institute for Health and Clinical Excellence recommend an extension of the suggested 8 to 12 sessions of trauma-focused psychological therapy for PTSD when an individual presents with traumatic bereavement. Imagery techniques have been evaluated as effectively treating distress linked to traumatic memories (Wild, Hackmann, & Clark, 2007; 2008) and are a key component of cognitive behavioural therapy for PTSD.

Key Learning Objectives

Participants will learn key imagery exercises to address loss in patients with PTSD.

Participants will learn how to update common emotional hot spots linked to traumatic bereavement.

Participants will learn how to combine imagery and reliving techniques to facilitate recovery from traumatic grief. The workshop will use didactic presentation, videotaped demonstrations, and experiential exercises to develop participants' knowledge base and skills.

Dr Jennifer Wild is an honorary consultant clinical psychologist and senior lecturer at the Institute of Psychiatry in London. She has been a key contributor to the development and evaluation of cognitive therapy for social phobia, and trauma-focused psychological therapy for PTSD. She runs a large-scale project in collaboration with the London Ambulance Service to identify predictors of PTSD in this at-risk population.

Arntz, A., & Weertman, A. (1999). Treatment of childhood memories: Theory and practice. *Behaviour Research and Therapy*, 37, 715-740.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38(4), 319-345.

Wild, J., Hackmann, A., & Clark, D.M. (2007). When the present visits the past: Updating traumatic memories in social phobia. *Imagery Special Edition: Journal of Behavior Therapy and Experimental Psychiatry*, 38, 386-401.

Wild, J., Hackmann, A., & Clark, D.M. (2008). Rescripting early memories linked to negative images in social phobia: A pilot study. *Behavior Therapy*, 39, 47-56.

### **Beyond Relapse Prevention in CBT for Bipolar Disorder: The Roles of Positive Self-Appraisal and Recovery-Based Outcomes**

Steve Jones, University of Lancaster

The prevention of relapse has to date been a primary focus of CBT interventions in bipolar disorder. Although relapse reduction can be an important outcome there are other areas which CBT can usefully focus on. Two areas which this skills class will consider are changing self-appraisal processes and enhancing recovery experiences. The class will provide a rationale for addressing these areas, consider methods for encouraging change and describe tools for assessment of these outcomes. Service user accounts of experiences of therapy will be used to inform the skills class. New intervention research studies incorporating these areas will be described.

### **Using Enhanced Reliving to Access and Work with Trauma Memories**

Kerry Young, University College London, and Debbie Lee, University College London, and Berkshire Traumatic Stress Service

In spite of a compelling evidence base many clinicians working with PTSD are reluctant to work directly with people's trauma memories for fear of making people worse or re-traumatising them. Yet working with trauma memories is key to both trauma focused CBT and EMDR which are the recommended treatments for PTSD (NICE, 2005). So this clinical skills workshop offers clinicians an opportunity to learn how to do use reliving to access trauma memories and uncover unhelpful meanings.

The class will briefly outline the theoretical underpinning to this technique, and then describe how to do reliving. A video demonstration will be used to aid learning and promote discussion about this method.

The workshop is suitable for clinicians who are already familiar with Trauma focused CBT and work with PTSD but would like the opportunity to explore this particular technique.

Brewin, C., Dalgleish, T. & Joseph, S. (1996). A dual representation theory of PTSD. *Psychological Review*, (Vol 103, No4): 670-686.

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

Grey, N., Young, K., Holmes, E. (2002) Cognitive Restructuring within Reliving: A treatment for peritraumatic emotional "hotspots" in post-traumatic stress disorder. *Behavioural and Cognitive Psychotherapy*, 30, 37-56

## **Open Papers**

### **Bipolar Disorder and Psychosis**

Chair: Katherine Berry, University of Manchester

### **Engaging patients in the early warning recognition and prevention of relapse in acute episodes of bipolar disorder: a cognitive behavioural development**

Donna Swinden, Tees, Esk and Wear Valleys NHS Foundation Trust, Christopher Rae, The Logos Centre. Tees, Esk and Wear Valleys NHS Foundation Trust

Bipolar patients are generally regarded as being difficult to engage in psychological therapies, particularly when in, or emerging from, a manic episode. In addition, there is a lack of access to CBT as many mental health services do not offer it to bipolar patients consistently, despite there being a burgeoning evidence base for the efficacy of CBT interventions. This paper will outline a five-stage model of engagement, specifically designed for bipolar patients (though most likely applicable to other disorders too). In addition, the most efficacious CBT interventions for bipolar disorder will be described in practical terms i.e. how to implement them with patients. The outcome of combining a targeted engagement model with relevant CBT interventions is hypothesised to improve engagement with CBT, increase the efficacy of the interventions and improve access to services by expanding the number of professionals who feel confident to take this approach. The therapeutic engagement model that has been developed has not been tested in clinical practice - it is based on theoretical information from the available literature. It would be prudent to test the model, particularly in an inpatient ward environment. It would also be valuable to explore the hypothesis that there may be an optimum time to engage bipolar patients psychotherapeutically; and that this could involve a "getting better signature".

- The engagement model provides a framework so that mental health professionals can use their skills effectively.
- Duration of engagement sessions should be tailored to the patient's needs, as well as considering timing.
- The order of the therapy process may also be of importance particularly for inpatients descending from a manic/hypomanic episode.

### **Cognitive and personality styles in twins discordant for Bipolar Disorder**

Manasi Sharma, University of Exeter, Fergus Kane, Institute of Psychiatry, Anna Georgiades, Institute of Psychiatry, Sridevi Kalidindi, Institute of Psychiatry, Robin Murray, Institute of Psychiatry, Jan Scott, Institute of Psychiatry, Eugenia Kravariti, Institute of Psychiatry

Introduction: CBT is well-established for Unipolar Depression, however, underlying mechanisms of change in CBT for Bipolar I Disorder are yet to be adequately developed (Scott et al 2001). The present twin study design thus examined whether specific cognitive and personality indices represent state-dependent characteristics or trait vulnerability markers of Bipolar I disorder. Methods: The study included 12 twin pairs concordant for Bipolar I disorder (11 MZ and 1 DZ pair), 24 twin pairs discordant for Bipolar I disorder (16 MZ and 8 DZ pairs), and 84 Healthy Controls (57 MZ, 27 DZ). The subjects were administered the Rosenberg self-esteem scale; Dysfunctional Attitudes Scale-24 items; Eysenck Personality Questionnaire; BIS/BAS scales; and Positive and Negative Affect Scale. Differences in mean scores on these measures were investigated in patients, high-risk co-twins, and healthy controls across four comparison analyses, using regression analyses for clustered observations. Correlations between scores on these self-report measures and mood ratings were also tabulated. Results: None of the cognitive and personality style measures demonstrated any viability as endophenotypes of Bipolar I disorder. Instead, low self-esteem, higher levels of dysfunctional attitudes, elevated psychoticism and neuroticism levels, high BIS activity, and high negative affect may be inferred as disorder-related, environmental factors. It was also found that, in bipolar patients, higher BIS activity, more dysfunctional attitudes, higher neuroticism, greater negative affect, lower positive affect, and lower self-esteem are related to depressed mood states, whereas greater DAS achievement and self control are related to manic mood states. Discussion and Conclusion: This study suggests that certain cognitive and personality patterns are associated with a clinical diagnosis of bipolar I disorder, but not necessarily with the bipolar diathesis. Future studies should investigate whether CBT interventions can modify these specific thinking styles, and whether such modifications can improve patient well-being and illness course and/ or outcome.

### **Illness perceptions in people with Bipolar Disorder and their relatives: Using the Self-Regulation Model to investigate systemic factors in mental health**

Lalitha Iyadurai, University of Manchester, Fiona Lobban, Lancaster University

Recent focuses in research and policy concern the application of CBT to health conditions (e.g. Turner et al., 2007). However, the application of health psychology models to mental health is less established, despite increasing evidence for its utility (Barrowclough & Parle, 1997; Lobban et al., 2003). The Self-Regulation Model (SRM; Leventhal et al., 1984) highlights the key role of people's beliefs about the identity, causes, timeline, consequences and controllability of their illness in determining their choice of coping behaviours and subsequent adaptive outcome. Studies have begun to apply the model to mental health, and shown that it provides a reliable and valid model of illness representations in people with psychosis (Lobban et al., 2005), depression (Fortune et al., 2004) and eating disorders (Holliday et al., 2004). The current study aimed to assess its applicability in people with bipolar disorder and their relatives, given the importance of family factors in outcome for this group. 33 participants with bipolar disorder and 33 relatives completed novel adapted versions of the Revised Illness Perception Questionnaire (Moss-Morris et al., 2002), to assess dimensions of the SRM. Expressed emotion in relatives was assessed using the Five Minute Speech Sample (Magaña et al., 1986), and measures of mood and functioning were completed in both samples. Following minor amendments, both illness perception questionnaires were found to be internally consistent, reliable over a 1-month time period and associated with mood and functioning. Mean scores indicated that the disorder was perceived to be caused predominantly by genetic factors and stressful life events, was chronic in duration, cyclical in course, and amenable to personal and treatment control. Of particular interest, discrepancies in beliefs between participants with bipolar disorder and their relatives were associated with aspects of expressed emotion. The study provides further support for the utility of the Self-Regulation Model in mental health. Moreover, it suggests that systemic factors that impact on mental health outcome can be usefully explored in terms of differences in family members' illness beliefs. This preliminary finding supports earlier findings in psychosis (Lobban et al., 2006), and warrants further attention. Assessing illness representations in mental health may provide an important avenue for improving adherence and outcome in therapy. The findings also highlight the potential benefits of addressing discrepancies in illness models in family focused interventions for bipolar disorder.

### **An investigation of adult attachment and the nature of relationships with voices**

Katherine Berry, University of Manchester, Alison Wearden, University of Manchester, Christine Barrowclough, University of Manchester

The study investigated associations between adult attachment and voice hearing. We hypothesised associations between insecure attachment, severity of voice hearing and distress in relation to voices. We also hypothesised associations between attachment and the nature of relationships with voices. In a cross-sectional design, 73 participants with a diagnosis of schizophrenia spectrum disorders, self-reported anxiety and avoidance in attachment relationships and we coded experiences of voice hearing from interviews. There were significant positive associations between attachment anxiety and both severity and distress in relation to voice hearing, but no associations between attachment avoidance and these dimensions. We found evidence of predicted associations between attachment avoidance and themes of rejection, criticism and threat in relationships with voices. Contrary to predictions, there were no significant associations between anxious attachment and the theme of control in relationships with voices and no association between anxious attachment and the theme of threat. The study is important in demonstrating associations between attachment and the nature of relationships with voices. This highlights the importance of assessing attachment styles in developing formulations of voice hearing. Findings suggest attachment theory may help develop CBT formulations and CBT for voice hearing.

### **The effect of psychological resources on experimentally-induced paranoia in a non-clinical population**

Lyn Ellett, Royal Holloway, University of London, Caroline Lawlor, Royal Holloway, University of London, Paul Chadwick, Institute of Psychiatry

The development of an effective and collaborative therapeutic relationship is recognised as a crucial part of CBT. Developing and maintaining a therapeutic alliance with clients with distressing psychosis may be particularly difficult, especially if they are experiencing persecutory delusions. The aim of this study was to explore therapists' experiences of working with clients with paranoia, and how they develop and maintain a therapeutic alliance over the course of therapy. 10 clinical psychologists, all of whom had at least 2 years post-qualification experience of CBT for psychosis, were interviewed using a semi-structured interview schedule. Topics covered in the interviews included: therapist perceptions of what promotes trust in therapeutic relationships with clients with current paranoia; how therapists respond when trust breaks down in the therapeutic relationship; how therapists respond when clients incorporate them into their paranoid belief systems and consideration of phases of relationship building when working with clients with paranoia. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis. Therapists discussed their beliefs about factors that contribute to trust and mistrust in the therapeutic relationship and how they respond to mistrust or ruptures when they occur. Accounts of being incorporated into paranoid belief systems were also described. The findings provide insights into therapists' experiences of working with clients with paranoia and some of the common difficulties experienced. The study also highlighted common conflicts experienced by therapists when working with clients with paranoia, as well as the techniques used by therapists to develop and maintain a therapeutic alliance in CBT for psychosis. Implications in terms of highlighting common difficulties that are experienced by therapists working with clients with paranoia, and how these can be managed.

## Basic Processes and New Developments

### Keynote Addresses

#### Mental imagery: From Flashbacks to Flashforwards

Dr Emily Holmes, University of Oxford

MICKEY MOUSE. What shape are Mickey Mouse's ears? We experience mental imagery when we see in our mind's eye, hear with our mind's ear, and so on. Imagery has fascinating properties which allow us to mentally time-travel and make creative leaps. It can also cause profound distress. Intrusive, affect-laden images occur across a range of psychological disorders, notably as flashbacks in post-traumatic stress disorder (PTSD). While intrusive images are striking to clinicians, compared to work on verbal cognition, imagery has been surprisingly neglected in both research and practice. Our experimental research is the first to demonstrate that compared to verbal thought, imagery has a more powerful impact on emotion (Holmes & Mathews, 2005, Emotion; Holmes, Mathews, Mackintosh & Dalgleish, 2008, Emotion). We have proposed that imagery is special due to its powerful relationship with emotion, perception, action and memory (Holmes & Mathews, 2010, Clin Psy Review). FLASHBACKS. In comparison to studying memory that is deliberately recalled we know relatively little about involuntary memories and images. Work will be presented on experimental studies of intrusive memory (e.g. Holmes, Coode-Bates, James & Deeprose, 2009, PLoSONE). It has been motivated by our research with patients with PTSD on 'hotspots' images (e.g. Grey & Holmes, 2008, Memory). In the laboratory, films with traumatic content are used as an analogue for real trauma which allows us to prospectively study intrusive image development. Initial work explored "peri-traumatic" processing, and more recently we have begun to consider "post-traumatic" processing by manipulating cognitive processing in the immediate aftermath of a traumatic film. Certain cognitive tasks - including the computer game Tetris - appear to protect against intrusion development. FLASHFORWARDS. The powerful impact of mental imagery leads us to explore whether it occurs in novel domains, e.g. in the area of bipolar disorder (Holmes, Geddes, Colom & Goodwin, 2008, BRAT) or imagining suicide - "flashforwards" (Holmes, Fennel, Crane & Williams, 2007, JBTEP). But can we harness the properties of imagery for good use? Imagery rescripting is an exciting growth area (Holmes, Arntz & Smucker, 2007, JBTEP). We have recently used computerized cognitive bias modification techniques to promote more positive imagery biases e.g. imagining a more positive future in depression (Holmes, Lang & Shah, 2009, Jnl of Abnormal). PUTTING THE "SEE" IN CBT. If mental imagery occurs across disorders what are the overarching implications for cognitive therapy? It is suggested that in addition to considering patients' verbal cognitions (1) the importance of assessing for negative imagery during assessment across disorders (2) the benefits of promoting more positive imagery in treatment. Imagination is a powerful tool. (p.s. unlike most mice, Mickey has round ears).

#### Expressive Writing in Clinical Practice

Professor James Pennebaker, University of Texas, USA

Writing about emotional upheavals in controlled experiments tends to improve physical and emotional health. How do the research findings generalize to real world clinical practice? Drawing on recent studies on writing and natural language use, a number of recommendations will be suggested concerning who should write, when the writing should be done, how the writing samples should be treated, and ways to think about writing as homework or direct boost to therapeutic sessions.

### Symposia

#### More News from the Imagery Front

Convenor and chair: Ann Hackmann, University of Oxford

#### Imagery rescripting as a stand-alone treatment for depressed patients with intrusive memories

Jon Wheatley, Central & North West London NHS Trust & Royal Holloway University, Chris Brewin, Trishna Patel, and Pasco Fearon, University College London, and Ann Hackmann, Department of Psychiatry, Oxford University. Many depressed patients report intrusive and distressing memories of specific events in their lives. These memories are often of key defining moments from autobiographical memory such as loss of loved ones, interpersonal crises or childhood abuse. Where present, these memories are believed to act as a maintaining factor. A series of ten patients with major depressive disorder and intrusive memories, many of them reporting

severe, chronic, or recurrent episodes of depression, were given an average of 8.1 sessions of imagery rescripting as a stand-alone treatment. Hierarchical linear modelling demonstrated large treatment effects that were well-maintained at one year follow-up. Seven patients showed reliable improvement, and six patients clinically significant improvement. These gains were achieved entirely by working through patients' visual imagination and without verbal challenging of negative beliefs or behavioural activation methods. Spontaneous changes in beliefs, rumination, and behaviour were nevertheless observed. Brief case examples will be given to illustrate the treatment, and potential mechanisms of change will be considered.

#### **Imagery Rescripting for Obsessive Compulsive Disorder**

Nicholas Page, David Veale & Paul Salkovskis, Institute of Psychiatry, Kings College London

**Introduction** As part of a wider study into treatment adjuncts for Cognitive Behavioural Therapy for Obsessive Compulsive Disorder (OCD), Imagery Rescripting as an experimental treatment adjunct was investigated for its efficacy in addressing Obsessive Compulsive symptomatology. The presentation will include an overview of the study as a whole and a more detailed look at one particular case. **Objectives and Methodology** The study aimed to establish whether Imagery Rescripting could be an effective intervention for OCD. 10 participants were involved in a randomised case series. All participants were first involved in a semi-structured interview to establish imagery phenomenology and then randomized to 7, 14, 21 or 28 days where they received the imagery intervention session. All participants had a placebo session 7 days prior to the imagery intervention. Outcomes were measured by idiosyncratic daily measures, weekly self-report measures and a weekly Y-BOCS clinician administered questionnaire. The subject presented here in more detail received an Imagery Rescripting session similar to that outlined in Arntz's Treatment of Childhood Memories (1999). **Results** The case detailed in the presentation (a 50 year old male with OCD characterized by a fear of harming others originating from events age 14) showed significant improvements on many of the measures following the imagery intervention. **Discussion and Conclusion** Imagery interventions show promise as treatment adjuncts to Cognitive Behavioural Therapy as usual for OCD and could be particularly useful in treatment resistant OCD. They are entirely consistent and therefore compatible with the Salkovskis (1999) model for OCD. **Keywords** Obsessive Compulsive Disorder, Imagery **References** Arntz, A. Weertman, A. (1999) Treatment of childhood memories: theory and practice. *Behaviour Research and Therapy*, 37, 715-740. Salkovskis, P. M. (1999). Understanding and treating obsessive-compulsive disorder. *Behaviour Research and Therapy*, 37, s29-52.

#### **Relating differently to intrusive images: The impact of Mindfulness Based Cognitive Therapy on Intrusive Images in health anxiety (Hypochondriasis)**

Freda McManus, Kate Muse & Mark Williams, University of Oxford

Consistent with findings in other anxiety disorders, distressing intrusive images have been found to affect the majority of patients with health anxiety (Muse, McManus, Surawy, Williams & Williams, in press). Although research exploring the use of imagery interventions has increased in recent years, little is known about the impact of Mindfulness Based Cognitive Therapy (MBCT) on intrusive imagery (Holmes, Arntz & Smucker 2007). MBCT may be particularly beneficial for health anxious patients experiencing intrusive imagery for two reasons. First, the majority of images identified by health anxious individuals relate to future illness/death related events (Muse, McManus, Williams & Williams, in press; Wells & Hackmann 1993). This reflects the fact that health anxious patients' fears tend to have a much longer time course than other anxiety disorders (e.g., developing cancer and dying in 5 years' time as compared to, for example, the patient with panic disorder who fears he will pass out in the next ten minutes), which may present challenges for traditional imagery modification techniques that seek to directly manipulate the content/meaning of images. By contrast, MBCT is an indirect intervention which shifts the focus away from challenging the content of images towards attempting to change patient's relationship with their images, seeing them as images rather than indicative of reality. Previous research suggests that MBCT may be helpful in increasing the individual's ability to detach from negative automatic thoughts (Frewin et al 2008) and thus it may also aid the detaching from intrusive imagery. Second, MBCT encourages patients to modify unhelpful meta-cognitive processes and may therefore facilitate patients foster more helpful response strategies to distressing imagery than the maladaptive responses such as avoidance and rumination which maintain the experience of intrusive phenomena and associated anxiety (Hackmann & Holmes, 2004). Hence, the current study seeks to explore the impact of MBCT on health anxious patients experiencing intrusive imagery. This talk will present results from 34 patients who met DSM-IV criteria for the diagnosis of hypochondriasis, 17 of whom will have received MBCT treatment as part of a larger randomised controlled trial. The impact of MBCT treatment on the frequency, associated distress and difficulty in letting-go of images, as well as engagement in maladaptive responses (e.g. avoidance), will be presented in comparison to the 17 patients who have received treatment-as-usual.

#### **Can we dampen down intrusive imagery such as flashbacks soon after a stressful event using simple tasks?**

Catherine Deepprose, Shuqi Zhang, Ella James & Emily Holmes, University of Oxford

Intrusive, negative imagery (e.g. flashbacks) is the hallmark symptom of posttraumatic stress disorder (PTSD) but also plays an important role in other psychological disorders, including depression and social phobia. We use the stressful film paradigm to induce intrusive imagery in healthy volunteers. This laboratory-based approach allows us to investigate the cognitive mechanisms underlying the development of intrusive imagery and to explore the application of novel treatment interventions. Previous research has shown that completing particular cognitive tasks during a stressful film can influence the development of subsequent intrusive imagery (Holmes & Bourne, 2008). In accordance with clinical models of PTSD and theoretical models of working memory, visuospatial working memory tasks decrease intrusive imagery whereas other tasks do not (Holmes, Brewin, & Hennessey, 2004). However, to be applicable to real-world treatment innovation, we need to investigate whether completing cognitive tasks after a stressful event may also serve to modulate intrusive imagery. We present a series of studies investigating the effects of completing cognitive tasks in the memory consolidation phase i.e. after the stressful film (e.g. Holmes et al, 2009). We will argue that simple cognitive tasks may provide a cost-effective and easily accessible intervention in reducing the development of intrusive, negative imagery both in PTSD and other psychological disorders.

**Projective Flashbacks: "What if" in Imagery**

Sally Standart, Newcastle Cognitive Therapies Centre  
Sally Standart, North East Traumatic Stress Centre

Projective Flashbacks are future orientated "memories" first described by Grunert, Weis and Smucker in 2007, in Post Traumatic Stress Disorder. These tend to have poor outcomes when treated with traditional prolonged exposure methods and are often not dealt with as the therapist is not aware of them. Projective flashbacks are images in traumatic imagery which did not actually occur in the trauma, but could have happened so could be conceptualised as "what if" phenomena closely linked to generalised anxiety (GAD). GAD is a common co morbid condition in Post Traumatic Stress Disorder. This phenomenon has also been described as prospective imagery (Deeprise and Holmes 2010) and a new questionnaire to elucidate the imagery is described by them. The cognitive therapist needs to be aware of projective flashbacks so that they can be treated appropriately. Often clients are reluctant to talk about these images as they see them as a sign of madness. This presentation will describe several cases of projective flashbacks and how to work with them with imagery rescripting and cognitive transformation. Hackmann 1993 lists imagery distortions such as frozen in time etc. and these "what if" images could be added this expanding list.

**Understanding Anhedonia and Positive Information Processing in Depression: From Basic Science to Clinical Intervention.**

Convenor: Barney Dunn, MRC Cognition and Brain Sciences Unit

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**Experimental investigations of positive information processing in depression**

Barney Dunn, MRC Cognition and Brain Sciences Unit

Until recently CBT interventions for depression have primarily focused on reducing negativity rather than on augmenting positivity. This talk will review recent findings from our laboratory that suggest that reductions in positivity across a range of domains are a central component of depression that warrant greater clinical attention. Studies will be presented examining how depressed individuals feel in response to a variety of positive material, whether depression alters how accurately people can 'forecast' their emotional reactions to future positive events, and if information processing of positive material becomes biased in depression. In addition, recent studies examining whether positive emotional experience can be increased in depressed individuals by encouraging them to elaborate the processing of positive material will be discussed.

**Anticipating positive future experiences: Its role in well-being and mental health**

Andrew McLeod, Royal Holloway

Positive aspects of experience have received relatively little attention in the clinical sphere. This is true either for thinking about their inherent value or for considering the role that they may play in mental health problems. In the realm of future-directed thinking, there is clear evidence that the lack of positive future thinking is different from the presence of negative future thinking, and that reduced positive future thinking rather than increased negative future thinking characterise the cognitions of those who are depressed and suicidal. These findings suggest that interventions to enhance positive future thinking may be valuable in clinical practice. Evidence of the effectiveness of such interventions will be reviewed with a particular emphasis on enhancing goal setting and planning abilities to increase anticipation of future positive experiences.

**Evaluating a self-help, positive goal-focused intervention to increase well-being in people with depression**

Helen Barlow, Cambridge and Peterborough NHS Foundation Trust

Self-help interventions are an accessible, first-step treatment for depression in the UK. Well-being interventions focus on increasing people's resources and bringing about positive feelings and behaviours and could enhance self-help interventions for depression by increasing well-being as well as reducing depression. This talk will present a recent study evaluating whether a manualised goal-setting and planning (GAP) intervention can both increase well-being and reduce depression within a sample from a depression self-help organisation who scored above clinical cut-offs for current depressive symptoms. Implications for augmenting existing CBT treatments with well-being approaches will be discussed.

**Fostering positivity in cognitive therapy for depression: A clinical perspective**

Richard Moore, Cambridge & Peterborough NHS Trust

Cognitive therapy is usually thought of as addressing primarily the negative aspects of experience. However, fostering positive experience has always had an important role at different stages of cognitive therapy. Aspects of therapy that aim to enhance positive thoughts and feelings will be reviewed and their emphasis in the new wave of therapies considered. It will be argued that across models of therapy experiential avoidance is a key factor that inhibits positive experience. Strategies for increasing engagement and enhancing positive experiences will be illustrated with clinical case material. The potential benefits of making the focus on enhancing positivity more explicit will be explored.

**Utilising Control Theories in the Science and Practice of CBT**

Convenor: Warren Mansell, University of Manchester

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**Depression and anxiety in relation to goal coherence and goal conflict in adolescents' personal goal systems**

Joanne Dickson, University of Liverpool & Nick Moberley, University of Exeter

Control theories posit that psychological distress is due to unresolved conflict between personal goals (Mansell, 2005; Powers, 2005). In the present study we investigated whether symptoms of anxiety and depression are independently associated with conflict and reduced facilitation within personal goal systems. The sample comprised a non-clinical adolescent school sample ( $N = 119$ ). Participants listed their personal goals and rated the extent to which each goal inhibited or facilitated every other goal. Anxious and depressive symptoms were both found to be associated with reduced levels of goal facilitation, although regression analyses revealed that

depressive symptoms but not anxious symptoms independently predicted reduced levels of goal facilitation. Similarly, ratings of distress and repetitive thinking associated with participants' most conflictual goals were independently associated with depressive symptoms but not anxious symptoms. There was no association between the number of goals listed and anxious and depressive symptoms. Conflict is thought to be a normal consequence of pursuing a variety of goals. Our preliminary data, suggest that both anxious and depressive symptoms are associated with reduced goal coherence. However, only symptoms specific to depression, but not symptoms specific to anxiety, are independently predictive of reduced coherence in personal goal systems and a negative preoccupation with conflicting goals. The present findings further contribute to our understanding of the nature of anxious symptomatology and depressive symptomatology from a goal-motivational perspective in adolescence. However, future research would benefit from the use of additional measures of depression and particularly anxiety to study whether these findings are replicable.

#### **Ruminative thinking and goal strivings: Conflict, difficulty, ambivalence and avoidance**

Nick Moberley, University of Exeter & Joanne Dickson, University of Liverpool

Ruminative thinking is a common phenomenon in depression and anxiety and has been identified as a transdiagnostic process in psychopathology. Control theory perspectives suggest that ruminative thinking is instigated by unsatisfactory rates of progress towards important goals and an inability to disengage from unobtainable goals. Maladaptive features of the structure and content of personal goal hierarchies may disrupt self-regulation and thereby increase ruminative thinking. In a cross-sectional study, a non-clinical sample of 210 undergraduates completed a personal strivings assessment in which they listed ten goal strivings before rating each on several dimensions including conflict, difficulty and ambivalence. Participants also completed various self-report measures of ruminative thinking and depressive/anxious symptoms. Ruminative thinking was predicted to be independently associated with perceptions of greater goal conflict, difficulty and ambivalence, and a greater proportion of avoidance goals. Results are discussed in terms of control theory and relevance for clinical conditions.

#### **Self-regulation processes in reactive depression: partial engagement with over-valued goals**

Stephen Barton, Newcastle University

This paper presents part of a self-regulation framework for conceptualising reactive depression (Barton, Armstrong, Freeston & Twaddle, 2008) and it reports the results of two analogue studies seeking to test a key aspect of the model. A central claim of the model is depression can be maintained by dysregulation of goal engagement systems such that, contrary to stereotype, some depressed people remain engaged in highly valued activity regulated by goals that have become unattainable (or have a very low probability of attainment). This creates the setting conditions for frustration-based depression in which lack of progress towards an overvalued goal is taken as the input for goal re-engagement. Over time, iteration through positive feedback cycles maintains goal overvaluation, increases frustration, dysphoria and makes regulatory control "reluctant" to disengage and pursue alternative goals. Evidence from two analogue studies is presented using an anagram task in which the anagrams become increasingly difficult to solve in the time available. In spite of the explicit option to disengage from the task at any point, most participants continue to pursue their goal for the task and experience intensifying frustration and dysphoric mood. The strongest associate of dysphoric mood was partial engagement; that is, having a moderately low level of hope in the goal when task difficulty increases; the hope level was not high enough to engage strongly with the task to achieve the goal, but neither was it low enough to disengage from the task and engage with more rewarding alternatives. Partial engagement with highly valued goals is discussed as a potential maintenance process in major depression.

#### **Dynamic Hierarchies in Exposure Therapies**

Alec Brady, Keresforth Centre, Barnsley PCT

Control theories posit that it is the control of percepts - conceptualised as internal states caused by external stimuli - that determines the function of behaviour. Alec Brady uses this notion to develop the concept of Dynamic Hierarchies in Exposure Therapies (Brady and Raines, 2009). By structuring the hierarchy in terms of moment-to-moment control of the state of arousal (which plays the role of the percept in this formulation) the therapist enables the client to integrate exposure work into their daily activities in a much more organic way. The method also makes use of experimental results which show how safety behaviours can be made a part of the hierarchy, rather than being seen as inimical to it (Milosevic and Radomsky, 2008). This talk will explain the basic approach, and will explicate the hypothesised function of cognitive dissonance and appraisals in determining what counts as sensitising and desensitising exposure.

References: Brady, A. & Raines, D. (2009). Dynamic hierarchies: a control system paradigm for exposure therapy *The Cognitive Behaviour Therapist*, 2, 51-62. Milosevic I, & Radomsky, A. S. (2008). Safety behaviour does not necessarily interfere with exposure therapy. *Behaviour Research and Therapy*, 46, 1111-1118.

#### **Working with goals, self-discrepancies and executive deficits following brain injury: can control theories help?**

Fergus Gracey, Oliver Zangwill Centre, Cambridgeshire NHS Trust

Emotional difficulties are common following acquired brain injury (ABI), anxiety and depression being most common, with both prevalence and lifetime incidence at about 30%. Cognitive impairments in executive functions (self regulation of mood, behaviour and cognition), attention and aspects of memory are also very common and can impact significantly on ability to function independently and to engage in psychological therapy. A key focus of rehabilitation is to support individuals to improve and maintain their social participation through the collaborative setting of personally meaningful goals. Control theories highlight the detection and management of discrepancies between current state and the desired or aspired to goal state as central to self-regulation. They have been drawn upon in the literature to help understand specific aspects of rehabilitation, such as collaborative goal setting, and understanding emotional adjustment. Research into interventions for emotional problems following brain injury suggests that goal setting is helpful for improving mood in rehabilitation soon after injury. In longer term adjustment, individuals experience social discrepancies (negative subjective experiences in previously familiar social contexts such as family, friends, and the workplace) and personal discrepancies (feeling at odds with themselves now compared to how they used to be pre-injury). Extent of personal discrepancy may underpin



extent of adjustment-related emotional distress. Executive functions are also commonly impaired following brain injury resulting in reduced ability to self-monitor progress towards practical goals and self-regulate accordingly. In this presentation we argue that control theories provide a helpful conceptual framework for integrating ideas across diverse areas of rehabilitation practice, understanding post-injury emotional adjustment in terms of self-discrepancy and executive control, and informing the practice of cognitive therapies with people with brain injury. Our ideas will be illustrated with reference to clinical material in which behaviour appears driven by non-conscious 'hot goals' which serve a function of reducing self-discrepancy in the short term at the cost of achieving practical, day-to-day intentions and long term good emotional adjustment.

#### **Emotion Regulation of Others and Self: Studies of Function and Dysfunction**

Convenor: Peter Totterdell, University of Sheffield

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##### **A phenomenological analysis of emotion regulation through an interview and diary study**

Miriam Samad, Rebecca Kelly, Warren Mansell, Alex Wood, University of Manchester

In everyday life, people utilise a number of strategies in order to regulate their own emotions and the emotions of others. Parkinson & Totterdell (1999) note that such strategies are often deliberate and intentional, and aim to improve, worsen or maintain current emotions or moods. Not all the strategies that people employ may be helpful, indeed, an individual's emotion regulation strategies, as well as the goals that drive such strategies, may conflict with one another (Koole, 2009), especially when a person attempts to balance their own emotion regulation needs with those of other people.

Although qualitative methods have been used to study a range of mental health topics central to clinical psychology (e.g. Burton, 2000; Kearney & O'Sullivan, 2003), historically, research into emotion regulation has been predominantly quantitative. As a result, an understanding of the processes that people engage in when attempting to regulate emotions may be lacking. The current study therefore sought to explore the process of emotion regulation through qualitative methodology, namely through the use of an emotions diary and a semi-structured interview.

Twelve student participants (six male, six female) kept a daily diary for a period of one week. The diary asked participants to note their own and other's emotions, and any strategies employed to manage such emotions. This diary was designed to help facilitate interviewees' reflection on their emotion regulation strategies, and also to provide the interviewer with a useful tool which would allow for a more sensitive interview (Wells, 1998). Following completion of the diary, participants attended an interview in which their emotion regulation was explored in more depth. The interviews were analysed using Interpretive Phenomenological Analysis (IPA), which allowed the identification of recurring themes. Such themes included the use of the self as a model when managing other's emotions, the interlink between one's own emotions and the emotions of others, and the constant strive for an emotional equilibrium. These themes among others will be presented and discussed.

##### **Emotion regulation in close relationships**

Gwenda Simons, Brian Parkinson, Laura Taylor & Ilmo van der Löwe, University of Oxford, Department of Experimental Psychology

We are interested in how people in close relationships (both romantic relationships and friendships) regulate their own and their partner's emotions when discussing emotion-related topics. We focus particularly on how (facial) expressions of emotion are oriented to the actual and anticipated reactions of the other person, and on the extent to which the recipients of emotion communication respond to its other-orientation. For example, when your partner's facial expression suggests that (s)he is worried about a problem, you may indicate that you share that worry; you may indicate that you understand that worry but not necessarily share it or you may imply that the worry is misplaced and present a different appraisal of the situation. Each of these responses may be genuine and representative of how you are feeling, or they may be regulated. You may, for example, present a calm exterior in order to prevent your partner from becoming overly worried. Our contention is that relationship partners can get locked into habitual patterns of expression and response as a function of consistent relational feedback (e.g., Fogel, Nwokah, Dedo et al., 1992; Lewis, 1996). For example, one partner might habitually express concerns while the other habitually minimises these concerns. These patterns might have both positive and negative consequences for such factors as relationship satisfaction and closeness. We will report findings from a number of our studies using time-dependent observational and diary measures to study interpersonal emotional experience and emotion regulation within romantic couples and close friendships. In a series of observational studies we have video-recorded relationship partners or friends discussing emotion-related topics in the lab. Analysis of data from video-cued recall procedures (e.g., Levenson & Gottman, 1985) reveals interesting individual and relationship-level differences in the extent to which emotion and regulatory intent are matched across pairs of participants and in the extent to which participants' perceptions of emotion and regulatory intent match their partners' corresponding self-reports. These differences relate in turn to various situational, relational and dispositional variables, including those relating to individual emotion-regulation styles. The results seem to be consistent with approaches that see emotion regulation as operating at the level of interpersonal interaction as well as at the individual level. As well as discussing these findings we will explore evidence for the various regulatory patterns and the possible consequences for the couples.

##### **Using Implementation Intentions to Promote the Effective Self-Management of Anxiety**

Thomas Webb, University of Sheffield, Paschal Sheeran, University of Sheffield, Margarita Ononaiye, University of East Anglia, John Reidy, Sheffield Hallam University & Anastasia Lavda, University of Sheffield

**\*\*Final author: Rachel Varley, University of Sheffield\*\*** Effective self-management of anxiety requires that the person identify (i) suitable opportunities to manage anxious symptoms (e.g., feeling worried) and (ii) functional responses to these opportunities (e.g., use a breathing technique). Two studies investigated the effects of forming implementation intentions that require participants to do this thinking in advance and to link anticipated opportunities with functional responses in an if-then contingency. Study 1 investigated the efficacy of augmenting self-help materials with implementation intentions. At baseline, participants who reported anxious symptoms completed the Hospital Anxiety and Depression Scale (HADS) and were randomized to augmented self-help,

standard self-help, or no-intervention conditions. At eight weeks follow-up a significant reduction in anxiety in the augmented self-help condition was found compared to the other conditions (caseness rates on the HADS at follow-up were 21%, 49% and 44%, respectively). Study 2 investigated whether forming implementation intentions could help people with social anxiety to control their attention and make more realistic appraisals of their performance in a stressful situation. Participants with low and high levels of social anxiety were asked to give a speech and a subsample of the highly socially anxious participants formed the implementation intention; "If I feel concerned, then I will focus on the back wall of the room!" Participants with high levels of social anxiety underestimated their performance (relative to observer ratings); however, forming implementation intentions engendered more realistic appraisals of performance. Taken together, these findings suggest that forming implementation intentions may provide an effective means of promoting the effective self-management of anxiety.

#### **Gaining control: The effects of cognitive training on emotion regulation**

Susanne Schweizer, Adam Hampshire, Dean Mobbs & Tim Dalgleish, MRC Cognition and Brain Sciences Unit  
In everyday life we continuously attempt to manipulate information in the service of multiple desired goals; whether our attempts are successful is partially dependent on our executive control (EC) capacity. EC enables both active selection of goal-relevant material and inhibits attention and responses to distracting/conflicting goal-irrelevant information in our environments. Individuals who are good at keeping active goal-representations in the presence of salient distractors, that is, are high on EC capacity, tend to be more successful across various life domains including the social domain, academic performance and mental well-being; whereas psychopathology, especially disorders of emotional dysfunction, tends to be associated with low levels of EC. It seems then, that increasing our EC capacity would have the potential to optimize goal-directed behavior and increase resilience to psychopathology. However, until recently interindividual differences in EC were thought to be highly heritable and stable across the life-span. Novel evidence contradicts the above assumption by showing working memory training to improve people's EC capacity. Though to date, the handful of executive training studies that have evaluated effects of training all used affectively neutral material. Yet, 'real world' EC often requires the manipulation of emotionally-laden material in the context of emotionally-laden distractors, especially in individuals with emotional disorders. In a series of studies we explored the type of EC deficits experienced in emotional disorders including PTSD and depression. Our results showed disorder specific deficits. We further investigated whether and how emotion regulation capacity is differentially related to EC of emotional versus neutral material. Finally, we looked at the possibility of training EC in an affective context by comparing the effects of training in three different conditions: I.) training high on EC demands and emotional stimuli, II.) training high on EC demands neutral stimuli and III.) a neutral control training low on EC demands. The active training task (I and II) was a highly demanding dual n-back task of the type that has been shown to improve working memory and fluid intelligence. We aimed to replicate the cognitive transfer effects of training onto working memory and fluid intelligence. We were additionally interested in the effects of training I compared to II and III onto affective measures including an emotional Stroop task. We will discuss our findings and address the question of the role of EC in emotion regulation and emotional dysfunction. Our results have a wide range of implications especially for the advancement of novel treatment research in the realm of emotional disorders.

#### **Cognitive behavioural treatment of cyclothymia: Regulatory control mediates mood change**

Steven Kellett, University of Sheffield

Regulatory control of cognition is implicated in the amplification of mood variability in cyclothymia and bi-polar disorders. This study examined whether CBT directed at enhanced awareness and change of cyclothymic mood, could subsequently change global functioning, mood variability and regulatory control. Using a prospective single case experimental design, mood ratings were recorded every 4 hours for 51 weeks in a patient diagnosed with cyclothymia; spanning a 5-week baseline, a 35-week CBT intervention period and an 11-week follow-up period. The patient had 24 sessions of CBT in total. Results indicate that the patient experienced reduced cognitions associated with mood variability, happier mood, less anxiety and greater regulatory control, but reduced energetic mood. As predicted, variability in mood and regulatory control were reduced. Moreover, CBT reversed a positive association between feeling activated and positive mood; this moderated effect was mediated by a change in control over thoughts. The results suggest that CBT directed at regulatory control can be effectively integrated into the treatment of cyclothymia and bipolar mood disorders.

#### **Putting Theory into Practice - Clinical Research Applications of Perceptual Control Theory**

Convenor: Tim Carey, Centre for Remote Health, Flinders University and Charles Darwin University, Australia

#### **MOL in Primary Care: Investigating Predictors of Outcome**

Marijke Lansbergen, University of Manchester

Method of Levels (MOL) is a form of psychotherapy based on the principles of Perceptual Control Theory (PCT). PCT understands psychological distress to arise when an individual is unable to control their experiences due to conflict between higher-order goals (e.g., "I want a promotion at work" vs "I want to remain loyal to my colleagues"). The MOL therapist asks the client questions about their experiences in order to direct their present-moment attention to their conflicting personal goals, thus allowing it to be identified and 'reorganised'. Recent studies of MOL therapy have found significant differences in symptoms of psychological distress from pre to post therapy (e.g., Carey & Mullan, 2007, 2008; Carey et al., 2009). The current study uses a longitudinal within-group design incorporating regression analyses to identify predictors of outcome following MOL therapy. The study was conducted in a primary care mental health service with clients presenting with a range of problems including anxiety and depression. The current design overcomes limitations of previous uncontrolled studies by ascertaining the relative contributions of a number of variables (number of therapy sessions, MOL adherence, working alliance, level of reorganisation and client readiness to actively solve their problems) on therapeutic outcomes, thus allowing further exploration of the therapeutic mechanism of change. A total of 60 participants were sought. It was predicted that 1) clients would experience an improvement in wellbeing; 2) MOL would be associated with a strong positive therapeutic alliance; 3) sessions which were more MOL adherent would promote better client outcomes; 4) high levels of reorganisation and client readiness to actively solve their own problems would predict

a positive outcome. The main dependent variable consisted of a composite score calculated from measures of anxiety and depression.

#### **Can a control model approach assist case formulation in psychotherapy?**

Christopher Spratt, NHS Fife

This is a presentation of a paper which looks at issues regarding case formulation in psychotherapy. Case formulation is well recognized as being helpful in the conceptualizing of psychological problems and as a useful tool in the practice of cognitive therapy. Control, as opposed to behaviour, is increasingly being seen as that human process most relevant to psychopathology. We look at the diagnosis and treatment of a small number of people, treated in a naturalistic setting, who were selected without any specific criteria other than being people whose problems were treated using the Method of Levels, a form of cognitive therapy based on the principles of Perceptual Control Theory, and who completed both pre- and post-treatment questionnaires. We then consider how the problems these people presented with, and their treatment, might be formulated as a result of taking this approach.

#### **The importance of conflict and arbitrary control in predicting problems managing everyday emotions and behaviours**

Rebecca Kelly, Miriam Samad, Warren Mansell, Alex Wood, University of Manchester

This research investigated how goals to express or suppress emotions and behaviours related to problems managing emotions and behaviours in six different domains: anger, anxiety, excitement, eating tasty food, drinking alcohol, and shopping. According to Perceptual Control Theory (PCT; Powers, 1972), conflict is central to psychopathology, and controlling one's experiences arbitrarily is dysfunctional.

A sample of 192 undergraduates rated the overall importance of their reasons for allowing themselves to express certain emotions and perform certain behaviours (expression), and the importance of their reasons for not allowing themselves to do so (suppression). They also rated the extent to which they had problems managing each emotion and behaviour, and completed self-report measures of well being and psychological symptoms.

Multi-level modelling analyses were performed, using a domains-within-individuals design. The results indicate that 1. The presence of internal conflict between goals for controlling emotions and behaviour is problematic, and causes distress, in line with PCT. 2. If one's goals are in conflict with the consensus of a group as a whole, this is problematic. This consensus could reflect either a cultural rule or an accurate view of adaptive goals for managing the emotion or behaviour. In PCT terms this conflict could be viewed as arbitrary control. 3. There is the additional problem of attaching high importance to goals for suppression of emotions or behaviour, whether or not these goals are in consensus with the group. Suppression may be problematic because it implies rigid control, or because it prevents awareness and communication.

Implications for effective therapy and MOL specifically: Effective therapy should encourage people to talk about their problem and associated emotions, thus bringing them into awareness. It should also allow people to consider the amount of importance they attach to their goals and what is driving this. Finally, once in awareness, conflicting goals should be considered and reprioritised to improve functioning.

#### **MOL: Rolling with the Punches**

Tim Carey, Centre for Remote Health, Flinders University and Charles Darwin University, Australia

MOL is a flexible and adaptive form of cognitive therapy that focuses on the experiences and perceptions of the client as they are reported by the client. MOL begins with the client's perception of the problem and seeks to help the client reach a successful resolution to the difficulties they are experiencing. The case study presented in this workshop describes the use of MOL with a young man who had a long history of contact with mental health services. He displayed what would be described as chronic and complex difficulties including anger issues and substance abuse problems. He was initially quite suspicious and pessimistic about embarking on yet another course of therapy. From the first session, however, he remarked that this particular therapy seemed to be different from what he had previously experienced. He commented that he found it helpful and interesting to be examining his beliefs and attitudes in this way. This presentation describes the way in which the client was able to determine many of the parameters of the treatment such as the timing of the appointments and even the length of the sessions. Also described is the way in which a variety of sources of data were used to monitor the progress of the client. It is suggested that MOL might be a useful intervention to use with clients who are difficult to engage with or who have difficulty to define problems.

#### **Cognitive Bias Modification: Exploring the Role of Mental Imagery**

Convenor: Catherine Deepprose, University of Oxford

#### **Comparing Visual and Auditory Presentation for the Modification of Interpretation Bias**

Helen Standage, University of Essex, Chris Ashwin, University of Bath & Elaine Fox, University of Essex

This research compares the effects of visual vs. auditory presentation of cognitive bias modification (CBM) training scenarios upon interpretation style and emotional vulnerability. For both modalities, negative, but not positive interpretation biases were successfully induced relative to a baseline. Mood declined for the auditory but not the visual group throughout the CBM procedure, irrespective of the valence of the CBM condition. This deterioration in mood raises an important methodological issue and indicates that the increased testing time brought about by auditory compared to visual presentation needs to be addressed. The CBM procedures did not influence emotional vulnerability as assessed by behavioural measures, but counter-to-prediction, CBM procedures did increase self-reported depression vulnerability for the positive but not negative CBM condition.

#### **Enhancing the effectiveness of Cognitive Bias Modification: active selection of emotional meaning and imagery.**

Laura Hoppitt, University of East Anglia, Andrew Mathews, University of California, Davis, USA, Jenny Yiend, Institute of Psychiatry, King's College London & Bundy Mackintosh, University of East Anglia

Individuals who show high levels of anxiety also tend to show negative interpretive bias (i.e., a tendency to interpret emotional ambiguity in a negative way). Cognitive bias modification (CBM) is a novel way of reducing symptoms such as anxiety by directly targeting and modifying maladaptive cognitive biases using computer based methods. As studies are now showing the benefits of using CBM in a therapeutic setting it is important to understand the underlying cognitive mechanisms in order to ensure we use it most effectively. One aspect that appears to be an important component is active selection of emotional meaning during training. In the present study an active training condition (in which participants were required to actively select threat or non-threat interpretations of emotionally ambiguous stimuli) was compared to a passive training condition (in which participants were passively exposed to valenced scenarios). Both groups were required to use imagery during the training phase, and the test phase was a task in which participants were required to form images of emotionally ambiguous scenarios and rate their emotionality. The results suggested that it was only when encouraged to actively select meanings during training that there was modification of emotional responses in the subsequent imagery task. The active trained group showed modification of emotionality of images in a training congruent direction, but the passively trained group showed no modification. Interestingly, a further study suggested that these differences were only apparent when imagery was used in the test session. This finding supports the view that active generation of meaning during interpretive training is critical for the modification of later emotional responses and that engaging imagery during the test phase enhances these differences.

#### **Using Computerised Cognitive Bias Modification to Reduce Intrusive Memories in Depression**

Catherine Deeptose & Tamara Lang, University of Oxford, Michelle Moulds, University of New South Wales & Emily Holmes, University of Oxford

Since negative intrusive memories are a maladaptive feature of depression it has been suggested that targeting maladaptive appraisals regarding these may be beneficial (Birrer, Michael, & Munsch, 2007). Importantly, the negative interpretations of such intrusions (e.g., "having this intrusive memory means that I am coping badly") serves to maintain both the occurrence of intrusive memories and depressive symptoms (Starr & Moulds, 2006). We present an experiment in which a cognitive bias modification (CBM) technique for appraisals of depressive, intrusive memories was tested (Lang, Moulds, & Holmes, 2009). Our CBM paradigm was developed to specifically target appraisals of intrusive memories as typically endorsed by people with depressive symptoms. Participants were randomly allocated to a session of either positive or negative CBM. Following CBM training, participants watched a depressive film. During the following week, participants recorded any intrusive memories of the depressive film and at the end of the week returned for follow-up assessment. Participants who underwent the positive version of the CBM paradigm reported a greater positive appraisal bias than participants who underwent negative CBM. In addition, positive CBM participants reported significantly fewer intrusions of the depressive film across the week and significantly lower intrusive symptomatology assessed using a clinical scale anchored to intrusive symptomatology of the depressive film. We suggest that computerised CBM may provide a useful tool to reduce the frequency and distress associated with intrusive memories and images in depression.

#### **Modifying Interpretation and Imagination in Clinical Depression: A Single Case Series using Cognitive Bias Modification**

Simon Blackwell, Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust & Emily Holmes, University of Oxford

Depression is characterized by negative interpretation biases (Beck, Rush, Shaw, & Emery, 1979), that is a tendency to interpret information in a negative way. Depressed mood is also associated with a deficit in generating positive imagery about the future (Holmes, Lang, Moulds, & Steele, 2008). A Cognitive Bias Modification (CBM) paradigm targeting both interpretation bias and positive imagery may therefore have particular potential in developing innovative treatments for depression (Holmes, Lang, & Deeptose, 2009). However, translating a paradigm from the laboratory to the clinic inevitably poses a number of challenges. We present a study that aimed to bridge this gap by testing the effectiveness of a CBM paradigm targeting imagery and interpretation with a clinical sample of participants experiencing a current major depressive episode, while using participants' feedback to develop the package from a laboratory procedure to one suitable for future clinical implementation and testing (Blackwell & Holmes, 2010). We used a single case series design to investigate the impact of repeated sessions of this CBM paradigm on the interpretation bias, mood, and mental health of participants. Seven participants completed daily sessions of CBM at home for one week. Outcome measures were completed pre and post a one-week baseline period, and after the week of daily CBM. Depressive symptoms were also assessed at a 2-week follow-up. Four of the seven participants demonstrated improvements in mood, bias, and/or mental health after one week of CBM, with improvements in depressive symptoms maintained at follow-up. Participants' feedback of their experience of the CBM provided novel insights into the success or otherwise of a repeated sessions paradigm, suggesting developments to maximize its potential clinical efficacy.

#### **50 years of Control Theory: How Does it Impact our Current Understanding and Practice?**

Convenor: Sara Tai, University of Manchester

#### **A Balance of Forces**

Bill Powers, Lafayette, Colorado, USA

The enormous change that the concept of negative feedback control implies has yet to penetrate the understanding of neuroscientists, biologists, psychologists, and most others in the life sciences. There are great forces at work, on the one hand urging a scientific revolution, and on the other hand pushing on to ever more astonishing feats of biochemistry and genetic detective work. We can symbolize these opposing forces with a pair of rubber bands knotted together. With one hand, I pull one end to the left; with the other hand, I pull the other end to the right. And you will notice that as I do this, the knot in the middle remains in about the same place. Of course it does, you may say. The two rubber bands are equal in strength; the knot has to stay halfway between them. The forces are in balance. That is how a neuroscientist would reason, along with most other kinds of scientists. Control theory tells us that, with this little demonstration, I have just shown that in fact the opposite is

the truth: the position of the knot is the cause of the balance of forces. How that can possibly be true is the subject of this talk.

#### **Perceptual Control Theory through the 1980s**

Rick Marken, University of California, Los Angeles, USA

I discovered PCT in 1974, just after getting my PhD and before leaving to start my first teaching job as a Professor of Psychology at Augsburg College in Minneapolis, Minnesota. I will talk about the series of events that led to my becoming actively involved in doing PCT research starting in 1979. I will also talk about my experience with resistance to PCT from the Psychological "establishment", learning about the phenomenon of "pseudo" PCT, efforts to develop a group with a common interest in PCT (the CSG, starting in 1985) and the start of the internet discussion group CSGNet at the end of the 1980 (I believe it actually started in 1990).

#### **Method of Levels: A Methodical and Systematic Beginning**

Tim Carey, Centre for Remote Health, Flinders University and Charles Darwin University, Australia

The theoretical and conceptual underpinnings of the Method of Levels (MOL) have been available since at least the early 1970s. Efforts to implement MOL in a systematic and comprehensive way, however, did not occur until the beginning of the 21st century. Early positive results from a case study encouraged the more widespread use of the technique. Initially, this began with one clinician working in the Adult Primary Care service of the National Health Service in Scotland. The results achieved by this clinician encouraged other clinicians to become involved. At each stage of development the application of MOL was evaluated before further developments were planned. While the evaluations were being conducted it became apparent that the principles of PCT could be used to inform not only the type of therapy that was delivered but also the way in which it was delivered. It was discovered that organizing services such that patients were able to schedule their own appointments led to dramatic improvements in access to services. Waiting lists and waiting times diminished and service capacity increased. Paradoxically, when patients were able to make as many appointments as they wanted, they made fewer appointments than when clinicians scheduled appointments for them. This feature of MOL alone should be of interest to service managers and policy makers; however, MOL also achieves positive clinical outcomes. Patients, generally, find their own solutions to problems and many patients report beginning to question themselves in the same way outside of therapy that the MOL clinician questions them within therapy. This suggests that MOL might fulfil an important relapse prevention function as well as helping people with their current distress. During the implementation of MOL a collaboration was formed with a clinical researcher at the University of Manchester. As a result of this collaboration, further research has begun through the University of Manchester. Beginning with studies conducted in naturalistic settings involving one therapist, then two, then four, the research at the University of Manchester is continuing to increase the research demands and further explore the applicability of MOL. To date, a growing number of publications have become available describing the results of using MOL and a special interest group has been formed within the BABCP. Also, a Special Issue of the journal *The Cognitive Behaviour Therapist* devoted to MOL was published in 2009. Interest in MOL is steadily expanding with training being conducted in the UK, Australia, Canada, and the US. Initial findings indicate that MOL is an efficient and effective form of therapy that invites a transdiagnostic approach to the formulation of psychological problems making it especially useful with issues of complexity and comorbidity. Importantly, MOL enables patients to assume control of their mental health service delivery and, in this way, reflects important NHS policy initiatives.

#### **Perceptual Control Theory and Cognitive Behavioural Therapy**

Warren Mansell, University of Manchester

In the last decade or so, cognitive behavioural therapies have been developing in a variety of ways. Their evidence base has been burgeoning, they are becoming increasingly adopted by the clinical services, and they are diverging into a 'family' of related approaches with somewhat diverse influences, such as mindfulness, attachment theory and metacognition. Nevertheless, there remain a range of challenges concerning, for example, the degree to which CBT can be said to have a clear, coherent link between its theory and its practice, and issues over how it is provided in an accessible way to a wide range of client groups (Mansell, 2008). The term CBT itself belies an uneasy alliance between cognitive theory and behavioural theory, which use different terminology and make different assumptions about the importance of internal mental states and observable behaviour. I came across control theory initially through the work of Carver and Scheier (1982), which influenced the development of the cognitive model of social phobia (Clark & Wells, 1995), among others. However, it was only later that I accessed the original work on control theory that Carver and Scheier utilised - Bill Powers (1973, 2005) book *Behavior: The Control of Perception*. This provided a full and detailed mechanistic, biological, mathematical and philosophical expansion of the theory which came to be known as Perceptual Control Theory (PCT). The theory provided a breath of fresh air to me in terms of what 'theory' really means within psychology, and it appeared to resolve the strain between cognitive and behavioural accounts in the literature. The theory is both familiar and radical; it makes the uncontroversial claim that behaviour is goal-directed; yet in specifying the exact mechanisms for this to occur, reveals an architecture of the mind that is unique and highly versatile. In the last decade, the relevance of PCT has expanded, including a role of control theory in several approaches to CBT (e.g. Brady & Raines, 2009; Watkins, 2008;), a special issue of *The Cognitive Behaviour Therapist* on the topic, a new SIG of the BABCP, and a research programme focused on evaluating and exploring the mechanisms of change of Method of Levels, a person-centred cognitive therapy based on PCT (Carey et al., 2009). I will also summarise a recent paper in *Clinical Psychology Review* which integrates the mechanism of change across a diverse range of psychotherapies using PCT (Higginson, Mansell, & Wood, in press).

## **Panel Discussion**

**Ann Hackmann - a Career Through the Looking Glass**

Convenor: Emily Holmes, University of Oxford

Speakers: Chris Brewin, University College London

Jon Wheatley, Central & North West London NHS Foundation Trust & Royal Holloway University

David M Clark, Institute of Psychiatry, King's College London  
 Mark Williams, University of Oxford  
 Emily Holmes, University of Oxford

BABCP is pleased to bring together this panel in honour of Ann Hackmann who retires in 2010. Ann has been a regular presenter at BABCP conferences, an active member since the early days of BABCP, and is well known for her expertise in mental imagery. The speakers have all had the pleasure of working with Ann on clinical research during her career. Highlights will be discussed. A focus of the discussion will be the interweave between clinical psychology and research, especially in the context of mental imagery. The discussion will welcome questions from the audience

## Open Papers

### Psychological Disorders, Imagery, and the Social Self

Chair: Lusia Stopa, University of Southampton

#### Adolescent and maternal perceptions of social competence in adolescent internalizing disorders

Kalliopi Triantafyllou, University of Manchester, Sam Cartwright-Hatton, University of Manchester, Christine Barrowclough, University of Manchester

There is some debate in the literature as to whether depression and anxiety in adolescence are associated with social skill deficits. A number of studies have demonstrated that children with anxiety or depression have social deficits (e.g. Inderbitzen-Nolan, Anderson & Johnson, 2007; Renouf, Kovacs & Mukerji, 1997). On the other hand, studies have indicated that children with social anxiety or depression do not lack social skills, but simply perceive themselves as performing badly (e.g. Cartwright-Hatton, Tschernitz & Gomersall, 2005; Marton, Connolly, Kutcher & Korenblum, 1993). The majority of the studies have employed analogue non-clinical samples and therefore, the applicability of these findings to adolescents with clinical internalizing disorders is questionable. Furthermore, a number of studies have used subjective ratings and there may be a fundamental difference between self-appraisals of social skills, and appraisals of social skills made by observers. Moreover, it has been suggested that children's and adolescents' perceptions of their competence are influenced by the feedback that they receive from significant others (Cole, 1990). Accordingly, many studies have shown that parental involvement plays an essential role in children's self-perceptions (e.g. Ladd & Hart, 1992; Rubin, Bukowski, & Parker, 1998). In particular, Jacquez, Cole, and Searle (2004) demonstrated that negative maternal feedback was associated with adolescents' perceived poor social skills, which in turn had an impact on their depressive symptoms.

This study aimed to examine the relationship between social skills and clinical internalizing disorders in adolescents. Three groups of adolescents and their mothers participated in the study: 23 with internalizing disorders, 22 with externalizing disorders and 26 non-referred controls. After completing the Multidimensional Anxiety Scale for Children (MASC; March et al., 1997) and the Children's Depression Inventory (CDI; Kovacs, 1985), adolescents were invited to give a presentation. Subsequently, they were asked to rate their performance by completing the Performance Questionnaire (PQ-C; Cartwright-Hatton et al., 2003). Mothers watched the videotaped presentation and completed the Performance Questionnaire (PQ-P; Cartwright-Hatton et al., 2003), the Beck Anxiety Inventory (BAI; Beck & Steer, 1993) and the Centre for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). Finally, two independent observers rated the adolescents' performance.

Independent ratings showed that there were no differences in the performance between the three groups. However, the clinical internalizing group underestimated their performance significantly more than the control groups. Maternal anxiety symptoms were significantly associated with perceptions of child social inadequacy. Adolescents with internalizing disorders are not necessarily socially inadequate, but they appraise aspects of their performance as poor. Mothers with anxiety symptoms appear to underestimate their child's performance. Overall, these results suggest that a treatment focusing on the negative cognitions of patients could have positive outcomes on the diminution of anxiety and depression. Moreover, it is suggested that maternal perceptions may not always be accurate and objective. Therefore, in clinical practice, in order to minimize bias in the information that is obtained about social skills, the clinicians should always have independent evaluations, in addition to those sought from parents.

#### Cognitive Behaviour Therapy for low self-esteem: A preliminary randomised controlled trial in a primary care setting

Polly Waite, University of Reading, Freda McManus, Oxford Cognitive Therapy Centre & University of Oxford Department of Psychiatry, Roz Shafran, University of Reading

Low self-esteem is a common and disabling problem (Silverstone and Salsali 2003), that has been associated with various psychiatric disorders including depression, eating disorders and substance abuse (Brown, Andrews et al. 1986; Akerlind, Hornquist et al. 1988; Button, Sonuga-Barke et al. 1996). Furthermore, low self-esteem has been shown to impede the progress of cognitive behaviour therapy (CBT) for Axis I disorders (Blatt, Quinlan et al. 1995). A cognitive conceptualization of low self-esteem has been proposed and a CBT protocol developed (Fennell 1997; Fennell 1999), but this treatment has not been systematically evaluated. The aim of this study was to evaluate CBT for low self-esteem in a small randomised controlled trial. Twenty-two patients were recruited and randomly allocated to either immediate or delayed treatment, involving ten sessions of CBT over fourteen weeks accompanied by workbooks. At the end of treatment, the group that received CBT had significantly improved scores on measures of low self-esteem, overall functioning, anxiety and depression and effect sizes were large. Of the twenty-two participants in the study, eighteen went on to complete treatment; two participants dropped out before treatment began and the other two participants dropped out during treatment. All participants who completed treatment were assessed at the end of treatment and after a ten-week follow-up. There was a significant difference on all measures from pre to post-treatment and this was maintained at follow-up with large effect sizes. This study provides preliminary evidence that a focused, brief CBT intervention can be effective in treating low self-esteem and associated problems. This is consistent with the findings of existing transdiagnostic studies (Riley et al., 2006) that demonstrate the effectiveness of a treatment approach that emphasizes a single

common pathway across diagnostic categories. Our results also suggest that the presence of negative core beliefs about the self can be targeted effectively with a relatively small number of sessions, even when the individual may have already had a significant number of previous therapy sessions. We suggest that there may be some circumstances when low self-esteem should be the focus of treatment but other circumstances when it would be more helpful to use this treatment approach as an adjunct to existing, well-validated cognitive behavioral interventions. Further research is required to better understand the relationship between low self-esteem and associated problems and to determine when focusing on low self-esteem as the primary problem is likely to be most effective.

#### **Imagery as a route to the self in social anxiety**

Stopa Lusia, University of Southampton, Brown Mike, University of Southampton, Hirsch Colette, Institute of Psychiatry, Kings College, London & University of Western Australia  
Cognitive models of social phobia emphasise the role of negative and dysfunctional views of self in the maintenance of social anxiety (Clark & Wells, 1995; Rapee & Heimberg, 1998; Hofmann, 2007, Moscovich, 2009). These negative views of self are often represented by visual images and experimental manipulation of positive and negative images of self demonstrate that negative self-images are associated with more anxiety, worse performance in social situations, and that they block benign inferences and inhibit the retrieval of positive autobiographical memories (e.g. Hirsch et al., 2003, Stopa & Jenkins, 2007). However, to date, no-one has examined the impact of positive and negative self-images on self-related measures. 80 participants (40 low and 40 high socially anxious) held either a positive or a negative self-image in mind and then completed measures of state self-esteem, state self-concept clarity, and a computer task that measured the consistency of self-descriptions. Participants who held a negative images in mind reported lower state self-esteem, less self-concept clarity, and were less positively, and more negatively consistent in their self-descriptions in the computerised task. They were also less confident about the judgments they had made about self-characteristics on the computer task. Participants also rated how anxious and how well they would perform in two hypothetical social situations. We conducted a mediation analyses following Baron and Kenny's (1986) methodology and then followed this up with a bootstrap analysis to investigate whether changes in self-related variables mediated the relationship between self-imagery and anxiety and performance. In both analyses, state self-esteem was a full mediator and state self-concept clarity was a partial mediator. We propose that negative self-images represent the individual's current 'working self' (Conway & Pleydell-Pearce, 2000), which is linked to a network of beliefs, attitudes and memories of embarrassing or anxiety provoking incidents that are associated with a pattern of physiological and emotional responding. Working with imagery in social phobia might be effective because it helps the individual to access alternative, more functional self-representations that then inhibit the negative self-representations that normally characterise individuals with this disorder. This study provides evidence in support of imagery-modification work in social anxiety. Individuals with social phobia can benefit from deliberately constructing a more positive and functional image of themselves and practice holding these images in mind and replacing the distorted negative images that are often present.

#### **Imagery rescripting and the self**

Soljana Čili, University of Southampton, Sharon Pettit, University of Southampton, Lusia Stopa, University of Southampton  
Imagery rescripting (IR) is a cognitive-behavioural technique that aims to change the meaning of memories of negative/traumatic experiences that are associated to recurrent, intrusive images present in various forms of psychopathology. So far, it has been used successfully to address distressing images and alleviate symptomatology in a series of disorders, such as bulimia nervosa (Ohanian, 2002), social phobia (Wild, Hackmann, & Clark, 2007, 2008), posttraumatic stress disorder (e.g. Rusch, Grunert, Mendelsohn, & Smucker, 2000), and depression (e.g. Wheatley et al., 2007). The research conducted so far, however, has focused mainly on the impact of this technique on specific symptoms and has not investigated the impact it has on the self. The aim of the current study is to investigate the outcome of one session of IR in a student population. The question it tries to address is: What is the impact of one session of IR on distressing memory characteristics and on the individuals' self, affect, and automatic thoughts? The main hypothesis tested is Brewin's (2006) retrieval competition hypothesis, which argues that cognitive-behavioural therapeutic techniques such as IR make positive self-representations more accessible so that they are more likely than maladaptive ones to be activated in response to situational triggers or to negative/traumatic memory recall. The study uses a within-participants design and consists of three sessions. In the first session, participants go through a semi-structured interview aimed at exploring a negative memory and images related to it. In the second session, a clinician helps participants rescript the memory. In the third session (the follow-up), participants go through the interview once again. In each session, they complete questionnaires and tasks focusing on affect, automatic thoughts, and different aspects of the self, such as state self-concept clarity, state self-esteem, and self-structure. Data collection for this study has just started. Results are expected to show that one session of IR leads to increased self-esteem and self-concept clarity following the negative/traumatic memory recall, a more positive self-structure, reduced strength of the belief encapsulated in the memory, reduced memory and image vividness and distress, increased positive affect, and increased frequency of positive automatic thoughts. If the results go in the expected direction, they will be taken as evidence supporting Brewin's (2006) retrieval competition hypothesis. Understanding the mechanisms of change involved in the effectiveness of imagery rescripting (mainly the impact it has on the self) may help us refine this technique in order to maximise therapy gains.

#### **Cognition, Metacognition and Mindfulness**

Chair: Dawn Proctor, IHBI, QUT

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#### **Metacognitive therapy versus exposure therapy for post-traumatic stress disorder**

Dawn Proctor, IHBI, QUT, Deborah Walton, NHS, Karina Lovell, University of Manchester, Adrian Wells, University of Manchester

Existing treatments for post-traumatic stress disorder typically incorporate some imaginal exposure but symptomatic recovery is not universal. Metacognitive therapy (MCT) is a non-exposure focused approach that aims to remove perseverative thinking that is considered to block in-built recovery processes. This randomised controlled trial (RCT) compared (MCT) with Exposure therapy (E) and a waitlist control condition (WL). The sample consisted of 32 participants with symptom chronicity of  $\geq 3$  months, recruited from four UK Clinical Psychology Departments. Following an initial assessment those opting into the trial were randomly assigned to one of the three conditions, eight sessions of therapy (MCT v. E) or an eight week wait period (WL). The study aimed to examine the efficacy of MCT compared with a well-established active treatment and to measure the rate of change across conditions. Both active treatments resulted in significantly lower symptoms of PTSD, anxiety and depression compared with the WL control. The completer analysis (N=30) showed that MCT led to greater reductions than Exposure across symptoms of psychological distress and physiological arousal in response to trauma memory (heart rate). Recovery rates were higher for MCT at both post treatment and follow-up compared with E. Eighty per cent of those completing MCT and 70 per cent of the Exposure group showed clinically significant change at post-treatment on the PDS symptom severity score. In conclusion, both treatments were effective, MCT appears to have an advantage on some indices and may specifically exert effects more rapidly. The clinical implications and suggestions for future research are discussed.

#### **Metacognitive beliefs and hallucination-proneness: A meta-analytic synthesis of the empirical evidence**

Filippo Varese, Bangor University, Richard Bentall, Bangor University

The metacognitive model of hallucinations proposed by Morrison et al. (1995, *Behavioural and Cognitive Psychotherapy*, 23, 265-280) assumes that dysfunctional metacognitive beliefs might lead to the misattribution of intrusive thoughts to external sources, therefore generating hallucinatory experiences.

A series of meta-analyses were carried out to summarize the empirical findings on the association between hallucination-proneness and different metacognitive beliefs allegedly implicated in the genesis of hallucinatory experiences. The results revealed that whilst metacognitive beliefs are robustly associated with hallucination-proneness in non-clinical samples, they were only moderately associated with hallucinations in clinical samples. Additional analyses also revealed that after controlling for the effect of comorbid symptoms (e.g. emotional symptoms, intrusive thoughts, psychotic symptoms other than auditory and visual hallucinations), hallucination-proneness was weakly related to metacognitive beliefs. The results of this research synthesis found little support for the existence of specific associations between hallucinations and dysfunctional metacognitive beliefs, and suggested that the large associations observed in previous research might be stemming from the failure to consider the covariation between different symptoms associated with maladaptive metacognitive beliefs. These findings have important implications in relation to the investigation of symptom-specific associations between metacognitive factors and different psychopathological complaints, and in relation to the development and implementation of metacognitive-focused cognitive behavioural techniques for the treatment of psychotic symptoms.

#### **Mindfulness groups for psychosis: Key issues for implementation on a specialist inpatient unit**

Pamela Jacobsen, South London and Maudsley NHS Foundation Trust, Kathleen Hodkinson, Oxleas NHS Foundation Trust, Eric Morris, South London and Maudsley NHS Foundation Trust, Louise Johns, South London and Maudsley NHS Foundation Trust

There is emerging evidence that mindfulness groups for people with distressing psychosis are safe and therapeutic. The present study aimed to investigate the feasibility of running and evaluating a mindfulness group on a specialist tertiary inpatient ward for individuals with chronic and treatment resistant psychosis.

Patients were invited to attend a mindfulness group which ran weekly for 1 hour for 6 weeks. Each session included two 10-minute breathing meditations, and facilitated group discussion following the adapted protocol for psychosis developed by Chadwick and colleagues. Pre-post measures of symptoms and mindfulness were administered, in addition to within-session measures of distress and symptom interference (using a visual analogue scale). Eight participants attended at least one session. Mindfulness exercises were acceptable and well-tolerated by participants. Participants were able to reflect on their experiences of mindfulness within the session; for example, relating them to previous meditative experiences such as being in a church or out in nature. Some participants had difficulty completing standardised measures, but the within-session measures were generally more accessible. These findings link back to the original application of mindfulness in improving outcomes for clinical populations who have not responded to conventional treatment (e.g. chronic pain). There may be systemic challenges to integrating mindfulness approaches within inpatient settings, as this may conflict with the usual emphasis placed on experiential control and symptom reduction within the ward milieu. We conclude that mindfulness groups are a feasible intervention for inpatients with treatment-resistant psychosis, and this warrants further research. Many service users with psychosis experience chronic and distressing symptoms which may be only partially ameliorated by pharmacological interventions. CBT for psychosis has an established evidence base in this population, and more recent research has demonstrated that third wave cognitive therapies including mindfulness may also be beneficial. This study shows that even service users with chronic, treatment-resistant psychosis can engage in mindfulness groups, indicating the potential for improving clinical outcomes for this population using this approach.

#### **Mechanisms of change in mindfulness-based cognitive therapy (MBCT)**

Andrew Bromley, Mood Disorders Centre, University of Exeter (*BABCP 2009 Excellence Award Winner*), Willem Kuyken, Mood Disorders Centre, University of Exeter

Mindfulness-based Cognitive Therapy (MBCT) is an 8-week meditation-based group intervention program developed for preventing depressive relapse in people with recurrent depression. While recent studies have supported the efficacy of MBCT, there is a lack of data to support the mechanisms presented by theory.

The first study presented is part of a larger MBCT trial that investigated how MBCT compares against maintenance anti-depressants in preventing depressive relapses. At the final follow up 15 months after randomisation, participants who had completed the MBCT programme were asked about their experiences of MBCT and their sustained recovery or relapse. Eleven of the 53 transcribed interviews were analyzed using thematic analysis to



identify themes related to what participants had identified as being helpful and unhelpful in the mindfulness course, and to explore what changes they had experienced in relation to depression.

The eight MBCT change themes generated from the data were Awareness, Attention, Skilful Action, Control, Acceptance, Group, Difficulties, and Transformation.

Results from the qualitative study and subsequent process outcome studies investigating MBCT change-themes will be presented with the intention of defining those mechanisms of change within MBCT that are central to the efficacy and effectiveness of this treatment for recurrent depression. Through using a triangulation of qualitative and quantitative methodologies the studies set out to investigate people's experience of MBCT as a relapse prevention program, investigate whether the proposed mechanisms of change of MBCT mediate treatment outcome, to examine whether participation in specific MBCT mindfulness practices relates to favourable outcomes, and to explore the longer term effects of MBCT. Preliminary findings will be presented at the conference.

#### **Brain, cognition, and clinical practice: Hippocampal volume in vulnerability and resilience to depression**

Stella Chan, University of East Anglia (*BABCP 2009 Excellence Award Winner*), Harmer CJ, Mackay CM, Portella MJ, Massey-Chase R, O'Sullivan U, Ayres R, Goodwin GM

In this presentation, I will first re-visit my last year's talk entitled 'Hippocampal volume in vulnerability and resilience to depression.' This study examined whether differences in hippocampal volume occur as a function of vulnerability to depression. These research findings will be discussed alongside my clinical observations, specifically focusing on how research into brain and cognition may (or may not) be linked to clinical practice. Neuroticism is a predisposing factor for developing depression. We therefore recruited participants with high neuroticism scores who had either never experienced depression or had recovered from at least one episode of DSM-IV major depression. Hippocampal volumes were compared to a control group with low neuroticism scores. Results showed that experience of previous depressive episodes is associated with reduced hippocampal volumes, while high neuroticism (high risk for depression) is associated with increased hippocampal volumes. Further investigations are underway to explain this apparent paradox.

## **Posters**

### **14. EMDR and Metacognitive Therapy: Same Destination, Different Language**

Matthew Cole, York Stress & Trauma Centre

The information processing model has been described in many different ways and is potentially the underlying process that describes the psychotherapy change process, regardless of orientation. In this poster I will briefly compare Eye Movement Desensitisation and Reprocessing and Meta-Cognitive Therapy in light of this information processing model and conclude that although they may use different language to describe their theories, a unifying information processing model describes both paradigms. Human beings are meaning making machines (Robbins, 2009). We give meaning to the world, the deeds we do and the interactions we have, as well as the more fundamental senses we experience (Frankl, 2004). Information arises either from external stimulus or internal process's and this information goes through our filters where we delete, distort and generalise this information based on the rules created in our information processing unit (Fig 1). This information processing mechanism gives meaning to this filtered information and generates a response, this response interacts with this information and the cycle then repeats in a self regulatory manner. This process is repeated for everything we do; we are and continues until we die. Mental health issues arise when this self regulatory system fails to make a useful functional meaning of the information. Eye Movement Desensitisation and Reprocessing (EMDR) was developed by Francine Shapiro (1989) for the treatment of trauma memories and associated emotions, changing the meaning the person gives to their experiences. Metacognitive Therapy (MCT) was developed by Wells and Matthews (1984) as a way of defining the processes that underpin a range of psychological disorders.

One of the features of psychological disorders such as anxiety or depression is that thinking becomes difficult to control and biased in particular ways that lead to a worsening and maintenance of emotional suffering. Many clients report that they feel that they have 'lost control' over their thoughts and behaviours. Another important feature is that the persons thinking and attention becomes fixed in patterns of brooding and dwelling on the self and threatening information. Both EMDR and MCT describe an information management/processing system that organises and carries out various tasks such as how to open a door, how to get dressed, how to be anxious, how to respond to a trauma memory Both therapies appear to change this system / process to something that is much more adaptive for the client, as if they change the master information management control programme that runs this system, in the same way a conductor influences the orchestra and the music they produce. Both models describe the same process, although they utilise different language to describe this change process.

Perhaps a change of focus for the development of psychotherapy towards more process change models rather than content change interventions.

### **15. Detached Mindfulness versus Thought Challenging in high Socially Anxious individuals: A Comparison**

Styliani Gkika, University of Manchester, Adrian Wells, University of Manchester

The Self-Regulatory Executive Function (SREF) model (Wells and Matthews 1994) suggests that detached mindfulness, a way of developing meta-awareness and of interrupting conceptual processing, can reduce symptoms of emotional disorders. This study examines this suggestion in a sample of high socially anxious individuals. Twelve participants practised detached mindfulness and thought challenging in a cross-over repeated measures design. It was expected that both techniques would lead to improvements but that detached mindfulness would be superior overall.

Results are discussed in terms of the potential incorporation of detached mindfulness in the treatment of social anxiety disorder. Results showed that both techniques reduced the outcome variables, but detached mindfulness showed greater change than thought challenging in worry ( $Z = -2.797$ , Exact  $p = .003$ .), belief levels ( $Z = -2.04$ , Exact  $p = .042$ ), and the observer perspective ( $Z = -2.22$ , Exact  $p = .031$ ). Moreover, thought challenging seemed to increase worry, anxiety and belief levels when delivered after detached mindfulness. This study shows that detached mindfulness may be useful in social anxiety. Further studies are needed to explore its potential

applications as a stand-alone technique or within the framework of meta-cognitive therapy. The study also suggests that it may be counter-productive to combine some techniques in some sequence.

#### **16. The effect of Guided-Meditation Practice on Attentional Network Function in healthy volunteers**

Ben Ainsworth, University of Southampton, Rachael Eddershaw, University of Southampton, Daniel Meron, University of Southampton, Paul Chadwick, Kings College London, David S. Baldwin, University of Southampton, Matt Garner, University of Southampton

Efficacious mindfulness-based interventions may in part affect clinical improvement through stabilizing maladaptive attentional biases. We sought to compare the effects of open- and closed-attentional focus training (often featured in mindfulness packages) on selective attention to emotional cues and attention control, assessed using a modified Attention Network Task (Fan et al. 2002). 74 undergraduate volunteers attended a pre-test session, completing an emotional variant of the ANT (comprising negative, neutral words and non-emotional non-words). Participants were subsequently randomized to 3 groups: open-focussed attention meditation training; closed-focussed attention meditation or a no-intervention control. Intervention groups completed three 1-hour group sessions (across 1 week) and 10 minutes of daily guided practice each day until follow-up testing. All groups re-completed the ANT and self-report measures at follow-up. The finding that meditation training can improve executive attention extends effects observed in long-term meditators and following integrated mindfulness training. Psychological interventions focussing on executive attention may reduce pathology, particularly selective attention deficits observed in depression and anxiety. Future studies should clarify the extent to which early changes in attention control can i) persist and augment correction of broader cognitive biases; ii) protect against psychopathology in healthy individuals. Executive attention scores were entered into a 4-way mixed-design ANOVA with group (open-focussed/closed-focussed/control) x time (pretest/posttest) x emotion (negative/neutral/non-emotional) as independent variables. A significant time x group interaction was characterized by significant (and similar) improvement in executive attention for both meditation groups at follow-up (with no effect observed for control participants). Groups did not differ in baseline ANT performance. This study is the first to assess the impact of a guided-meditation intervention on specific, objectively-measured cognitive aspects of attention control. Findings of the study emphasise executive attention as one component through which psychological interventions may reduce pathology, and in particular the deficits in selective attention and attention control commonly observed in depression and anxiety.

#### **17. A Reciprocal Relationship between Inflated Responsibility and Negative Affect**

Gary Britton, University of Sussex, Graham Davey, University of Sussex

A number of constructs have been implicated in Obsessive Compulsive Disorder and compulsive checking including inflated responsibility (Salkovskis, 1985) and negative affect (Davey, Startup, Zara, McDonald and Field, 2003). Little is known, however, about how these constructs are related.

Two studies are reported. In the first, participants were placed into either a positive or a negative mood group and the affect on levels of inflated responsibility was observed. In the second experiment participants were placed into either a high or low inflated responsibility group and the affect on mood was observed.

These findings suggest that a simple causal relationship where either inflated responsibility or negative affect appears to be the primary cause of the other cannot be assumed. It instead appears that inflated responsibility and negative affect have a reciprocal relationship where an increase in one is likely to be accompanied by an increase in the other. The theoretical implications of this finding will be discussed as well as the possibility that both constructs are actually outcomes of some third variable.

In the first experiment participants in the negative mood group displayed significantly higher levels of inflated responsibility than the positive mood group. In the second experiment participants in the high inflated responsibility group displayed significantly higher levels of negative affect than the low responsibility group who in turn displayed significantly higher levels of positive affect.

Possibly could help inform CBT given for obsessive compulsive disorder.

#### **18. Phenomenological Aspects of Intrusions in the General Population**

Vanessa Jones, University of Reading, Craig Steel, University of Reading

Intrusive memories have been associated with a wide range of mental health problems, including schizophrenia, bi-polar disorder, social phobia and post-traumatic stress disorder. They are also observed in a non-clinical population: a general population survey carried in 2009 (by the authors) reported that 39% (131 participants) had experienced intrusions. However, little is known about the phenomenological qualities of IM's. The current study used a semi-structured interview in order to explore these qualities in a general population, with the aim of developing an interview for use within a clinical population. A semi-structured interview was compiled based on data from the above survey and an interview originally used with people suffering from major depressions (Patel, et al., 2007). This was conducted on 24 psychology undergraduates who also completed questionnaires measuring schizotypy personality and anxiety, plus a checklist of traumatic events. This study produced a wealth of data, both quantitative and qualitative, about the phenomenological aspects of intrusions. This will be compared with data from a study currently in progress, exploring intrusions in a clinical population of people diagnosed with Schizophrenia, with or without a diagnosis of Post-Traumatic Stress Disorder. 29% of participants had experienced intrusions. The connected emotions were negative: 71% experiencing fear, 14% anger, 14% sadness. The intrusion's content was mostly associated with death and included images, thoughts, sounds and smells. Most participants stated their intrusions interfered with their life 'a little' or 'somewhat': 86% reported their intrusions caused distress (57% reporting 'some' or 'very much' distress). This will increase knowledge about which aspects of intrusions cause distress to people with schizophrenia which will allow the targeting of clinical treatment to those areas.

#### **19. Transfer effects of Cognitive Bias Modification for Anxiety: Training a Benign Attentional Bias reduces Negative Interpretation Bias**

Josephine Illingworth, University of East Anglia, Laura Hoppitt, University of East Anglia, Gisela Perez-Olivas, University of East Anglia, Bundy Mackintosh, University of East Anglia

Anxiety is associated with negative biases in interpretation and attention. Prior research has shown that such biases can be modified, resulting in reduced stress vulnerability and trait anxiety (Mackintosh, Mathews, Yiend, Ridgeway and Cook 2006; See, MacLeod and Bridle 2009). This study investigates the extent to which training a particular bias may affect other cognitive domains, with important implications for both theory and practice. Anxious first-year undergraduates were allocated to one of three training conditions. (a) Training in attentional bias, away from negative words; (b) Interpretation bias training involving positive resolution of ambiguous scenarios; (c) Control bias training using neutral stimuli. A dot-probe test of attentional bias and a recognition-memory based test of interpretation were administered before and after a training block that consisted of eight 30-minute sessions administered over four weeks. The observed transfer of attentional bias training to interpretation bias suggests that such training is not restricted to a single cognitive domain, and therefore may have greater therapeutic applications than previously assumed. Secondly, the finding supports the hypothesis that different cognitive biases may be underpinned by some common mechanism, which is currently a matter of debate in the field. Further research should investigate the apparent lack of transfer from interpretation training to attentional bias. Interpretation bias became more positive in both the attentional training and interpretation training groups, compared to the control condition ( $p=0.044$ ). No such effect was found on the attentional bias test. The fact that cognitive bias modification (CBM) has effects beyond the trained cognitive domain suggests it may also show transfer to a number of cognitive processes that are targeted in CBT. Offering CBM as an adjunct to CBT has the potential to significantly improve treatment outcomes.

#### **20. How do Emotional Contents modulate the Belief-Bias Effect?**

Marios Eliades, The University of Manchester, Isabelle Blanchette, Université du Québec, Trois-Rivières, Warren Mansell, The University of Manchester

Our ability to reason deductively is highly influenced by the prior believability of a conclusion (Goel & Dolan, 2003). Yet, little is known about how the emotional nature of stimuli affect this tendency to rely on beliefs instead of logic. Our hypothesis was that belief-bias effects would be more prominent in emotional compared to neutral conclusions. 64 women evaluated the logical validity and emotionality of believable and unbelievable categorical syllogisms. Three content categories were used: neutral, generally emotional and sexual abuse-related. The hypothesis was supported. Belief-bias effects were more prominent in the two emotional categories compared to the neutral category. Nevertheless, unbelievable sexual abuse items were associated with decreased emotionality and even more logical fallacies. Building on the 'affect-as-information' hypothesis (Schwarz & Clore, 1983), the value of unbelievable items was less emotional in the sexual abuse than the generally emotional category, possibly because of lack of personal experience with sexual abuse. Unbelievable sexual abuse items were associated with more logical fallacies, possibly because they were experienced as less salient. Goel, V., & Dolan, R. J. (2003). Explaining modulation of reasoning by belief. *Cognition*, 87(1), B11-B22. Schwarz, N., & Clore, G. L. (1983). Mood, Misattribution, and Judgments of Well-Being - Informative and Directive Functions of Affective States. *Journal of Personality and Social Psychology*, 45(3), 513-523.

#### **21. Exploring the role of Intolerance of Uncertainty in Perseverative Worry: Is the Mechanism Increased Systematic Processing?**

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

Perseverative worry is associated with high intolerance of uncertainty (IoU) and negative mood. Previous work in our lab has demonstrated that negative mood increases self-report measures of variables known to increase systematic processing (effortful, analytic processing). Within the systematic processing literature, the sufficiency principle suggests individuals exert whatever level of effort is needed in order to be confident processing goals are met (Chaiken, Liberman & Eagly, 1989). IoU may increase systematic processing by raising the sufficiency threshold. Participants experienced an IoU manipulation (Kelly, 2009, unpublished doctoral thesis). Participants read two stories about a character that displayed thoughts consistent with high/low levels of IoU, and described an event in their own life where they were unsure if the outcome would be positive or negative. Participants wrote a journal entry about the uncertain event from the perspective of the character in the stories and completed 100-point Visual Analogue Scales (VAS) measuring IoU. Participants read two vignettes consisting of catastrophic chains of statements about a worry. After each vignette, participants completed 100-point VAS measuring systematic processing facilitators (task importance, personal relevance, responsibility, desire for control, accountability, and need for cognition). Participants completed a catastrophising interview (behavioural worry measure) (Davey, 2006). Conclusions will be made regarding whether the results are consistent with the view that IoU may cause perseverative worrying by facilitating factors known to influence the deployment of systematic information processing. Data are presented examining whether increased IoU results in higher scores on self-report measures of systematic processing facilitators and worry. If the data are consistent with the view that intolerance of uncertainty may cause perseverative worry by increasing factors that influence the deployment of systematic processing, an implication is that CBT interventions could focus on reducing levels of intolerance of uncertainty. In addition, practice should consider levels of systematic processing facilitators, such as accountability, responsibility, desire for control, and need for cognition. An awareness that feeling intolerant of uncertainty can lead to perseverative worry may help clients understand that their worrying is not necessarily reflective of a problem that requires effortful, analytical systematic processing.

#### **22. Intolerance of Uncertainty and Decision-Making in Healthy Adolescents**

Louise Harrison, Newcastle University, Jacqui Rodgers, Newcastle University, Jennifer Riley, Newcastle University, Mark Freeston, Newcastle University

Generalised Anxiety disorder is associated with high levels of worry and intolerance of uncertainty (IU). Clinical observations suggest that in uncertain circumstances anxious individuals, particularly those with high IU, delay decision making feeling less certain about decisions they make, and believe that they make poor decisions. Empirical evidence is however equivocal regarding whether those with high IU are impaired in their decision making ability. Using an analogue sample this study aimed to determine whether high levels of IU were associated with poorer performance and delayed response latency on a well established decision making task, the Iowa Gambling Task. A two group design was employed using the Intolerance of Uncertainty Scale for Children (IUS-C; Walker, 2009), to define groups of high or low IU. 42 healthy adolescents aged 12-13 years old completed the Iowa

gambling task, a computerised task which assesses 'decisions under ambiguity' and 'decisions under risk'. A measure of appraisals was administered at intervals during the task. Participants also completed the Wisconsin Card Sort Task, to assess perseveration and a random number generation task to assess executive function ability. The profile of decision-making by intolerance of uncertainty will be discussed, and the implications for future research and clinical practice considered.

## Behavioural Medicine

### Keynote Address

#### **Fatigue within a Chronic Illness: What, Why and How (to help) in Rheumatoid Arthritis**

Professor Sarah Hewlett, University of the West of England

Fatigue is a common problem in a range of physical long-term conditions, yet often the therapeutic emphasis by clinical teams is on the management of pain. This presentation will explore fatigue in rheumatoid arthritis, and how patients themselves have driven a fatigue research agenda, which is changing clinical practice. It will explore the meaning and cause of RA fatigue, where it differs from and where it has symmetry with other types of fatigue, and look at the current broad research programme that aims to help patients manage this major problem.

Findings from a randomized controlled trial of CBT will be presented. Throughout the presentation, real-life examples from a nurse-led clinic will illustrate the context of fatigue in a physical long-term condition and the support that can be provided by clinical nurses or occupational therapists within the team, reflecting the current situation where most teams do not include a clinical psychologist. This presentation is closely linked with Workshop 13.

### Symposia

#### **Managing Chronic Fatigue Syndrome (CFS/ME)**

Convenor and Chair: Alison Wearden, University of Manchester

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#### **Pragmatic rehabilitation for CFS/ME in primary care**

Alison Wearden, University of Manchester

People with chronic fatigue syndrome (CFS/ME) experience severe, disabling fatigue for which there is no medical explanation. A pragmatic treatment for CFS/ME, based on providing patients with a physiological dysregulation model of the condition, followed by a collaboratively designed rehabilitation programme, had proved effective in a secondary care setting. We aimed to evaluate the effectiveness of pragmatic rehabilitation (PR) when delivered by general nurses to patients recruited from primary care. We compared PR with supportive listening (SL) and general practitioner treatment as usual (GPTAU). 296 patients aged 18 and over who fulfilled the Oxford criteria for CFS/ME were randomly allocated to either pragmatic rehabilitation (PR; n=95), supportive listening (SL; n=101) or GP treatment as usual (GPTAU; n=100). PR and SL were delivered in patients' homes over 18 weeks by one of three specially trained adult-speciality general nurses. Primary clinical outcomes were fatigue and physical functioning at 20 and 70 weeks; secondary outcomes included sleep and depression. Analysis was by intention-to-treat. The trial registration number is IRCTN74156610. At 20 weeks, patients allocated to PR had significantly improved fatigue, sleep and depression but not physical functioning compared to patients allocated to GPTAU. These improvements were not maintained at 70 weeks. SL (compared with GPTAU) was not associated with improved outcomes. For CFS/ME in primary care, PR delivered by general nurses improves fatigue during treatment but the effects are not maintained. SL is not an effective treatment. We discuss reasons why PR treatment was less effective in this study than in the previous secondary care trial.

#### **Illness cognitions and socialization to the treatment model: predictors of outcome in a randomised controlled trial for the treatment of CFS/ME**

Jo Daniels, IAPT Services, 2gether NHS Foundation Trust, Gloucester

Objective: Successful therapy for chronic fatigue syndrome (CFS/ME) may involve a process of socialization to a model of the illness and its treatment. Previous work suggests that an enhanced sense of control and lower levels of focussing on symptoms are associated with better outcomes. We investigated whether socialization to a physiological dysregulation model of CFS/ME was associated with improved outcome, and whether perceived control and reduced symptom focussing mediated this effect. Method: Participants were adults who fulfilled UK criteria for CFS/ME. Data was generated from therapy tapes of 50 participants from the pragmatic rehabilitation arm of a randomised control trial of pragmatic rehabilitation. Utterances from initial and final therapy sessions were extracted and coded using an extraction and coding manual devised to measure socialization to the pragmatic rehabilitation model, personal control and symptom focussing. Outcomes were measured by change in physical functioning and fatigue between baseline and the end of treatment. Results: At the end of treatment, higher levels of socialization to the treatment model were associated with improvements in fatigue, and higher levels of personal control over the illness were associated with improved physical functioning. However, there were no findings indicating that change in socialization or change in personal control cognitions mediated change in outcome. Symptom focussing did not predict outcome. Conclusion: Research into socialization to the treatment model and the mediating role of control in the management and treatment of illness warrants further attention.

#### **Levels of psychiatric disorder and outcomes of treatment in patients with Chronic Fatigue Syndrome**

Mary Ridge and Trudie Chalder, Department of Psychological Medicine, King's College, London, Weston Education Centre, Cutcombe Road, London, SE5 9RJ

Background: Previous research has indicated that there is an association between psychiatric disorders and Chronic Fatigue Syndrome/ Myalgic Encephalopathy (CFS/ME) (David, 1991). The aims of these two studies were;

1) to compare psychiatric morbidity in 225 patients with CFS/ME in a specialist clinic in secondary care to 185 patients with chronic fatigue in primary care and 189 non-fatigued controls in a cross-sectional design and

2) To examine whether psychiatric morbidity predicts outcomes after CBT in patients with CFS in a specialist clinic prospectively. Methods: An ANOVA was used for the cross-sectional part of the study, to compare rates of psychiatric morbidity using the Clinical Interview Schedule, revised version (CIS-R) and the Hospital Anxiety and Depression scale (HADS), total score. We also examined the extent to which physical functioning was predicted by psychiatric morbidity in each group. In the treatment study CBT consisted of 12 sessions fortnightly. The focus was on facilitating a gradual increase in activity, encouraging the patient to adopt a sleep routine and cognitive restructuring which addressed fearful cognitions regarding activity and perfectionism. The main outcomes were the Chalder Fatigue Questionnaire, physical functioning and social adjustment. Secondary outcomes included the Penn State Worry Questionnaire and the Frost Perfectionism Scale. Multiple Regression was used to assess whether distress (measured in a variety of ways) and perfectionism predicted the outcome measures; fatigue (as measured by the Chalder Fatigue Questionnaire), physical functioning (a subscale of the SF-36) and social adjustment (the Work and Social Adjustment scale). Results: In the cross sectional study a continuum of distress was evident, with lower levels of distress in the controls, higher levels in the participants with chronic fatigue, and the highest levels in the patients with CFS. Psychiatric morbidity predicted level of physical functioning in both of the community groups (fatigued and non-fatigued). There were lower levels of physical functioning in the CFS group compared to the community groups, and psychiatric morbidity did not significantly predict physical functioning in the CFS group. This suggests that other factors account for the disability seen in the CFS group. In the treatment study CBT resulted in reductions in the main outcomes of fatigue, physical functioning and social adjustment. Worry assessed by the Penn State Worry Questionnaire did not change while perfectionism reduced significantly. None of the other baseline measures predicted response to treatment, but the sample was relatively small. Conclusions: Although there are higher rates of psychiatric morbidity in patients with CFS in secondary care than people with chronic fatigue in primary care, other psychological or social factors may be more important in predicting physical functioning and outcome after CBT than the presence of psychiatric disorder.

#### **Implementing research into clinical practice: issues for delivering nurse-led therapy for CFS/ME**

Sarah Peters, University of Manchester

Introduction: The evidence-base for a range of psychological interventions for managing CFS/ME is becoming well-established. However, in practice, many patients do not have access to (or wish to engage in) specialist mental health services. In addition, NICE guidelines recommend that patients with CFS/ME should be managed in primary care. Non-specialist primary care nurses are increasingly involved in the management of long-term conditions, so are likely to also have a growing role in managing CFS/ME. Whilst evidence from trials indicate this approach can be effective, little is known about how these findings translate outside a research context and therefore how best to implement nurse-led therapy for CFS/ME into routine primary care. To understand the challenges faced by non-specialist nurses when delivering therapy for CFS/ME and to identify the potential barriers to developing the role of primary care nurses when delivering psychological therapy for CFS/ME within a clinical setting. A series of qualitative studies were conducted to examine the experiences and acceptability of nurse-led psychological management of CFS from the perspectives of nurses (n=29) without any prior training in either CFS or psychological intervention and nurses (n=3) experienced in pragmatic rehabilitation. In addition, interviews were conducted with therapy supervisors (n=3) and patients (n=46). Exploring data from a range of perspectives provides data triangulation, and therefore increased trustworthiness of the analysis. Data were generated through individual in-depth interviews and an iterative approach used to develop conceptual categories from the dataset. Primary care nurses' understanding about CFS/ME was variable and had been largely gained through contact with patients, friends, personal experiences and the media rather than formal training. Nurses had little understanding of psychological therapies, describing management options in terms of advice-giving, self-help or counselling. Nurses identified a potential role they could have in managing CFS/ME but devalued their own skills in psychological intervention and recognised a need for further training and ongoing support and supervision from both medical and psychological colleagues. Amongst nurses trained and experienced in pragmatic rehabilitation, several challenges arose including i) change in role from nurse to therapist, ii) engaging patients in the therapeutic model, iii) dealing with emotions, iv) complexity of the primary-care setting. Several strategies had been developed to manage these tensions. The current role of primary care nurses in the ongoing management of patients with CFS is limited. Training in CFS/ME and psychological therapy is needed before extending this role. Even with training, tensions exist for nurses when attempting to deliver therapy for CFS/ME within the context of primary care. This has implications for developing therapeutic alliance, delivering therapy and the need for supervision.

#### **Where is Pain at? Novel Processes and Treatment INPUT for Chronic Pain**

Convenor: Claire Goodchild, Institute of Psychiatry, King's College London

#### **When physical pain becomes mental suffering: The role of mental defeat in chronic pain**

Nicole Tang, King's College London, Institute of Psychiatry

Mental defeat is a construct that has recently been applied to the experience of chronic pain as a way of characterising the impact of pain on self-concept. It can be described as a state of mind marked by a sense of a loss of autonomy, agency and human integrity. Whilst some patients with chronic pain show remarkable resilience living a fulfilled life in spite of the pain, many patients seeking treatment from specialist pain centres reported feeling "defeated" by the pain. The feeling of mental defeat is noted to be particularly strong when the patients see their lives as being taken over by the pain, which restricts what they can do, changes the way they live and slowly destroys their identity. In psychological terms, mental defeat can be defined as a type of self-processing where persistent pain triggers negative beliefs about the self in relation to pain. Just as the concept of defeat has proved to be fruitful in post-traumatic stress disorder and depression research, it has been proposed that mental defeat may be linked to pain severity and success in pain management. The current paper will describe the development of the concept in the field of chronic pain and present findings from two studies that demonstrate a link between mental defeat and several key outcome variables: (1) pain-related interference, (2) distress, (3) disability and (4) treatment-seeking behaviour in chronic pain patients. Based on these findings, it is concluded that mental defeat may be involved in the maintenance of chronic pain syndrome. Targeting mental defeat in

treatment - through the use of cognitive therapy that focuses on restoring identity and autonomy - may potentially help improve quality of life of chronic pain patients.

#### **Thinking about thinking about pain: A qualitative study investigating rumination in chronic pain**

Melanie Edwards, Anwen Wright, Nicole Tang, Paul Salkovskis, Institute of Psychiatry, King's College London & Carolyne Timberlake, Princess Royal University Hospital, South London Healthcare NHS Trust

Pain intensity and disability in chronic pain have recently been linked to pain-related rumination. However, while rumination is commonly observed in chronic pain patients, the nature of rumination in chronic pain is poorly defined and the mechanisms through which rumination may act to increase pain and disability remain unspecified. In this talk, I will report the findings of a qualitative study that aimed to establish the phenomenology of rumination in chronic pain and generate testable hypotheses for empirical investigation. I will discuss the themes extracted from the data - including that rumination is triggered by pain and negative emotion (and vice versa), positive beliefs about rumination, negative beliefs about the self, rumination precedes and affects sleep - and highlight differences between a minority of participants who were identified as infrequent ruminators and the rest of the sample. Theoretical and clinical implications of these findings will also be discussed.

#### **Cognitive-behavioural based pain management in patients with chronic pain prior to a neuromodulation implant improves surgical outcome**

Jared Smith and Sarah Barker, INPUT St. Thomas' Hospital, London

Both cognitive behavioural-based pain management programmes (PMPs) and neuromodulation (NM), an invasive procedure that targets chronic pain through transmission of nociceptive information in the central nervous pain pathway, are well established treatments in the management of chronic pain. Although interventions and PMPs have, at least traditionally, been regarded as separate endeavours, as the biopsychosocial understanding of pain has accumulated evidence, so too has an appreciation that a more realistic approach will likely be one that combines pharmacological, physical, and psychological components, perhaps with a balance among these tailored to each patient's needs (Turk, Swanson, & Tunks, 2008). The present study examined whether a customised 'pre-neuromodulation' programme (preNMP) incorporating pain management principles enhanced clinical and functional outcomes of NM treatment in patients with chronic pain. Specific objectives of the study were to: establish that the preNMP improves patients' psychological and physical adjustment in the short-term; identify predictors of the decision to go ahead to NM trial; and identify predictors for success of NM trial/implant. A retrospective analysis was administered on the outcome of 154 patients (73 male, 81 female) who participated in the preNMP. All patients had been assessed as suitable for a NM device by a consultant in pain management and anaesthesia and had been assessed as suitable for a residential group programme by a multidisciplinary team. The preNMP was set within a cognitive-behavioural framework. It covered the main components of pain management, provided technical information about the NM procedure, and taught decision making skills. It consisted of eight days of sessions over two weeks, with a follow-up at a later date. Patients completed measures of average pain intensity/distress, psychological adjustment and physical function, both pre- and post-programme. One-hundred and forty-seven patients (96.08%) completed the entirety of the preNMP, while outgoing measures were recorded for 144 consenting patients. Participants evidenced large gains across the programme with respect to both psychological health (mood, catastrophising thoughts about pain, self efficacy to cope with pain) and physical function (walking, stair climbing) with differences between pre- and post-programme scores highly significant for all measures ( $p < .001$ ). Self-efficacy to cope with pain at pre-programme was higher in the small group of patients ( $n=11$ ) who subsequently opted not to have a NM trial compared to patients who went ahead with trial and permanent implant, even after controlling for pain intensity. There were also trends for lower depression and increased walking ability in this group of patients. Of those patients opting for a NM trial, improvements during the programme in psychological mood and level of catastrophising about pain predicted successful outcome of NM treatment (permanent implant;  $n=93$ ). The results demonstrate the benefits of a tailored multidisciplinary programme based on a cognitive-behavioural approach prior to implantation of a NM device. Such programmes appear to have potential in ensuring functional and psychological goals are integrated with goals surrounding pain reduction, as well as preparing patients mentally and physically for the NM procedure.

#### **CBT for Insomnia: Traversing the Iceberg**

Convenor: Jason Ellis, Northumbria University

#### **Is CBT-I appropriate for Acute Insomnia? An evidenced based examination**

Jason Ellis, Northumbria University

Despite consistent reports of positive outcomes associated with Cognitive Behavioural Therapy for Insomnia (CBT-I) for those with Chronic Insomnia, to date, CBT-I has not been administered to those in the early stages of the disorder (i.e. acute or transient insomnia). The aim of this talk is to examine whether CBT-I would be appropriate, in its current form, as a treatment strategy for acute insomnia. By deconstructing the existing elements of CBT-I and examining each of these components in relation to a series of existing studies on people in the early stages of insomnia we can see that some elements would most likely not be as efficacious for acute insomniacs as they appear to be for chronic insomniacs and vice versa. An example of one dimension which appears to be more pertinent to acute insomniacs than chronic insomniacs is that of sleep preoccupation where we have shown that experimentally inducing acute insomnia results in a) significantly increased levels of sleep preoccupation (Mean Baseline 40.57 (SD 17.1) Acute Insomnia Period 58.67 (SD 21.35)  $p < 0.001$ ) and b) higher levels of preoccupation compared to normal sleepers and chronic insomniacs (Chronic Insomnia Mean 56.3 (SD 19.34)). More specifically, this existing research not only identifies significant differences between acute and chronic insomniacs in terms of psychological factors (i.e. cognitive coping style, levels of sleep preoccupation, and types of catastrophic dysfunctional thinking) but also identifies significant behavioural differences. One relevant finding that may underpin why there are psychological and behavioural differences between these two groups is the actual make-up, or architectural differences, in the sleep of acute and chronic insomniacs. The findings will be explored in relation to a modified CBT-I (i.e. CbT-I) for acute insomniacs.

**CBT-I for Insomnia: The challenge after the evidence**

Colin Espie, University of Glasgow

Insomnia is a common and debilitating problem, comprising difficulty initiating and/ or maintaining sleep, with associated daytime consequences affecting the person's energy, mood, concentration, and/or performance. Conservatively, insomnia affects 10% of the adult population on a chronic basis and is the foremost clinical predictor of first episode depression and recurrence of depression. As a psychophysiological disorder, insomnia is conceptually well suited to psychological intervention. Indeed cognitive behavioural therapy (CBT) interventions have been developed and tested for more than 25 years. Controlled studies of CBT (individual and small group) have found it to be efficacious and clinically effective for persistent insomnia. There are around a dozen systematic reviews and meta-analyses demonstrating moderate to large effect sizes for improvement in sleep and in daytime function, and these effects are sustained at medium to long-term follow up. Head to head studies and meta-analyses of CBT versus pharmacotherapy for chronic insomnia indicate that CBT is as effective as PCT in acute treatment and that CBT is the treatment of choice in the long-term. An important challenge for CBT is how to make it available for the large numbers of people who might benefit from it.

**Insomnia and CBT-I in Older People**

Kevin Morgan, Loughborough University

Insomnia is the most frequently reported psychological symptom in the UK, a major cause of impaired personal and social functioning, and the main reason for prescribing benzodiazepine agonists in primary care. The prevalence of insomnia is also strongly age-related, increasing steadily from early adulthood through mid and later life. As societies continue to age, therefore, insomnia levels continue to increase. Through a brief résumé of epidemiological and clinical trials evidence, this presentation will show how an appropriately structured clinical approach, based on a knowledge of the natural history of late-life insomnia, and utilising the principles of cognitive behavioural therapy, can deliver lasting benefits to older patients with chronic sleep difficulties.

**Real life insomnia in the NHS sleep clinic**

Kirstie Anderson, Loughborough University

Insomnia is the commonest primary sleep disorder but is also seen in association with many other medical problems and also seen with other primary sleep disorders. Sleep medicine within the United Kingdom is a small subspecialty and even within a specialist sleep clinic, there are a few centres that offer CBT-I. This talk will focus upon the practical application of CBT-I within a busy NHS sleep clinic with limited resources. The Regional Sleep Service within Newcastle serves a population of 3 million and receives 2500 referrals a year with approximately 500 non respiratory sleep disorders. A dedicated insomnia service has been in place for the last 2 years seeing patients with primary insomnia but also those with medical and psychiatric comorbidities. The available literature regarding treatment (which is sparse) will be reviewed but more importantly a practical approach to treating insomnia within the NHS will be outlined. This will include Insomnia mimics - the importance of screening for other primary sleep disorders and medical comorbidities Assessment tools - how to select those who will benefit When to retreat gracefully - those who fail CBT-I and why they do

**Four conditions, many outcomes: How Health Psychologists help people to manage Long-Term Health Conditions**

Convenor: Alison Wearden, University of Manchester

**Developing a CBT intervention to assist with psychological adjustment to early stage multiple sclerosis**

Laura Dennison, University of Southampton

Laura Dennison, Centre for Clinical Applications of Health Psychology, University of Southampton, UK; Rona Moss-Morris, Centre for Clinical Applications of Health Psychology, University of Southampton, UK; Trudie Chalder; Institute of Psychiatry, King's College, London, UK; Lucy Yardley, Centre for Clinical Applications of Health Psychology, University of Southampton, UK

Multiple Sclerosis (MS) is an unpredictable but potentially disabling disease of the central nervous system. MS can have profound consequences across many life domains and many patients encounter difficulties with psychosocial adjustment. We produced an eight session manualised CBT intervention to be delivered by nurses to help people with early stage MS adjust to living with the disease. This talk focuses on a literature review and a qualitative study conducted in order to inform the development of an appropriate intervention. Seventy two empirical studies which examined psychological correlates or predictors of adjustment outcomes (e.g. distress, quality of life) in people with MS were identified and synthesised in a systematic review of the literature. Evidence suggested that a range of cognitions and behaviours were related to adjustment outcomes. These included cognitive and behavioural responses to MS and its symptoms, and also broader factors such as perceived social support, perceived stress, and cognitive biases. Following the review, we proposed a cognitive-behavioural model of adjustment to MS in which the development, diagnosis or progression of MS were conceptualised as critical events which disrupt emotional equilibrium and quality of life, at least in the short term. The continued experience of negative psychosocial outcomes is influenced by individuals' cognitive and behavioural responses, as well as social and environmental factors; all potential targets for intervention. We also conducted in-depth, semi-structured interviews with thirty people with early-stage MS about their experiences of adjustment. An inductive thematic analysis found broad support for the systematic review findings and the proposed model but added fresh insights. Early-stage MS was typically considered a difficult but manageable condition which was best dealt with through positive thinking and practical strategies to preserve 'normal' life. However, participants described a 'precarious' adjustment; where they achieved well-being which appeared to be contingent on current minimal disease activity and progression. Participants also described disinclination towards involvement in the world of MS; exposure to reminders of disability and illness appeared threatening to their identity and emotional adjustment.

The systematic review and qualitative study findings informed the development of an intervention which was theory and evidence-based and patient-centred. The CBT intervention has recently been tested in a randomised controlled trial.

### **Helping Improve Diabetes-Related Health Outcomes.**

Andrew Keen, Adults Diabetes Centre, Woolmanhill Hospital, Aberdeen

Type 1 diabetes is a relatively common medical condition typically diagnosed during childhood. It is characterised by a catastrophic failure of the pancreas to produce insulin because the cells that do so have been destroyed. Insulin is the hormone responsible for the absorption of glucose in our body which we later use as energy. The absence of insulin to drive this process results in increased levels of blood glucose following digestion of carbohydrates. Until about 100 years ago all those with type 1 diabetes faced a significantly shortened lifespan - among the young most were dead within a year. In the early 1920s, however, this all changed following the discovery of insulin which although not a cure is used to treat diabetes. The aim of modern treatment regimens is to try to keep blood glucose levels as near to normal levels as possible. This typically means multiple injections of insulin daily, and these are used to continually balance the effects of carbohydrate intake and exercise. Almost all responsibility for this lies in the hands of people with diabetes who must also manage the usual stresses and strains of every day life. It is largely the success or otherwise of people with diabetes to self-care that influences their health outcomes, both in the shorter- and longer-term. There are a range of psychological and social factors that can inhibit self-care behaviours. These factors can be conceptualised as potential barriers to improved blood glucose control, which need to be identified and addressed if health outcomes are to improve. Some of the potential barriers to improved self-care can include fear of hypoglycaemia (low blood glucose levels) and fear of hyperglycaemia (high blood glucose levels) both of which can be associated with problematic self-care health behaviours. Furthermore, anxiety and depression are more prevalent among people with diabetes than the general population and both have been found to be associated with poorer blood glucose control. The fact that variations in blood glucose naturally produce somatic symptoms that overlap with emotional problems such as anxiety and depression can cause further confusion to those trying as best they can to manage their condition. The use of cognitive behavioural interventions and mindfulness-based treatments to help people with diabetes identify and overcome barriers to better self-care will be explored from a clinical perspective.

### **Developing interventions to address psoriasis associated comorbidity**

Lis Cordingley, University of Manchester

Psoriasis is a common, life-long inflammatory skin disease that affects 2-3% of the population. The disease is associated with high levels of disability and currently is incurable. Whilst there are wide variations of responses to this condition, people with psoriasis have increased rates of depression and anxiety, and many individuals significantly restrict their levels of social engagement. There is emerging evidence that psoriasis confers an independent risk of developing significant cardiovascular disease (CVD) and other components of the metabolic syndrome. The highest relative risk of myocardial infarction appears to be in younger individuals with severe psoriasis but currently the precise mechanisms are unknown. It is likely that there are both direct (physiological or psycho-physiological) mechanisms as well as indirect behaviourally mediated routes. Patients with psoriasis are less likely to engage in physical exercise and are more likely to smoke and drink heavily. No studies have yet examined the impact of communicating this risk information to people with psoriasis. It is possible that knowledge of increased risk of CVD will act as a motivator to engage with health protective behaviours. Alternatively, people may feel less in control, more burdened, more anxious, and engage in unhelpful coping responses such as increased smoking and alcohol use. In this presentation we will demonstrate the ways in which we have used recent and ongoing research to design a number of studies including a complex intervention to improve health outcomes for people with psoriasis associated co-morbidity. We will describe the theoretical and pragmatic reasons underpinning the selection of outcome and process measures used in the evaluation of the intervention. We anticipate that these studies will start to advance our understanding of both causes and consequences of physical and psychological co-morbidity in people with long-term conditions.

### **Advances in Psychological Therapy for Emotional Disorders following Acquired Brain Injury**

Convenor: Anna Adlam, University of East Anglia

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### **CBT for PTSD after Mild Traumatic Brain Injury: A challenge and an opportunity**

Huw Williams, University of Exeter

Huw Williams & Luke Mounce, University of Exeter

Traumatic Brain Injury (TBI) is thought to be the biggest cause of death and disability in children and working age adults. Around 80% of TBIs are "mild". Of these 15% are associated with long term problems. It had been thought that PTSD could not occur after TBI due to loss of memory for the event. The evidence now shows that, not only can PTSD occur after TBI, it may be elevated in TBI groups. They may lack coherent memories of events for organising an adaptive response. They may lack cognitive (executive) control over processing of fear to modulate such responses. Recent research, particularly in Emergency Department patients and military populations, have shown that it may even be the factor that drives concussion type symptoms over time. We will review causal mechanisms for PTSD after MTBI and identify core issues for treatment via CBT approaches. We will make recommendations for future clinical research in the area so that those with MTBI and PTSD may be enabled to adjust to their traumatic experiences.

### **Towards an evidence-based cognitive-behavioural model of adjustment following brain injury**

Fergus Gracey, Oliver Zangwill Centre

Emotional difficulties are common following acquired brain injury (ABI), anxiety and depression being most common, with both prevalence and lifetime incidence at about 30%. Deterioration in mental health over time post injury is also common with one study suggesting suicidality to be four times higher amongst brain injured, with the peak risk period between 5 and 7 years post injury. Whilst organically based impairments contribute to the presentation of emotional disorders, psychological and social factors are thought to be most important to emotional outcomes. Effectiveness of CBT receives some support in published cases and outcome studies. However, an evidence based cognitive model of post-injury adjustment is still lacking. Research into adjustment highlights threat to self, loss of self and self discrepancy as potentially important processes underpinning



emotional disorder. Although impairments of awareness may be 'protective' of mental health in some, for others a tendency for over-sensitivity to problems is apparent. Research on coping style clearly shows that those with emotion focused coping styles fair poorer emotionally than those with problem oriented coping. Social factors such as access to support and rehabilitation, maintenance of social group membership and perceived social stigma may also be important in post-injury adjustment. In this presentation, the literature on psychological and social adjustment factors will be integrated into a proposed CBT model for post-injury emotional adjustment problems. The model will be illustrated with reference to a clinical case. It will be argued that attending to the meanings of personal and social discrepancies, and understanding the presenting problems in terms of both 'threat-to-self' reactions and attempts to preserve coherence of personal and social identity is central to identification of interventions. Reference will be made to adaptations to therapy that may be required due to the presence of acquired cognitive impairment. Further research is required to test and develop the components of the model and to evaluate it through well controlled clinical outcome studies.

**The conceptualisation of contextual factors in neuropsychological intervention following acquired brain injury occurring in childhood: A single case study.**

Anna Adlam, School of Medicine, Health Policy and Practice, University of East Anglia, Fergus Gracey, Cambridge Centre for Paediatric Neuropsychological Rehabilitation, Cambridgeshire and Peterborough Foundation Trust, Anna Vizor, Suffolk Mental Health Partnership, Leyla Prince, Oliver Zangwill Centre for Neuropsychological Rehabilitation & Ayla Humphrey, Department of Developmental Psychiatry, University of Cambridge

The importance of contextual factors in neuropsychological rehabilitation following adult-onset acquired brain injury (ABI) is well established, as represented, for example, in neuropsychological rehabilitation programmes. In neuropsychological rehabilitation following child-onset ABI attention to developmental processes is also required. Here we present, John (16 years old), to illustrate the importance of providing interventions within a developmental contextual framework. John suffered an ABI (aged 13 years) following a road traffic accident. Assessments revealed difficulties with prospective memory, executive function, and emotion regulation (e.g., aggression). These difficulties had a significant effect on his interpersonal relationships and mood. A shared contextual formulation of John's presenting problems was developed with John and his family. The formulation was guided by a cognitive behavioural framework of interpersonal process (Vizor & Adlam, in preparation). Specific interventions to help reduce John's prospective memory difficulties and manage anger were provided. These aimed to address interpersonal difficulties at home by increasing John's independence and his parents' confidence in his ability to care for himself. John's prospective memory for a specified task increased leading to reduced reliance on family reminders and an increased confidence in his ability to manage tasks. In addition, John showed a clinically significant reduction on a standard measure of anger. This was corroborated by his parents who reported fewer anger outbursts and increases in prosocial behaviour. The findings from this study confirm the importance of developing a contextual formulation of neuropsychological difficulties following ABI in adolescence.

**Using a Compassionate Mind Approach after a Traumatic Brain Injury: A Case Illustration**

Fiona Ashworth, Fergus Gracey, The Oliver Zangwill Centre for Neuropsychological Rehabilitation & Paul Gilbert, Mental Health Research Unit, University of Derby

Emotional problems are prevalent following traumatic brain injury (TBI), however, the evidence base on interventions is limited. Gilbert's compassionate mind (CM) model draws on affective neuroscience to understand affective systems. CM can be integrated into the cognitive behavioural therapy (CBT) model and so may be helpful in understanding emotional changes after brain injury and for guiding interventions. Clinical cases using CM following TBI are not evident in the literature. In order to consider the potential effectiveness of CM in TBI, we present the case of Penelope, a 23-year-old women who suffered a TBI 3 years prior to rehabilitation. Penelope presented with low self-esteem, depression and disordered eating. Neuropsychological assessment revealed executive problems. She entered a holistic neuropsychological rehabilitation programme aimed at improving her complex interacting difficulties and received CBT-based interventions as part of the program. Formulation of Penelope's difficulties is presented based on the CM model. The CM intervention technique employed is described, which aimed to facilitate an emotional shift with Penelope by up-regulating positive affect mediated by a 'soothing' affective system in order to down-regulate the 'threat' affective system. Adaptations to the approach in the context of Penelope's TBI are discussed. Outcome evaluation using self-report measures of mental health and self-esteem indicated positive changes, implicating the usefulness of CM in this case. Implications for broader use of CM in the context of impaired affect regulation systems are considered. In conclusion, Gilbert's CM model may be useful in conceptualising emotional and behavioural responses and for developing intervention in rehabilitation following TBI.

**Helping People Cope whilst Suffering**

Convenor and chair: Andrea Edeleanu, Surrey and Borders Partnership NHS Foundation Trust

**Improving psychological wellbeing when physical and emotional suffering will remain a major focus in life**  
Andrea Edeleanu, Surrey and Borders Partnership NHS Foundation Trust

When we work with people who have long term or life limiting conditions we have to create treatment goals and plans which promote hope and purposefulness and at once accept that while the physical and emotional suffering will remain a major focus of life despite therapy we can aim to reduce its overwhelming impact on individuality. Often the primary task in CBT therapy in physical health care is to find a way to tolerate the problem/discomfort rather than overcome it and to re-establish self-esteem and purpose around what really matters to the person. Compassionate case conceptualisation, honest acknowledgement about what can be achieved, a focus on personal strengths, personal values and factors enhancing resilience can enable people to reconnect with a meaningful life despite physical problems and shortened future

**The role of hopelessness in self regulation**

Nigel Sage, Primary Care Psychology and Counselling/Beacon Centre, Surrey Community Health

This paper discusses the facilitative function of the experience of hopelessness in the process of goal appraisal and adaptation to changed circumstances. The clinical relevance of Carver and Scheier's (1998) model of self-regulation is discussed in the context of chronic and life-limiting illness and anecdotal evidence is provided of its adaptation for use in clinical practice. Carver, C. and Scheier, M. On the self regulation of behaviour Pub: Cambridge University Press 1998 Graser, H "Developmental counselling" in Greve, W, Rothermund, K. and Wentura, D. (eds) The adaptive self Pub: Hogrefe & Huber 2005 De Ridder, D. and de Wit, J. (eds) Self regulation in health behaviour Pub: J. Wiley and Sons 2006

#### **Integrating third wave CBT into a group intervention for people with long term health issues.**

Lorraine Nanke, Katherine May & Jacqui Seaton, Surrey and Borders Partnership Foundation NHS Trust  
We will present issues we encountered in Integrating third wave CBT into a group intervention for people with long term health issues. We will share our "learning from experience", which is based on curious collaboration, and is a mixture of what has and has not worked, theoretical dilemmas that have emerged and blind alleys that have been followed. We will include our reflections on an evolving process by both the therapists who provide the service and the people who use it.

#### **Negotiating ethical and team issues in providing evidence based psychological therapies for people with compromised capacity in physical rehabilitation settings**

Ian Kneebone, University of Surrey

Behavioural interventions such as flooding for specific phobia are dramatic techniques with proven efficacy. The recognition of this has provided the opportunity to extend the use of such procedures to new populations such as those with complex disability in rehabilitation settings. Despite this therapist, multi-disciplinary team, family and ethical concerns may need to be overcome to ensure treatment proceeds. This paper considers these issues as they arose in the treatment of phobia to having her feet touched by physiotherapists in a client with Downs syndrome and a recent head injury. Faith in the empirical basis of the intervention, developing the co-operation of the team and the family via education and appreciation of ethical issues were keys to success in this case.

#### **Augmenting CBT for Older People with Depression comorbid with Physical Health Problems**

Ken Laidlaw, Section of Clinical Psychology, School of Health in Social Science, University of Edinburgh & Edinburgh Psychological Services for Older People, NHS Lothian

CBT for late life depression has been extensively examined and the consensus is that this is an efficacious approach. Given the strength of the empirical evidence base one might assume that the application of CBT with older people with depression comorbid physical health problems (e.g. post-stroke depression and Parkinson's disease) will be relatively straightforward, especially as the pragmatic problem-solving orientation of CBT is very well attuned to the nature of emotional problems commonly experienced by older people (Laidlaw, Thompson, Dick-Siskin & Gallagher-Thompson, 2003). However, the data for CBT for post-stroke depression does not yet make a compelling case and in depression in Parkinson's disease, there is at best an emerging consensus about the applicability of CBT. This paper provides a brief overview of the empirical evidence but focuses mainly on the case for augmented CBT with these populations.

## **Child and Adolescent Mental Health**

### **Keynote Address**

#### **Taking parenting programmes that work to the people: Learning from "scaling up" the Triple P-Positive Parenting Program**

Professor Matt Sanders, University of Queensland, Australia

This paper highlights the importance of viewing parenting problems from a population health perspective. An overview of the theoretical and scientific basis of a multi-level population approach to the promotion of parenting competence in the prevention of behavioural and emotional problems in children and child maltreatment. The Triple P-Positive Parenting Program is a tiered multi-level approach incorporating media, primary care, school, mental health and workplace intervention to promote competent parenting and reduce coercive parenting and family conflict. The system aims to promote parental self regulation and enables parents to become more self sufficient, improves self efficacy, self management skills and problem solving skills. A series of studies that have informed the development of the intervention model are used to illustrate the importance having a flexible suite of evidence based family intervention tools, use of consumer preference data to tailor interventions and the benefits of blending a universal perspective and more targeted indicated interventions for high need families within a cohesive integrated model. Policy level and clinical implications for mounting large scale initiative are discussed.

#### **Anxiety of Childhood: Helping Parents help their Children**

Dr Samantha Cartwright-Hatton, University of Manchester

Anxiety is probably the most common psychological disorder of childhood, yet it is only in recent years that research into treatments has begun. Early treatments were directed largely towards the individual child. Increasingly, however, there has been recognition that parents may have an important role to play in both the development and treatment of their child's anxiety. This presentation will overview recent research into the role that parents have in the development and maintenance of childhood anxiety and will explore ways in which they might be involved in preventing and treating it. Much of the research into parenting and child anxiety has focussed on the role of parental overprotection and parental warmth. Recent research has extended this to consider the role of general behaviour management and discipline style, and suggests that child anxiety may be maintained by difficulties in these parenting areas. Likewise, it has long been recognised that anxiety runs in families, and whilst part of this transmission is genetic, much of it is not. Research examining environmental pathways in the transmission of anxiety from parent to child will be reviewed. Given our growing understanding of the ways in

which parents influence anxiety in childhood, are there ways that we can employ parents as a resource in treating their anxious child? The final part of this presentation will focus on treatment research, exploring the different ways in which parents have been included in treatment, and the somewhat mixed results that this has produced.

## Symposia

### The Role of the National Academy for Parenting Research

Convenor: Sajid Humayun, Institute of Psychiatry

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#### The Role of the National Academy for Parenting Research: Evaluation and Dissemination of Evidence Based Parenting Interventions

Stephen Scott and Moira Doolan, Institute of Psychiatry, King's College London

Antisocial behaviour in children and adolescents is a serious and widespread problem in the United Kingdom. Good parenting can maximize children's potential and promote resilience. Although effective parenting programmes are available, ineffective approaches are still widely used. The National Academy for Parenting Practitioners was set up in 2007 to offer free training in evidence-based interventions across England and conduct research into ways of increasing their effectiveness. This paper will provide an overview of the role of the Academy. The Academy's mission is to transform the quality and size of the parenting workforce across England so parents can get the help they need to raise their children well. There are two strands of work: training and research. Free training is being offered in evidence-based programmes for 3400 practitioners, followed by ongoing supervision to refine their skills. At a managerial level, local authority staff who commission parenting services are helped to purchase better programmes through an online quality rating system. Currently, the many parenting programmes used in England vary greatly in theoretical orientation, quality of written materials, sophistication of training available for practitioners, and evidence of effectiveness. Commissioners need to know which programmes are 'fit for purpose', so they can know which to purchase (and which to drop). The Academy has developed four detailed criteria to rate programmes and a team from the London School of Economics is assessing programme costs and benefits. Developing and testing of parenting interventions is also under way for several groups of children in need. Questions addressed by all the trials include whether the intervention works and if so, for how long, for whom it works (moderators), how it works (mediators), the impact of therapist skill, and its acceptability and cost-effectiveness.

#### Talking and Listening with your Child (TLC): An Innovative Adjunct to Parent Training, Targeting Child Emotional Competence and Parent Socialization of Emotion

Jennifer Allen, Kat Legge, Nathan Faulkner, Caroline Moul, Clare Chivers, Charlotte Wormald, Bonamy Oliver, Mark Dadds, Institute of Psychiatry, King's College London

Children with high levels of callous-unemotional (CU) traits designate a subgroup at greater risk for chronic and severe antisocial behaviour and failure to respond to existing treatments. The development of effective interventions for these children is vital and interventions emphasizing parental warmth and responsiveness in relation to the child's empathy, emotion regulation, and moral understanding are the next generation of intervention targets. This paper describes an innovative adjunct to parent training (*Talking and Listening with your Child - "TLC"*), where parents are trained to engage emotionally with their child in a warm and sensitive manner. In this pilot study, parents of oppositional children aged 4 to 7 years received TLC plus standard individual family parent training. Case studies (N = 8), along with video clips pre- and post-treatment will be used to describe the adjunct. TLC will be evaluated via outcomes on child symptom measures, in addition to direct parent-child observation and child emotional competence measures. Preliminary findings suggest that adjuncts targeting child emotion processing deficits and the parent socialization of emotion have potential for improving treatment outcome for antisocial children.

#### The Study of Adolescents' Family Experiences (SAFE): A Randomised Controlled Trial of Functional Family Therapy with Young Offenders and Antisocial Youth

Sajid Humayun, Institute of Psychiatry, King's College London, Joanna Pearce, Brighton & Hove Youth Offending Service, Melanie Chesnokov, Lauren Herlitz, Amy Li, Carrie Nakan, Ruth Spence & Elizabeth Malpass

Whilst youth crime and antisocial behaviour are a key government priority there is a large gap in experience and knowledge in the UK about programmes which work specifically for young offenders. This paper will describe the Study of Adolescents' Family Experiences (SAFE), a randomised controlled trial of Functional Family Therapy with young offenders and antisocial youth. Functional Family Therapy (FFT) is a family-based intervention which has strong evidence from the US for reducing youth offending, reoffending and antisocial behaviour. An overview of the evidence of the intervention on reoffending and its cost-effectiveness will be provided and the intervention and the SAFE study will be described. In addition to assessing the impact of FFT on reoffending, SAFE will also address crucial questions around the implementation of a US manualised intervention in an English setting. For example, how acceptable will it be to commissioners, caseworkers and families; how could it fit into the existing landscape; what are the barriers to successful implementation? Case studies of families will be presented along with preliminary results.

#### The role of Parental Cognitions in our Understanding of Child Anxiety Disorders

Convenor and chair: Charlie Wilson, University of East Anglia

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#### Parental cognitions and behaviour: Associations with child and parent anxiety

Cathy Creswell, Lynne Murray & Peter Cooper, University of Reading

Parental cognitions and expectations are likely to play a key role in the development of anxiety disorders. Specifically, in a recent model of the intergenerational transmission of anxious information processing, we suggest that heightened parental threat interpretation and expectations of child vulnerability will lead to parental behaviours known to be associated with increased child anxiety, and these cognitions will be particularly common amongst parents who are themselves anxious (Creswell, Murray & Cooper, 2010). The aim of the current study is to

identify potentially anxiogenic parental cognitions associated with parenting behaviours, in the context of child and parent anxiety. The study sample comprises 50 clinically anxious children and their non-anxious mothers, 50 clinically anxious children and their anxious mothers, and 50 non-anxious children and their mothers. All mother-child dyads completed a laboratory assessment in which parental cognitions and behaviours were assessed under conditions of mild stress. Parental cognitions and expectations were evaluated using ambiguous scenarios questionnaires and pre and post-task interviews. Observed parental behaviours were rated by coders, blind to child and mother anxiety status. Associations between parental cognitions and behaviours will be reported, as will associations with child and mother anxiety. The findings will be discussed in the light of cognitive-behavioural models of family processes in the development and maintenance of child anxiety and their implications for treatment.

#### **The attributions and expressed emotion of foster carers towards their 'looked after' children**

Sara Katsukunya, University of East Anglia, Peter Langdon, University of East Anglia, Sian Coker, University of East Anglia, Charlie Wilson, Trinity College, Dublin

Looked after children have a variety of psychological difficulties at higher rates than the general population (Blower et al., 2004; Meltzer et al., 2002). In addition, their carers have a number of additional stresses such as dealing with the nature of short term placements. This can place extra strain on the relationships (Farmer et al., 2005). Previous research has found that high levels of parental expressed emotion and negative attributions are associated with externalising behaviour problems in children (Bolton et al., 2003) and are predictive of poor attendance in behavioural training programmes (Calam et al., 2002; Peters et al., 2005). However, little is known about expressed emotion and attributions in foster carers. This research investigated whether there is a link between the expressed emotion and attributions of foster carers, concerning their 'looked after' children. It was expected that expressed emotion and attributions would be associated with the level of externalising behaviour problems in the child, but it was unclear whether these variables would be also associated with internalising behaviour problems. A cross sectional correlational design was used to examine these constructs with this client group. Participants were asked to complete the Preschool Five Minute Speech sample, providing a measure of their expressed emotion. The speech sample was also coded for foster carer attributions, regarding their looked after child, using the Leeds Attributional Coding System. Implications for foster carer support and training are discussed.

#### **Parent and child responsibility beliefs, parenting and OCD**

James Kiff, University of East Anglia, Shirley Reynolds, University of East Anglia, Charlie Wilson, Trinity College, Dublin

Parental childrearing style and behaviour have been extensively examined in the context of anxiety and depression in recent years, and appear to influence the development of anxiety and depression in adults and children (see Rapee, 1997; Turner, 2006). Research into OCD suggests that the role of the family is implicated in the development, onset, and duration of the disorder and in children's response to treatment (Turner, 2006). The role of the family has been proposed as an important factor in the cognitive development of children (Waters & Barrett, 2000) and hence in encouraging OCD related beliefs (Pollock & Carter, 1999). However, although there is some consistency in the literature that affectionless control by parents has a role to play in OCD symptom development or maintenance, there is little evidence that such parental childrearing is specific to OCD. In contrast there is evidence that inflated responsibility beliefs are specific to OCD (Salkovskis, et al., 2000) and are relevant in adolescent OCD (Matthews et al., 2006). Recent models (Taylor, 2002) propose that parenting might influence childhood OCD through the impact on the child's responsibility beliefs. Furthermore, parenting itself might be influenced by parental responsibility beliefs. The current study examined the role adolescent responsibility beliefs and attitudes in relation to adolescent OCD symptoms, parent and child perceived parenting and parental responsibility beliefs and attitudes. Sixty-one parent-adolescent dyads completed questionnaires on responsibility attitudes (Responsibility Attitudes Scale) and parenting (EMBU; my memories of upbringing). Adolescents also completed measures of anxiety (Spence Children's Anxiety Scale) and OCD symptoms (Child - Obsessive Compulsive Inventory). Adolescent responsibility beliefs were associated with adolescent OCD symptoms, maternal responsibility beliefs and with child and mother reports of overprotective parenting. Finally, adolescent report of inflated responsibility was shown to illustrate a partial, but significant, mediation of the relationship between adolescent perception of maternal overprotection and adolescent obsessive-compulsive symptoms. There were too few fathers in the current study to draw strong conclusions, but the results suggest that different parenting factors might be important when considering fathers. The results of this study are consistent with Salkovskis et al.'s (1999), and imply that overprotective parenting might place young persons at greater risk of developing one of the main cognitive vulnerabilities that, in turn, is associated with OCD. This study supports previous research that has identified parental childrearing behaviour as a component in the development and maintenance of OCD. In examining parental childrearing in relation to both a core cognitive vulnerability and symptom expression, initial support of the indirect impact of parental childrearing on OCD through the presence of inflated responsibility beliefs has been illustrated. Future research should further explore the role learning experiences have on the development of cognitive vulnerabilities that reside at the core of OCD. In addition, through the employment of family-based psychological interventions addressing the role parents play in the development and maintenance of these cognitive vulnerabilities, it is hoped that the efficacy of treatment can be improved.

#### **Parenting, parental attributions and children's anxiety**

J Menary, Ben Laskey, & Sam Cartwright-Hatton, University of Manchester

Research into intergenerational transmission of anxiety symptoms from parents to children has largely focussed on parenting "styles" including over-control, criticism and modelling (Wood et al, 2003) and demonstrated a role for parental discipline (Laskey and Cartwright-Hatton, 2009). However, more recent interest has been shown in the role of parental cognitions (Field et al., 2008). Numerous studies show associations between negative parental attributions and externalizing behaviour problems in young children (Nix et al. 1999) but to date little research has explored how parental attributions may be associated with parenting in internalizing disorders (Chen et al, 2008). Such attributions have been shown to play a role in family treatments for externalising problems (Morrissey-Kane & Prinz, 1999) and it is unclear whether parental cognitions may impact in similar or different ways on the treatment

of childhood anxiety. This study, investigates parents' attributions (including parenting self-esteem and parental locus of control) for the behaviours of children, the relationship of these attributions to child/parent anxiety symptoms, and parents' choice of discipline styles. Results are discussed in relation to the treatment of children's anxiety and the specificity of mechanisms involved in child psychopathology.

#### **Maximising Population Reach and Uptake of Parenting Interventions**

Convenor: Rachel Calam, University of Manchester

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##### **How can we maximise reach and engagement in parenting interventions?**

Rachel Calam, University of Manchester

There are many ways of helping parents to access evidence based approaches to improving family life. A number of studies have shown that the Triple P Positive Parenting Programme has proven capacity to move beyond face-to-face delivery and to make use of a wide range of self-directed and seminar-based approaches to engage families who may not be reached by more traditional individual or group-based programmes. These approaches offer the potential to engage very large numbers of parents, and hence contribute to maximising population reach. This in turn has the potential to impact significant population indicators, for example levels of child maltreatment. This paper will set out an overview of some issues in helping parents to access evidence based parenting programmes using a range of different delivery modes. The potential benefits of web-based and multi-platform resources will be discussed, and the different issues and empirical questions that these approaches raise. Examples of online parenting studies will be given, including a preliminary online study of an adapted version of Triple P for parents with bipolar disorder, which has shown the potential to produce significant change for families. The scene will then be set for the subsequent presentations, drawing out some key questions that need to be addressed in engaging families when using a much wider range of media and resources, to offer multilevel access and improve population reach.

##### **Does a psychological enhanced brief priming intervention clip predict recruitment at a Triple-P web-based parent training programme?**

Louise Dawson, University of Manchester

At present, there are a number of interventions available throughout the NHS, community and voluntary sector, which aim to ameliorate child disruptive disorders and antisocial behaviour (NICE, 2006). These interventions are among the most powerful and thoroughly evaluated (Sanders, Markie-Dadds, Tully and Bor, 2000). Unfortunately despite empirical support, the data suggests recruitment for these interventions is limited. Concerns about the population reach of parenting programmes has prompted the development of a public health approach. One means of increasing parents' exposure to evidence based parenting has been to use universal approaches including the mass media (Sanders, 1999). However, the mechanisms and the psychological characteristics involved in the engagement and recruitment of parents must be understood to maximise uptake of these novel approaches. The study to be reported investigated the impact of a psychologically enhanced priming clip upon (1) intention to enrol on a web-based Triple-P positive parenting programme, (2) recruitment to a Triple-P web-based parent training programme and (3) number of Triple-P web-based parent training seminars viewed. An experimental design, using opportunity sampling, with participants randomly allocated to one of three conditions was employed. In the control condition, participants were given a brief introduction to the study, completed assessment measures, were asked about their intention to enrol (yes/ no) and were then given instructions for how to start to view the seminars in the online parenting programme. In the standard condition, participants in addition viewed footage taken from a TV series showing children both behaving well and misbehaving before the instructions on how to start the seminar series. In the enhanced condition, participants also completed the same steps as the control condition, but then viewed video clips from the TV series that incorporated parental attributions and expectations, and statements promoting self-efficacy, in addition to demonstrating successful outcomes of parenting intervention, prior to being given access to the seminar series. The findings will be presented and implications for developing media-based approaches discussed.

##### **Triple P and Asthma: Implications for engagement and Health-Related Quality of Life (HRQOL)**

Sally-Ann Clarke and Hayley Nixon, University of Manchester

Objective: Childhood asthma affects approximately one in eleven UK children (Asthma UK, 2004). Children with asthma can show greater behavioural difficulties compared with healthy populations (Calam, Gregg, & Goodman, 2005) and parents often struggle with the skills and confidence needed for asthma management tasks (Morawska, Stelzer, & Burgess, 2008). The Triple P Positive Parenting Programme is a well established intervention which has been shown to reduce behavioural and emotional problems in non-asthmatic children (Sanders, 1999). We report three studies that aim to investigate the effectiveness of Triple P with asthmatic children and methods to facilitate engagement amongst parents. Study One: aims to examine whether providing illness specific information predicts compliance to a web-based Triple P parent training programme. Focus groups will inform the information for parents. 150 parents will be recruited into two groups to receive either behaviour (generic) or asthma and behaviour (asthma specific) information followed by web-based seminars. Study Two: aims to examine the effects of a web-based parenting intervention on quality of life (QOL) and parental confidence in childhood asthma management. Parents (N=120) will be recruited into two groups (intervention and wait list control group). The intervention includes asthma specific tip-sheets followed by a web-based intervention over a 12 week period.

##### **Testing the Efficacy of Baby Triple P in mothers at risk or with postnatal depression**

Zoe Tsvos and Anja Wittkowski, University of Manchester

While traditional treatments for perinatal disorders have evidenced efficacy, their ability to demonstrate long-term effectiveness remains limited. In addition, these treatments often conceptualize the parent and child as exclusive entities. Baby Triple P is a new variant of the Triple P Positive Parenting Programme designed for pregnant women and new parents with infants from 0 to 12 months. Baby Triple P has been developed to enhance the knowledge, skills and confidence of parents of babies. It addresses several areas pertinent to the adjustment

of parenthood and works in a multidimensional framework. It aims to foster positive parenting practices which ultimately function to strengthen foundations for infant development. Whilst a current trial in Brisbane is assessing the usefulness of face to face Baby Triple P sessions in an antenatal context with telephone support in the postnatal stages, no study to date has examined the effectiveness of Baby Triple P in the treatment of women at risk of or with Postnatal Depression (PND). This presentation will provide an overview of the Baby Triple P programme, its current application and the proposed research trial, which will focus on a) improving the psychological well-being of the main caregiver (often the mother); b) thereby providing the infant with a positive start in life. It is hypothesized that the implementation of Baby Triple P will be associated with significant improvements in self-report and assessor-rated measures from baseline to post-treatment and three month follow-up assessments. This study will also examine the impact of Baby Triple P on the parent-infant relationship and include dimensions of happiness as an outcome measure.

#### **Optimising Triple P rollouts: Creating conditions for success**

Majella Murphy-Brennan, University of Queensland

Managing the transition from science to practice and building a climate conducive to change poses challenges worldwide for government and non-government organisations supporting the health, education and social service sectors, as funding bodies increasingly stipulate the requirements for funded projects include the adoption of services that can be accounted for by cost effective, measurable outcomes. Large scale implementations of Triple P have gathered momentum in recent years, particularly in the United Kingdom as policy developments have supported the widespread implementation of this program. Triple P has been a key program disseminated within UK's health, education, social welfare and youth offending sectors. The dissemination of Triple P across these diverse community groups has come with challenges as government and policy makers work closely with the disseminating team to successfully implement the program. An essential goal of Triple P, and organisations adopting the program, is to support the dissemination process by assisting both management and practitioners implementing the program to achieve these desired outcomes. Extensive knowledge has been acquired since Triple P International and The University of Queensland commenced the dissemination of the Triple P system on a large scale within government and non-government organisations worldwide. Lessons learned from national rollouts within the UK will be discussed within this presentation.

#### **Obsessionality in Young People**

Convenor: Ben Laskey, University of Manchester & CIC Psychology Team Cornwall

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#### **Pathways to responsibility cognitions in obsessive compulsive disorder**

Tim Williams, Berkshire Healthcare NHS Trust and University of Reading, and Peter Lawrence, Oxfordshire and Buckinghamshire Mental Health Trust

Cognitive theories of Obsessive Compulsive Disorder (OCD) focus on beliefs relating to inflated responsibility as central to this disabling condition. Evidence from experimental studies with clinic and non-clinic populations tends to support this view with a recent meta-analysis providing further evidence for the importance of responsibility cognitions. Although putative pathways to the type of responsibility cognitions associated with OCD have been suggested, no previous studies have investigated the origins of these thinking patterns. OCD has its first peak of onset during adolescence when cognitive structures are developing rapidly and adult thinking patterns are emerging. Five potential pathways to inflated responsibility beliefs have been proposed:

- 1 A broad and heightened sense of responsibility develops early in life, which is encouraged by significant figures;
- 2 Rigid codes of conduct;
- 3 Being shielded from responsibility during development and being treated as incompetent to cope with responsibility;
- 4 A specific incident, or series of incidents, in which one's actions or inactions contribute to some negative outcome for self or other(s);
- 5 A specific incident in which one's thoughts or actions are incorrectly considered to have led to some negative outcome for self or other(s).

This study aimed to determine whether these routes to inflated responsibility could be identified in young people with OCD and whether these young people reported different responsibility-related experiences to a non-clinic group. A retrospective questionnaire design was used with between group comparisons. A novel measure, the Origins Questionnaire for Adolescents (OQA), was developed to assess experiences on the five pathways. The experiences on the five pathways to inflated responsibility beliefs of sixteen adolescents with a history of OCD were compared to sixteen adolescents with no history of OCD. Parents also reported on adolescents' experiences on the five pathways. Inter-rater reliability was high. The internal consistencies of the subscales were only partly satisfactory. The groups differed on one pathway - the clinical group reported a higher sense of responsibility for significant incidents with a negative outcome prior to onset of OCD.

An inflated sense of responsibility, in combination with the occurrence of specific incidents, may act as a vulnerability factor for development of OCD. Future research should consider how to measure the subtle effects of responsibility-related experiences over the course of development.

#### **Manipulation of Thought-Action-Fusion in Children: Impact on anxiety, responsibility and neutralising behaviour.**

Alison Sillence, Shirley Reynolds, Sian Coker, University of East Anglia & Charlie Wilson, University of Dublin, Trinity College

Thought-action fusion (TAF) is the belief that a thought is equivalent to an action either because thinking a thought - for example about a loved one becoming ill - will make it more likely to happen (TAF-Likelihood) or because having a thought - for example about shouting in church - is just as morally wrong as actually doing that action (TAF-moral). Strong thought-action fusion beliefs are associated with obsessive-compulsive disorder (OCD) in both children and adults. However, some evidence suggests that thought-action fusion, which is very close to a concept called 'magical thinking', is raised in normally developing children, compared to adults. This suggests that some children may have relatively strong thought-action fusion beliefs without developing OCD symptoms, raising

questions about exactly how thought-action fusion is related to OCD symptoms in children. Currently, prominent psychological models of OCD disagree over whether thought-action fusion contributes directly to symptoms or whether the relationship is mediated by other psychological factors. A small number of studies have looked at this question, but these use mainly observational designs, making it difficult to determine the direction of relationships. Furthermore, most research has used adult participants. This research used an experimental design to manipulate thought-action fusion in children and tested how this impacted on anxiety, responsibility and neutralising behaviour. It also examined how various outcome measures related to responsibility beliefs. Results will be discussed in light of methodological difficulties of manipulating cognitive processes in children. Implications for the understanding and treatment of OCD in children will be discussed.

#### **Incidence and features of obsessional thinking in non-clinic adolescents**

Ben Laskey, Cornwall PCT & University of Manchester, Jenny Crye, Salford Primary Care & University of Manchester & Sam Cartwright-Hatton, University of Manchester

There is a substantial body of research examining obsessional thinking in non-clinical adult populations. Studies in this area tend to highlight similarities between content of obsessions in clinic and non-clinic populations, with clinical populations normally distinguished by the meaning they ascribe to such phenomena and to the distress associated with intrusive thoughts. Information derived from studies in non-clinical adults has been used clinically to normalise the experience of intrusive thoughts in clinical populations. Little is known about obsessions in community adolescent samples. Some studies in the adult literature have included older teenagers, but there have to date been no published studies investigating features of intrusive thoughts in younger adolescents. The reported study examined the frequency and content of intrusions in adolescence, and a number of process variables that have been associated with obsessions in adults. Sixty-two adolescents (aged 12-14 years) were recruited through schools. They completed questionnaire measures of obsessions and metacognitive beliefs. They were interviewed about recent episodes of obsessional thought, including content, frequency, acceptability, distress, dismissibility, interference and avoidance. They then received normalising information, and the impact of this on metacognitive beliefs was assessed. A significant number of participants reported the presence of obsessions. Frequency, distress, dismissibility, acceptability, interference and avoidance, were associated with metacognitive appraisals. Normalising information significantly reduced deleterious metacognitive appraisals. Frequency of reporting of obsessional thoughts in this population and the relationship between obsessional thinking and metacognitive beliefs are discussed. Comparisons are drawn with the findings in the adult literature. The implications of the findings are discussed as they relate to applicability of adult models of obsessional thinking to young adolescent populations. The implications for treatment and development of interventions, including possible normalising approaches, for this population are considered.

#### **The family experience of OCD in a clinical sample: content, interference and symptom stability**

Cynthia Turner, South London and Maudsley NHS Trust

Obsessive Compulsive Disorder (OCD) is a chronic and disabling anxiety disorder. Epidemiological studies suggest it has an incidence of around 1% in the adolescent population (Heyman et al, 2001). A number of treatment models have been proposed mostly based on cognitive-behavioural paradigms and these have been applied with mixed success in CAMHS populations. OCD appears to be one of the more intractable anxiety disorders with many adult sufferers reporting childhood onset. OCD sufferers often conceal their symptoms from others and are slow to seek treatment. They tend to be under-represented in CAMHS referrals at a national level. Treatment outcomes in generic CAMHS services are mixed and, as with other disorders, outcomes found in routine services appear to be less impressive than in settings (such as high-quality controlled trials or specialist super-regional centres) where therapists have particular expertise in treating this disorder. The experience of OCD for young people and families has received relatively little formal attention in the literature to date. The work that has been conducted in this area has tended to involve relatively small samples. Access to substantial numbers of clinical cases to enable the drawing of meaningful conclusions is limited to larger trials and specialist services. This paper will look at data in relation to a large clinical sample of young people diagnosed with obsessive compulsive disorder. Information from the perspective of both young people and parents will be reported. Factors including the frequency of different obsessions as well as the content and themes of intrusive thoughts will be covered. We will look at the characteristics that may be associated with various obsessions (such as age, gender, etc) as well as the resulting interference and distress. The paper will also undertake a preliminary investigation of the issue of stability in a young person's symptoms of OCD over time.

#### **The Development of Affect-related Cognitions in Youth**

Convenor: Cathy Creswell, University of Reading

#### **Interpretation of ambiguity in children: A prospective study of associations with anxiety and parental interpretations**

Cathy Creswell & Sarah Shildrick, University of Reading, & Andy Field, University of Sussex

Interpretation of ambiguity is consistently associated with anxiety in children, however the relationship between interpretation and anxiety over time remains unclear, as do the developmental origins of interpretative biases. This study set out to test a model of the development of interpretative biases in a prospective study of 110 children aged 5 to 8 years of age. Children and their parents were assessed three times, annually, on measures of anxiety and interpretation of ambiguous scenarios (including, for parents, both their own interpretations and their expectations regarding their child). Three models were constructed to assess associations between parent and child anxiety and threat and distress cognitions and expectancies. The three models were all a reasonable fit of the data, and supported conclusions that (i) children's threat and distress cognitions were stable over time and were significantly associated with anxiety, (ii) parents' threat and distress cognitions and expectancies significantly predicted child threat cognitions, and (iii) parental anxiety significantly predicted parents cognitions, which predicted parental expectancies. Parental expectancies were also significantly predicted by child cognitions. The findings varied depending on assessment time point and whether threat or distress cognitions were

being considered. The findings support the proposition that child and parent cognitive processes, in particular parental expectations, may be a useful target in the treatment or prevention of anxiety disorders in children.

#### **Meta-Cognition and Emotional Difficulties in Healthy Children and Adolescents**

Marie-Louise Reinholdt-Dunne, University of Copenhagen

Theoretical views and research findings suggest that there is an association between meta-cognitions and emotional difficulties in children (e.g., Cartwright-Hatton et al., 2004). The present study aimed to investigate the specific relationships between meta-cognitive beliefs and high levels of generalized anxiety (GAD) and depression in a community sample of 290 children and adolescents (9-16 years old). Meta-cognitions were measured using the Meta-Cognition Questionnaire. GAD was assessed using the GAD-subcales of the Screening of Child Anxiety Related Emotional Disorders (SCARED) and the Revised Child Anxiety and Depression Scale (RCADS). Depression was measured using the RCADS depression subscale. Results indicated that meta-cognitions related to negative worries significantly predicted GAD levels; whereas, high levels of depression was predicted by meta-cognitions associated with uncontrollability and danger. This suggests that there is a differential relationship between meta-cognitive beliefs and high levels of GAD and depression. Findings will be discussed in relation to current models of meta-cognition and emotional disorders.

#### **Longitudinal associations between anxiety, depression and anxiety sensitivity**

Helena M.S. Zavos, Frühling V. Rijsdijk, & Thalia C. Eley, Institute of Psychiatry, King's College London

Anxiety sensitivity, the fear of anxiety related sensations, has been found to be associated with both anxiety and depression. The present study sought to determine the direction and etiology of the association between anxiety sensitivity and both anxiety and depression. The relationship between anxiety and depression over time was also examined. Self reports of anxiety, depression and anxiety sensitivity were collected from approximately 1300 twin and sibling pairs at two time points (mean ages 15 and 17). The direction and etiology of the associations between these traits were examined within a longitudinal cross-lagged model. Results showed that whilst time 1 depression predicted time 2 anxiety, the converse association was not found. In contrast, there was evidence of a reciprocal relationship between anxiety sensitivity, and both anxiety and depression over time. As the current sample consists of twin and sibling pairs, genetic effects and environmental effects on relationships over time were also estimated. Generally, genetic effects were found to be more stable across time, although new genetic influences were evident at the second time point. Environmental effects, conversely, tended to be more time specific. This study adds to our understanding of the temporal precedence of anxiety and depression in adolescence and the risks underlying their association. The current study is also able to add to our understanding of the mechanisms by which anxiety sensitivity is associated with both anxiety and depression.

#### **An experimental test of the 'FEAR' effect**

Hannah Murray, University College London

There is strong evidence for the family aggregation of anxiety disorders, and research has increasingly begun to focus on the specific components (e.g. cognitive/ behavioural) of anxiety in an attempt to understand how families communicate anxiety. Threat cognitions are associated with increased anxiety in both children and adults and appear to have a causal role in the development of anxiety leading to the hypothesis that children's information processing style may result from internalisation of parental perception of threat. Furthermore, parents' expectations have been found to be a longitudinal predictor of children's anxious interpretation. One way in which parents may communicate enhanced perceptions of threat is via the conversations they have with their children. Barrett, Rapee, Dadds and Ryan (1996), for example, asked children with clinical anxiety, oppositional defiant disorder (ODD) and non-clinical children to rate the outcomes of ambiguous scenarios before and after discussing them with their parents. They found that, following the discussion, anxious children were more likely to make avoidant plans for the scenarios that they had discussed (while ODD children were more likely to change to aggressive plans). The authors labelled this the 'FEAR effect': Family Enhancement of Avoidant Responses. Dadds, Barrett, Rapee and Ryan (1996) analysed the content of these conversations and found that parents of anxious children listened less to their child, were less likely to point out positive consequences of a plan, and were more likely to reciprocate avoidant plan proposals. These behaviours were linked to an increase in children's avoidant solutions to ambiguous scenarios. These studies leave crucial questions unanswered. First, the involvement of clinical populations raises the possibility that parents are simply responding to how their (anxious) child tends to behave in potentially challenging situations. Second, if parent-child discussions do influence how children respond to ambiguous scenarios, it will be important to establish whether this also generalises to novel scenarios, or is restricted to the specific content of the parent-child discussion. Finally, it is unclear whether some children may be more easily influenced by characteristics of parent-child discussions, due to, for example, an anxious temperament. The current study aimed to address these questions using an experimental methodology. Following a training period in which mothers were taught to either encourage threat interpretations (as in the FEAR effect) or non-threat interpretations, 30 children (aged 7-8 years) and their mothers discussed two ambiguous scenarios. Contrary to predictions, children in the 'FEAR' condition did not change their interpretations following the conversations, nor did they interpret later situations as more threatening. However, in the 'Non-FEAR' condition, children were more likely to change to non-threatening responses, and interpreted less threat in novel scenarios. The effect was not moderated by child trait anxiety. The results suggest that anxious parents do not create anxiety in their children, they rather fail to reassure them by encouraging non-threatening responses. This also leads to a potential avenue for treatment of childhood anxiety.

#### **Are you thinking what I'm thinking? Peer group similarities in adolescent hostile attribution tendencies**

Sarah Halligan & Katie Philips, University of Reading

A bias towards attributing hostile intent to others has been linked to aggression. In an adolescent sample, we investigated whether peer group homophily exists in the tendency towards attributing hostile intent. We assessed hostile attribution tendencies and self-reported aggressive behaviours in a normative sample of 910 adolescents, and computed average peer group scores based on friend nominations. Results indicated that adolescents showed significant correlations between their levels of aggression and that of their peer group; and a similar



correspondence existed in terms of their hostile attribution tendencies. The latter effect was retained once own and peer group level of aggression were controlled.

**Good friend, bad friend: an experimental investigation of peer influences on adolescent hostile attributions**  
Kim M. Freeman, University of Southampton, Sarah Halligan, University of Reading & Julie Hadwin, University of Southampton

Aggressive behaviours in children and adolescents are associated with a bias towards attributing hostile intent to others (Crick & Dodge, 1994). The current study examined whether the tendency towards attributing hostile intent is transmitted amongst adolescents in a community sample of boys and girls (13 - 14 years old), using a computerised 'Chat-room' experimental paradigm. Adolescents ( $N = 134$ ) were randomly assigned to one of two experimentally manipulated conditions and were led to believe they were communicating with students from other schools (i.e., 'e-confederates') who endorsed either hostile (condition one) or benign intent (condition two) attributions. Four possible moderators of peer contagion were tested; gender, dispositional levels of social anxiety, baseline levels of aggression and friendship styles (reciprocated/unreciprocated). Contagion effects were demonstrated across conditions with adjustment in individual attribution scores occurring in response to both benign and hostile "peer group" conditions, although the latter appeared to be more potent. Furthermore, adolescent's dispositional levels of social anxiety moderated peer contagion; socially anxious adolescents showed fewer contagion effects, specifically in response to hostile peer attributions. The present study offers preliminary evidence for conditions that may moderate adolescents' susceptibility to peer contagion effects in the development of a hostile attribution bias.

**Perinatal Psychology - Insights into how best to Improve Maternal Well-being and the Mother-Infant Relationship**

Convenor: Anja Wittkowski, University of Manchester

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**Symposium summary**

Anja Wittkowski, University of Manchester

It has long been established that having a parent with mental health difficulties is a significant risk factor for child development and that the postnatal period is particularly crucial for the infant dependent on the appropriate responsiveness of his or her care-giver. The timely offer of intervention for a mother's mental health problems, including postnatal depression, has been advocated by the 2007 NICE guidelines. However, interventions should not only focus on alleviating maternal symptoms but also on the quality of the mother-infant relationship. This symposium will focus on recent developments in the psychological treatment of depressed mothers and their infants. In the first paper, Heather O'Mahen will illustrate how CBT can be adapted for perinatal depression by presenting findings from her effectiveness trial, conducted in the United States with a racially diverse population. Christine Puckering will then explain how the baby can act as co-therapist in bringing about a change in maternal responsiveness and she will show video clips illustrating this therapeutic effect, first identified by Selma Fraiberg. In the third presentation, Corinna Reck will continue to explain how the mother-infant relationship can be improved by focussing on interactive co-ordination. She will present observations from play and reunion episodes. Finally, Mia Cleary and Alex Howe from Manchester's Children and Parents' Service will then describe current developments in their community-based parenting interventions in the first year. Their presentation will provide an overview as well as preliminary outcome data of two group parenting programmes offered to parents in the community. They will try to answer the question whether universal parenting interventions are enough for parents with mental health problems to improve the relationship with their infant or whether they do require additional psychological therapy.

**Adapting CBT for perinatal depression: Treatment Engagement and Clinical Outcomes**

Heather O'Mahen, University of Exeter, Heather Flynn, University of Michigan & Joe Himle, University of Michigan  
Despite its high prevalence and morbidity, few women suffering from perinatal depression receive treatment. Treatment of perinatal depression presents special challenges since most women will not seek outpatient psychiatry care, choose not to take anti-depressant medications, prefer psychotherapy, and have unique barriers to depression care. The need to adapt existing empirically supported treatments to meet the content and delivery needs of childbearing women has received international recognition. The goal of this study was to develop a psychotherapeutic intervention tailored to the unique individual-level issues (such as physical mobility, energy and childcare limitations, depression and motherhood beliefs) faced by women during the perinatal period as identified in obstetrics settings. Specifically, both the treatment delivery method and content of Cognitive Behavioral Therapy-CBT was adapted from information learned from a qualitative study. Based on that study, the following psychotherapy components were added or retained: Behavior activation, cognitive restructuring specific to motherhood-related beliefs, interpersonal communication, rumination-focused strategies, and psychoeducation about depression in terms of pregnancy, labor and delivery, and parenting. The treatment was then tested in a Phase II pilot trial, and demonstrated a significant reduction in EPDS scores,  $t(1) = 4.85$ ,  $p < .01$ . For the effectiveness trial, 1,788 women were screened in several obstetrics clinics. Of those, 53 completed a diagnostic interview based on depression risk, and 27 (85% of those offered the treatment) have been randomly assigned to receive either the modified CBT or Treatment as Usual. The sample is racially diverse (49% Caucasian; 51% African American). All women have completed at least 1 session of the therapy in the obstetrics setting (additional sessions have been in home or over the telephone). For the women enrolled, we have shown an average of an 8 point decrease on the Edinburgh Postnatal Depression Scale (EPDS) from 13.4 (4.6) to 5.6 (3.4),  $p < .01$ . Cognitive (rumination), behavioral (avoidance /activation) and other key predictors of response will be examined in the full sample of 60 (expected completion July 2010). This study improves on rates of depression treatment engagement found in other studies of high risk samples of perinatal women. Information on pathways to depression, treatment and outcomes will be discussed.

**Mother-baby relationships: the baby as co-therapist in post-natal depression**

Christine Puckering, Royal Hospital for Sick Children and University of Glasgow

Good evidence has grown of the effectiveness of pharmacological and psychological treatment for post-natal depression. Few studies have looked at the effect of the mother's treatment on the outcome for the child, which has been identified as being at risk if the depression lasts even as long as the first year of life. The uniquely rapid pace of development in the child's first year makes the child very responsive to the effects of experience. The child will make the best use of whatever the circumstances in which she or he finds himself. Where the mother is depressed and psychologically unavailable, that can result in the child being passive and undemanding with little expectation that interaction is rewarding or to be sought after. This acclimatisation to the qualities of available relationships may go some way to explaining why even when mother's depression remits, the relationship with the child does not automatically self-correct. A disconnection between the relationship and mother's current level of depression can be expected if the recovery from depression happens after the very early period in which the child's expectations of relationships are being formed. Paradoxically, the same openness to the effects of experience can make the child respond to even quite small changes in the mother's responsiveness, which in turn energises and rewards the mother, provided these benign changes happen early enough. The baby is the co-therapist in striving towards the best outcome. This therapeutic effect, identified initially by Selma Fraiberg, will be illustrated in this presentation with video clips from mothers and babies during treatment.

#### **The interactive coordination of clinically depressed mothers and their infants**

Corinna Reck, University of Heidelberg

Postpartum mental illnesses and their ensuing effects on infant development are attracting increasing attention within inpatient treatment centers. Approximately 10-15 percent of all women develop a depression in the period following the birth of their child. It is well known that babies are very sensitive towards their mothers' emotional state. Interactions in healthy mother-infant dyads are characterized by a pattern of mismatching interactive states with quick reparation of the mismatches to interactive matching states. By contrast postpartum depression is associated with impaired mother-infant interaction in the first months of life. Most of the studies demonstrating these interactive and compromising effects have used community samples and not in-patient depressed samples in which the effects would be expected to be stronger. The primary goal of this study was to evaluate specific patterns of dyadic coordination and the capacity for repairing states of miscoordination in a sample of postpartum clinically depressed mothers and their infants compared to a healthy control group. A German sample of 34 depressed dyads and 34 healthy dyads (range = 1 - 8 months, mean age = 3.9 months) were videotaped in the Face-to-Face Still-Face Paradigm focussing on the play and the reunion episode. Depressed dyads had lower levels of coordination of positive matched states and longer latencies to repair interactive mismatching states to positive matched states than the healthy dyads. Clinical implications and specific mother-infant focussed therapeutic interventions will be discussed.

#### **Developing community-based parenting interventions in the first year**

Mia Cleary & Alexandra Howe, Children and Parents' Service, Manchester

Having a parent with mental health problems is a significant risk factor for child development. The postnatal period is a particularly vulnerable time when the infant's brain is in a critical period of accelerated growth (Schore, 2001a). Parental mental health problems occurring in this period present the child with experiences that will crucially - and potentially adversely - affect their cognitive development, self-regulation skills, language acquisition and social and emotional development into middle childhood and beyond (e.g. Deave et al., 2008; Ramchandani et al., 2005). Adverse child outcomes are not necessarily linked to specific parental diagnoses but to the persistence of the disorder and its effects on the parents' ability to function. For example, a depressed or anxious parent may show less play with her infant. Her play, when it does occur, tends to be more intrusive or hostile. Furthermore, her ability to sooth her infant is impaired, leaving the infant for long periods in a distressed state that are beyond his or her immature coping strategies (Dawson & Ashman, 2000; Schore, 2001). This can adversely influence the development of the infant's limbic system resulting in higher emotional reactivity and increasingly unsophisticated coping responses. The infant therefore becomes more difficult to sooth or engage, which may contribute to their parent's perception of themselves as having less personal control over the infant's state and less ability to influence their infant positively. Thus the experience of mental health problems in the postpartum period sets in train a pattern of relating to the infant that remains compromised in the longer term even when the mental health problem has remitted (Weinburg & Tronick, 1998) or been treated (Cooper & Murray, 1997). Interventions occurring within the first year of life appear to offer the greatest hope for the child's future. This presentation will provide a detailed overview of two group interventions as well as preliminary outcome data comparing parents with mental health problems who have accessed either service over the past 12 months. The first intervention, the Parent Survival Course: The First Year is a universal seven-session group intervention for parents with a child under 12 months of age. The syllabus targets parental sensitivity, empathy and responsiveness as well as their developmental expectations of their infant in order to promote positive infant outcomes. It is, as yet, unclear whether parents with mental health problems can make changes in their relationship with their child by attending a universal parenting intervention or whether they require additional support targeting their own emotional wellbeing in order for this work to be successful. A second group intervention programme has therefore been developed in conjunction with parents and leading Perinatal Clinicians: the Parent Survival Course: The First Year and You. This group intervention is modular and incorporates the same syllabus as the shorter first year course. However, this work is preceded by five sessions specifically targeting parents' emotional wellbeing. This approach will help to determine whether it is possible to change parental sensitivity and responsiveness without treating the mental health problem.

## **Skills Class**

#### **From Timid to Tiger: Parenting-based Techniques for Managing the Anxious Child**

Samantha Cartwright-Hatton, University of Manchester

This session will detail selected techniques from the 'Timid to Tiger' treatment manual for working with parents of young anxious children. The Timid to Tiger programme incorporates two key components. First, parents are encouraged to provide their child with a consistent, calm, predictable and warm parenting environment, within

which their child can begin to develop the 'Seven Confident Thoughts'. The Seven Confident Thoughts concept is introduced, and some of the key parenting techniques that can be used to develop them are demonstrated. In particular, the use of parental praise, reward and effective limit setting to encourage confident children will be covered in detail. The second component of the programme is educating parents in the basic psychological components of anxiety, and cognitive-behavioural techniques to overcome these. Methods for explaining and tackling fight-flight response, avoidance, and parental modelling of anxiety will be demonstrated. The aim in these parenting programmes is always that participants have fun, and it is hoped that this will be reflected in this skills workshop.

## Open Papers

### Children and Adolescents

Chair: Sharon Dawe, Griffith University, Australia

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#### **Improving Family Functioning in High Risk Families: The Parents under Pressure Program**

Sharon Dawe, Griffith University, Australia & Paul Harnett, University of Queensland

There is widespread agreement that improving family functioning in high risk families with parental substance misuse is critical. There are many adverse outcomes seen in children raised in environments characterized by parental psychopathology, substance misuse, poverty, social isolation and poor parenting. However, targeting a subset of problems such as substance misuse, in isolation from the broader family context, does little to improve family functioning. Interventions need to be multifaceted and address many of the risk factors, including the potential for current or probable child abuse and neglect. There have been a number of attempts to intervene in families with multiple risk factors and there has been a striking lack of success in making changes in either parental functioning or child behaviour. It is within this context that the current program of research developing a multisystemic parenting intervention, the Parents under Pressure program, was undertaken. Some eight years on there have been many successes and equally, many failures. In this talk an overview of the PUP program will be provided and research evidence from trials including parents on methadone, women existing prison and child maltreatment will be presented. Obstacles to implementation and dissemination will be addressed.

#### **The Helping Families Programme: A new parenting intervention for primary-aged children with severe and persistent conduct problems**

Day, C, Child and Adolescent Psychiatry, Institute of Psychiatry, King's College London & Centre for Parent and Child Support, South London and Maudsley NHS Foundation Trust, Ellis, M. Child and Adolescent Psychiatry, Institute of Psychiatry, King's College London & Centre for Parent and Child Support, South London and Maudsley NHS Foundation Trust, Wedgwood, L., Thomas, H., & Lakin, J. Child and Adolescent Psychiatry, Institute of Psychiatry, King's College London

The detrimental costs of severe and persistent conduct problems in middle childhood are serious and long-lasting, scarring both the child's emotional and social development, while escalating the risk of school exclusion, criminal activity, substance misuse and later unemployment. There are also wider social implications, both in relation to family functioning and peer relationships. Families are frequently subject to a multiplicity of inter-related risk factors that fundamentally impede their capacity to look after and parent their children in a consistent and involved way. At the same time, many families themselves feel highly suspicious of, alienated from while concurrently surrounded by, services and practitioners. These difficulties pose fundamental challenges to the effectiveness of current interventions and the capacity of services and practitioners' to make a difference. Using an ecological perspective, a clinical research team from the Institute of Psychiatry, King's College, London, and in collaboration with the University of Queensland and Griffith University, Brisbane, Australia, has developed an innovative, multimodal intervention for primary school aged children with severe and complex behavioural difficulties, called the Helping Families Programme. The Programme, which is strengths based and goal-orientated, focuses on parenting skills, cognition and emotion regulation in relation to 5 key family risk factors that typically undermine or prevent change. Partnership working is core to this approach to ensure parents are genuinely involved in the process of systematically using the manualised programme. This paper will describe the methods used to develop the Helping Families Programme and will present preliminary results from the pilot trial.

#### **Adjusting to a new reality after serious and life-threatening illness: Families' experiences of recovery in the year after a paediatric intensive care admission.**

Ellie Atkins, University of Surrey & Gillian Colville, St George's Hospital/University of London

Some families leave intensive care displaying few trauma symptoms, but after a year are significantly traumatised about the event. For other families the reverse is true (Colville, 2008a). Whilst there is now a growing body of research about the effect of Paediatric intensive care (PICU) on children and families, little is known about the journey following discharge. This research aimed to identify what processes were occurring in the year following a PICU admission and hoped to establish what experiences were leading to some families becoming traumatised. Children who had experienced an admission to PICU of more than 24 hours were interviewed, along with one or both of their parents. The data was analysed using grounded theory, which aims to develop a theory based on the participants understanding of their experiences, rather than fit the data to existing literature.

Initial results suggest that families expect life to return to normal after discharge but that in reality life is very different following such an experience. Families attempt to develop coping strategies and models of recovery to help guide them through the experience. They must also attempt to cognitively and emotionally process what has happened to them which often involves returning to their memories of the experience repeatedly as they attempt to create coherent narratives of their experience.

#### **Vicarious fear learning in children: The role of stimulus fear-relevance**

Chris Askew, Kingston University, Guler Dunne, Kingston University, Andy Field, University of Sussex

Evidence suggests that children can acquire fears vicariously by observing other people who already have the fear (Askew & Field 2007; Gerull & Rapee, 2002). Studies with monkeys indicate however, that fear vicarious learning

only occurs for 'fear-relevant' stimuli (Cook & Mineka, 1989). The current study investigated vicarious learning in children for two types of stimuli with differing levels of fear-relevance. Two groups of children (aged 6 - 10 years, N = 64) saw two novel animals (quoll and cuscus) or flowers (red avens and dotted loosestrife), either on their own or together with pictures of scared faces. Thus group 1 saw one of the animals presented with scared faces (vicarious learning) and the other animal on its own (control). This was repeated in Group 2 but children saw flowers instead of animals. Two fear-related measures were taken: 1) fear beliefs for the animals/flowers before and after vicarious learning; and 2) children's avoidance feelings for animals/flowers determined by where they placed a figure representing themselves on a board (the 'nature reserve') relative to the animals/flowers. As in previous studies, children's fear beliefs increased for animals seen with scared faces compared to the control animal. However, in contrast to Cook & Mineka (1989) similar changes in fear beliefs were also found for flowers. The same pattern of findings was also found for the avoidance measures. The findings suggest that vicarious fear-learning in children is not influenced by the fear-relevance of the stimulus involved in learning. If clinicians understand how and why a fear was acquired this should assist treatment.

#### **A comprehensive measure of positive beliefs about worry for use with adolescents**

Jenny Riley, Newcastle University, Mark Freeston, Newcastle University, Louise Harrison, Newcastle University, Jacqui Rodgers, Newcastle University

A number of psychological models have emphasised the importance of positive beliefs about worry (PBW) in the development and maintenance of worry. Evidence suggests that participants as young as adolescents hold PBW, for example, the belief that worry helps one to work well (Cartwright-Hatton et al., 2004), or the belief that worry helps one to avoid the worst (Gosselin et al., 2007). In order to fully understand the relationship between PBW and worry in adolescents, adequate tools must exist to measure the construct. Existing measures of PBW lack content coverage, which could pose a threat to content validity. Therefore, this study aimed to develop a comprehensive measure of PBW which has good psychometric properties. Details of the development of the measure will be discussed. A pilot study was carried out using the new measure (Why Worry III) with an analogue sample (N=157, mean age= 12 years, 6 months). Overall, the measure demonstrated adequate psychometric properties; however, relevant amendments were made in order to improve reliability. Following this, the final version of the measure was administered to an analogue sample (N=146, mean age= 12 years 8 months). The measure demonstrated good psychometric properties (internal consistency, convergent validity and content validity), and possessed the comprehensive content coverage that previous measures lacked. Furthermore, data will be presented on the use of the newly established measure in a regression based analysis of the best predictors of worry in an adolescent sample. Limitations will be discussed, alongside implications for future research and clinical practice. There is the potential for the measure to be used in clinical practice to identify individuals who hold strong PBW.

#### **"Before I got to the therapists chair"...How do young people who self harm prepare for psychotherapy?**

Allan Brownrigg, Northumbria University

This paper reports on the initial findings from a PhD study entitled "Young peoples accounts of Psychotherapy following self harm". Through semi structured interviews, which are informed by the Biographical Narrative Interpretative Method (Wengraf, 2007), accounts from young people about the Psychotherapy they received have been gathered. Using Heidegger's Interpretive Phenomenological Analysis, as described by Conroy (2003), I have explored how young people construct their psychotherapeutic experience and considered what factors contributed to their engagement with, and completion of Psychotherapy. Furthermore, I have explored the cognitive representations young people hold about themselves prior to, and following psychotherapy. This paper will therefore explain how the following phenomenon was reached. • Interpersonal labels when experienced negatively appear to be trigger for change. • Positive engagement in psychotherapy occurs when the young person can find the words to describe their experiences. • Actions of professionals experienced as intrinsic to young person's belief system. They mirror what they receive. References: Conroy, S. A. (2003) A pathway for Interpretive Phenomenology. *International Journal of Qualitative Methods*. 2 (3) September. Article 4. Wengraf, T. (2007) Guide to BNIM biographic-narrative interpretive method: interviewing for life histories, lived situations and ongoing personal experiencing. Version 8.01a.

This paper offers an opportunity for therapist to reflect upon their beliefs about clients who self harm and about the active process clients engage in prior to attending psychotherapy. In doing this therapist can have opportunity to reconsider their usual therapy practice in light of the findings which place higher levels of respect onto our clients than are often documented within the available literature.

## **Eating Disorders and Impulse Control**

### **Keynote Address**

#### **Translating Experimental Neuroscience into Treatment of Anorexia Nervosa**

Professor Ulrike Schmidt, Institute of Psychiatry, King's College London

Treatment of adults with anorexia nervosa remains a major challenge. Existing psychological treatments for adults with anorexia nervosa have poor outcomes and high drop-out rates. To address these problems, we have developed a novel maintenance model, drawing on our group's findings of the neurobiology of anorexia nervosa. Our model is aetiologically based, includes both individual and interpersonal maintaining factors, and targets cognitive and emotional processes and traits, rather than focusing only on the content of experiences and beliefs. Based on this model, we have developed a modularized and manualised treatment. In this talk I will summarise the evidence underpinning the model and will present findings from our own group and others regarding the efficacy of the treatment based on it.

### **Symposia**

## Cognitive Processes and the Treatment of Obesity

Convenor: Amy Ahern, MRC Human Nutrition Research Unit, Cambridge

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### Psychological treatment for obesity: How effective is it?

Zafra Cooper, University of Oxford

It is remarkably difficult for people with obesity to maintain a new lower weight following weight loss. Behavioural treatments for obesity generally achieve weight loss of between 5%-10% of initial body weight, but in the majority of cases much of the weight lost is regained once treatment ends. While subsequent therapeutic support of various forms appears to delay this weight regain, the effects are modest and do not persist in most cases. In recent years cognitive behaviour therapy has been shown to result in many patients with eating disorders making lasting changes to the way that they eat. The aim of the present study was to examine the immediate and longer-term effects of a new cognitive behavioural treatment that was explicitly designed to minimise post-treatment weight regain. One hundred and fifty female participants with obesity were randomized to the new treatment, behaviour therapy (the leading alternative psychological treatment) or guided self-help (a minimal intervention). Both of the main treatments resulted in an average weight loss of about ten percent of initial body weight whereas weight loss was more modest with guided self-help. The participants were subsequently followed-up for three years post-treatment. The great majority regained almost all the weight that they had lost. The new treatment was no better than the behavioural treatment in preventing weight regain. These findings lend further support to the notion that obesity is resistant to psychological methods of treatment.

### Post Treatment Weight Regain in Obesity

Amy Ahern, MRC Human Nutrition Research Unit, Christopher Fairburn, Annabel David & Zafra Cooper, University of Oxford

In the great majority of cases, weight lost during behavioural and pharmacological treatment of obesity is regained within 3 years of treatment cessation. To understand the psychological processes involved in post-treatment regain, individuals who had lost weight in a randomised controlled treatment trial were interviewed about their experience of weight management after treatment ended. Participants were 53 women who had previously lost  $\geq 5\%$  initial weight and who had attended follow up assessments for 3 years post treatment. This group included both those who had maintained their post-treatment weight at the 3 year follow up assessment, and those who had regained weight. Mean time since treatment ended was 9.1 years. At the time of the interview, almost all participants had regained weight, with considerable fluctuation reported. Participants discussed how maintaining weight lost required considerable effort and focus, which was difficult to continue long term. New behaviours did not appear to have become sufficiently well established habits to be maintained during negative life experiences. Participants reported returning to their old habits, which led to weight regain. Difficult interpersonal relationships and a lack of post-treatment support also appeared to contribute to weight regain. Early signs of weight regain often went unnoticed or were ignored. Participants reported difficulty in maintaining motivation without the encouragement of a therapist. This study highlights the problems faced by people with obesity who wish to maintain their new lower weight. The implications of these findings for obesity treatment will be discussed.

### The influence of memory for recent eating on food intake: implications for obesity treatment

Suzanne Higgs, University of Birmingham

Evidence from neuropsychological studies of amnesic patients and experimental studies of healthy volunteers suggests that an important cognitive influence on food intake is memory for recent eating episodes. Boosting memory for recent eating by reminding healthy volunteers of lunch eaten earlier that day decreases later afternoon snacking compared with recall of non-food related information or recall of lunch eaten the previous day. On the other hand, disrupting meal memory encoding during lunch increases later snacking. These data are consistent with the finding that amnesic patients, who are unable to recall having eaten recently, consume multiple meals as they are offered, indicating impaired satiety. One implication of these findings is that impaired memory may contribute to some forms of overeating and that strategies that improve meal memory may be helpful in reducing food intake. Furthermore, because obesity is associated with neuropsychological deficits, including memory deficits, it is possible that cognitive impairments contribute to the maintenance of obesity and therapies targeting memory-related processes could provide a novel approach for obesity treatment.

### Mindfulness based interventions for obesity: What should we attend to?

Paul Lattimore & Peter Malinowski, Liverpool John Moores University

Mindfulness based interventions (MBI) have been developed to treat a range of psychological and physical disorders; most notably, depression and stress reduction. Mindfulness is distinct from other forms of dispositional awareness that facilitate adaptive self- and emotion-regulation; it is distinct from reflexive awareness because it operates upon rather than within thought whereby the mind can be engaged and disengaged more choicefully. Mindfulness is likely to facilitate more adaptive self- and emotion-regulation by "de-automatizing" habitual responding to external cues. MBIs for eating disorders and obesity are in their infancy. In this paper we propose that the conceptual basis for eating related MBIs should be rigorously investigated so that mechanisms of operation can be identified. In this respect we have focused on trait disinhibition, a factor that influences eating behaviour and acts as a behavioural proxy for body weight variation. We present empirical data that shows how dispositional mindfulness is inversely related to trait disinhibition and how dispositional mindfulness mediates the relationship between anxiety/depression and trait disinhibition. This evidence supports a proposition that the expression of trait disinhibition; opportunistic eating, is underpinned by automatic habitual processes that reflect the power of hedonic drivers of appetite. Evidence about impaired hunger and satiety responses in obese individuals is reviewed to illustrate how hedonic appetite is governed by automatic habitual processes. In doing so we propose that opportunistic overeating that characterises the development of obesity can be stalled by enhancing dispositional mindfulness. Future empirical investigations are discussed in the context of therapy developments.

### Impulse Control and Addiction

Convenor: Matt Field, University of Liverpool

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### **The Neurobiology of Impulsivity and Substance Use**

Marcus Munafo, University of Bristol

There is evidence from twin studies for a shared genetic component that influences liability to use different substances, such as tobacco and alcohol. Part of this shared genetic liability may be mediated by personality traits such as impulsivity. Recently, molecular genetic evidence has begun to emerge suggesting specific candidate genes may be associated with both trait impulsivity and various substance use phenotypes. This evidence will be reviewed, and implications for the laboratory study of the role of impulsivity in drug taking will be discussed.

### **Habit learning in impulsive humans**

Lee Hogarth, University of Nottingham

Cognitive-behavioural therapy partially relies on intentions being able to influence behaviour. However, according to instrumental learning theory, whereas goal-directed actions are intentional in the sense of being mediated by knowledge of the consequences, habitual actions are reflexive, being elicited by Pavlovian cues automatically. As such, habitual actions should be less susceptible to cognitive-behavioural therapy. This talk will present evidence that trait impulsivity in humans is associated with a predominance of habitual as opposed to goal-directed control over instrumental performance (using the outcome revaluation procedure translated from animal behavioural neuroscience). The implication of these findings is that impulsive humans, by virtue of their predilection for habit learning, will be more resistant to the beneficial effects of cognitive-behaviour therapy.

### **The Role of Disinhibition in Hazardous Drinking**

Abi Rose, Institute of Psychiatry, King's College London

Hazardous drinking, such as binge drinking, is associated with both alcohol dependent and non-dependent individuals, and continues despite Government initiatives aimed at highlighting the risks of excessive drinking and reducing consumption levels. In addition, anecdotal evidence suggests that people often consume more alcohol than they originally intended to, leading some to suggest that hazardous drinking involves impaired control processes. Alcohol priming (when an initial dose of alcohol motivates further drinking) is believed to be important in binge drinking and alcohol relapse. Data from several experimental studies investigating priming will be presented. Results suggest that both dispositional and alcohol-induced impulsivity may be involved in determining drinking behaviour. However, the research has also identified alternative processes, such as positive reinforcement and the subjective effects of alcohol, as being important. Given the significant negative consequences of excessive drinking, it is important to understand the factors which motivate consumption and help maintain alcohol use once initiated. Recent addiction models which incorporate multiple processes, including but not exclusive to control, are likely to offer the greatest advantage in identifying potential treatment targets for alcohol use disorders.

### **State fluctuations in impulsive responding in addiction**

Matt Field, University of Liverpool

'Impulsivity' is generally considered to be a multidimensional trait that differs between individuals but is relatively stable within individuals. There is clear evidence that elevated impulsivity is associated with the abuse of and addiction to a variety of substances, including alcohol, tobacco and cocaine. However, temporary fluctuations in impulsive responding have been relatively under researched, but it is important to study this because it can throw light on the psychological processes that increase the risk of relapse to drug-seeking. I will discuss recent studies which suggest that (a) some aspects of impulsivity, such as delay discounting, are increased during acute withdrawal from nicotine and opiates, and (b) the presence of drug-related cues in the environment leads to increased impulsivity in a different domain, namely inhibitory control failures. Clinical implications, such as the need for interventions that improve impulse control, are discussed.

### **Set Shifting and Perseveration in Eating Disorders**

Convenor: Gillian Todd, University of East Anglia

Perseverative task performance under fasting and non-fasting conditions

Lucy Serpell, Heather Bolton, Paul Burgess, Sam Gilbert, University College London

Rigid thinking, conceptualised in the literature as *perseveration*, is a possible maintaining factor in anorexia nervosa (AN), and is likely to impede treatment. Perseveration is likely to be exacerbated by starvation in AN. Hence this study examines the relationship between perseverative thinking and starvation in a non-clinical group. A repeated measures design was used over 2 testing sessions, healthy females were required to fast for 16 hours before one testing session, and to be satiated for the other. At each session, participants undertook two computer tasks measuring perseveration and completed the Hospital Anxiety and Depression Scale [HADS]; Persistence, Perseveration Perfectionism Questionnaire [PPPQ]; and the Eating Disorders Examination Questionnaire [EDE-Q]. We hypothesise that the tendency to perseverate (as measured by the PPPQ) will be exacerbated by starvation and that those with high EDE-Q scores will have impaired performance on food trials of the computer task. Full results will be reported.

### **The effect of psychological treatment on set-shifting abilities in anorexia nervosa**

Lot Sternheim, Institute of Psychiatry, Kings College London

Introduction: Anorexia Nervosa is a life threatening and often chronic mental illness with high relapse rates. The use of maladaptive coping strategies seems to be an important factor in developing and maintaining the illness. Literature suggests that people with AN often experience difficulties coping and tend to engage in avoidant and submissive styles of coping. Recent research shows that anorexic symptomatology is linked to impaired ability to infer emotions and it seems that specifically within a social context people suffering from AN tend to engage in non-effective problem solving. This study seeks to gain a better understanding of how people with anorexia resolve difficult everyday social situations. Method: Social problem-solving in 30 patients with anorexia, and 30 matched controls was assessed using a social cognition task. Participants were recruited, via flyers and circular emails to

students and staff at King's College London, and people with anorexia were additionally recruited from the Eating Disorders Out-Patient Services at the Maudsley Hospital in London. The task consists of scenarios involving awkward everyday situations and participants are asked to generate both the most appropriate courses of action to resolve the situation as well as specify what their course of action would be. Answers were rated on their social and practical effectiveness. Results: The AN group performed poorer at the social problem-solving compared to the control group, and reported differences between their most effective generated solution, and their actual solving strategies. Discussion: This study suggests that people with AN have difficulty coping with daily issues in a wider social environment and treatment strategies to enhance the skills required in these situations are called for.

**An experimental investigation of perseverative thinking in bulimia nervosa versus a non-eating disorder group**  
Gillian Todd, University of East Anglia, Myra Cooper, university of Oxford, Tim Croudace & Ian Goodyer, University of Cambridge, & Adrian Wells, University of Manchester

Repetitive and Perseverative thinking is common in psychological disorders. Wells & Matthews Self-Regulatory Executive Functioning Model (S-REF) proposes that psychological disorder is associated with a pattern of cognition and behaviour called the Cognitive-Attentional Syndrome (CAS) that consists of perseverative thinking in the form of worry, rumination, attentional strategies of threat monitoring and coping behaviours that fail to modify dysfunctional beliefs. The CAS arises out of metacognitive beliefs that control and regulate cognitive-behavioural processes. The aim of this study was to investigate if the S-REF model applies to BN by first establishing if perseveration was present. The sample included 12 females with BN (DSM-IV) and a non eating disorder control group. The experimental task involved asking subjects to contemplate three hypothetical scenarios, 2 that were related to triggers for binge eating (a standardised weight & shape trigger and an idiosyncratic scenario generated by the subject) and 1 neutral condition. Subjects were randomly assigned to complete all 3 scenarios in one of six orders. After explaining the procedure subjects were asked to close their eyes while the first scenario was read out loud. Instructions were given to create an image the situation as if it were happening right now. Following a manipulation check subjects were asked a series of questions in relation to the scenario that were repeated until specific stop rules applied. After a filler task the next scenario was introduced until all three had been completed. Consistent with the hypotheses, BN subjects generated a greater number of ideational steps in response to the ED scenarios compared to the neutral scenario and control group. The results suggest that BN patients have a tendency to ruminate in response to specific self-relevant situations, and suggest that the S-REF model might apply to BN. CBT for BN might need to address different domains of cognitions in addition to cognitive processes such as worry and rumination.

**Unravelling the Socio-Emotional Processing Stream in Anorexia Nervosa and Other Eating Disorders**  
Convenor: Ulrike Schmidt, Institute of Psychiatry, King's College London

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#### **Social cognition and neurocognition: linking experimental findings to function**

Anna Oldershaw, Lot Sternheim, Kate Tchanturia, Janet Treasure & Ulrike Schmidt, King's College London, Institute of Psychiatry

Anorexia Nervosa (AN) is a disorder marked by self-starvation, hyperactivity and extreme concerns about weight, shape or eating. In adults, the disorder and the most appropriate means to treat it remain elusive; however several recent models have highlighted that emotional and interpersonal difficulties may serve as maintenance factors. This proposal appears to be supported by recent experimental work demonstrating deficits in AN across both social cognitive and neurocognitive domains. Yet, the relationship between such experimental tasks and actual interpersonal functioning or symptomatology in AN is unknown, despite a clear link demonstrated in other disorders, such as psychosis. Moreover, whilst some psychosis researchers have proposed that social cognitive and neurocognitive domains overlap, others suggest they are distinct but highly related; indeed it is hypothesized that in psychosis the link between neurocognitive ability and community functioning is mediated by social cognition. The present study examined social cognition (emotion recognition, emotion theory of mind), neurocognition (set-shifting, detail focus) and actual function (self-reported psychosocial impairment) in fifty consecutive adult AN referrals to the Maudsley Eating Disorders Unit. It sought to assess the link between these domains and to explore whether they act dependently or independently in AN. Findings and their implications for future maintenance and treatment models of AN will be discussed.

#### **Emotional and social perception in Bulimia Nervosa**

Nelum Samara, Helen Startup, Anna Lavender, Frederique Van Den Eynde & Ulrike Schmidt, Institute of Psychiatry, King's College London

Emotional and Social perception in Bulimia Nervosa. There is considerable evidence in the literature indicating that individuals with Bulimia Nervosa (BN) experience difficulties in the social domain: these can be evident during childhood (Troop and Bifulco, 2002; Fairburn et al, 2007) where individuals are typically shy, compare themselves negatively with others and have few friends or they can become apparent later. Notably, significant life events and chronic difficulties in the social/interpersonal domain trigger onset of BN in most cases (Schmidt et al, 1997; Welch et al, 1997). Furthermore women with BN perceive themselves to have a lower social rank, and compare themselves unfavourably to other women (Troop et al, 2003; Morrison et al, 2003) as well as report having more limited social networks with fewer supportive relationships (Tiller et al, 1997) Despite this to date very little work has been done to explore social cognition in BN. Social cognition is "the mental operations underlying social interactions, which include the human ability to perceive the intentions and dispositions of others" (Brothers, 1990). Social cognition includes: emotional processing, attributional bias, social knowledge, theory of mind (ToM) and social perception (Green et al, 2008). This talk will introduce some work done to explore the latter two in BN: theory of mind and social perception. There is some evidence that suggests ToM is significantly impaired in BN (Bydlowski et al., 2005), but overall results are inconclusive and predominantly focussed upon Anorexia Nervosa. We used Baron-Cohen's Reading the Mind in the Eyes (RME) Task and Reading the Mind in the Films (RMF) Task as measures of basic emotional ToM (emotion recognition) and complex emotional ToM (inferring emotional and mental states using singular content and contextual information) respectively. Social perceptive abilities have yet to be investigated in BN. We utilised the Interpersonal Perception Task-15 (IPT-

15; Constanzo & Archer, 1989) to explore social perception in BN across 5 themes: intimacy, competition, deception, kinship and status. Results of a study comparing performance of n=40 individuals with BN with n=40 healthy controls (HC) will be presented and discussed. Overall individuals with BN did not perform significantly differently from HCs on the RMEs and IPT-15, suggesting preserved basic eToM and social perceptive skills. However contrary to expectations, individuals with BN scored higher than HCs on the RMF task; interpretations of which will also be discussed alongside more detailed differences in task performance.

#### **Behavioural correlates of positive and negative affect in anorexia nervosa**

Helen Davies, Ulrike Schmidt & Kate Tchanturia, Institute of Psychiatry, London

Experiments in social psychology have shown that expressing signs of positive and negative emotion is advantageous in social interaction, allows others to respond and potentially helps in getting needs met. Self-report studies have previously found that people with anorexia nervosa (AN) have difficulty expressing their emotions due to beliefs about negative consequences of this behaviour. The current exploratory study is the first to use an experimental paradigm to measure facial emotional expressivity in a group of AN and healthy control (HC) participants. Salient film clips (positive and negative) were shown to participants and their facial response was recorded. In addition, the participants' subjective response was also recorded. Results show that people with AN are less facially expressive than HC during positive and negative film clips. The AN group reported feeling less positive emotion but not less negative emotion than HC participants. In addition, people with AN looked away significantly more than HC during the negative film clip. Results from this study show that emotion expression is attenuated in AN and support the notion that there is avoidance of emotional stimuli. These findings contribute to our understanding of why people with AN have difficulties in relating to the self, the social milieu and also potentially why they are a difficult group of people to treat.

#### **Social problem solving in anorexia nervosa**

Lot Sternheim, Ulrike Schmidt, Institute of Psychiatry, King's College London, Shelley Channon, Department of Cognitive, Perceptual and Brain Sciences & Helen Startup, Institute of Psychiatry, King's College London

Anorexia Nervosa is a life threatening and often chronic mental illness with high relapse rates. The use of maladaptive coping strategies seems to be an important factor in developing and maintaining the illness. Literature suggests that people with AN often experience difficulties coping and tend to engage in avoidant and submissive styles of coping. Recent research shows that anorexic symptomatology is linked to impaired ability to infer emotions and it seems that specifically within a social context people suffering from AN tend to engage in non-effective problem solving. This study seeks to gain a better understanding of how people with anorexia resolve difficult everyday social situations. Social problem-solving in 30 patients with anorexia, and 30 matched controls was assessed using a social cognition task. Participants were recruited, via flyers and circular emails to students and staff at King's College London, and people with anorexia were additionally recruited from the Eating Disorders Out-Patient Services at the Maudsley Hospital in London. The task consists of scenarios involving awkward everyday situations and participants are asked to generate both the most appropriate courses of action to resolve the situation as well as specify what their course of action would be. Answers were rated on their social and practical effectiveness. The AN group performed poorer at the social problem-solving compared to the control group, and reported differences between their most effective generated solution, and their actual solving strategies. This study suggests that people with AN have difficulty coping with daily issues in a wider social environment and treatment strategies to enhance the skills required in these situations are called for. Using CBT strategies, specific aspects of social problem-solving can be targeted.

#### **Dialectical Behavior Therapy for Substance Abuse in Individuals With Borderline Personality Disorder: State of The Art**

Convenor: Thomas R. Lynch, University of Exeter

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#### **State of the Art: An overview of DBT for Substance Dependence.**

Michaela Swales, University of Bangor

Analyses of outcomes for BPD individuals receiving community treatment-as-usual suggest that traditional treatments are marginally effective at best when outcomes are measured two to three years following treatment. Comorbidity between SUD and BPD, particularly when other Axis I or II disorders are present, further compromises treatment outcome. The latest empirical findings and clinical approaches of DBT for substance dependence will be reviewed and future directions identified.

#### **Randomized Controlled Trial of DBT vs. Drug Counselling for Opiate-Dependent BPD Men and Women: Methods and Findings**

Thomas R. Lynch, University of Exeter

Following guidelines for psychosocial treatment-development, formulated at both NIMH and NIDA workshops, we developed a treatment for individuals comorbid for SUD and BPD based on a one-year cognitive-behavioral treatment (Dialectical Behavior Therapy; DBT). The major modifications to standard DBT are the addition of 1) specific targets relevant to drug use, 2) a set of attachment strategies, 3) greater reliance on arbitrary reinforcers at treatment start, 4) weekly urinalysis, and 5) an opiate drug-replacement program (suboxone, i.e., buprenorphine in combination with naloxone). Findings from the multi-site (n = 126) study suggest that DBT may be superior to IGDC in terms of helping BPD-SUD reducing drug usage and DBT appears to outperform IGDC in reducing co-occurring mental health problems (e.g., depression, anxiety), suggesting that DBT may be a superior treatment for opiate addicts with both BPD and high rates of comorbid Axis I disorders.

#### **Skills or Validation? Mediators of Mental Health & Drug Abstinence Outcomes**

Ben Whalley, University of Plymouth

Treatment targets in DBT are arranged in hierarchical order, and reduction of behaviors which are life-threatening, therapy-interfering, or reduce quality of life is given high priority. In addition, considerable time in treatment is devoted to replacing maladaptive responses with skillful interpersonal behaviors, thus improving



emotion regulation and increasing mindfulness and distress tolerance. However, equally important is the therapeutic relationship and validation of the client. This paper will present findings from the multi-site study examining the relative importance of these potential mediators; i.e., relationship/validation versus skills acquisition.

#### **Developments in Body Dysmorphic Disorder**

Convenor: Martin Anson, Institute of Psychiatry, King's College London

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##### **Behavioural Experiments in Body Dysmorphic Disorder**

Martin Anson, David Veale, Victoria Oldfield & Nell Ellison, Institute of Psychiatry, King's College London  
People with Body dysmorphic disorder (BDD) experience significant preoccupation and distress relating to perceived or slight flaws in appearance, which they believe make them look ugly and defective. In this presentation, the role of behavioural experiments (BEs) in cognitive-behavioural therapy for BDD will be discussed. BEs are defined by Bennet-Levy et al (2004) as 'planned experiential activities' carried out by patients in order to gather new information aimed at: (1) testing the validity of current beliefs relating to their problem; (2) helping them to develop new more adaptive beliefs; and (3) developing the cognitive formulation of their problems. The presentation will discuss issues relating to the use of BEs in addressing a number of unhelpful behaviours, processes and beliefs in BDD, including checking, avoidance and safety-seeking behaviours, rumination and appearance comparison, self-focused and selective attention, interpretational bias and appearance-related beliefs and assumptions. A distinction will be drawn between testing the content of beliefs, and testing the role of cognitive processes and safety behaviours in maintaining preoccupation and distress in BDD. Issues relating to engagement, maximising benefits, identifying and tackling unhelpful behaviours and processes during experiments, potential obstacles, pitfalls and difficulties, and building on outcomes will be discussed. Bennett-Levy, J., Butler, G., Fennell, M., Hackmann, A., Mueller, M. & Westbrook, D. (2004). *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. Oxford University Press, Oxford. Veale, D. and Neziroglu, F. (2010). *Body Dysmorphic Disorder: A Treatment Manual*. Wiley-Blackwell, Chichester.

##### **The stopping criteria for mirror-gazing in body dysmorphic disorder**

Emma Baldock, Martin Anson & David Veale, Institute of Psychiatry, King's College London  
There is evidence that counter-productive stopping criteria contribute to the prolongation of compulsive actions in obsessive-compulsive disorder (Wahl et al., 2008), and it was hypothesised that the same would apply to compulsive mirror-gazing in body dysmorphic disorder (BDD). Stopping criteria are defined with reference to internal states (e.g. 'feeling just right' or 'knowing for certain'), as opposed to the sensory perception of an external change (e.g. seeing that a task is finished). Data will be presented from a study that was designed to elucidate compulsive mirror-gazing in BDD by investigating the decision-making processes involved in terminating a mirror session. Individuals with BDD and healthy controls were interviewed about a recent mirror session and were then asked to fill in questionnaires both about this recent session and about their mirror use in general. The questionnaires consisted of a list of items falling into either subjective/internal (i.e. counter-productive) stopping criteria, or objective/external stopping criteria, to allow comparison of the use of each category of criteria across groups. Clinical implications will be discussed. Wahl, K., Salkovskis, P.M. & Cotter, I. (2008). 'I wash until it feels right' The phenomenology of stopping criteria in obsessive-compulsive washing. *Journal of Anxiety Disorders*, 22: 143-161.

##### **Imagery Rescripting in Body Dysmorphic Disorder**

Rob Willson, David Veale, Institute of Psychiatry, King's College London, & 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 (Veale, 2004). 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 rescripting may benefit individuals with social phobia (Wild et al, 2008), which shares a number of features with BDD. Data on a single case series design of using imagery re-scripting with individuals who have BDD will be presented. To illustrate the process in more depth the treatment of one participant will be presented in detail. Wild, J., Hackmann, A., & Clark, D. M. (2008). Rescripting early memories linked to negative images in social phobia: a pilot study. *Behavior Therapy*, 39: 47 -56. Veale D. (2004) *Advances in a cognitive behavioural model of body dysmorphic disorder*. *Body Image* 1:113 - 125.

##### **Body Dysmorphic Disorder in (a) general dermatology settings (b) private cosmetic gynaecology settings**

Nell Ellison & David Veale, Institute of Psychiatry, King's College London  
Body Dysmorphic Disorder (BDD) is more likely to present in cosmetic surgery or dermatological settings. This presentation will describe an epidemiological study involving the identification of people with BDD in (a) general NHS dermatology settings (b) private cosmetic gynaecology settings. The prevalence of BDD, as well as the characteristics and psychopathology of those with BDD compared to those without BDD (but who have the same ratings of appearance with no noticeable defect) will be described. This has particular implications for the engagement of people with BDD and for understanding the beliefs and behaviours in context. The need to embed and adapt CBT for dermatological and cosmetic surgery settings will be discussed.

## **Clinical Roundtable**

### **A case of Chronic Anorexia Nervosa: Can we offer something new?**

Convenor: Lucy Serpell, North East London Foundation Trust & University College London

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Speakers: Bryony Bamford, South West London & St Georges NHS Trust/ St Georges Medical School  
Ulrike Schmidt, Institute of Psychiatry, King's College London  
Thomas Lynch, University of Exeter

Zafra Cooper, University of Oxford

Good evidence exists for the use of CBT in bulimia nervosa and binge eating disorders. Recent efforts have been made to measure its efficacy more broadly across all eating disorders, including anorexia nervosa. However, clinical teams still struggle to know how to help people who have suffered from anorexia nervosa over many years and in whom the disorder has become chronic. Such individuals have often tried many different therapeutic approaches and it can be difficult to offer something new which leads to effective changes, however small. Three experienced clinicians will offer a formulation and treatment plan from a different orientation for a case of chronic anorexia nervosa. Time will be allowed for discussion amongst the panellists and questions from the audience.

## Open Papers

### Treatment of Eating Disorders

Chair: Bryony Bamford, St. Georges, University of London

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#### **A randomised control trial of NSCM vs CBT in longstanding Anorexia Nervosa**

Bryony Bamford, St. Georges, University of London, Hubert Lacey, St. Georges, University of London, Stephen Touyz, University of Sydney, Australia, Daniel Le Grange, University of Chicago, United States

Whilst there have been recent advances in the treatment of anorexia nervosa, it is estimated that between 20 and 50% of individuals remain ill after 10 years. These individuals have been said to experience serious medical and psychological consequences from their anorexia, be intensive users of healthcare provisions, suffer high unemployment levels and extreme isolation and pose a significant burden to their families, carers and the wider community. The clinical literature attests to the difficulties engaging, retaining and adequately treating these individuals that are experienced by even expert clinicians. The current evidence base for how best to treat severe and enduring eating disorders is limited with many international treatment guidelines failing to address psychological treatment options for these individuals. This study is the world's first treatment study for chronic anorexia and compares 30 sessions of a non-specific supportive clinical management, found to be superior to more specialised psychotherapies in a previous trial (McIntosh et al., 2005), with cognitive behaviour therapy, found to be more effective than nutritional counselling in the post-hospitalisation treatment for anorexia nervosa in an alternative trial (Pike et al., 2003). The innovative aspect of the treatment is that weight-gain is not central (though the patient needs to remain safe), but concentrates on quality of life and improved socialisation. Participants were randomised to 30 sessions of either specialised CBT or NSCM to take place over 6 months. A range of assessment measures including EDE, quality of life measures, treatment expectations and assessment of motivation were given at baseline, 15 week, end of treatment and at 6 and 12 month follow up. 60 patients have currently completed treatment within this trial across the two sites in London and Sydney. Preliminary findings of this trial including drop out rates, qualitative feedback from patients and clinical impressions will be discussed. Implications for the psychological treatment of individuals with severe anorexia nervosa will be discussed. Results from this trial will contribute to the understanding and effective treatment of severe and enduring anorexia nervosa. Previous studies have found traditional CBT to be less effective than a control treatment in a cohort of individuals with anorexia suggesting that adaptations may need to be made to improve the suitability and efficacy of CBT in this client group. This trial addresses many of these possible adaptations and aims to provide an evidence base for the psychological treatment of individuals with severe and enduring eating disorders.

#### **The effectiveness of guided CBT self-help for Binge Eating Disorder and Bulimia versus one-to-one Integrative Psychotherapy: A non-randomised live clinic study**

Caroline Vermes, North West Centre for Eating Disorders

National clinical guidance recommends evidence-based guided self-help (GSH) as a possible first step in the treatment of bulimia (BN) and binge eating disorder (BED), and referral to specialist services for more severe cases (NCCMH, 2004). Doctors generally do not follow this advice (Currin, et al., 2007). They may not have time to offer guidance to patients following self-help programmes; and also tend not to refer on. This leads to inadequate planning and commissioning of secondary care specialist eating disorder services nationally. A potential solution is provision of community-based lower-intensity specialist treatment for BN and BED that can be promptly accessed, as part of a stepped mental health care pathway. Stepped care offers a framework for efficient use of rationed resources (Clark, et al., 2009). There is limited evidence that symptom remission using GSH may be equivalent to those of group CBT at end of treatment, with GSH being significantly more effective than group CBT at one year follow-up (Bailer et al., 2004). Delivery of CBT in GSH format requires less clinician time than group or individual therapy and is therefore a potentially cost-effective alternative treatment. The author hypothesises that GSH will have equivalent outcomes to integrative psychotherapy (IP) but will cost significantly less to deliver, permitting more patients to be helped with the available resources. The current study compares clinical outcomes for 28 BN/BED patients completing a CBT GSH programme to a cohort with similar symptom severity undertaking integrative psychotherapy (IP). IP clients wait 12 weeks or more to start treatment. Participants are self-selected from a subset of patients referred to a specialist outpatient eating disorders clinic in Stockport. The primary outcome variable is cessation of binge eating and purging by end of treatment. Other outcome measures include CORE-OM (CORE, no date), PHQ-9 (Spitzer, Williams and Kroenke, 1999), Sterling Eating Disorder Scales (Williams and Power, 1995). Data collection is ongoing until June 2010. Preliminary analysis will be completed by July 2010. To date 50% of CBT GSH cohort attained symptom remission at end of 12 week course. Uptake of IP has been poor, suggesting that if clients do not start treatment right away they are more likely to drop out. An alternative waiting list control group will be used. Clients completing GSH for binge eating disorder using CBT group therapy appear to achieve remission of binge eating and purging at rates similar to one-to-one CBT (Fairburn et al. 2009). GSH is cheaper to deliver than one-to-one therapy. GSH for eating disorders is currently underutilised nationally yet could form part of an effective care pathway. Follow-up data on this study's cohorts is needed to test the durability of remission rates and whether or not clients continue to make gains after treatment is finished.

With adequate planning and structure, GSH for binge eating and EDNOS is a feasible, effective option for GP practices and eating disorders services dealing with regular numbers of these clients. Group therapy is a generally acceptable and tolerated form of guidance. Training in implementation of CBT for eating disorders is required.

#### **Discerning thoughts from feelings: A discussion of the hurdles faced by those with Eating Disorders**

Helen O'Connor, Leigh House Hospital & Paul Jenkins, University of Birmingham and Sussex Partnership NHS Trust  
The phenomenon of "emotional dissonance" in eating disorders, used to refer to the difficulty some clients face in translating what they 'think' cognitively to what they 'feel' emotionally, is a potentially useful concept in clinical work. However, little systematic exploration of this has been made, and it is felt that a discussion of the concept is a useful starting point to develop work. A clinical description of emotional dissonance is presented as a core difficulty in emotional processing of information by patients with eating disorders, where a difference is reported between "understanding" the content of therapy and "feeling" it. Drawing on existing research the paper aims to provide a concise definition of emotional dissonance, before moving on to discuss a number of psychological theories that might shed some light on this often-seen but seldom understood phenomenon. These include the role of emotional awareness and alexithymia, cognitive and emotional development, and neuropsychological theories. Parallels with emotional regulation will also be drawn, and discussion with related areas, such as depression, will also represent a focus of the paper. The paper concludes by suggestion directions for future research, including recommendations for further delineating the causes and explanations behind emotional dissonance. Particularly, studies looking at emotional processing in eating disorders are worthy of further exploration.

#### **The pathways to recovery: An innovative CBT-based inpatient treatment approach. A pilot study**

Dan Round, The Retreat, Annette Cockfield, The Retreat

Treatment of patients with eating disorders is often based on their BMI. This can be a rigid and non collaborative approach leading to therapeutic impasses. In an attempt to address these issues we have developed a dynamic intergrated care pathway (The Naomi Pathway to Recovery- NPR), this paper presents the evaluation of the pilot study. A stratified sample of patients were recruited from an inpatient population, representing different stages of recovery. Three focus groups were held by an independent researcher, one prior to the pilot with patients, and two after four months, one with patients and one with staff. The groups were recorded, anonymised, transcribed, and analysed using Thematic Content Analysis. Key themes identified: the patients felt that the BMI based approach focussed on physical restriction and didn't aid development of skills, or psychological recovery. Patients and staff felt the NPR enabled recovery by considering different variables and creating a customised recovery plan. The NPR integrated core principles of CBT in an inpatient treatment program, and enabled the development of an innovative treatment approach which was acceptable to both patients and staff. Preliminary findings indicate that this approach was both motivating, and recovery facilitating. This has led us to question whether BMI has a place in an inpatient treatment approach. This model could potentially be applied to any diagnosis for which CBT has an evidence base, including patients with co-morbid conditions, usually excluded from research trials and many inpatient units. This skills based model could also be used as an assessment, therapeutic and motivational tool in clinical practice. It may also aid clearer communication between inpatient and community teams facilitating successful transitions.

## **Posters**

### **36. Core beliefs in Adolescent Females with Eating Disorders**

Richard Cosway, NHS Lothian

Recent research using the Young Schema Questionnaire (YSQ-SF) has suggested that core beliefs may be related to eating disorder symptomatology. However, few studies have accounted for the possible confounding influence of comorbid depression and none have investigated these beliefs in a clinical adolescent sample. Three groups of adolescent females were compared on the YSQ-SF: eating disorder (n=13), depression (n=14) and school based control (n=20). BDI scores were used as a covariate and depression and control participants were screened for eating disorder symptomatology. A discriminant function analysis (DFA) was also conducted to see which variables were best able to predict group membership. The results suggest that adolescent females with eating disorders are characterised by perfectionistic attitudes, which may have developed in response to beliefs of mistrust and abuse. These perfectionist attitudes may be manifest in disordered eating during adolescence when the body is going through physical changes. There were few significant differences between groups on core beliefs when depressive symptoms were accounted for. Beliefs of unrelenting standards and of mistrust/abuse were, in addition to depressive symptoms, able to distinguish the groups. The eating disorder group had strong beliefs of unrelenting standards and moderate beliefs of mistrust/abuse. The depression group had very strong beliefs of mistrust/abuse. This research highlights a potential focus of treatment - on core beliefs rather than food, weight or body image specific cognitions - with adolescent with eating disorders.

### **37. Emotion Regulation in Adolescent Females with Eating Disorders**

Richard Cosway, NHS Lothian

Research has suggested that eating disorder symptoms are maladaptive strategies which individuals use to reduce awareness of aversive emotions. This appears to be in contrast to a ruminative style of coping characteristic of depression where individuals focus upon their emotions and cognitions. Three groups of adolescent females (eating disorder, n=13, depression, n=14, and school based control, n=20) were compared on the Trait Meta-Mood Scale (TMMS; Salovey et al, 1995) which measures attention to emotions, clarity of emotions and emotion regulation. Depression and control group participants were screened for presence of eating disorder symptomatology. The BDI was used as a covariate in the analyses to account for the possible confounding influence of depressive symptoms. The results suggest that adolescent females with eating disorders demonstrate no difference from depressed individuals or non-clinical controls on ability to regulate emotions as assessed by the TMMS. Both the clinical groups demonstrated poorer ability to perceive their emotions clearly or regulate them effectively compared to non-clinical controls. However, these differences did not reach significance, particularly when depressive

symptoms were accounted for. There were no differences found between the two clinical groups. This research suggests that eating disordered and depressed adolescents do not differ with regard regulation of emotions and, consequently, similar interventions related to management of emotions may be applicable.

### **38. Clinical Validation of the Vomit Phobia Inventory: A Measure of Symptom Severity for Use in Formulation, Case Tracking and Outcome Assessment**

Nell Ellison, Institute of Psychiatry, Kings College London, David Veale, Institute of Psychiatry, Kings College London, Kareina Henry, Institute of Psychiatry, Kings College London, Chantelle Whelan, Institute of Psychiatry, Kings College London

There are currently no measures available that assess the severity of Specific Phobia of Vomiting (SPOV) or any measuring treatment outcome. The Vomit Phobia Inventory (VPI) will be validated against measures of disgust; health anxiety; obsessive compulsive disorder; and depression in 3 different clinical populations (people with a specific phobia of vomiting seeking treatment, people with a specific phobia of vomiting on an internet support group, and healthy controls). The stability of the VPI over time will also be assessed by measuring test retest reliability. VPI scores will be tracked during treatment to determine whether it is sensitive to change. The usefulness of the VPI for assessment, treatment planning and measuring treatment outcome will be presented. We will detail the psychometric evaluation of the (VPI), a new 15 item self report scale which assesses the severity of vomit phobic symptoms. The Vomit Phobia Inventory focuses on the cognitive and behavioural processes that are characteristic of the disorder. This measure can be used for CBT assessment, formulation, case tracking and measuring treatment outcome.

### **39. Development of a Cosmetic Procedure Screening (COPS) questionnaire for Body Dysmorphic Disorder**

Nell Ellison, Institute of Psychiatry, Kings College London, David Veale, Institute of Psychiatry, Kings College London, Tom Werner, Institute of Psychiatry, Kings College London, Rupa Dodhia, Institute of Psychiatry, Kings College London, Marc Serfaty, University College School of Medicine, University College London, Alex Clarke, University College School of Medicine, University College London

There is need for a screening questionnaire (a) to identify people with Body Dysmorphic Disorder (BDD) who require further assessment before a cosmetic procedure (b) to develop a research tool that might prospectively predict both dissatisfaction with a cosmetic procedure and changes in symptoms after treatment. A new screening measure was developed and completed by two groups: a group with BDD who wanted a cosmetic procedure and a cosmetic procedure group who were either about to have cosmetic surgery or were planning a procedure. Item characteristics, reliability and factorial structure were analysed. Convergent validity with the Hospital Anxiety and Depression Scale, Body Image Quality of Life Scale, Body Image Disturbance Questionnaire and the multidimensional Body Self Relations Questionnaires was determined. The results confirm the validity of the COPS as a sensitive and specific screening measure for BDD that can be recommended for routine use in cosmetic surgery settings and as a potential research tool. The most sensitive items that discriminated between the two groups were used to form the final questionnaire. Receiver Operating Characteristics (ROC) analysis was used to assess sensitivity and specificity of the COPS in discriminating between the groups and a suitable cut-off score was devised. People with BDD are more likely to present to cosmetic surgeons than to mental health professionals. This results in considerable delay in their presentation for CBT which has significant implications for their engagement in treatment. Once people with BDD can be reliably identified by cosmetic surgeons we can learn how to embed and adapt CBT for such settings.

## **IAPT and Primary Care**

### **Keynote Addresses**

#### **Improving Access to Psychological Therapies: Overview of findings from the three year evaluation of the demonstration sites**

Professor Glenys Parry, University of Sheffield

The evaluation of the demonstration sites for Improving Access to Psychological Therapies (IAPT) in was commissioned by NIHR Service Delivery & Organisation programme in 2006, commenced in early 2007 and complete in May 2010. There are three strands to the evaluation: i) a study of the clinical outcomes and service costs for people with anxiety and depression in Doncaster and Newham compared with those in socio-demographically matched sites and with archived datasets; ii) an intensive case study of the process of implementation of IAPT in terms of organisational systems and iii) a qualitative study of the experience of people receiving the services. We shall present the key findings from all three aspects of the evaluation and bring them together to give an overview of the whole picture. The keynote will be presented on behalf of the full IAPT evaluation team: Glenys Parry Michael Barkham, Gillian Hardy, Jo Rick, Tony Kendrick, John Brazier, Kim Dent-Brown, Dave Saxon, Eleni Chambers, Rebecca Hutten, Janice Connell, Kate Doran, Rachel Horn, Simon De Lusignan, Peter Bower and Karina Lovell.

#### **Depression and Coronary Heart Disease: A primary care perspective**

Professor Andre Tylee, Institute of Psychiatry, King's College London

A primary care perspective will be provided on the current role of psychological therapies in the treatment of depression in primary care (both IAPT and non-IAPT) in the context of the most recent NICE guidelines for depression. Care pathways newly developed by the South London and Maudsley Foundation Trust and Institute of Psychiatry for Kings Health Partners Academic Health Sciences Centre will be used to illustrate the choice of appropriate psychological approaches for depression. Preliminary findings from UPBEAT-UK, an NIHR funded Programme Grant to understand and improve the care for depression in patients with coronary heart disease in primary care will also be presented. Patients' and primary care professionals' perspectives on treatment will be presented as will plans for piloting an improved system of case management in primary care that responds to patient views.

**IAPT: Achievements, Lessons and the Future**

Professor David M Clark, Institute of Psychiatry, King's College London

The Improving Access to Psychological Therapies (IAPT) initiative aims to greatly increase access to NICE recommended psychological treatments for depression and/or anxiety disorders (including PTSD) by training an extra 3600 psychological therapists and deploying them in new, stepped care services within each PCT. This presentation provides an overview of the programme, describes evaluations of the initial demonstration sites (Newham and Doncaster) and of the 35 year one sites, outlines progress to date, highlights problems, and discusses recent research that has important implications for the programme.

**Symposia****Going beneath the tip of the iceberg: How well is the Multi-level, Multi-purpose STEPS Low-intensity Primary Care Service performing?**

Convenor and chair: Jim White, STEPS

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**'Mood Matters': a new group approach for depression and low mood**

Michael Ross, STEPS

'Mood Matters' is a new CBT approach developed by STEPS for those suffering from depression. It involves interactive group sessions and uses easily-understood booklets with reading age scores appropriate to an area of significant deprivation. It meets in a community venue. As with all STEPS services, it is accessed via self-referral. Individuals do not need to be assessed before attending. This talk will look at the performance of the approach in its first two years. It will compare the initial 8 session approach to the newer 6 sessions and will compare the CBT version with the newer behavioural activation approach. Issues such as recruiting and advertising the course will be looked at along with treatment outcome data.

**Non-face-to-face contacts**

Siobhan Murphy, STEPS

As part of the 'horses for courses' philosophy, STEPS offers various non-face-to-face options for those who do not want or need therapist contact. This also allows the service to reach much greater numbers of individuals. This talk will focus on several of these options. 'Healthy Reading' replaced book prescribing. Instead of a professional choosing a book for the individual, we set-up dedicated sections in each of the 34 libraries in Glasgow and so allow individual to choose their own from a wide range of booklets. Due to the high reading scores of most self-help books, STEPS has also ensured all our easily understood booklets are part of the collections, along with our relaxation packs, and audio and video options. The [www.glasgowsteps.com](http://www.glasgowsteps.com) site offers information, self-assessment and self-help along with audio and video downloads. The site contains service information and hopes to shortly offer on-line booking to some of our services. The [www.glasgowhelp.com](http://www.glasgowhelp.com) is an easily updated resource directory useful in a social deprived area. STEPS has a wide range of booklets on common mental health problems. Some of these are translated into Urdu, Polish and Slovak. This talk will look at how these resources aid the other parts of the service.

**How do you reach the 'Hard to Reach'?**

Jim White, STEPS

STEPS data suggest that, despite a service that is highly accessible - no waiting lists, self-referral for all services - the 'hard to reach' remain exactly that. Evaluation data show that the service continues to struggle to reach the over 65s, men and, in particular, those in the most deprived areas. Reaching these groups requires more than simply making services more accessible. This is crucial if, as we expect, those on incapacity benefit often fit into the 'hard to reach' category. The final talk looks at innovative ways of reaching these populations, e.g. assertive outreach, Recovery approaches, collaborating with Celtic football club, working with community organisations, 'Strategy Factory' approaches, use of the media and social prescribing. It looks at what services can realistically offer to those living in often very difficult social circumstances.

**'Stress Control': a CBT 'evening class' for common mental problems**

Pauline Gillon, STEPS

'Stress Control' didactic evening and afternoon classes follow a transdiagnostic CBT model that allows large numbers to attend the six session course (around 100-140 at the evening classes) and remains by far the most popular service. The class is used in many parts of Britain. People can 'walk in off the street' to a class and are encouraged to bring others with them if they feel they could benefit. All classes meet in community settings and are widely advertised in the area. A set of easily understood booklets accompany the class. The six sessions are: Understanding stress Controlling your body Controlling your thoughts Controlling your actions Controlling your panic Controlling your sleep problems and Controlling the future This talk will look at how the classes operate along with effectiveness, efficiency and user-satisfaction data.

**'Call-back' - replacing GP referral: empowering users, improving efficiency and offering rapid access**

Vicky Manson, STEPS

Previous evaluation of GP-referral to individual therapy showed significant attrition at each stage - opt-in, first appointment and later drop-out. Completion rates for both CBT and person-centred counselling were under 30%. 'Call-back' was introduced to improve on this. GPs are no longer able to refer but can signpost users to the wide range of services STEPS provide. A detailed service brochure, available in a range of places, describes these self-referral options. Users leave a message on a 24/7 answering machine; therapists call-back and carry out a protocol-driven assessment on the phone and, if appropriate, arrange service during the call. This talk will look at the performance of the service over the first two years, focusing on, e.g. profiles of those who call the service; time taken to call-back; onward referral options; how long people wait to enter a service; satisfaction with the service; and attrition rates in individual therapy.

**Low Intensity CBT: Advancing the New Paradigm**  
 Convenor and chair: Paul Farrand, University of Exeter

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**Low-intensity Psychological Therapies: Driving the Paradigm Shift**

Heather O'Mahen, Joanne Woodford & Julia McGinley, University of Exeter

This paper will examine the drivers behind the new paradigm that is 'low-intensity CBT'. It will reflect on the frequently conflicting motives of mental health professionals as they open and close the gates to psychological therapies. Political and cultural changes in modern medicine provide both energy and restraint whilst consumer advocacy can both assist and impede the development of evidence based treatments. These paradoxical pressures will be explored with the audience as the presentation takes a peek behind the curtain into the future of CBT and other evidence-based psychological treatments.

**Developments in Low intensity working: a Scottish perspective**

Chris Williams, University of Glasgow

Across the world, health services are looking again at how they offer access to evidence-based psychological therapies. Low intensity working refers to interventions that require fewer resources than the traditional individual therapy model in terms of clinician time (Bennett-Levy et al 2010). They aim to provide an evidence based intervention, delivered by a practitioner, often using flexible resources, with flexible support and at a range of locations including traditional health service settings. In England, the focus on IAPT has been to train and employ new staff to work in new teams to radically alter how delivery occurs. In Scotland, a different route has been taken which has predominantly focused upon working with the existing workforce to introduce new assessment models, and new ways of working. These have been exemplified by large pilot projects covering significant parts of the country. These include the Doing Well by People with Depression project, and the WISH (Widening access to Self-Help) project. This is large training project that provides centrally paid for resources and employs local champions and trainers to cascade training in the use of CBT self-help resources and classes. Linked to these changes have been ambitious changes based around the introduction of an Integrated Care Pathway (ICP) for depression and SIGN treatment recommendations for the non-pharmaceutical treatment of depression. Similarities and differences in developments in the two countries highlight different models of delivery each of which bring strengths and potential challenges.

**Advancing Towards Evidence-Based Self-Help Books for High Prevalence Mental Health Problems**

Paul Farrand & Joanne Woodford, Mood Disorders Centre, University of Exeter

Support for book based CBT self-help is a significant part of the Psychological Wellbeing Practitioner (PWP) role. Whilst CBT self-help in general is recommended for the treatment of mild to moderate depression and anxiety, how can the PWP be confident that any specific title is evidence based or likely to engage the reader. This presentation reports on a two stage process undertaken to identify CBT self-help titles that may be appropriate to be supported. The first part of the process was based on a systematic review specifically undertaken on randomised control studies examining supported written CBT self-help books versus a control condition. On the basis of this search specific high prevalence disorders have been identified as having an evidence base with respect to CBT self-help. Using a 'class effect' argument all CBT self-help books currently in print and focussed on these conditions were then reviewed with respect to factors hypothesized as impacting upon their ability to engage patients (Richardson, Richards & Barkham, 2010), such as evidence of common factors and reading ease. The output from this process is the first attempt to develop a list of 'recommended titles' that service managers, PWP's and those responsible for Books on Prescription schemes can use to support their selection of individual CBT self-help titles. Alongside this advance however a major caveat will also be raised concerning the potential for CBT self-help to do harm and the necessity for anyone providing support to have a thorough knowledge of every title adopted.

**Telephone support for guided CBT: Is any face-to-face contact required?**

Karina Lovell, University of Manchester

The delivery of psychological treatments, principally CBT based, is rapidly changing with innovations being adopted which have the potential to enhance the accessibility, availability, and cost-effectiveness of mental health care services. The telephone has the ability to overcome many of the social, physical and economic barriers which prevent access to mental health services, and is increasingly being used as a means to support treatment delivery. The telephone has been used in differing and flexible ways to deliver psychological interventions, with some studies using mixed models, using both face to face and telephone sessions, as an adjunct to other treatments, and treatment delivered completely by telephone. Drawing on work from our group on a number of completed and ongoing trials including 1) The MUSICIAN study which evaluated the efficacy of telephone delivered CBT for chronic widespread pain 2) an evaluation of a pilot study which evaluated the feasibility and acceptability of telephone CBT in workplace settings, 3) a pilot study of young people with OCD and 4) a trial comparing telephone delivered interventions with face to face CBT in adults with OCD, the efficacy, feasibility and acceptability and the practical application of telephone delivered CBT will be discussed.

**Condition Management, Occupational Health and Return to Work**

Convenor: Helen Macdonald, University of Sheffield

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**The influence of coping styles on return to work**

Fiona Ford, University of Central Lancashire

Methods

173 East Lancashire CMP participants completed the Brief COPE at the beginning and end of participation in CMP. These results were compared with the scores of 9 subjects of an IASO qualitative research project exploring the experiences of people who had returned to work without access to CMP, who completed Brief COPE at the time of

interview. Mean values of use of coping styles as identified by Brief COPE were subjected to paired t tests, and compared with mean values of the IASO study of Liverpool people who returned to work following mental health problems. The overall pattern of coping strategies of people completing CMP was very similar to that found in the largely qualitative study of return to work, with significant increases in outcome scores for active coping, acceptance and positive reframing, which might help the person to regain control over their life while accepting the limitations of a long-term condition/disability. Similarly, low/falling scores for avoidant and self blame coping strategies indicated the effectiveness of the intervention in empowering participants. The subjects who returned to work without help showed significantly greater use of acceptance and planning strategies, and of instrumental and emotional support compared to the CMP participants. This suggests that improvement may have been dependent on support from the programme, and may indicate the need for follow up support after return to work if improvement is to be maintained. Participation in a Condition Management Programme is associated with significant changes in coping styles, including increases in active and decreases in avoidant coping. These changes are likely to be useful in both improving wellbeing and empowering the individual to return to work.

#### **Condition Management Programmes as part of the Pathways to Work initiative**

Eric Sharp, Derbyshire County PCT

Condition Management Programmes were developed as part of the Pathways to Work initiative. We are now developing revised approach to health support for people on benefits. What did we learn from delivering the programmes about helping people back into work, and how can this learning be incorporated into psychological therapy services and the delivery of welfare to work services.

#### **Evidence for a Cognitive-Behavioural psycho educational group-based Condition Management Programme**

Steve Kellett, University of Sheffield

Stephen Kellett and colleagues will present evidence on the predictors of a return to work from Incapacity Benefit status, as this question has not previously been widely addressed in vocational rehabilitation research. Using a longitudinal, large (n > 2,000) prospective cohort design, psychological and demographic variables at assessment and termination of a cognitive-behavioural intervention were regressed onto 3 standards of occupational outcome at three-month follow-up. The intervention was a low intensity 7-session CB psychoeducational mixed-condition and group-based Condition Management Programme. The results indicate that lower levels of pre-intervention psychological distress and impairment predict a successful return to work, as does experiencing a clinically significant change during the group programme. The results are discussed in terms of the context of the Pathways policy, methodological failings and the future research agenda.

#### **Evaluating the impact of case management on the health of long term Incapacity Benefit recipients in the North East of England**

Clare Bamba, Jon Warren & Kayleigh Garthwaite, University of Durham

This paper will introduce and outline a large research project which has been funded by County Durham Primary Care Trust (PCT). The level of ill health in the working age population in the North East of England exceeds that any other English region. Across County Durham there are over 40,000 people receiving Incapacity Benefit (IB) due to health problems, representing 12% of the working age population. County Durham PCT, in partnership with other local agencies is therefore implementing a major intervention to improve the mental and physical health of people in County Durham who have been in receipt of IB for three years or more. The intervention aims to provide recipients with a case manager who will offer individually tailored packages of support in order to ultimately lead to an outcome of health improvement. The main part of the research involves an evaluation of this intervention. Through a mixed methods approach, the evaluation will assess the impacts of the programme by comparing trends in IB recipients between intervention and non-intervention groups; undertaking quantitative data analysis, including economic evaluation and contextual analysis of place effects; and undertaking qualitative interviews with samples of programme users to understand narratives and experiences of IB recipients in more depth. This paper will explore several areas. Firstly, the background and context of long term sickness and incapacity in the North East of England. Secondly, it will present some of the initial findings from the evaluation, from both the intervention group and those in the control group who have not undergone the intervention, this group have been accessed via Jobcentre plus "Choices" outreach events. Finally, the paper will offer some reflections upon the NHS "world class" commissioning process.

#### **Enhancing PWP skill development in engaging patients with the issue of work and occupation**

Jane Briddon, University of Manchester

The rationale for IAPT has been linked to evidence that work and occupation are generally good for mental wellbeing. The core training for the Psychological Well-being Practitioner (PWP) is based on a 'low-intensity' method of CBT which focuses on specific behavioural and cognitive interventions to help people manage symptoms of anxiety & depression. Practitioners, however, can find the issue of work and occupation difficult to integrate into collaborative treatment plans highlighting the need for a biopsychosocial model of mental health care. This presentation explains how PWP skills training can be enhanced by a biopsychosocial model of mental health care which draws on a developing evidence base from the fields of social capital and social inclusion. This allows issues of work and occupation to be better integrated into PWP assessment and problem formulation making the link between recovery and work meaningful and constructive.

#### **Bringing Low Intensity CBT into Communities**

Convenor: Christopher Williams, University of Glasgow

#### **Overcoming Anorexia Online: A resource for supporters of individuals affected by anorexia nervosa**

Chris Williams, University of Glasgow, Calum Munro, NHS Lothian, Joanne Woodford, University of Exeter, Louise Ewan, University of Glasgow, Rebecca Martinez, University of Glasgow

Anorexia nervosa is a disorder which affects many women, men and also their families and friends. It has been estimated that the annual incidence of anorexia nervosa in Scotland is 8.1 per 100,000 individuals, with women

representing approximately 90% of cases. However, although the situation is improving there is a lack of provision of specialist eating disorder services within the UK to support sufferers and their supporters, with many individuals only having access to specialist services once their condition becomes severe or chronic. Due to a lack of availability of specialist treatment waiting lists for such services are significant and eating disorder services are often forced to only treat individuals whose condition is severe and life threatening, leaving sufferers with mild or moderate illness without specialist treatment. This leaves individuals being supported by relatives, friends etc who often have limited knowledge and skills as to how to help the person with the disorder. Supporters of individuals with eating disorders often experience high levels of distress. Research has found that the burden of care experienced by family members of people with anorexia nervosa is comparable to caring for someone with psychosis. Parents in particular identify issues around finding help for their child and themselves, sometimes feeling unable to offer support, a lack of resources being available, and a breakdown in family routine. In addition caregiver's often have high levels of expressed emotion, with emotional reactions such as criticism, hostility, overprotection, guilt and shame influencing the time-course of the illness. Such emotional reactions may cause family and friends to accommodate the illness or be drawn in to enable core symptoms. Thus interventions which have the potential to lower expressed emotion, in turn reducing caregiver strain and impacting the individual with anorexia nervosa positively are needed. One means of overcoming some of these problems is through self-help resources. An online package has recently been created, which focuses on helping supporters. 'Overcoming Anorexia Online' aims to help supporters offer effective support, identify problematic responses and better self manage how they cope through education, cognitive behavioural therapy based advice and systemic interventions. The package has only recently been developed and therefore there is no published evidence as to its efficacy and to date no randomised control trials have been undertaken. However, an off-line paper-based version of the programme has recently been piloted. The results of this initial study look very promising with supporters reporting reduced anxiety, decreased expressed emotion and increases in care-giving capacity. This paper will discuss the concept of online CBT based supporter resources, drawing on preliminary findings from a more recent pilot study of the online version of the package. This study recruited supporters of individuals with anorexia nervosa from community based sources such as carer support groups, social networking sites and via Google advertisements, in order to try and provide support as early as possible and to the widest network of individuals.

#### **Internet-based Cognitive-Behavioural Therapy for Bulimia Nervosa**

Varinia C. Sánchez-Ortiz, Daniel Stahl, Jennifer House, Helen Startup, Janet Treasure and Ulrike Schmidt, Institute of Psychiatry. Calum Munro, Royal Edinburgh Hospital. Christopher Williams, University of Glasgow.

Bulimic eating disorders are common amongst female students, yet the majority do not access effective treatment. Shame commonly acts as a barrier to help-seeking. In an RCT of 76 students with Bulimia Nervosa or EDNOS, recruited directly by email, we explored whether supported internet-based Cognitive Behaviour Therapy (iCBT) was able to bridge this gap. The participants received either immediate iCBT with e-mail support over 3-months or a 3-month waiting list followed by iCBT (waiting list/delayed treatment control). Eating disorder outcomes were assessed with the Eating Disorder Examination (EDE) at baseline, 3-months and 6-months. Other outcomes included depression, anxiety (HADS) and quality of life (WHOQoL-bref). Half of the students had not been diagnosed with an eating disorder prior to the study and over 70% had not previously received any form of psychological treatment, yet the sample was as severe as samples drawn from outpatient eating disorder services. The e-mail support amounted to less than one hour on average of clinician time per participant. The outcomes of the trial, the use of email support and the patient experience of using iCBT will be discussed.

#### **A systematic review and meta-analysis of individual guided self-help and computerised CBT interventions for symptom reduction**

Joanne Woodford & Paul Farrand, University of Exeter

Individual guided self-help and computerised CBT are recommended by NICE (2009) for the treatment of depression in adults with chronic physical health conditions. Specifically these guidelines make reference to the evidence base for low intensity interventions in general depression. However, without an evidence base for individual guided self-help and computerised CBT for depression and anxiety within physical health populations it is uncertain whether these interventions are appropriate to be delivered. A systematic review and meta-analysis of individual guided self-help and computerised CBT interventions for symptom reduction with secondary analysis of reduction in depression and / or anxiety for people with physical health conditions is presented. The review highlights that high quality studies within this field are limited, with tinnitus, angina, IBS and chronic back pain the only physical conditions randomised controlled trials have examined. Furthermore, studies have been found to include participants with low levels of depression and/or anxiety resulting in "floor effects" which are commonly found in intervention literature (Coyne et al, 2006). This review suggests that a stronger evidence base for guided self-help CBT needs to be established prior to its application to the treatment of depression and anxiety in physical health populations with several methodological limitations in previous research discussed.

#### **Use and support of online CBT resources in voluntary sector settings**

Rebecca Martinez, Merseycare NHS Trust

Rebecca Martinez, Merseycare NHS Trust & Chris Williams, University of Glasgow

This presentation will report the findings of a Randomised Controlled Trial comparing the use of supported cCBT with non directive email support, for participants recruited via the voluntary organisation National Phobics Society (NPS). The NPS study is a randomised controlled trial comparing an online life skills package delivered by the Living Life to the Full website delivered with brief email support (about one email per week), compared with matched email support in the other arm of the study both provided in the context of the voluntary sector agency, National Phobics Society. The study has a recruitment target of 200 participants, the primary outcome measures are changes in the BDI and BAI scores. The outcome data for the RCT is examined in terms of: a)take-up, retention and drop-out in the two arms of each of the studies b)the relative effect size of the interventions c)the acceptability of the approach to participants and self-help support workers d)The effect that the severity of symptoms has on people's use and benefit from the site. e) Perceptions of the support intervention f)Both quantitative and qualitative data will be reported



**The IAPT evaluation: Discussion of Results and Lessons for Service start up and Development**  
 Convenor: Glenys Parry, IAPT evaluation team

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**Introduction**

Glenys Parry, IAPT evaluation team

This symposium gives an opportunity for BABCP conference delegates to explore the IAPT evaluation, overviewed in the keynote talk, in greater detail. Results will be presented and discussed by members of the evaluation team who will draw out some implications for IAPT services in development. An independent discussant will comment on the findings. Each of the presentations is made on behalf of the full evaluation team: Glenys Parry, Michael Barkham, Gillian Hardy, Jo Rick, Tony Kendrick, John Brazier, Kim Dent-Brown, Dave Saxon, Eleni Chambers, Rebecca Hutten, Janice Connell, Kate Doran, Rachel Horn, Simon De Lusignan, Peter Bower and Karina Lovell.

**Evaluating IAPT: meeting the challenge.**

Glenys Parry and Kim Dent-Brown, University of Sheffield

IAPT is a fast-moving policy initiative which creates a moving target for evaluation strategies. Evaluating its implementation, costs and outcomes in two very different demonstration sites is a challenge. We briefly describe the way the team designed the evaluation and some of the problems we encountered in completing it, to set the stage for presentation of results.

**Learning from the patients: the experience of being an IAPT service user.**

Gillian Hardy, IAPT evaluation team

We drew a sample of people who had been recently 'discharged' from the IAPT service to explore what they thought and felt about the experience and the salient issues from their point of view. The sample was designed to tap a wide range of different types of patients with different outcomes. We conducted semi-structured interviews with 77 recently 'discharged' patients: 23 from Newham; 54 from Doncaster. The 'Framework' method yielded rich information about a range of themes including people's expectations, issues of access, service flexibility, autonomy, choice, work and employment, attitudes to the service including the experience of 'stepping up' in stepped care, and personal change. Implications of the findings for user-centred IAPT service design are discussed.

**IAPT implementation and organizational systems change**

Jo Rick, IAPT evaluation team

An analysis of service documentation and in-depth organisational case studies were conducted in Newham and Doncaster. A purposive sample was drawn from a 'diagonal slice' of collaborating organisations, consisting of strategic managers (including PCT & MH Trusts & Chief Execs, partner orgs), operational managers (IAPT & partners), other stakeholders (GPs, project consultants), front line staff (therapists & case managers), and national IAPT leaders. A total of 57 staff was interviewed and follow up interviews were conducted with 12 key staff including staff from comparator sites. The data analytic approach was based on the Framework method, influenced by Greenhalgh et al's model of the dissemination and sustainability of innovations in health service delivery and organisation. The emergent themes of policy context, service design and implementation, partnership working, project management and clinical supervision and system capacity contain valuable lessons for those implementing and developing IAPT services.

**Patient-reported outcomes, benchmarks & service effectiveness**

Michael Barkham, IAPT evaluation team

We report on the throughput of referrals through the two demonstration services between March 2006 and May 2009 in terms of the numbers referred, assessed, offered an intervention and completing an intervention. The clinical outcomes that patients reported are presented and the full dataset compared with early findings reported by Clark et al (2009) and Richards & Suckling (2009). The overall service outcomes are located within a range of outcomes obtained outside these settings but with similar clients. To place the results in a wider context, comparisons are made both with the outcomes obtained in research trials on depression and anxiety disorders and with those obtained in routine NHS data sets, including common mental health problems in primary care and condition management programmes.

**The IAPT model: is it cost-effective?**

John Brazier, IAPT evaluation team

To examine the cost effectiveness of IAPT we recruited samples of patients consulting GPs with depression and anxiety in Doncaster and Newham and comparator sites (City & Hackney, Barnsley and Wakefield), and followed them up at four and eight months, whether or not they had access to an IAPT service. Approximately 20% of eligible patients participated, giving a total sample of 530. Follow up rates were good (approximately 80%) and the demographic profile of the comparison cohort was a good match. Results are presented on comparative rates of access to psychological services, service costs and outcomes. The health economic component estimates the consequences of the new investments at the two demonstration sites in terms of full societal costs, health related quality of life, and overall well-being.

**IAPT: A National Update**

Convenor: David M Clark, Institute of Psychiatry, King's College London

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Speakers: James Seward, Department of Health  
 David Richards, University of Exeter  
 Graham Turpin, University of Sheffield  
 Jeremy Clarke, New Savoy Partnership  
 Roslyn Hope, Department of Health

The Improving Access to Psychological Therapies initiative is in its second year. Three quarters of all PCTs in England now have an IAPT service and most of the remainder plan to start a service in the autumn. This symposium provides an update on the programme focusing on achievements, difficulties and lessons learned, as well as challenges for the future as the programme aims for a full national roll-out. Presentations will cover: the results of year one, work in progress to broaden the range of therapies that are available in the services, issues for the PWP workforce, and accreditation of IAPT training courses and practitioners. Each presenter is a National Advisor for the programme. At the end of the symposium, a substantial period has been set aside for the audience to address questions to the Advisors.

## Panel Discussion

### Cognitive Therapy Scale (CTS) Yardstick or beating stick? Has the widespread use of the CTS as a measure of competence done more harm than good?

Convenor: Robert Dudley, Newcastle University

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Speakers: Gillian Haddock, University of Manchester  
 Robert DeRubeis, University of Pennsylvania, USA  
 Jennifer Wild, Institute of Psychiatry, King's College London  
 Sheena Liness, Institute of Psychiatry, King's College London  
 Ian James, Northumberland Tyne and Wear NHS Foundation trust  
 Jane Floyd, Hampshire PCT

Cognitive behavioural therapy (CBT) has become the evidence based psychological therapy for a range of presenting issues. In part, this success is owing to the commitment to an empirical approach, which is one of the defining features of CBT. Establishing that CBT is efficacious and effective has been a key task for practitioners and researchers. This concern about measurement and evaluation extends beyond outcome though and also focuses on the competence of the therapists offering CBT. Commonly assessment of competence is based in part, on performance on either the Cognitive therapy scale (CTS) or the revised version (CTS-R). This panel will consider the utility and value of such scales from the perspective of those involved in developing the scale (Ian James, Peter Armstrong), from the perspective of its use in research trials (Rob DeRubeis), and those involved in the training of cognitive therapists (Sheena Liness) as well as from the perspective of the accrediting body for therapists, the BABCP (Gill Haddock). The debate will also consider what it is like to be evaluated on the scale in terms of one's own practice (Jane Floyd). It will also consider whether the scales are appropriate when considering the skills necessary to effectively implement disorder specific treatment (Jennifer Wild) and whether the competencies described in the scales map on to those described more recently developed by Tony Roth and colleagues. With the IAPT initiative producing large numbers of therapists it is timely to consider whether they are being equipped with the skills to offer effective treatment (Sheena Liness). Therefore, it is important to ask whether the CTS (or CTSR) help us demonstrate such competence, and if so, whether we need to use these measures more or less often.

## Open Papers

### Increasing Accessibility of Psychological Treatment

Chair: Debbie Brewin, Kings College, London and Sarah Egan, Curtin University

#### Behavioural activation for depression delivered by generic mental health workers. A meta analysis and RCT of clinical and cost effectiveness

David Ekers, Tees Esk & Wear Valleys NHS Foundation Trust/Centre for Mental Health Research, Durham University

Depression affects 5-10% of the population, is set to become the second largest cause of disease burden by 2020 and is the third most common reason for primary care consultation. Cognitive Behavioural Therapy (CBT) is the gold standard treatment consisting of both behavioural and cognitive interventions; lack of clarity exists regarding the optimum mix of these. Behavioural activation (BA) alone has been seen to be as effective as full CBT and may offer increased access if suitable for delivery by a wide range of mental health staff.

We conducted a meta analysis of trials of behavioural treatments of depression to ascertain clinical efficacy of such approaches & develop a pragmatic RCT. Powered from review results we delivered a controlled clinical trial to test the feasibility of BA delivered by generic mental health workers. Therapists had no previous formal therapy qualifications. Depression symptom level and functioning were compared at 3 months via analysis of covariance using multiple imputations to replace missing data. Satisfaction was compared post treatment. Service use data was converted to cost and compared between arms and cost utility estimated based upon health state data from EQ5D at baseline and 3 months. Meta Analysis-Twenty trials were identified. BA is effective compared to controls (SMD -0.70, 95% CI -1.0--0.39) and as effective as CBT (SMD 0.08 95% CI -0.14 to 0.30). All trials used experienced psychotherapists hence parsimony has not yet been demonstrated., RCT- Forty seven participants with high levels of baseline severity and duration of depression entered the trial and were randomised. We found a large effect size in favour of BA compared to usual care in symptom level -1.15 (-1.85 to -0.45) and functioning -1.14 (-1.84 to -0.45) with superior satisfaction for BA at post treatment. Cost utility is currently being evaluated and will be presented at the meeting. This pilot study indicates effective BA is suitable for delivery by generic mental health professionals without previous experience as therapists. It represents the first RCT to test the parsimony of BA and the cost utility of this approach. Generalisation is limited due to the small scale and lack of follow up, however results strongly suggest large-scale trial comparisons with an active comparator such as full CBT are needed. BA potentially lends itself to wider dissemination with brief training. If effectiveness is maintained using the single strand approach it may improve availability of therapy for depression.

### **Behavioural Activation for depression in older adults delivered via videoconferencing: A single case experimental design series**

Sarah Egan, Curtin University

Depression affects up to 35% of older adults. Under-detection and subsequent under-treatment of depression in older adults has been attributed in part to difficulties in older adults being able to access treatment.

This study explored the acceptability and efficacy of a brief behavioural activation treatment delivered via videoconferencing to three participants diagnosed with major depressive disorder aged between 64 and 73 years. The results indicated that a five session behavioural activation treatment delivered via videoconferencing produced clinically significant and reliable decreases in depression and negative affect and improvements in positive affect. Treatment gains were maintained at 1-month follow-up. Preliminary results suggest that videoconferencing may be a valuable and tool in increasing accessibility to psychological treatment for older adults. Clinicians who are working with older adults may consider using videoconferencing as a way of delivering CBT to older adults who are unable to access clinic based services or who are in rural and remote areas.

### **Assessing suitability of Cognitive-Behavioural Therapy for older people with anxiety and/or depression: Development, validation and evaluation of a new assessment method**

Jon Williamson, University of Birmingham, Jan Oyebode, University of Birmingham and Birmingham and Solihull Mental Health Foundation Trust, Susan Adams, Birmingham and Solihull Mental Health Foundation Trust National Institute for Health and Clinical Excellence (NICE) guidelines state that a full range of psychological interventions, including cognitive-behavioural therapy (CBT), should be available to older adult clients (Department of Health and Care Services Improvement Partnership, 2005) and issues concerning the provision of CBT for an aging population are receiving greater prominence from researchers and clinicians. Whilst there is an increasing body of research examining what adaptations may need to be made to CBT in order to be optimally effective with older people (e.g. Laidlaw, Thompson, Dick-Siskin & Gallagher-Thompson, 2003), no formal measures or assessments have been to date devised to aid clinicians in judging the extent to which CBT is suitable for addressing an older person's mental health difficulties. Some research has examined this issue with adults of working age, most notably the work of Safran & Segal (1990) who devised a semi-structured interview protocol to aid clinicians in judging clients on ten suitability criteria. However, such a measure is unlikely to be directly applicable to older people given the varied age-related issues they present with (Laidlaw & Thompson, 2008). We will describe a research project that aims to develop, validate and evaluate a new means of assessing the suitability of CBT for older people with anxiety and/or depression. This new measure takes the form of a semi-structured interview and whilst including some of the suitability criteria proposed by Safran & Segal (1990) also considers age-related issues such as cognitive functioning and physical health, disability and mobility. The research will hopefully result in a means of assessing CBT suitability that takes account of age-related issues and is better tailored to older people than measures designed for adults of working age. The assessment method emerging from the research could potentially be used by professionals working with older people to assist in planning and adapting CBT interventions.

### **Employment support in the third sector: A preliminary evaluation of the acceptability and impact of a combined Cognitive Behavioural Therapy and Vocational Rehabilitation intervention for people who are long-term unemployed**

Debbie Brewin, Kings College, London, Sophie Papageorgis, Work Stress Solutions

The psychological value of work is well documented as is the adverse effect of long term unemployment (Waddell & Burton, 2006). Outcomes from Improved Access to Psychological therapies (IAPT) sites have demonstrated success in improving psychological well being (Doncaster IAPT Report 2007). CBT has also been shown to be effective in reducing negative beliefs about work, promoting self esteem and improving mental health (Della-Posta & Drummond, 2006). The Doncaster IAPT pilot site report showed the net increase of people at work and not on Statutory Sick Pay following CBT treatment corresponded to 7.2% of the population; however there is limited data on the effects on reduction of long term sickness benefits. The report recommended more cross-cutting evaluation and a range of service options integrated with treatment, particularly for those who are long-term unemployed and with enduring mental health problems. There is growing evidence that Independent Placement and Support (IPS) is the most effective form of support in to employment for people with mental health problems, however clients need to be motivated and work ready (Rinaldi & Perkins, 2007). Work Stress Solutions is a community voluntary project in a non-IAPT area combining individual and group CBT interventions with work experience and skills training. It adheres to the five key principles of IPS and offers graded exposure to a work environment. This paper reports the development and preliminary evaluation of the impact of this integrated treatment approach for people who are long term unemployed with a physical or mental health problem. Each participant received pre-employment training, individual or group CBT and graded work experience for up to 26 weeks. The primary outcome measure was achievement of a minimum of 8 hours paid work or regular voluntary work. Additional measures were taken on half the total sample pre, post and at six month follow-up using the Rosenberg Self Esteem Scale, Work and Social Adjustment Scale and a self report measure of function. Although this was a small sample (N= 23), 56% of the sample achieved work outcomes (36% in open employment) and showed statistically significant improvements on self esteem and social adjustment scales. Work outcomes were maintained at 6 month follow up. Self report measures of function and post evaluation feedback indicated that social/relationship skills improved most and were rated as an important aspect of the programme. Feedback from participants indicated that this intervention was beneficial and acceptable, particularly for those with enduring mental health problems as well as achieving encouraging outcomes. The results are promising and justify a larger scale study. This study integrates CBT and work rehabilitation in order to demonstrate a clear impact and economic benefit of CBT. It highlights the work agenda and identifies and promotes CBT strategies for enhancing work related skills.

### **Psychological factors implicated in homelessness**

Nick Maguire, University of Southampton

Despite years of investment from successive governments culminating in the reduction in rough sleeping by two thirds in 2002, homelessness is still a serious problem in the UK, with around 500 people sleeping on the streets

every night. Figures for those without a home but not sleeping rough are much higher, e.g. in London alone outreach workers see around 3000 people every year. Until recently, government funding has focussed on practical support, excluding psychological therapies. A research programme at Southampton has been generating evidence to support the position that funding should now be targeted at interventions to deal with the psychological factors, both predisposing and resulting from repeat homelessness. Such factors include experiential avoidance, emotion dysregulation, attachment difficulties, rumination and negative core beliefs about self which are hypothesised in the main to result from childhood neglect and abuse. Recent evidence has highlighted the role of PTSD and complex trauma in addition to the links between emotion dysregulation, aggression and antisocial behaviours.

These factors have been built into a hypothetical model which predicts the behaviours thought to lead to repeated experiences of rough sleeping. The presentation will detail the model and research programme which has resulted in supporting evidence.

#### **Beating the Blues in prison**

Miriam Samad, University of Manchester, Nic Seccombe & Nicky Lidbetter, Self Help Services

In March 2009, a computerised Cognitive Behavioural Therapy (cCBT) package was piloted within a prison (HMP Manchester) for the first time. The package known as 'Beating the Blues' was originally piloted within a community setting in 2007, and since then has been offered at a number of community venues throughout the Greater Manchester area. 'Beating the Blues' is an eight-session programme targeted at those who are suffering from mild to moderate mental health problems such as anxiety, depression and low mood. It was offered within a prison setting following the recognition that there was a shortage of psychological interventions available for prisoners suffering from primary care mental health problems. The pilot project ran for eight months from the healthcare department at the prison. 80 individuals were referred for cCBT, although not all were suitable for the package. Of the 80 referred for therapy, 41 started the programme, and 19 completed all eight sessions giving a completion rate of 46%. PHQ-9 and GAD-7 scores were collected at assessment, at each therapy session, and on completion of the course. These figures indicated that the average client was suffering from moderately severe depression before beginning the programme (which is higher than the average pre-therapy levels in the community), and that following completion of the package patients on average had moved into the mild depression range (a drop of 38%). Similarly patients seemed to experience a reduction in anxiety, as indicated by a 31% drop in GAD-7 scores following programme completion. The pilot project and its findings will be presented and discussed, along with a discussion of the difficulties of running the service from within a prison environment.

## **Intellectual and Developmental Disabilities**

### **Keynote Address**

#### **Third Wave Therapies for People with Intellectual Disabilities**

Professor Chris Cullen, Keele University and North Staffordshire Combined Healthcare NHS Trust

CBT is, rightly, promoted as the treatment of choice for straightforward psychological problems, but - almost by definition - the psychological problems of people with intellectual impairments are rarely straightforward. They are often compounded by difficulties in understanding, poor health, inadequate socio-economic conditions, and prejudice. In recent years there has been a remarkable resurgence of interest and availability of so-called third wave therapies for people whose issues are not dealt with by simple CBT, but this has yet to have a significant impact in the intellectual disability world. The purpose of this address is to outline those parameters of Acceptance and Commitment Therapy (ACT) and Functional Analytic Psychotherapy that ought to have particular resonance when working with people who have intellectual impairments.

### **Symposia**

#### **Cognitive-Behavioural Approaches to working with Systems around people with Intellectual/Developmental Disabilities: New Developments**

Convenor: Barry Ingham, Northumberland, Tyne & Wear NHS Foundation Trust

#### **Using Acceptance and Mindfulness-Based Workshops with Support Staff for Adults with Intellectual Disabilities**

Stephen Noone, University of Bangor/Northumberland, Tyne & Wear NHS Foundation Trust & Richard Hastings, University of Bangor

Support staff in intellectual disability services may experience significant work-related stress. This stress has been shown to be associated with avoidance processes, and theoretical models of aspects of support staff behaviour have also implicated escape and avoidance processes. In the present paper, we review the case for the match between acceptance and mindfulness-based approaches and the work experiences of support staff. We also report data from 34 support staff who received the Promotion of Acceptance in Carers and Teachers (PACT) intervention. Staff reported less psychological distress post-PACT even though the perceived level of stress in the work environment did not reduce. Positive change was greatest for those staff without a professional qualification and who were reporting more stress at pre-intervention. Combined with other published data, these results suggest that support staff in intellectual disability settings may benefit from acceptance and mindfulness-based interventions

#### **From CBT to BFT: A case study illustrating the benefits of using Behavioural Family Therapy to enhance the therapeutic aspects of CBT for a person with an intellectual disability and their family**

Keith Marshall, NHS Lothian

It is suggested in CBT literature that inclusion of family members and carers can, at certain points in the therapeutic process, enhance treatment outcomes for people with intellectual disabilities. However, direction as to how we involve the wider system around the person is limited and there is uncertainty as to the effectiveness of

employing this approach. This case study highlights the difficulties with employing a CBT approach which focuses specifically on the person with an intellectual disability and their mental health issues. Inclusion of a family member to help maintain therapeutic gains within this approach did not prevent relapses and multiple crisis contacts with services. We therefore included the family member in the therapeutic process utilising a Behavioural Family Therapy (BFT) approach which explored the family system and potential maintaining factors for some of the difficulties encountered by the person with intellectual disabilities. BFT is a psychoeducational intervention which has a strong CBT influence to help families manage stress (Faloon et al., 1993). The process is manualised, incorporating individual assessment, family problem solving assessment, information sharing, communication and problem solving skill development. The approach is short term, ranging between 12-15 sessions. As with CBT for people with intellectual disabilities, we modified the BFT approach by simplifying the language and using visual materials. We also audio recorded the sessions and skills development components. Baseline and outcome data was collected on CORE and CORE-LD showing no change in distress after 10 sessions. However, there was a noticeable reduction in crisis contact with the community learning disability team post-BFT. CORE and CORE-LD was repeated at 6 month follow up demonstrating a considerable reduction in scores.

#### **Brief cognitive behavioural therapy informed interventions with staff teams**

Matt Selman, Northumberland, Tyne & Wear NHS Foundation Trust

Many people with intellectual disabilities are, in varying degrees, dependent on systems around them for their day to day living. Within this close relationship unhelpful beliefs and behaviours held in the system can exacerbate difficulties when individuals experience mental health problems or display challenging behaviours, and may indeed precipitate and maintain some difficulties. In Northumberland we have a well established behaviour analysis and intervention team that provides effective evidence-based treatment for severe challenging behaviour. However, this service is time intensive, uses a lot of resources and has limits to its capacity. For cases where the risk is not so clear or the presentation exhibits more mental health-related issues there are limited resources to apply the evidence-based practice. In response to this we are developing a brief formulation based intervention with direct care staff teams involving one or two training sessions that can be quickly delivered to prevent difficulties escalating with a follow-up session to monitor and consolidate the intervention. The approach involves a collaborative training session aimed at developing a biopsychosocial formulation based on: staff experience, a notes review, and informal psychoeducation from the facilitators. Where there is a need for specific psychoeducation, e.g. around challenging behaviour or mental health, then further specific training around the person and the link with formulation is provided. The aim is to enable staff to develop an informed understanding and through this address negative attributions that may be present, identify and address staff needs, and have a consistent approach based on the formulation. Depending on the needs, guidelines are developed which are based on current successful interventions by staff, ideas drawn from staff team through discussion and offering of evidence-based intervention. Initial outcome and satisfaction data is provided and a case example is provided to illustrate the approach. The implications for clinical practice are discussed.

#### **Cognitive-Behavioural formulation workshops for multidisciplinary staff working into inpatient intellectual disabilities services: a closer look**

Gemma Hymers, University of Newcastle/Northumberland, Tyne & Wear NHS Foundation Trust & Barry Ingham, Northumberland, Tyne & Wear NHS Foundation Trust

Multi-disciplinary staff teams play a crucial role in the recovery and support of individuals who experience psychosocial problems and have intellectual disabilities following admission to inpatient services. Previous research suggests that an increased understanding of an individual's difficulties through collaborative development of a cognitive-behavioural formulation can modify staff perceptions and attributions of that individual's psychosocial difficulties and subsequently positively impact upon staff and service user's therapeutic rapport (Berry, Barrowclough & Wearden, 2009) hopefully promoting recovery. Research has additionally indicated that staff satisfaction and team working improves with the development of formulations (Summers, 2006), aiding staff and service users to "negotiate the complex processes of inpatient care" (p. 388, Davenport, 2002). One way of collaboratively developing formulations with staff teams is through a formulation development workshop format, i.e. half-day workshop with a staff team to develop a biopsychosocial formulation using the Five Ps format (see Ingham et al., 2008). The study aims to explore what changes occur within staff as a result of the workshops (e.g. perception/knowledge/attitudes) and what processes or structures facilitate these changes to occur (e.g. notes reviews/peer reflection). This is examined using a phenomenological approach via semi-structured interviews with multi-disciplinary staff operating into an intellectual disability inpatient service. Thematic analysis suggests that staff gained additional information and viewpoints through reflection of different clinical perspectives, valuing joint multi-disciplinary development of action points. Further analysis suggests that case note reviews and an open, curious environment was advantageous; however, limited attendance from key staff hindered the process. The implications for this in terms of developing the evidence base for formulation workshops within the service will be outlined in the presentation.

#### **Anger Treatment for Adults with Intellectual Disabilities: Findings from Recent Outcome and Process Research**

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

#### **Cognitive Behavioural Anger Treatment for Adults with Intellectual Disabilities: Effects of Therapist Experience on Outcome**

John L Taylor, Northumbria University and Northumberland, Tyne & Wear NHS Trust

Background Anger has been shown to be associated with aggression and violence in adults with intellectual disabilities in both community and secure settings. Emerging evidence has indicated that cognitive behavioural anger treatment can be effective in reducing assessed levels of anger in these patient populations. However, it has been suggested that the effectiveness of cognitive behavioural interventions can be affected significantly by therapists' training and experience. Method In this study the pre- and post-treatment and follow-up assessment scores of 88 adults with intellectual disabilities and offending histories who received cognitive behavioural anger treatment were examined in order to investigate whether participants' responsiveness to treatment was a

function of therapist experience. Results The overall results indicate that the effectiveness of anger treatment was not the result of the therapists being qualified psychologists, graduate psychologists or clinical psychologists in training. There was some evidence that qualified therapists achieved better outcomes on measures of anger control and regulation than their non-qualified counterparts. Conclusions Cognitive behavioural therapy for anger control problems can be effective for people with intellectual disabilities and forensic histories. The results indicate that overall the effectiveness of anger treatment was not the result of therapists' experience. More experienced therapists are possibly able to obtain better results in terms of anger control measures. The implications for therapists training and practice are discussed.

#### **Cognitive Behavioural Treatment for Adults with Intellectual Disabilities Clients: Overview and Future Directions**

Raymond W Novaco, University of California, Irvine, USA

Anger and aggressive behaviour are significant clinical problems for persons with intellectual disabilities, whether they reside in community or institutional settings. This is now well established by clinical research, especially in the UK, as well as by international epidemiological studies. CBT anger treatment is gaining sway over formerly preferred behaviouristic antecedent control / contingency management and psychotropic medication regimes for challenging behaviour. The efficacy of CBT programmes for anger has been demonstrated across types of settings, types of institutions (forensic and non-forensic), and treatment formats (individual and group). An overview will be given of these outcome studies. Therapeutic intervention should be guided by knowledge of how anger dysregulation problems in this client group have been formed. From childhood onward, the life circumstances and psychosocial experiences of people with ID are conducive to anger and aggressive behaviour. Recurrent thwarting of physical, emotional, and interpersonal needs, as well as cognitive functioning deficits, impair their psychosocial adjustment, particularly those who reside in custodial settings. Persons with ID have higher risk for child abuse and domestic violence exposure, and parental disharmony, especially exposure to interparental anger/aggression, increases risk of adjustment difficulties. Critical periods, such as adolescence, may be especially important in development of normative beliefs about anger and aggression. Social learning of anger volatility and the acquisition of aggressive scripts is an asset to case formulation. Additionally, it will be noted that anger dysregulation is a transdiagnostic phenomenon. Anger activating and maintaining processes that occur across clinical disorder categories apply as well to those with ID. Within CBT programmes used with ID clients, giving consideration to processes such as threat perception, selective attention, interpretive bias, rumination, and personal goal aspirations can help us understand co-morbidity and improve the targeting of treatment.

#### **Coping skills, cognitive ability and carer support as potential moderators of the outcome of anger management interventions for adults with intellectual disabilities**

Paul Willner, Abertawe Bro Morgannwg University NHS Trust and Swansea University

Cognitive behavioural therapy (CBT) is used increasingly to treat mental health problems experienced by people with intellectual disabilities. The strongest evidence base relates to anger, where there is a body of studies comparing participants in anger interventions with waiting-list control groups, all of which demonstrate improvements as a result of the intervention that are maintained at 3-6 month follow-up. Three factors that have been identified as potentially influencing outcomes: 1. The Profile of Anger Coping Skills assesses the extent of usage of the different coping skills that are taught in an anger management intervention. There is a significant correlation between improvements in the response to provocation and the extent to which coping skills have been acquired. 2. Some studies of group-based anger management in community settings have reported that improvements in anger management are related to cognitive ability (verbal IQ or receptive language ability). This has not been observed in studies of individual anger treatment in forensic settings. There are several potential explanations of this discrepancy, including the greater difficulty in a group setting of adapting CBT to meet the needs of the individual client. 3. There is evidence that participants who are accompanied by carers benefit more from anger management interventions than those who attend alone. The benefit of carer involvement can be maximized by training staff who work with the clients on a daily basis to administer the intervention. An ongoing multi-centre randomized controlled trial of this approach will be described.

#### **A Comparison between Individual and Group Interventions for Anger amongst Adults with Intellectual Disabilities**

John Rose, University of Birmingham

Background There is a developing literature on the efficacy of cognitive-behavioural treatment for individuals with intellectual disabilities who demonstrate aggressive behaviours. Treatments have been provided in both group and individual formats however, little research exists comparing the efficacy of these two methods of service delivery. Design and Method A longitudinal group comparison design was employed. Changes over time in three groups were compared, including individual treatment, group treatment and a control group. Individuals who were referred to a community psychology service for people with intellectual disabilities were assigned to either group or individual anger treatment or a waiting list depending upon service availability. They were assessed using a range of measures, including a provocation inventory, both before and after the group and where possible at follow-up. Twenty-three people completed group treatment, 18 individual treatment and 21 acted as a waiting list control. Results A significant decrease in scores on the provocation inventory was found for participants in both individual and group work, compared to the control group. No differences were found between the individual and group treatment outcomes. Conclusions This project provides further evidence for the efficacy of interventions for inappropriately expressed anger in people with intellectual disabilities. Little overall difference was found between individuals participating in different forms of treatment; however, this could be due to a relative lack of sensitivity in the measures used.

## **Older Adults**

## Keynote Address

### An Integrated Health Care for Older Adults

Professor Antonette Zeiss, Department of Veteran Affairs, USA

The presentation will cover recommendations from the report of the American Psychological Association Presidential Task Force on Integrated Health Care for Older Adults. The fragmented care of our current health delivery systems too often results in a lack of preventive care, family stress, diminished quality of life, and poor medical outcomes for this population. The demographics of aging demonstrate the growing importance of older adults as a vital component of the world's population; this presentation focuses on the need to ensure that this growing segment of our population receives the best possible holistic health care. Basic interdisciplinary care models are presented, including how they differ from multidisciplinary care models and how interdisciplinary care is especially suited to the health care needs of older adults. Interdisciplinary health care is characterized by sensitivity to diversity and collaboration among health professionals. This approach can guide Cognitive Behavioural (CBT) therapists in working to enhance interdisciplinary collaboration while also delivering specific evidence-based psychotherapy services to older adults. Cognitive Behavioural therapists can treat mental health problems of older adults and deliver CBT-based Health Psychology interventions for many symptoms of chronic illness in older adults.

## Symposia

### IAPT Works with Older People Part 1

Convenor and chair: Cath Burley, PSIGE

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#### The Impact of IAPT on Older Peoples' Mental Health Services

Cath Burley, PSIGE

The group will outline the national picture in relation to Older Peoples IAPT looking at the relevant government directives and back ground to the study. They will present data comparing the IAPT measures to more relevant outcome measures for older people.

#### IAPT - A discriminatory process?

Sue Watts, Greater Manchester West Mental Health Foundation Trust

Sue Watts and a Salford Older Adult Primary Care Service colleague will outline the lessons learned during 15 years experience of providing psychology and counselling services to older people with mild to moderate mental health problems in primary care. They will describe in brief:

The need to challenge therapeutic nihilism in referrers

The need to raise awareness of later life mental health issues in primary care staff

The need to increase knowledge of how common mental health conditions such as depression and anxiety in later life may present in primary care services

An audit of the needs of people referred to the service

The importance of sharing understanding of older people's needs with service commissioners

Reflections on assessment processes and outcome measures

The presenters will consider the direct and indirect discrimination that may arise when older people are 'fitted in' to an IAPT model designed for working age adults, rather than developing a needs-based service model. They will consider how this might be remedied through training, adaptation of the model, therapeutic strategies and appropriate outcome evaluation.

#### Graduating from a primary care psychology service to an IAPT service - the Southwark experience

Grace Wong, Southwark Psychological Therapies Services (Southwark IAPT), South London and Maudsley Foundation NHS Trust

The Older Adults Primary Care Psychology Service was a three and half year project aiming at promoting equitable access to psychology service to older people living in the London Borough of Southwark. In November 2008, it became part of the new Southwark IAPT service. While we strive to operate effectively within an IAPT service, we are keen to ensure that the psychological needs of Southwark older residents are being met in what is essentially a service designed for getting people back to employment. The presentation will address our experiences and the outcome data we have collected so far.

### IAPT Works with Older People Part 2

Convenor: Cath Burley, PSIGE

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#### The first wave - an IAPT success story

##### IAPT for older people: what's happened in Western Cheshire?

Julia Boot and Lisa Hulmes, Cheshire and Wirral Partnership NHS Foundation Trust

Our psychology service in Western Cheshire became a "first wave" IAPT site in September 2008. This involved recruiting nine low intensity workers (LIWs) and seven high intensity workers (HIWs). Older adults were identified as a target group and three HIWs were allocated half their caseload to older adult clients. We have audited the adults of working age and older adults referred to the psychology department for the six months pre-IAPT and one year since we became an IAPT site. Whilst older adult referrals have doubled, they still remain approximately 10% of the total adult referrals. Since older adults represent approximately 16% of the adult population in Western Cheshire, they are still being under-referred by GPs and other clinicians in the community. At Steps 3 and 4, Clinical Psychologists are seeing the majority of older adult referrals, with a smaller number being seen by counsellors and HIWs. Over the first year since we became an IAPT service, HIWs are using only 17% of their predicted capacity for older adult clients. This is in contrast to their caseload for adults of working age, which is 144% of their predicted capacity. We have started to explore why the capacity for HIWs to see older adults is being

under-utilised and will present our plans to further improve access of older adults to psychological therapies in Western Cheshire.

#### **The St Ives Project - learning to meet older peoples needs**

Cath Burley, Julie Hare, Jim Leadbetter, Cambridgeshire and Peterborough NHS Foundation trust  
Cath Burley will outline the development of the St Ives Primary care project including the work with commissioners to develop care pathways for functional mental health and mild memory problems. Julie Hare will discuss the modifications to therapy and group work the team developed to best meet older peoples needs and Jim Leadbetter will talk about the benefits of the Medications Management approach,

#### **IAPT and older people: a training perspective**

Steve Davies, University of Hertfordshire  
The national IAPT training programmes have provided a useful test bed for the rapid education of psychological therapists in CBT. The initial focus for this training has been the so-called "Adults of Working Age" population,, principally because the modus operandi of the programmes was to return individuals to the workforce. With the realisation that psychological well-being is the universal aspiration for health and social care interventions the sights of the IAPT programmes have shifted to make CBT available to other groups of people. Older People is one of these groups. Now the challenge is to provide training for psychological therapists to combat ageism, optimise intervention effectiveness and to provide them with the specialist knowledge and skills to work with this group. This paper discusses the input needed to IAPT and CPD training programmes to make therapists both competent and confident in working with older people.

#### **Developments in the Application and Practice of CBT with Older People**

Convenor: Ken Laidlaw, University of Edinburgh and NHS Lothian

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#### **"Oh, you don't want to help me young man": Problems with and solutions to self-stigmatisation blocking progress with older people in CBT**

Steve Davies, University of Hertfordshire  
It could be said that ageism is the largest problem facing health and social care systems. There is worrying evidence that older clients are under-represented in psychological therapy services despite forming an increasing proportion of the general population at high risk of developing mental health problems; those facing bereavement, unemployment, chronic illness, cognitive impairment and change of residence. But the most serious barrier to CBT socialisation is often ageist self-stigmatisation by the older client themselves. As IAPT services expand to address the therapy needs of older people initial results indicate poor uptake of such opportunities and this has become a pressing issue. This paper presents a brief history of the problem of a stigmatised old age, a psychological model of how this problem occurs and clinical illustrations of how CBT therapists are well placed to finding solutions to this problem.

#### **Enabling novice psychological therapists to conduct and consume evidence-based research - using world-class clinicians in a local setting as a lever for change**

Angela Harris, NHS Lothian/Glasgow Caledonian University, Caludia Coelho, NHS Lothian & Ken Laidlaw, NHS Lothian/University of Edinburgh  
There is a substantial evidence base for the effectiveness of psychologically based interventions in improving physical and mental healthcare outcomes for older people. One of the key roles that psychologists can play is the training of colleagues in the application of specific psychological techniques and to increase psychological awareness. Prior to 2006, it was recognised that allied health professionals in the older people mental health service within Edinburgh (NHS Lothian) were not utilising the evidence base of psychological therapies. At the same time, there had been limited research conducted by practitioners within the service and a need was identified to educate staff in practical evidence-gathering skills. We adopted a three-prong approach of initiating a Masterclass series; a brief introduction to CBT with Older People course; and a Research Interest Group. A small amount of money was received to underwrite the costs. A separate qualitative analysis of stakeholder views on the widening of access to psychological therapies threw light on the acceptability of the three approaches.

#### **Using CBT Principles in the treatment of Challenging Behaviour**

Ian James, Northumberland Tyne and Wear NHS Trust  
The Newcastle Challenging Behaviour Team was established in 1999 to treat older care home residents displaying challenging behaviours. The 12 week intervention programme used by the team is labelled as a 'staff-centred, person-focused' approach, utilising basic and advanced CBT principles'. This presentation describes how the principles are used, and the manner in which they have been woven into the structural and process features of the award winning team's work.

#### **New Horizons QIPP and IAPT' - CBT models - addressing lifespan challenges**

Gwyn Higginson, North Staffs Healthcare NHS Trust  
IAPT service delivery and CBT models have the potential to support early detection and prevention at pre clinical stage of dementia (vascular cognitive impairment) in adults with 'brains at risk' aged 50 plus. Using mental health alerters in IAPT pathways in primary care. Making sense of CBT treatment failures and procedural resistance in assessment and treatment of common mental health problems. Combining Interacting Subsystems Model and Compassion Focus Framework within CBT can enable individuals to develop insight about their emotional response to the experience of information processing difficulties where memory deficits are not the primary symptom but are impacting on a previously well maintained mental health problem. Knowledge of new research confirming the impact of neurologically silent infarcts on information processing is crucial in working with individuals aged 50 plus with long term physical health conditions such as diabetes, blood pressure, heart disease, stroke, carotid and peripheral artery disease, atrial fibrillation and long term stress. Neurologically silent but emotional threat response to subtle changes can guide therapists in the development of new approaches based on compassion



focused therapy to manage and tolerate distress. With New Horizons removing age barriers CBT models designed with general adult populations now are required to add in potential internal environmental factors of the condition of our neurological networks supporting our information processing as we age - into assessment and formulation of all mental health problems. The myth of 'normal ageing' is no excuse not to explore the impact of processing on ability to achieve life's goals within one's value and belief systems. Several brief case studies describing cases diagnosed and treated for panic, OCD and PTSD that have been perceived as either treatment resistant are re-formulated. The subtle information processing difficulties were revealed using compassion in the therapeutic framework and safeness to explore and face the fear of the personal experience and social experience of the dissonance between experience of self current and self past with repeated 'splinter moments'.

## Psychosis

### Keynote Addresses

#### Suicide and Psychosis: From Theory to Prevention

Professor Nicholas Tarrier, University of Manchester

Suicide in psychosis is a substantial clinical problem and of great social concern. Estimated lifetime rates of completed suicide range between 4.9% and 10%. Rates of non-lethal suicidal behaviour are greater still. Approximately 50% of sufferers will have a history of suicide attempts and a similar number experience suicidal ideation at any point in time. Suicide ideation and attempts represent substantial risk factors for subsequent suicide attempts and completions and are distressing and disruptive in themselves. Although there is considerable research into risk factors associated with both completed suicide and suicide behaviour little is known about why individuals decide to take their own lives or on how to prevent this. This lecture will describe a programme of research aimed at understanding the underlying psychological mechanisms of suicide behaviour and the evaluation of a preventative intervention. The research strategy, supported in part by an NIHR programme grant (RECOVERY) has been 1) to develop a specific theoretical model of suicide behaviour in psychosis based upon Williams' Cry of Pain model and modifications derived from mining of existing data bases. This resulted in the Schematic Appraisal Model of Suicide (SAMS), 2) to test and develop this model through experimental studies, 3) to design a preventative intervention based upon the SAMS model, experimental work and a systematic review and meta-analysis of CBT in suicide prevention, 4) to evaluate the manualised treatment (Cognitive Behavioural Suicide Prevention for Psychosis; CBSPP). This lecture will describe this strategy and summarise the results.

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#### Substance use and Psychosis: Linkage, Interventions and Outcomes

Professor Christine Barrowclough, University of Manchester

It is well established that people with psychosis have rates of substance misuse - problem alcohol use and street drugs - above those of the general population, and there are strong indications that this co-occurring substance use puts people at higher risk for many adverse outcomes including increased symptom severity, suicide, hospitalisations. Because of the size and impact of the dual problems, there is a need for guidance as to the best ways to assist this client group to reduce or abstain from substances so as to improve outcomes. However, theoretical understanding of the links between psychosis, substance use and poor outcomes has been limited, hampering the development of therapeutic approaches that can specify why problems have developed and are maintained and hence predict the best way of producing change. Additionally, the evidence base for directing treatment has been slow to accumulate due to the many methodological challenges involved in developing and evaluating interventions for people with psychosis using substances. In Manchester UK, we developed a therapeutic intervention that combined motivational interviewing (MI) and cognitive behaviour therapy (CBT), and the therapy had encouraging results in a small published RCT. We further developed the therapy and evaluated it with London colleagues in a large trial: MIDAS (Motivational Interventions for Drug and Alcohol use in Schizophrenia) which is to date the largest RCT for people with psychosis and substance use. The integrated MiCBT was delivered over 12 months alongside the service user's routine care and aimed to take account of the dual and interactive nature of substance use and psychosis problems and the motivational stage of the service user. The main results from the MIDAS trial and the implications for future research and service developments will be presented and discussed.

## Symposia

#### Mindfulness and Acceptance Approaches with people with Psychosis: New Research

Convenor: Joe Oliver, South London & Maudsley NHS

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### **Mindfulness as a mediator of self-stigma: An investigation into whether mindfulness mediates the effect of self-stigma on social functioning in a First Episode Psychosis Sample.**

Lucy Mersh, Salomons, Canterbury Christchurch University, Fergal Jones, Salomons, Canterbury Christchurch University & Joe Oliver, South London & Maudsley NHS Trust

Luoma et al (2007) describe self stigma as 'shame, evaluative thoughts, and fear of enacted stigma that results from individuals' identification with a stigmatised group that serves as a barrier to the pursuit of valued life goals'. Self-stigma has been linked to loss of self-esteem (Wahl, 1999), self-efficacy (Corrigan & Watson, 2002), poor adherence to treatment plans (Sirey et al., 2001) and reduction of the pursuit of employment and independent living (Link, 1982). If an individual accepts stigma their identity may become dominated by their illness (Lally 1989). It has been proposed that the experience of engulfment is especially overwhelming for people experiencing first episode psychosis as they are often also grappling with the challenges of young adulthood. Research into the reduction of self-stigma has until recently focused on the use of psycho-education and CBT, finding limited success for both interventions (e.g. Alvidrez, Snowden, Rao & Bocceriali, 2008; MacInnes & Lewis, 2007). Recently a small amount of research has looked at Acceptance and Commitment Therapy (ACT) to reduce self stigma in substance misuse and obesity. From an ACT perspective the negative effects of self-stigma occur when an individual becomes entangled in their negative self-stigmatising thoughts and emotionally reacts to them. It could be hypothesized that the mindfulness component of ACT would allow individuals to step back from their thoughts and thus be less likely to self-stigmatise. This study explored the relationship between self-stigma and mindfulness, hypothesizing that individuals who were more mindful would be less likely to self-stigmatise and therefore would have higher social functioning. It was also hypothesised that this relationship would be independent of symptom severity. Four standardized measures for self-stigma, mindfulness, social functioning and symptom severity were employed. At the time of writing thirty three participants experiencing first episode psychosis had been recruited. At completion data from forty participants will be analysed using a regression analysis and clinical implications of findings discussed.

### **Psychological Flexibility and well-being in First Episode Psychosis**

Emma O'Donoghue, Royal Holloway, University of London, Eric Morris, South London & Maudsley NHS Foundation Trust & Michael Evangeli, Royal Holloway, University of London

Psychological inflexibility is 'the phenomenon that occurs when one is unwilling to experience particular negative internal experiences and attempts to alter them accordingly'. The concept of psychological flexibility underpins recent empirically derived approaches to psychological intervention (e.g. Mindfulness and Acceptance and Commitment Therapy). These approaches have been found to improve psychological functioning and alleviate a variety of mental health problems including chronic pain, generalised anxiety disorder and depression. Recent research has begun to focus on the usefulness of these interventions with individuals experiencing psychosis and has identified benefits such as improved social impairment and reduction of distress associated with psychotic symptoms. This is a relatively new focus in the treatment of psychosis and to date, no published research has explored these interventions or the concept of psychological flexibility in individuals experiencing first episode of psychosis. These individuals have a high risk of relapse, comorbid symptoms, suicidality when compared with normal controls. Research also indicates that the experience of negative intrusive cognitions, such as positive psychotic symptoms, can have profound implications for an individual's well-being, social functioning and satisfaction with life. Therefore, further research into effective psychological interventions for this group is warranted. This study explored the mediating effect of psychological flexibility on well-being and social functioning in response to experiencing negative intrusive cognitions (psychotic and non-psychotic) in a sample of individuals experiencing a first episode of psychosis. A purposive sample of forty two individuals (male - 28: female - 14), aged between 18 and 33 years, who were currently being treated for a first episode psychosis completed standardised measures of these constructs. The clinical research implications of these results will be discussed.

### **Person-based cognitive therapy groups for distressing voices: An evaluation**

Laura Dannahy, Hampshire Partnership NHS Foundation Trust, Clara Strauss, Sussex Partnership NHS Foundation Trust & Wendy Turton, School of Psychology, University of Southampton

Recent randomised controlled trials of group CBT for psychosis have yielded disappointing results (Barrowclough et al, 2006; Wykes et al, 2005). For this reason, there is increasing interest in the potential benefits of third wave cognitive therapies for psychosis. Person-based cognitive therapy for distressing voices (PBCT; Chadwick, 2006) integrates traditional cognitive therapy with a third wave acceptance based approach, including use of formal mindfulness meditation. By integrating the two in a meaningful way the potential benefits of both approaches are made available to participants. In this presentation outcomes of nine PBCT groups, involving 62 participants, are presented (Dannahy et al, submitted). Following the therapy groups there were significant improvements in psychosocial well-being as well as on measures of voice distress and voice control and these improvements were maintained at a one month follow up. Findings will be discussed in relation the interface between second wave and third wave cognitive therapies and the next step in evaluating PBCT groups for distressing voices will be presented. References Chadwick, P. (2006). Person-Based Cognitive Therapy for Distressing Psychosis. Chichester: Wiley Dannahy, L., Hayward, M., Strauss, C., Turton, W., Harding, E. & Chadwick, P. (2010). Group Person-Based Cognitive Therapy for distressing voices: Pilot data from nine groups. Manuscript submitted to Behaviour Therapy and Experimental Psychiatry.

### **Predicting Changes in Delusional Ideation: The Role of Mindfulness & Negative Schemas**

Joe Oliver, South London & Maudsley NHS Trust, London, Kennedy McLachlan, Open Polytechnic, New Zealand, Emmanuelle Peters, Institute of Psychiatry, London & Paul Jose, Victoria University, New Zealand

Traditional definitions of delusions have described them as discrete entities that exist only within the population of the seriously mentally ill. This definition has been forced into reconsideration as evidence has accumulated to strongly suggest that delusions are in fact multi-dimensional and exist widely in the general population (Bentall & Slade, 1985; Cox & Cowling, 1989; Johns & van Os, 2001; Romme, Honig, Noorthoorn & Escher, 1992). Research demonstrating that normal populations report sub-clinical level delusional ideation was further evidence of a continuum, but also pointed to the possibility that clinical and non-clinical ideation were functionally related.

Several streams of research have suggested that non-clinical levels of delusional ideation are linked to later development of clinically significant delusions (e.g. Krabbendam & van Os, 2005; Poulton, et al. 2000; van Os, Hanssen, Bijl & Ravelli, 2000). A better understanding of factors that worsen non-clinical delusional thinking may provide insight into the aetiological underpinnings and developmental processes involved in clinical symptoms. Two potential factors are negative schemas and psychological inflexibility. This study used a longitudinal design to explore the impact of mindfulness and negative schemas on changes in delusional ideation over time in a sample of 204 college students. Using structural equation modelling, the results indicated that the effect of negative schemas on changes in specifically delusional distress was mediated by mindfulness. Clinical and research implications of these results will be discussed.

#### **Anxiety Processes in Psychosis**

Convenor: Katherine Newman Taylor, University of Southampton & Hampshire Partnership NHS Foundation Trust

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#### **The Role of Anxiety Processes in Paranoia**

Laura Flower, University of Southampton

This research examined anxiety processes in non clinical paranoia. The focus of the study was on cognitive factors typically associated with the maintenance of anxiety, in people with high and low levels of non clinical paranoia. A between-subjects experimental design was used to compare participants with high and low non clinical paranoia. University students were screened and 27 participants were recruited into each group. Participants completed a threat activation task, measures of state and trait anxiety, thought control, self focused attention and imagery. The threat activation task was used to induce paranoid cognitions in order to assess the impact of heightened paranoia on the use of thought control strategies, self focused attention and imagery. High non clinical paranoia was positively associated with state and trait anxiety. The threat activation task increased state anxiety in both high and low paranoia groups and the high paranoia group experienced more paranoid cognitions following the task. No differences were found between the groups on depressive cognitions. The thought control measures indicated significant differences between the high and low paranoia groups on the use of suppression, worry, punishment and social control strategies. No differences were found between the groups on self focused attention or imagery measures. The clinical implications of these findings are considered, and future directions for further experimental research are suggested.

#### **The Development and Maintenance of Social Anxiety following Psychosis**

Ruth Turner, Norfolk and Norwich Mental Health NHS Foundation Trust & University of East Anglia

Social anxiety is a common problem among people recovering from psychosis (Birchwood et al, 2006; Tollefson & Sanger, 1999). Recent studies have shown that up 70% of people recovering from early psychosis have clinical levels of social anxiety symptoms, despite being regarded as having recovered from acute psychotic episodes (Fowler et al, 2009). Social anxiety has also been shown to persist long after the remission of psychotic symptoms, and to have a direct impact on peoples' long-term social and occupational functioning, quality of life and frequency of relapse (Huppert et al, 2001; Pallanti et al, 2005). At present it is unclear to what extent this client group can be treated using the established protocols developed for working with people who have social anxiety but have not had an episode of psychosis. This presentation will discuss some of the early findings from the Social Anxiety Research Clinic. This clinic was set up to explore the nature and treatment of social anxiety following first episode psychosis. Data will be presented from studies looking at the extent to which core beliefs, interpretation biases and imagery play a role in the development and maintenance of social anxiety following psychosis. This will be illustrated with discussion of cases from within the clinic. There will also be a discussion of the issues involved in formulating and intervening with this complex client group.

#### **Social Phobia Processes in Paranoia**

Katherine Newman Taylor, University of Southampton & Hampshire Partnership NHS Foundation Trust & Lusia Stopa, University of Southampton

**Objective** This research examined cognitions and behaviour that are typically associated with social phobia, in people with paranoia. Content specificity of thoughts and beliefs, particular metacognitive processes, and behaviour were assessed in people with social phobia and persecutory delusions. The aim was to determine the extent to which socially anxious cognitions and behaviour are experienced by people with persecutory delusions, in order to further our understanding of paranoia and to consider the implications for therapeutic work. **Design** We used a cross-sectional between-subjects design to compare participants with social phobia, persecutory delusions (without social phobia), a clinical control group with panic disorder, and a non-clinical control group. **Method** Ten to 15 people were recruited to each of the four groups, with a final total of 48 participants. Each person completed measures of automatic thoughts, underlying assumptions, core beliefs and behaviour, and took part in a semi-structured interview designed to assess process (self-consciousness and attentional focus) and metacognitive beliefs. **Results** Surprisingly, measures of automatic thought, underlying assumptions, core and metacognitive beliefs and process yielded no systematic differences between people with social phobia and persecutory delusions. Similarly, there were no systematic differences in behaviour between people with social phobia and persecutory delusions. **Conclusions** These results indicate that people with persecutory delusions experience overt and underlying cognition more typically associated with social phobia, and to a comparable extent. Furthermore, people with persecutory delusions behave in similar ways to people with social phobia in response to perceived social threat. A model of paranoia drawing on current models of paranoia, and based on the cognitive model of social phobia, is presented for clinical use.

#### **Recovery after Psychosis: The Relational Roots of Emotional Recovery and Relapse Prevention**

Convenor: Andrew Gumley, University of Glasgow

### **Attachment organisation and recovery following a first episode of psychosis: A prospective 12-month follow-up study.**

Angus MacBeth, Andrew Gumley, University of Glasgow, Matthias Schwannauer & Rebecca Fisher, University of Edinburgh

We can think about psychosis as a threatening life event which disrupts core attachment, interpersonal and affect regulatory processes, which are instrumental in the unfolding of individuals' developmental trajectories. Alternatively, psychosis might exploit pre-existing vulnerabilities further undermining transition and recovery after psychosis. The Glasgow Edinburgh First Episode Psychosis Study was a three-year prospective cohort study funded by the Scottish Government. In this study we investigated core predictors of outcome following first episode psychosis: specifically the roles of duration of untreated psychosis (DUP) and Premorbid Functioning. We also investigated attachment organisation and reflective functioning as reflected in discourses observed during the Adult Attachment Interview ((AAI; Main, Goldwyn & Hesse, 2002). We wished to explore the role of attachment organisation in the unfolding psychiatric and emotional recovery in the first 12-months following a first episode psychosis. In this presentation we will present the key results of the study and explore the implications of our findings with respect to the core processes of affect regulation in shaping the evolution of recovery and adaptation following psychosis.

### **Glasgow-Edinburgh Study of First Episode Psychosis: Pilot data**

Angus Macbeth & Andrew Gumley, University of Glasgow, Matthias Schwannauer & Rebecca Fisher, University of Edinburgh

Attachment theory offers a promising psychodevelopmentally grounded framework for understanding onset, help seeking, adaptation and resilience in the experience of first episode psychosis. Research on attachment in first episode psychosis has to date focused on self-report measures of attachment. Use of the narrative based Adult Attachment Interview (AAI; Main, Goldwyn & Hesse, 2002) represents the gold standard for delineation of attachment classifications. The AAI can also be used to ascertain mentalising capacity, operationalised as Reflective Function (RF). The current paper reports attachment data from a cross-sectional cohort of 34 individuals in the initial year of treatment for a first episode of psychosis (FEP). It is also the first study to measure levels of RF in psychosis. Attachment classifications and reflective function scores were derived from the AAI. Psychotic symptomatology (Positive and Negative Symptoms Syndrome). PANSS, premorbid adjustment (Premorbid Adjustment Scale, PAS), duration of untreated psychosis, quality of life (WHO Quality of Life scale, WHOQOL-BREF), and interpersonal functioning (Inventory of Interpersonal Problems, IIP-32) were also measured. Attachment distribution was heterogeneous in the sample, although the majority of participants were classified as dismissing of attachment. Mentalisation scores were consistent with previous clinical samples of borderline personality disorder. Attachment and mentalisation were unrelated to psychotic symptomatology. The study demonstrates the validity and applicability of assessing attachment and mentalisation via narrative methods. The findings have clinical implications for understanding the process of engagement and adaptation in first episode psychosis, particularly with regard to identifying trajectories of problematic recovery and the emergence of resilience.

### **Mentalisation and reflective function in first episode psychosis**

Matthias Schwannauer, University of Edinburgh, Andrew Gumley, University of Glasgow, Rebecca Fisher, University of Edinburgh & Angus MacBeth, University of Glasgow

This paper is aiming to examine first episode psychosis from a developmental perspective. It appears from the recent discourse of the role of affect dysregulation and other related psychological processes such as the impact of trauma on first presentations of psychosis, that we need a better understanding of the developmental processes underlying many of the psychological factors instrumental in psychosis and an up-to-date developmental psychopathology of psychosis. Previous developmental considerations highlighted the considerable overlap of common experiences in psychosis and in normal adolescent experiences that might be deemed psychotic if viewed from a purely clinical perspective, and we also gained a better understanding of normal adolescent life experiences and transitions that might heighten individual's vulnerability to the development of a psychotic disorder. At the heart of these developmental trajectories are concepts of attachment, reflective functioning, and mentalisation, in particular in interaction with psychological and psychosocial factors such as early experience of loss and trauma. The paper will consider attachment theory and reflective function in particular as a constructive context in which to understand the basic developmental principles of affect regulation and later difficulties in close interpersonal relationships that impact on help seeking and recovery in first episode psychosis. We know from numerous developmental studies that positive attachment experiences aid the development of reflective function and mentalisation, or the capacity to understand oneself and others in their intentionality, feelings and beliefs; this ability of interpersonal interpretation is hence a catalyst for many self-regulatory processes. These processes seem essential to any psychological formulation of psychotic symptom experience or psychotic episode. We will present data from a recent prospective study of first episode psychosis to illustrate the specific role that reflective function may play in relation to premorbid functioning, service engagement and recovery.

### **Compassion-Focused Group Therapy for Recovery after Psychosis: Results from a Pilot Randomised Controlled Trial**

Christine Braehler, NHS Ayrshire & Arran, University of Glasgow, Andrew Gumley, University of Glasgow, Janice Harper, NHS Ayrshire & Arran & Sonia Wallace, NHS Ayrshire & Arran

Objective: Shame, entrapment, stigma, fear of recurrence and social isolation are known to block emotional recovery after psychosis. Compassion-focussed group therapy for psychosis (CFTgp) aims to counteract defeatist, self-attacking and avoidant attitudes by developing compassionate relating to self and others. This pilot randomized controlled trial aimed to evaluate the feasibility and preliminary effectiveness of CFTgp in promoting emotional recovery from psychosis compared to standard care alone. Method: 40 adult outpatients with schizophrenia-spectrum disorders and identified psychological needs were randomly assigned to either 16 sessions of CFTgp and treatment as usual (TAU) or to treatment as usual alone. Each of the three therapy groups were delivered by 2 clinical psychologists. An independent assessor blind to assignment conducted assessments at baseline and post-treatment. Primary outcomes consisted of observer-rated global clinical improvement and self-

reported depression (Beck Depression Inventory II); positive and negative affect (Positive and Negative Affect Scale); shame, loss, entrapment, humiliation and control in relation to psychosis (Personal Beliefs about Illness Questionnaire - Revised); fear of recurrence (Fear of Recurrence Scale) and compassion (Relational Compassion Scale). Therapy mechanisms were assessed using a semi-structured interview. Transcribed interviews were then coded for affect regulation as reflected in the organization of narratives. Results: Differences between CFTgp and TAU on outcome measures will be presented. To explore potential mechanisms of change, the associations between coping style and outcome across the sample will be presented. Conclusions: This is the first controlled trial of compassion-focussed therapy. The clinical and theoretical implications of results for emotional recovery from psychosis will be discussed.

**Metacognition in Psychological Treatments for Psychosis: Perspectives on Theory and Measurement**  
 Convenor: Yvvy Huddy, Institute of Psychiatry, King's College London

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**Metacognitive skill in accurately appraising one's own cognitive function - how do we measure it and does it mediate the relationship between cognitive skills and work performance?**

Clare Reeder, Yvvy Huddy, Tory Pile & Til Wykes, Institute of Psychiatry, King's College London

The metacognitive ability to reflect upon one's own cognitive skills accurately has been implicated in theories of the relationship between cognitive skills (e.g. memory, attention, executive function) and everyday functioning in people with a diagnosis of schizophrenia. A number of self-report questionnaire measures exist to assess this aspect of metacognition, but these cannot tell us about the accuracy of the metacognitive appraisals that are elicited. This study aims to develop new objective ways of assessing metacognitive skill in appraising cognitive function, using self-report metacognitive measures in combination with observable behavioural responses. These adapted tools will then be used to investigate (a) the relationships between cognition, metacognition and work performance at a single time point and (b) the role of metacognition in the transfer of new cognitive skills to improved work performance following cognitive remediation therapy. 57 people with a diagnosis of schizophrenia and in some kind of structured work activity were recruited for a cognitive remediation treatment study investigating the impact of changes in cognition on work status and work performance. All participants completed a battery of cognitive, metacognitive and work assessments prior to undertaking cognitive remediation therapy. Novel ways of assessing metacognition will be reported, along with cross-sectional and longitudinal associations between metacognitive skill, cognition and work performance. This may help us develop tools which provide an objective measure of metacognitive ability rather than metacognitive appraisals, and to gain a better understanding of the impact of metacognition on the relationship between cognitive function and work performance.

**The developmental basis for impairments in metacognition in first episode psychosis**

Andrew Gumley, University of Glasgow, Angus MacBeth, University of Glasgow, Suzy Clark, Greater Glasgow and Clyde NHS, Matthias Schwannauer, University of Edinburgh, & Giancarlo DiMaggio, Third Centre for Cognitive Therapy, Rome

Metacognitive function refers to how individuals make sense of their own and others' behaviour in terms of mental states and their utilisation of this capacity to solve problems and to cope with specific mental states that are a source of distress (Semerari et al., 2003). Problems in metacognition have been implicated in schizophrenia, Borderline Personality Disorder (BPD) and personality disorders in general, and complex trauma and PTSD. Normative developmental pathways, which are important to metacognition, are compromised amongst people who are later diagnosed with complex mental health problems particularly trauma related disorders, personality disorders and psychotic disorders including Schizophrenia. From this perspective, complex mental health problems including personality disorder and psychotic disorders including Schizophrenia can be conceived as disorders of affect regulation underpinned by weakened or compromised metacognition and mentalization. A crucial implication of this model is that change is possible at many points despite earlier unsuccessful attempts at adaptation and the return to positive functioning also remains possible. This has important implications for the development of psychological therapies focussed upon recovery from complex mental health problems. The paper will use single case material to illustrate the relationships between impairments in metacognition as assessed by the Metacognitive Assessment Scale (Semerari et al., 2003) and attachment security as assessed using the Adult Attachment Interview (AAI; Main, Goldwyn & Hesse, 2002) alongside the clinical and therapeutic implications for supporting recovery after psychosis.

**The Neural Basis of Metacognitive Skills**

Richard Drake, School of Community Based Medicine, University of Manchester, Kunal Kala, Greater Manchester West Mental Health NHS Foundation Trust, Shane McKie, School of Community Based Medicine, University of Manchester, Rebecca Elliott, School of Community Based Medicine, University of Manchester & Shon Lewis, School of Community Based Medicine, University of Manchester

Introduction. Metacognitive skills of the type used to manage neurocognitive task performance are likely to be important in schizophrenia. For instance, the ability to manipulate task level representations of stimuli, distinct from object level representations, during a modified form of the Wisconsin Card Sort predicted better insight in first episode schizophrenia sufferers. These skills may moderate the relationship between neuropsychological deficits and everyday function, e.g. the ability to anticipate and mitigate poor performance. However, their neural basis is still little understood even in those without illness. We set out to explore the metacognitive skills common to a variety of tasks using fMRI, hypothesising that across differing tasks common skills would activate common areas. Methods. 12 adults (8 men, 4 women) without illness were recruited by advertisement. They performed three tasks during fMRI (1.5T): a lexical decision task, a modified card sorting task and a line length categorisation task. Each task had two forms: the MC form was metacognitively demanding (requiring judgment of probability each response was correct and staking money on the outcome); and the C form was undemanding (the same questions but with an obviously high probability of a correct response). The functional MR scan was divided into blocks for analysis: C was contrasted with MC in a random effects ANOVA for each task. A comparison with the global null hypothesis was then made to delineate potential areas of common activation. Within these areas a

comparison with the partial null hypothesis clarified areas meeting intensity and extent criteria for common activation across two or more tasks. Post hoc, activation at these sites due to the C v MC contrast for each task was compared. Results. Posterior medial frontal cortex (BA 6/8) and inferior parietal lobule bilaterally (BA40) showed consistent activation leading to  $p(\text{FWE}) < 0.05$  activation on all conjunction analyses. Evidence of activation across tasks was somewhat consistent in anterior bilateral middle and superior frontal gyri (lateral BA10) and posterior inferior frontal gyrus/anterior insula (BA47), especially right BA47. Discussion. Areas required to maintain attentional set were not picked out by the C v MC contrast. We concluded there was good evidence of activation of areas required for strategic evaluation of serially presented information (BA 6/8) leading to updating of response plans and preparing to switch attention across tasks (BA40). There was evidence of activation of areas often associated with decision making under uncertainty, though areas activated by tasks where information was presented cross-sectionally or participants were uncertain about stimuli rather than rules had slightly less evidence for consistent activity (BA10, BA47). Since these functions and areas are affected by schizophrenia further investigation in this group is warranted.

#### **Metacognitive beliefs in people with distressing psychotic experiences**

Tony Morrison, University of Manchester

Recent models of emotional disorders and psychosis implicate metacognitive beliefs in the development and maintenance of psychological distress. A series of studies examining metacognition in people with psychosis and those at high-risk of developing psychosis will be described. Patients with psychotic diagnoses and those at high risk of developing psychosis score higher on metacognitive belief dimensions than non-patients. Patients with psychosis appear to score similarly to patients with anxiety disorders on such measures. Predictions derived from a metacognitive model of psychosis and the S-REF model have been confirmed in large samples of people with psychosis and those at high-risk: negative metacognitive beliefs are positively associated with several dimensions of symptomatology, particularly distress, and positive metacognitive beliefs appear to be particularly implicated in the frequency of psychotic experiences. The implications of these studies for theory and clinical practice will be considered.

#### **Cognitive Therapy for People with Psychosis refusing Antipsychotic Medication: Recent Developments and Future Directions**

Convenor: Tony Morrison, University of Manchester

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#### **A user-led qualitative study of participants' experiences**

Rory Byrne, University of Manchester

It is increasingly argued that service users should be consulted to evaluate their subjective experiences of mental health services and participation in research trials. Similarly, it is considered valuable to conduct qualitative and user-led research with those with mental health difficulties. This study is a user-led qualitative study and aims to evaluate the subjective experiences of participants in a recent research trial of CBT for psychosis for people who refuse antipsychotic medication. Semi-structured interviews are being conducted with participants based on Grounded Theory methodology, and we hope to interview between 8 and 10 individuals. It is hoped that the study will have been completed for this presentation, when results, conclusions, and implications will be described. If the study is not complete at the time of presenting, interim findings and interim conclusions and implications drawn from the data available will be presented.

#### **Cognitive therapy for people with a diagnosis of psychotic illness who are not taking antipsychotic medication due to refusal or intolerance: Illustrated by case examples**

Paul Hutton, Greater Manchester West NHS Trust

Case examples will be used to illustrate issues which may be faced by cognitive therapists when working with people with a diagnosis of psychotic illness who are not taking antipsychotic medication due to refusal or intolerance. There will be a particular focus on presenting clinical material which demonstrates: (1) the importance of developing idiosyncratic shared goals for continued engagement; (2) the toxic role of stigma and the antidote of normalisation; (3) the use of individualised cognitive formulations to guide intervention; (4) the key role of specific catastrophic appraisals (cognitive and metacognitive) and safety behaviours in maintaining distress; (5) successful change techniques; (6) balancing risk management with engagement and treatment progress and (8) balancing reduction of distress with promotion of autonomous decision-making. This will be followed by some tentative speculation regarding the positive and negative impact of antipsychotic medication on the effectiveness of cognitive therapy for psychosis.

#### **Cognitive Therapy for People with Psychosis refusing Antipsychotic Medication: Rationale and design of a randomised controlled trial**

Anthony Morrison, University of Manchester, Douglas Turkington, University of Newcastle, Alison Brabban, University of Durham, Paul Hutton, GMW MH NHS Trust & Melissa Wardle, GMW MH NHS Trust

Whilst antipsychotic medication is the first line of treatment for schizophrenia, there is mounting evidence that many service users choose to refuse or discontinue their pharmacological treatment; for example, the largest study to compare newer antipsychotics found that 74% of patients with a diagnosis of schizophrenia chose to discontinue their medication within 18 months. Cognitive therapy has been shown to be effective when delivered in combination with antipsychotic medication, but has yet to be formally evaluated in the absence of such medication, although there have been promising case series demonstrating some benefits. The rationale for a randomised controlled trial of cognitive therapy for people not taking antipsychotic medication will be described, as will the design and methodology of the trial. Outcome measures include psychotic experiences, distress, disability, and satisfaction. Currently, there is very little evidence to support any alternative interventions when people refuse antipsychotics. This research will provide commissioners with valuable data for improving choices for service users and equip service providers with information regarding alternative evidence-based interventions when service users refuse medication initially or discontinue due to side effects or lack of efficacy

**CBT for patients with schizophrenia spectrum disorder who refuse antipsychotics: a prospective cohort study**  
 Douglas Turkington, University of Newcastle, Anthony Morrison, University of Manchester, Alison Brabban, University of Durham, Helen Spencer, NTW NHS TRUST, Sarah Barratt, GMW NHS TRUST  
**Background** CBT has been shown to be an effective treatment for resistant positive and negative symptoms in schizophrenia spectrum disorder when delivered in combination with antipsychotic medication. However, there are many reasons why patients with psychosis might never start or discontinue antipsychotic medication. These include lack of insight, lack of efficacy, side effects or stigmatisation. No prospective cohort study has ever been reported to indicate whether CBT might be an effective treatment in the absence of antipsychotic medication. If this were proven to be the case then patients with psychosis who persistently refuse medication might be offered the choice of CBT as an alternative treatment strategy. **Methodology** 20 patients with schizophrenia spectrum disorder were recruited across two sites in the North of Britain. All patients fulfilled criteria for schizophrenia spectrum disorder (ICD10). All patients were aged 16-65 years and had been antipsychotic free for at least 6 months or had never been prescribed antipsychotics. All patients were seen by experienced CBT therapists offering 20 sessions of CBT over a 9 month treatment window. All therapists were trained in the same manualised CBT intervention and received both individual and group supervision. Independent ratings of safety, overall symptoms, hallucinations, delusions and recovery were taken at Baseline, mid intervention and end of therapy. An effect size was to be calculated from the PANSS total score using Cohen's d methodology. **Results** End of therapy interim results will be presented on the above outcomes at the conference. **Discussion** The implications of these findings will be debated.

#### **Caregiving Processes in Early Psychosis**

Convenor: Juliana Onwumere, Institute of Psychiatry, King's College London

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#### **REACT - Relatives Education and Coping Toolkit**

Fiona Lobban, Lancaster University

REACT - Relatives Education and Coping Toolkit - is a supported self management package to provide information and support to relatives of people experiencing their first episode of psychosis. The toolkit is available as a series of booklets or online. Support is by telephone or email. The content and design of the toolkit is informed by a systematic review of interventions to support relatives and focus groups in which relatives told us about what they needed. The acceptability, feasibility and potential effectiveness of the toolkit in reducing distress of relatives is being assessed in a small RCT. Results from the review and focus groups will be presented. The trial is ongoing. REACT is part of a NIHR funded project. The views expressed are those of the author and not necessarily those of the NHS, the NIHR or the Department of Health.

#### **Are social cognition difficulties related to distress, understanding of problems and negative relationships in patients with early psychosis and their carers?**

Eleanor Tomlinson, Institute of Psychiatry; South London & Maudsley NHS Foundation Trust, Juliana Onwumere, Institute of Psychiatry; King's College London & Elizabeth Kuipers, Institute of Psychiatry; King's College London  
**Background:** Psychosis is associated with difficulties with social cognition (Brune et al., 2007) both in early psychosis (Bertrand et al., 2007), and in first-degree relatives (Janssen et al., 2003). We also know that the patient-carer relationship can be difficult, and that carer high expressed emotion predicts patient relapse in psychosis (Butzlaff & Hooley, 1998). **Aim:** This study examined whether patient and carer social cognition play a role in the patient-carer relationship in early psychosis. **Method:** 33 patients with early psychosis and 25 carers were recruited, of which 16 were matched patient-carer dyads. All participants completed two social cognition tasks; measuring theory of mind and facial emotion recognition. Carers completed measures of expressed emotion (EE) and burden. Patients completed measures of perceived carer criticism, symptoms and social functioning. Illness perceptions, mood, and beliefs about the self were also measured in both groups. **Results:** Both patients and carers showed impaired performance on social cognition tasks. High carer EE was related to carer burden, distress and beliefs about how much control patients have of the illness, illness duration and effectiveness of treatment. Patient perceptions of carer criticism were related to elevated anxiety, depression, negative beliefs about the self and others. Patient social cognition was not related to perceptions of carer criticism, social functioning or symptoms. Carer social cognition was not related to EE, or burden, but was negatively related to beliefs about patients' controllability of symptoms, the effectiveness of treatment and their understanding of the problem. Exploratory analyses of the patient-carer dyads showed no significant relationships between patient and carer social cognition and other relationship factors. **Discussion:** Social cognition difficulties were identified in patients and carers but were not associated with different aspects of the patient-carer relationship in this sample. However, carer social cognition was related to carer illness attributions, which were themselves related to EE and burden. Social cognition difficulties are present in early psychosis but appear to have minimal impact on the caregiving relationship when patients have a more stable presentation. Further studies with longer term patients and those in acute phases are recommended.

#### **Coping in carers of people with first episode psychosis: Developing hypotheses about mechanisms of change in a carers' support group. A paper translating practice into science**

Miriam Fornells-Ambrojo, Juliana Onwumere, Eric Morris & Elizabeth Kuipers, Institute of Psychiatry, King's College London & South London & Maudsley NHS Foundation Trust

**Background:** In 2003, a pilot randomised controlled trial of a support programme for carers of patients with psychosis (Szmukler, Kuipers, Joyce et al., 2003) was designed in the context of widespread awareness of the impact of psychosis on informal caregivers (e.g. family) but little understanding of how to best help them. The carers' programme did not show any significant benefits on hypothesised outcome measures (psychological morbidity, negative appraisals, coping or social support). The matter of how best to help carers remained elusive. There are a number of reasons to revisit this question in 2009. Carer support groups are common in early intervention for psychosis services in the United Kingdom. High levels of expressed emotion (EE) in carers have been associated with avoidant coping style, high distress and depression and high reported burden of care. High EE in turn has been linked to increased likelihood of relapse of psychosis. Although Family Interventions have been

shown to be effective in reducing relapse rates in recent meta-analyses, there seems to be an additive potential therapeutic role for carer support groups, particularly in relation to carers' reports of social isolation, stigma and, in the case of first onset of psychosis, issues of loss and trauma. Method: The study used a cross-sectional design with mixed methodology. Twenty-one carers who were attendees of the carers group in the Lambeth Early Intervention Service in South London completed questionnaire measures on wellbeing, illness perceptions and coping strategies. A focus group involving 13 carers and 5 individual audio-recorded interviews using a semi-structured interview format were used to elicit appraisals about the carer support group intervention. Results: Carers reported a range of coping strategies; most commonly from the problem-solving category including social support, planning and active coping, closely followed by emotion-focused coping. The least commonly used strategy was avoidance. Higher levels of carer emotional distress were associated with perceiving that the patient's mental health problems had more negative consequences for the carer and with higher carer self-blame. Avoidance coping strategies were associated with higher beliefs of illness control in both the patient and the carer. Finally, higher caregiver distress was negatively associated with problem-solving coping strategies. Thematic analyses of the data from focus group and the interviews with carers generated 6 key themes about the experience of attending the carers' support group: Experienced carers are believable sources of information/ reducing isolation/ processing trauma/ a non-stigmatising place for carers/ evaluation by social comparison/carers' group as a link to the service. Discussion: The implications of the results will be discussed in relation to cognitive models of psychosis and caregiving. Recommendations for future studies designed to test hypotheses derived from the current themes will be discussed.

**A comparative study of the experience of caring for someone with recently diagnosed anorexia nervosa and psychosis: A presentation of quantitative and qualitative results.**

Jenna Whitney, Institute of Psychiatry, King's College London; Central & North West London NHS Foundation Trust, Elizabeth Kuipers, Institute of Psychiatry, King's College London & Ivan Eisler, Institute of Psychiatry, King's College London

Caring for someone with a severe and potentially life threatening mental illness may be particularly distressing as these illnesses are likely to foster strong emotions and present unique demands on caregivers. Anorexia Nervosa (AN) and Psychosis typically develop in adolescence or early adulthood; the caregiving role generally falls by default upon the parents. Both problems have subgroups with high rates of patient relapse and a large impact on carers and the family as a whole. While similar emotional responses of seeing one's loved one develop a severe mental illness have been described within the literature, it is questionable whether the processes underlying carers' emotional responses are the same or different. There have been few comparative studies in the caregiving literature and little research examining models of caregiving in eating disorders. The aim of this study was to explore mothers' and fathers' experiences of caring for people with recently diagnosed AN or Psychosis (aged 16 to 35 years of age). Using questionnaires, the study examined differences between carers of people with AN and psychosis with regards to their perceptions of the illness, feeling of loss, levels of distress, coping strategies, and expressed emotion (EE) and the relationships between these variables according to proposed theoretical models of caregiving. The study also included a qualitative investigation of caregiving experiences. Thus, two focus groups were held (one for carers of people with AN and one for carers of people with psychosis) and analysed using thematic content analysis. A discussion of the findings with their clinical and research implications are presented.

**Substance use and Psychosis**

Convenor: Christine Barrowclough, University of Manchester

**Relationships between cannabis and psychotic symptoms: findings from the MIDAS study**

Christine Barrowclough & Richard Elmsley, University of Manchester, & Ruth Beardmore, Keele University  
Estimates of cannabis use by people with schizophrenia are high and use is associated with significantly worse outcomes for this client group. A number of lines of study suggest this negative impact may arise from the specific effects of cannabis on psychotic symptoms. However, alcohol and other street drugs are also associated with a range of adverse outcomes and to date, there is little available data with which to ascertain whether negative correlates of these substances are similar irrespective of the nature of the substance or whether there is a specific impact of cannabis on positive psychotic symptoms as suggested in previous studies. In a large sample of people with psychosis and a co-occurring substance misuse (drugs and alcohol) problems, this study aims to determine how cannabis use is differentiated from the use of other substances by comparing a range of demographic, attitude to medication, illness and symptomatic variables in people using cannabis with those not using cannabis (but using other drugs or alcohol), whilst controlling for other substances used. To further examine the links between cannabis and psychosis reported in previous studies of people with established psychosis, several hypotheses are tested. Firstly, that cannabis use will be associated with more positive psychosis symptoms compared with those people who do not use cannabis (but do use other substances). Secondly, there will be a dose effect such that greater cannabis use will be associated with increased positive psychotic symptoms. Thirdly, in a longitudinal analysis, after adjusting for potential confounders, changes in cannabis use will be associated with changes in positive symptoms.

**Reasons for Substance Use in Psychosis**

Lynsey Gregg, Christine Barrowclough & Gillian Haddock, University of Manchester  
Around half of all people with psychosis abuse drugs and alcohol. These 'dually diagnosed' patients are known to be at risk of poorer symptomatic and functional outcomes than their non substance using counterparts and studies have shown that even relatively minor substance use can have an adverse impact. There is a clear need to reduce the high levels of drug and alcohol consumption in this population but for treatments to be successful, we must have a better understanding of the reasons for this use. The results from a series of studies designed to examine reasons for use by people with psychosis are presented. We report on the development of a questionnaire to assess self reported reasons for drug and alcohol use and present the findings from two cross sectional studies which utilize the questionnaire to examine the relationship between reasons for use, psychiatric symptomatology and



substance use. A meditational model of substance use is proposed which hypothesises that reasons for use and coping strategies mediate the link between psychopathology and substance use for people with psychosis.

#### **The role of substance use and psychotic symptoms in the occurrence of aggression and violence in people with a diagnosis of schizophrenia**

Gillian Haddock, University of Manchester

**Background:** There has been much published research investigating the relationship between schizophrenia and violence. This research suggests that rates of violence in people with schizophrenia are higher than in community controls. However, findings are mixed, and other factors have been investigated, for example, the link between substance, schizophrenia and violence. When substance misuse is linked with schizophrenia, rates of violence and aggression are often higher than for schizophrenia alone. However, methodological differences between studies make it difficult to elucidate the extent and frequency of violence amongst people who have schizophrenia who have a co-occurring substance use problem and how this relates to specific psychotic symptoms. **Aims:** This study aimed to retrospectively and prospectively explore rates of violence in a cross-sectional sample of people with a diagnosis of schizophrenia who also met DSM-IV-R criteria for substance, misuse or dependence and to investigate the relationship between delusions, hallucinations, substance use and violence. It was hypothesised that there would be higher rates of violence compared to non substance using populations and that the presence of delusions and hallucinations would increase these rates. **Results:** Participants taking part in the Medical Research Funded study, the MIDAS trial, were recruited (n = 327). Twenty percent of the sample engaged in violence over a 2 year follow-up period. Alcohol use, but not drug use was associated with higher frequency of violence. Substance use was not associated with type or severity of delusions although severity of alcohol misuse was associated with severity of hallucinations. Retrospective rates of physical violence were positively correlated with delusions. Violence over the two year follow-up was positively correlated with negative symptoms. **Conclusions:** Violence in people with schizophrenia and substance use problems may be higher than in non-substance using populations. The presence of psychotic symptoms may contribute to violence suggesting that an understanding of the relationship between substance use and different types of symptoms may be important for developing interventions to tackle violence.

#### **Understanding factors influencing substance use in people with recent onset psychosis: a qualitative study**

Fiona Lobban, Lancaster University

This qualitative study identifies factors influencing the use of substances in young people with recent onset psychosis. A purposive sample of nineteen people from an Early Intervention Service in the English National Health Service (NHS) were interviewed using a semi-structured guide. All had experienced a psychotic episode and were within 3 years of first contact with the service. All were either currently misusing substances or had been doing so in the 6 months prior to first contact with the service. All participants were / had been regular cannabis users and for 13 (68%) cannabis was the primary drug of use. Eleven participants (58%) were regular users of more than one substance. The qualitative data were analysed by a team of academic researchers, clinical academic psychologists and a non-clinical academic with expertise in qualitative methodology. One team member has experience of substance use and using mental health services. Thematic analysis identified four key themes: Influence of perceived drug norms on behaviour; Attributions for initial and ongoing drug taking behaviour; Changes in life goals affecting drug use; Beliefs about the links between mental health and drug use. These findings have clear implications for interventions at a number of levels to support young people using substances in early psychosis including public health messages, education and psychological therapies.

#### **Challenges and Benefits of delivering MiCBT - Confessions of a Midas Trial Therapist**

Mike Fitzsimmons, Lancashire Care NHS Foundation Trust, Sarah Nothard, Greater Manchester West Mental Health NHS Foundation Trust & Paul Earnshaw, Greater Manchester West Mental Health NHS Foundation Trust

The integrated MIDAS therapy (MiCBT) was developed to address the complexities of working with people who experience psychosis and problematic substance use. We intend to explore the challenges of delivering this integrated psychological therapy in community settings drawing upon the experience of working as therapists on the MIDAS Trial. The presentation will illustrate the challenges faced by both clients and therapists. It will reflect upon the strengths of the therapeutic approach and consider future directions.

#### **Psychological Processes in Psychosis: Testing and Refining Models of Voices and Delusions**

Convenor: Robert Dudley, Newcastle University

#### **Better safe than sorry: The effects of arousal on auditory threat detection**

Helen Bolas, Guy Dodgson & Robert Dudley, Newcastle University

A common analogy used in CBT for anxiety disorders is of the over sensitive smoke detector. When we feel anxious and aroused the detector is too vigilant to "threat" and even detects a threat that is not actually there. In this study the effect of arousal on the discrimination of auditory threat stimuli was investigated to see if when aroused, we detect more threat and even mistake neutral material as threatening. A novel experimental paradigm; the Auditory Threat Discrimination Task (ATDT) was developed for this purpose. The ATDT presented participants with a repeated auditory discrimination task (threat and non-threat words) and an arousal induction. A total of 57 participants were included in the analyses (14 male, 43 female). Participants showed a significant increase in bias towards threat following the arousal induction. Those participants detected significantly more threat, measured by hit and false-alarm responses, following the arousal induction. Participants demonstrated significantly slower reaction times to detecting threat under conditions of arousal. This represents the first stage in testing the smoke detector analogy by investigating the effect of arousal on the discrimination of auditory threat. The findings provide initial evidence that auditory threat detection increases under conditions of arousal. The mechanism underlying this effect is a change in decisional bias towards identifying auditory stimuli as threatening. Extrapolating from the results is speculative and offers an etiological and maintenance mechanism of psychological threat related distress.

### **Investigating the role of rumination and safety behaviours in the maintenance of paranoid ideation in a non-clinical sample**

Jennifer Simpson, Bryony MacGreggor, Kate Cavanagh & Robert Dudley, Newcastle University

**Aim:** Freeman, Garety, Kuipers, Fowler & Bebbington, (2002) developed a cognitive behavioural model for persecutory delusions, in which it was hypothesised that persecutory delusions are maintained by both safety behaviours and cognitive processes, including rumination. This paper reports a study investigating the relationship between rumination and safety behaviours in the maintenance of paranoia in a non-clinical sample. **Methodology:** A single group cross-sectional design was utilised, measuring paranoid beliefs, safety behaviours, rumination and mood. This was to examine the relationship between these constructs, in order to determine how well rumination and engagement in safety behaviours explain the presence of paranoia. **Results:** Hierarchical multiple regressions revealed that engagement in safety behaviours and rumination explained 49% of the variance of paranoia when combined with age, gender and negative affect. **Conclusion:** This paper provides some evidence for the role of safety behaviours and rumination in the maintenance of persecutory delusions and paranoia, as stated in its cognitive behavioural model. This has implications on clinical practice, suggesting that processes of safety behaviours and rumination should be assessed for in patients with persecutory delusions. This presentation also highlights the need for further research in this area.

### **The nature and effect of adverse life events on paranoid ideation in a non clinical population**

Jim Greer, S Fawcett, Robert Dudley, Newcastle University & Mark Freeston, Northumberland Tyne and Wear Foundation NHS Trust

People with paranoia are suspicious and mistrustful of others. Hence, beliefs about other people seem to be particularly pertinent in understanding this experience. An important question is whether this suspicion and mistrust is a result of real experience of being victimised or unfairly treated. Hence, we examined how adverse life events such as being victimised are associated with paranoia and contribute to a person being suspicious and mistrustful of others. In a sample of over 260 undergraduate participants recent adverse life events were recorded, and the relationship with levels of paranoia, and beliefs about self and others considered. It was found that people reported a range of adverse life events such as suffering bereavement, ending a relationship, facing health challenges, or not meeting career or academic expectations. However, those high in paranoid ideation reported more victimisation events (such as being assaulted) than people low in paranoid ideas. These participants were followed up some three months later and the impact of these adverse life events on beliefs about self and other people were investigated. It can be seen that such information adverse life events may play an important role in helping understand the development and maintenance of persecutory beliefs. Beliefs about others may be specific targets for change using Cognitive therapy.

### **Attachment style and beliefs about self and others in paranoia and social phobia**

Kristina Askew & Robert Dudley, Newcastle University

How someone views themselves and other people affects interpersonal functioning. These beliefs are shaped by a person's early experiences and attachment organisations. Poor quality experiences in early life can affect attachment organisation and lead to later psychological difficulties. Furthermore, current attachment organisation may influence the maintenance of these difficulties. The objective of the study presented was to examine the differences in paranoia and social phobia in terms of interpersonal processes, specifically exploring how beliefs about self and others and adult attachment differs between these two conditions. 215 university students completed a selection of self-report questionnaires measuring levels of social phobia, paranoia, beliefs about self and others and attachment styles. A cross-sectional single group regression design was used to investigate the predictive utility of multiple regression variables on criterion variables of social phobia and paranoia. Hierarchical regression analysis revealed a relationship between social phobia and low positive-self and positive other evaluative beliefs and also high anxiety in attachment organisations. Analysis also revealed a relationship between paranoia and negative self, negative other and low positive other evaluative beliefs and also high avoidance and anxiety in attachment organisations.

### **Twenty years of Jumping to Conclusions**

Kate Cavanagh & Rob Dudley, University of Sussex

The last 20 years has seen a significant research interest into the phenomena of 'jumping-to-conclusions' (JTC) in people with delusional beliefs in the context of psychotic illness. JTC is a data-gathering bias characterised by limited search for evidence and hasty decision making. It appears to be a 'robust' clinical phenomenon (Dudley and Over, 2003). A recent meta-analysis has confirmed that people with delusions tend to request less information before making a decision in comparison to clinical and non-clinical controls (Fine et al., 2007). It is argued that this bias contributes to the development and maintenance of delusional beliefs (Dudley and Over, 2003; Garety and Freeman, 1999; Peters and Garety, 2005), and would be wisely addressed in therapeutic interventions for psychosis (Dudley and Over, 2003; Garety et al., 2005). It is timely to take stock not just of the strength of research findings relating the JTC bias but also their meaning. This presentation describes a systematic review of the literature exploring the JTC bias and considers the implications of research in this field for our understanding of the role of reasoning in delusional beliefs and how this can inform the development of therapeutic strategies for psychosis.

## **Skills Class**

### **Culturally Adapted Cognitive Behaviour Therapy for Psychosis: Using CBT with patients from ethnic minority groups**

Peter Phiri & Shanaya Rathod, Hampshire Partnership NHS Foundation Trust, & David Kingdon, University of Southampton & Hampshire Partnership NHS Foundation Trust

Cognitive Behaviour Therapy (CBT) is an evidence based treatment for Schizophrenia. The treatment is acceptable to patients and should be offered to any individual with persistent (positive and negative) symptoms of psychosis

and those on remission (NICE Clinical Guidelines, 2009). Literature shows rates of Schizophrenia to be 2 to 14 times greater for African-Caribbean than for white people in the UK (Fearon & Morgan 2006, King et al, 2005). Cultural adaptations and understanding of ethnic, cultural and religious interpretations is an area which currently remains underdeveloped (Rathod et al., 2008). Studies have shown that patients from Black and Minority Ethnic (BME) groups respond less favourably to CBT, resulting in disengagement with treatment, high drop-out rates and poor outcomes within this population in comparison to their white counterparts (Rathod et al., 2005). Moreover, models of mental ill health including cognitive behavioural approaches have been criticised of being 'Euro-centric' (McCulloch et al., 2005) and for their assertion that they are applicable across cultures "one size fits all". Qualitative work has indicated a range of appropriate adaptations (Rathod et al, 2009 & under review) which are now being evaluated. Cultural factors play an essential part as beliefs, behaviours, emotions and even psychological responses to situations will vary depending on the cultural background of the patient. For example in Western cultures, schematic beliefs reflect the high value accorded to individualism and independence. On the other hand, in Eastern cultures, they reflect the importance of being part of a group and approved by key family members. These factors influence a patient's response and participation in therapy. It is therefore imperative for CBT therapists to be cognisant of these if they are to develop strategies to improve patient participation with positive outcomes. The skills class aims to introduce pertinent issues of ethnic and cultural diversity fundamental for the practice of CBT in a multicultural society.

At the conclusion of this session participants will be able to: 1. Understand the reasons for culturally adapting Cognitive Behaviour Therapy to facilitate engagement and improve outcomes in patients from ethnic minority communities 2. Recognise themes and be able to adapt therapy to diverse cultures and appreciate the impact of culture on treatment when interacting with patients from these communities 3. Develop case formulations taking into account relevant cultural factors 4. Develop a dialogue and practice with confidence when addressing difficult cultural issues of patients 5. Increase awareness of the therapists' own culture and its impact on the therapy process.

Peter Phiri (Researcher and Cognitive Behaviour Therapist) is a Project Co-ordinator in a BME project 'developing culturally adapted CBT for psychosis for ethnic groups. He is undertaking his doctoral studies at the University of Southampton. He is currently conducting 'Feasibility study of Culturally adapted CBT for psychosis with ethnic groups' in three centres in the UK, to assess the feasibility and fidelity of CaCBTp for use in specified BME groups. Dr Shanaya Rathod, Consultant Psychiatrist and Associate Medical Director, leads Crisis Resolution & Home Treatment services in Winchester. She is project lead for the department of health (DRE) funded project - Developing culturally adapted CBT for psychosis for ethnic groups

Prof David Kingdon, Professor of Mental Health Care Delivery, Department of Psychiatry, University of Southampton, Royal South Hampshire Hospital, Southampton

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The Developing culturally sensitive CBT for Psychosis project website can be found at: [www.its-service.org.uk/equalities/en/our-work/delivering-race-equality/clinical-trailblazers/mid-hampshire-and-eastleigh/](http://www.its-service.org.uk/equalities/en/our-work/delivering-race-equality/clinical-trailblazers/mid-hampshire-and-eastleigh/)

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## Posters

### 27. Using Positive Emotions in Therapy: Effectiveness of the Broadmind Affective Coping (BMAC) Technique

Judith Johnson, University of Manchester, Patricia Gooding, University of Manchester, Peter Taylor, University of Manchester, Alex Wood, University of Manchester, Nicholas Tarrier, University of Manchester  
Recent years have seen growing interest into the benefits of positive emotions (eg. Fredrickson, 2006). These are thought to broaden thought-action repertoires leading to the building of social and material resources and may trigger positive upward spirals into well-being (Fredrickson, 2001; Fredrickson & Joiner, 2002). Particularly interesting is the possibility that positive emotions could be a useful tool for psychological interventions, although research in this area is currently limited. The present paper will describe research investigating whether a recently developed technique designed to elicit positive emotions may be beneficial in therapeutic settings. This procedure, known as Broadminded Affective Coping (BMAC; Tarrier, in press) uses the cued in-depth recall of a positive autobiographical memory and its associated sensory, emotional and interpretive aspects. The present research investigated whether the BMAC was more effective than a control task (listening to music) amongst a sample of individuals with schizophrenia-spectrum disorders for boosting mood immediately post-task, 2-3 hours later, and 2-3 days later. Results will be discussed with reference to the use of the BMAC in therapy and its potential associations with research into resilience. It is predicted that participants allocated to the BMAC will report higher levels of positive mood at each time point. Positive emotions could be an important tool for use in cognitive behavioural therapy, as it is thought that they may help broaden cognitions and build cognitive and material resources (eg. Fredrickson 1998; Fredrickson, 2001). The current research will indicate whether the BMAC technique could be a means for boosting mood as part of clinical interventions.

### **28. Relatives Education and Coping Toolkit (REACT)**

Laura Wainwright, Lancashire Care NHS Foundation Trust, Fiona Lobban, Lancaster University, David Glentworth, Greater Manchester West NHS Foundation Trust, Gillian Haddock, The University of Manchester, Vanessa Pinfold, Rethink, Warren Larkin, Lancashire Care NHS Foundation Trust

1 in 100 people will experience severe mental health problems. Commonly starting in adolescence, the majority will be living at home with families and this can be distressing for relatives who often have little knowledge of what is happening or how to manage it. This study aims to develop a supported self-help package for relatives of individuals experiencing a first episode of psychosis. Containing important information and guidance which is helpful to relatives in understanding what is happening and how best to manage it. Phase1: A systematic review was conducted to identify the contents of interventions that work in improving outcomes for relatives. We conducted focus groups of relatives for their views on what forms the package needs to take and what it should contain. Phase2: Relatives will be invited to try out the package and give feedback about their experiences and difficulties as part of an RCT. We will investigate whether distress and other measures of negative impact can be reduced by comparing the intervention group with a group receiving treatment as usual. Phase1 results; Systematic Review revealed that effective interventions contain; Education, Emotional aspects, Management of difficult problems, Problem solving skills, Information about specific situations, Stress management and coping - self care for relative, Communication, the Future. Briefly the Focus groups revealed that the toolkit should be basic and signposting to further sources. The toolkit should be multi-format; Website and Booklets, modular and workbook style. There needs to be an introduction to the toolkit from an STR worker. We are currently recruiting for phase2. Models of support like REACT demonstrate that CBT and other supportive interventions can be self-directed and distributed widely at low cost and using limited NHS resources.

### **29. Effect of Cognitive Dysfunction on Subjective Quality of Life in People with Schizophrenia**

Masahito Tomotake, Department of Mental Health, The University of Tokushima Graduate School, Yoshinori Ueoka, Department of Psychiatry, The University of Tokushima Graduate School, Tsunehiko Tanaka, Department of Psychiatry, The University of Tokushima Graduate School, Yasuhiro Kaneda, Department of Psychiatry, Iwaki Clinic, Tetsuro Ohmori, Department of Psychiatry, The University of Tokushima Graduate School

Enhancing subjective quality of life is important in the treatment of schizophrenia. Cognitive dysfunction is one of the core symptoms of schizophrenia and seems to influence self-evaluation of quality of life. However, there are few studies to investigate how much effect cognitive dysfunction has on subjective quality of life. The purpose of the present study is to elucidate the relation between cognitive function and subjective quality of life. Subjects were sixty stabilized outpatients with schizophrenia. Informed consent was obtained from all subjects. Subjective quality of life and cognitive function were assessed using the Schizophrenia Quality of Life Scale (SQLS) and the Brief Assessment of Cognition in Schizophrenia (BACS), respectively. Clinical symptoms were assessed with the Positive and Negative Syndrome Scale (PANSS) and the Calgary Depression Scale for Schizophrenia (CDSS). This study was approved by the Ethics Committee of University of Tokushima. We found that subjective quality of life was not related to cognitive dysfunction but was associated with depressive symptom in people with schizophrenia. These results suggest that treatment for depressive symptom may be important in order to improve patients' subjective quality of life. The CDSS score significantly correlated with the SQLS scores. Positive syndrome scale of the PANSS significantly correlated with psychosocial scale and motivation and energy scale of the SQLS. However, the BACS measures did not correlate with the SQLS scores. Stepwise regression analyses showed that the CDSS score was the most important predictor of the SQLS. This study suggests that cognitive behavioral intervention for depressive symptom of schizophrenia patients would be important to improve patients' subjective quality of life.

### **30. Identifying Underlying Factors in Bipolar Disorder: The role of Circadian Instability and Appraisal Style**

Faye Banks, Lancaster University

Sleep disturbance is frequently associated with bipolar disorder, yet little is known about the impact of sleep upon mood symptoms. According to Jones (2001), individuals who tend to internally appraise the effects of circadian disruption, are at increased risk of developing bipolar disorder compared to individuals who appraise such effects externally (i.e. exhibit normal appraisal). This research aims to investigate relationships between sleep and activity patterns, appraisal style and mood in clinical and non-clinical populations. It is hoped that this research will enhance our understanding of bipolar disorder and therefore hold implications for therapeutic interventions. The research will involve recruitment of non-clinical individuals, patients diagnosed with bipolar disorder, and a chronic illness population. The Experience Sampling Method (ESM) will be applied in order to assess participants' appraisal style moment-by-moment. Participants will be asked to wear an ESM watch which will beep randomly 10 times a day. Each beep will signal participants to fill in a diary assessing current thoughts and feelings, including appraisal. Additionally, participants will be asked to wear an actiwatch which will measure sleep and activity patterns. Measures of mood and social rhythm stability will also be administered. Although existing CBT programmes for bipolar disorder do highlight the importance of routine and stable sleep patterns, it is unclear exactly how this increased stability improves symptoms. Therefore by investigating possible mechanisms, such as appraisal style, the processes by which CBT improves symptoms of bipolar disorder will become clearer. This may highlight possible modifications to current CBT interventions, improving the long-term efficacy of such treatment.

### **31. The effectiveness of Cognitive Behaviour Therapy for Psychosis within a routine clinical service: Are treatment gains maintained at follow-up?**

Tessa Constable, PICuP Clinic, SLaM, Dr. Emmanuelle Peters, PICuP Clinic SLaM and Kings College London, The Institute of Psychiatry, Laura Smith, PICuP Clinic, SLaM, Dr. Elaine Hunter, PICuP Clinic, SLaM, Dr. Kathryn Greenwood, PICuP Clinic SLaM, Prof. Elizabeth Kuipers, PICuP Clinic SLaM and Kings College London, The Institute of Psychiatry

Over 30 RCTs have been conducted into the efficacy of CBTp, leading to its current status within the NICE guidelines for Schizophrenia. However, relatively few studies have considered the effectiveness of CBTp within routine services (Morrison et al 2004, Jakes et al, 1999), and few studies have included a long-term follow-up (Wykes et al, 2008). The aims of the present study were to (i) report on the effectiveness of CBTp within a routine

clinical setting and (ii) investigate whether gains were maintained at a follow-up of six months and above. The issues around assessing CBTp and the need for a non-quasi-neuroleptic approach (Birchwood and Trower, 2006) are also considered. Participants (n=181) who had received a minimum of 5 therapy sessions were assessed at 3 time points (baseline, pre-therapy and end of therapy), on a battery of measures assessing current symptoms of psychosis, emotional problems, general well being and functioning, as part of the routine outcome measurement for the PICuP Clinic over the past seven years. Clients were typically on the waiting list for around three to six months, and the median number of therapy sessions received was 17, these generally took place over a 6 month period, but this time length did vary due to individual need. All participants who completed therapy six or more months previously were contacted to take part in a follow-up assessment. Data was collected on 43 of the 150 eligible clients. The mean length of time between end of therapy and follow-up assessments was 21.4 months (sd = 11.1, range = 6 - 46). These results provide support for the effectiveness of CBTp in routine clinical services on a range of meaningful outcomes, and further suggest that gains are maintained following CBTp. However, the follow-up assessments were conducted on only 28.6% of the sample, which may not generalise to the rest of the sample. Participants showed no significant change in any measure during the waiting list period. Significant improvements following therapy were found in psychotic symptoms (PSYRATs-Voices and PSYRATs-Delusions), depression, anxiety, and quality of life. All gains were maintained at follow-up. This study has important implications for the practice of CBTp. It demonstrates that CBTp can be effective within routine services, outside of the controlled environment that most RCTs are conducted in. It also provides promising results that gains are maintained long-term

### **32. Engaging patients in the Early Warning Recognition and Prevention of Relapse in acute episodes of Bipolar Disorder: A Cognitive Behavioural Development**

Christopher Rae, The Logos Centre. Tees, Esk and Wear Valleys NHS Foundation Trust, Donna Swinden, Tees, Esk and Wear Valleys NHS Foundation Trust

Bipolar patients are generally regarded as being difficult to engage in psychological therapies, particularly when in, or emerging from, a manic episode. In addition, there is a lack of access to CBT as many mental health services do not offer it to bipolar patients consistently, despite there being a burgeoning evidence base for the efficacy of CBT interventions.

This poster will outline a five-stage model of engagement, specifically designed for bipolar patients (though most likely applicable to other disorders too). In addition, the most efficacious CBT interventions for bipolar disorder will be described in practical terms i.e. how to implement them with patients.

The therapeutic engagement model that has been developed has not been tested in clinical practice - it is based on theoretical information from the available literature. It would be prudent to test the model, particularly in an inpatient ward environment. It would also be valuable to explore the hypothesis that there may be an optimum time to engage bipolar patients psychotherapeutically; and that this could involve a "getting better signature".

The outcome of combining a targeted engagement model with relevant CBT interventions is hypothesised to improve engagement with CBT, increase the efficacy of the interventions and improve access to services by expanding the number of professionals who feel confident to take this approach.

- The engagement model provides a framework so that mental health professionals can use their skills effectively.
- Duration of engagement sessions should be tailored to the patient's needs, as well as considering timing.
- The order of the therapy process may also be of importance particularly for inpatients descending from a manic/hypo-manic episode.

### **33. Psychoeducation for Schizophrenia in a Forensic Unit in Japan**

Takeshi Furumura, Higashi Owari National Hospital

In Japan, the Act of Medicine and Intervention for Insanity became law in 2005. Our hospital has a forensic unit under this act and the majority of the patient we treat here has schizophrenia. One approach we use to them is a psychoeducational program. Our purpose is to increase the patient's knowledge and understanding of their illness and its treatment. We suppose that comprehensive knowledge enables patients with schizophrenia to cope effectively with their illness. In this study, we evaluated the effectiveness of the psychoeducational program for schizophrenia in a forensic unit in Japan. A total of 16 patients with schizophrenia in our forensic unit participated in this research. We received informed consent. The psychoeducational program consisted of two parts which took 5 months to complete. First, each the psychiatrist, psychologist, social-worker and occupational therapist conducted a psychoeducational intervention (4 sessions in total) in an interactive group setting. Second, nurses provided 15 sessions of Social Skills Training in a modular form. Each session lasted an hour. Patients were assessed before and after this program by Knowledge of Illness and Drugs Inventory (KIDI; Maeda, 1994), Self-Efficacy for Community Life Scale (SECL; Okawa, 2001), Insight Scale (IS; Birchwood, 1995) and Drug Attitude Inventory (DAI-10; Hogan, 1983). Data was analyzed by Wilcoxon signed-rank test. Psychoeducational group program increased knowledge and self-efficacy for community life.

KIDI and SECL improved significantly (p=.018 and p=.017, respectively). However, IS and DAI-10 did not improve (p=.492 and p=.339, respectively).

### **34. The Recovery Programme: Rebuilding self, Rebuilding life, and Hope for a better future.**

Sally Higginson, Rosie Beck, Kimberley Drummond, Samantha Hartley, Suzanne Heffernan, Natasha Snelson, Rachel Watts

A service user informed five year programme of research into understanding and promoting recovery from psychosis and bipolar disorder in a manner that is acceptable to and empowering of service users. The poster will outline the 5 projects within the programme.

The programme includes a range of innovative methodologies including qualitative interview studies, cross sectional questionnaire studies, patient preference trials, randomised controlled trials and experience sampling methodology. The full set of results will be discussed in reference to existing literature in the area, and in relation to service user defined concepts of recovery.

Preliminary results indicate that:

- A service user informed measure of subjective experiences of psychosis is both reliable and valid.
- Individuals have strong and rational preferences concerning the treatment they feel will best aid their recovery

- Recovery judgements are idiosyncratic, and there is a complex relationship between recovery judgements, psychological variables and measures of symptoms and functioning.
- Subjective recovery in bipolar disorder is viewed as being more than prevention of relapse and can involve rebuilding the self through meaningful activity
- Participants find Cognitive Behavioural Suicide Prevention therapy for psychosis to be useful for dealing with their difficulties
- It is possible for service users and professionals to work collaboratively within a research programme context.
- CBT can be used in novel ways to specifically address individuals' recovery goals and can be provided in ways experienced as acceptable to service users including telephone therapy, peer support and self help manuals.
- A cognitive behavioural suicide prevention therapy can be feasible and both acceptable to, and welcomed by, service users

### 35. Developing an Engagement Model for Bipolar patients.

Donna Swinden, TEWV NHS Foundation Trust

Bipolar patients are frequently regarded as difficult to engage in CBT, particularly when inpatients. Clinical experience suggests it is possible, however there is little evidence in the research literature that engagement has been the focus of empirical or qualitative studies.

The method is a critical literature review addressing the research questions: 1) what is therapeutic engagement? 2) can CBT models explain difficulties in engaging bipolar patients? 3) and if they can, does this provide evidence for specific engagement strategies? The model has not been tested in clinical practice - it is based on theoretical evidence - so it would be interesting to test it using an experimental paradigm. Also, is there an optimum time to engage bipolar patients and could this involve a "getting better" signature? There is no consensus regarding definitions of therapeutic engagement or its role in therapeutic processes. CBT models provide some evidence about potential engagement difficulties, and a specific 5-stage engagement model has been developed.

The model provides a framework for therapists to use their skills effectively. Duration of sessions should be tailored to the patient's needs, as well as considering timing. The order of therapeutic interventions may also be of importance.

## Training and Professional Issues

### Symposia

#### Words Don't Come Easy: Is the Medicalisation of our Language Preventing Progress in the Field?

Convenor: Fiona Kennedy, Private Practitioner

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##### What do we mean when we say we do CBT?

Fiona Kennedy, Private Practitioner

The essence of CBT is to bring to conscious awareness our thoughts about ourselves, the world and others. Then to collaboratively examine the accuracy and implications of these thoughts for our psychological well being. This paper proposes that it is time CBT practitioners applied these principles to our own activities as well as to those we work with. That is, we need to examine the language we use to describe our CBT professional activities and the implications of the language for the theory research and practice of CBT. Relational Frame Theory (RFT) focuses on the associational networks which give 'meaning' to the words we use, and the consequences of such meanings for our construction of reality and our conduct. ACT applies this theory to intervening in people's lives. What associational networks exist for us around words such as therapy, treatment, diagnosis, disorder? Are these the meanings we need? What are the consequences for us of adopting this language? Are we simply uncritically adopting the existing language of a more powerful (medical) group? The aim of this symposium is not just to debate the medicalisation of CBT language, but the wider issue of the categories and terminology we use to describe what is problematic for those we work with and how this construction of reality affects our progress. The debate has a long history and we hope to add to it by enquiring what a language unique to CBT might look and feel like if it was centred around psychological processes? The author will use the psychological process of dissociation as an example. The speakers at the symposium will examine all these issues further and there will be time for debate and audience contribution.

##### A measure of restraint

Tim Carey, Centre for Remote Health, Flinders University and Charles Darwin University, Australia

The notion of measuring constructs is firmly embedded in psychological discourse and research activities. In clinical psychology it is particularly common to discuss "measuring" psychological disorders such as depression and social phobia. Indeed, the success of psychological treatment is often determined by the way in which scores on a measure of psychopathology change between the beginning and the end of treatment. The argument is offered in this presentation, however, that psychological disorders cannot be measured in the same way that we might measure blood pressure or body temperature. Treating questionnaires as measures is problematic both conceptually and mathematically. Through the use of an example it is suggested that psychopathology questionnaires should be regarded as reporting devices rather than measures of psychological distress and restraint is needed in drawing conclusions from these questionnaires. By treating questionnaires as measures we may, in fact, be impeding progress in the field and ignoring communication efforts of our clients. By incorporating the information from questionnaires with other clinical data such as behavioural observations, more informed decisions might be possible regarding the way in which progress in therapy might best be maximised.

##### The survival of psychiatric diagnosis

David Pilgrim, University of Central Lancashire

This paper provides a general social and historical backdrop to the other papers in the symposium. Psychiatric diagnosis has been criticised on a number of grounds in the past 50 years from medical dissenters, professionals

making competing bids for legitimacy, such as clinical psychologists, and disaffected service users. Despite this contestation, psychiatric diagnosis survives and, paradoxically, with some support some of the time from some psychologists, psychological therapists and patients. The paper provides an account for the social context in which this contradictory picture has emerged. It focuses on competing medical understandings of madness and misery since antiquity, the provocation and orthodoxy of Kraepelin, the weakness of the Szaszian view about the 'myth of mental illness and professional and industrial interests. The conclusion is that psychiatric diagnosis will not collapse because of its own logical and empirical contradictions but requires a major political challenge underpinned by a clear understanding of: interest work (professional, industrial and lay); competing epistemologies (naturalism, constructivism and critical realism); and the ambiguous relationship between physical and mental illness.

#### **Psychological well-being: from academic research, through statutory regulation, to therapy**

Peter Kinderman, Liverpool University

There has recently been rapid growth in the visibility of psychological models of mental health and well-being. Such models suggest that psychological processes constitute a final common pathway in the development of mental disorder. In such models, biological abnormalities or physical insults, social factors such as poverty and social deprivation, and circumstantial factors or life events such as childhood sexual, emotional or physical abuse are hypothesised to lead to mental disorder when those factors adversely affect psychological processes. Such models have striking implications for mental health services and for individual therapists. Services should be planned and commissioned on the basis of need and functional outcome rather than diagnosis. Guided by such a model, mental health services would fully embrace the recovery approach, and there would be investment in preventative and health promotion work. There would be continued investment in high-quality, evidence-based psychological therapies, guided by expert assessments and based on psychological formulations addressing a person's wider well-being. Mental health services, working with other social services, should help clients to return rapidly to work wherever possible, and to keep them in work. Discrimination against people with mental health problems should be as unacceptable as racism or sexism, and services should adhere to the principles of Fairness, Respect, Equity, Dignity and Autonomy - the 'FREDA' principles - to help ensure human rights compliance. Services should facilitate genuine service user involvement; service users and carers should be involved at the outset in planning, delivering and evaluating mental health services. Carrying forward such initiatives, however, requires more than mere polemic. Academic research into the validity of both medical, diagnostic, approaches and possible alternatives is required. Policy must be developed which addresses staff training, employment, management and regulation as well as theoretical principles. Therapeutic practice, even within the family of psychological therapies, must evaluate the extent to which they support well-being rather than act as non-pharmacological quasi-medical treatments, prescribed for disorders.

#### **Diagnosis, science and values**

Richard Bentall, University of Bangor

Our decisions about how we describe psychological distress are informed by scientific evidence but also by our values. Over the three decades since the publication of DSM-III, much of the debate about the usefulness of medical diagnoses has focused on scientific issues. Are diagnoses reliable? Are they valid as indicated by their power to predict the future course of distress, or which interventions might be successful? The considerable resources that have been devoted to these issues have resulted in refinements to the diagnostic concepts (e.g. the imminent publication of DSM-V) and the publication of numerous psychometric instruments, although substantial disagreements remain (e.g. about whether distress is best described in terms of dimensions, usually favoured by psychologists, or categories, usually favoured by doctors). In much of this debate, the role of values in determining which kinds of behaviours and experiences are worthy of intervention (the boundaries of psychiatric concern) has often been forgotten. Sometimes changes in values can result in behaviour that was once regarded as pathological becoming reclassified as non-pathological (homosexual desire is the obvious example) but, over the last thirty years, the trend has largely been in the opposite direction. Childhood behaviour that was once seen as defiant is now seen as evidence of ADHD or paediatric bipolar disorder. Sadness has given way to an international epidemic of depression. The proposed DSM-V criteria for psychosis include at-risk mental states which, rather than being seen as evidence of risk, will probably be seen as a form of illness in due course. These changes are being driven partly by a de-contextualisation and individuation of behaviour, but also by powerful economic forces (as when the pharmaceutical industry attempted to deliberately manipulate Japanese conceptions of depression to make the activating effects of SSRIs more acceptable to the population). If we want to resist these developments, it is not sufficient to criticize the (often dubious) scientific evidence that is used to support them, but to challenge the values that lie behind them. The question we have to ask is: what kind of people do we want at the end of the twenty-first century?

#### **Developing Competence in CBT: How can Training and Supervision improve the effectiveness of clinical practice?**

Convenor: Sheena Liness, Institute of Psychiatry, King's College London

#### **Evaluating training in CBT: Using outcome measures to best inform training, supervision and clinical practice**

Sheena Liness, Institute of Psychiatry, King's College London

The Improving Access for Psychological Therapies initiative (IAPT) has led to a rapid increase in the provision of CBT training and supervision in the UK, and a national implementation of the use of the IAPT minimum outcome dataset. This presentation will review the use of outcome measures in training, supervision and clinical practice. It will focus on the IAPT minimum dataset plus specific process measures as a means to improve and evaluate the effectiveness of cbt training and clinical practice. The presentation will also focus on how to use outcome measures in clinical practice to identify cases, guide therapy and assess improvement in patients. Data from the first 2 cohorts of the Institute of Psychiatry IAPT High Intensity course will be presented plus clinical examples and service user feedback.

### **Developing Competence as a CBT Supervisor**

Nick Grey & Alicia Deale, South London and Maudsley NHS Foundation Trust

It is only relatively recently that there has been more sustained focus on the competences needed for a clinician to supervise others, including the specific competences for supervising cognitive behaviour therapy. In this presentation, we discuss our experiences of developing supervision competences. This draws on the individual supervision of therapists of varied backgrounds and levels of experience, and in particular discussions that we have had within a group of supervisors over the last two years providing group supervision for High Intensity IAPT trainees. In practice this has been peer 'supervision of supervision'. The presentation will be clinically focused, highlighting practical issues for supervisors and trainees. It will make explicit links with the Competences Framework for Supervision (Roth and Pilling 2008) where possible. Varied issues that arise within supervision and suggestions for developing competence will be discussed.

### **Evaluating training in CBT: Assessing disorder-specific and generic competency in IAPT high-intensity CBT training**

Jennifer Wild, Sheena Liness, David Clark, Institute of Psychiatry, King's College London & Stirling Moorey, South London and Maudsley NHS Foundation Trust

In this presentation, we present our disorder-specific competency scales for social phobia, panic disorder and post-traumatic stress disorder (PTSD). We present data, which show how they relate to generic competency scales, namely the Cognitive Therapy Scale Revised, as well as data to show their value in predicting clinical outcome. Our results highlight the competencies most important to train to achieve good clinical outcome for these disorders.

### **Training for Metacompetence in CBT**

Adrian Whittington, Canterbury Christ Church University

Metacompetencies have been defined as "procedural rules .... that enable therapists to implement therapy in a coherent and informed manner and to apply an intervention in a way that is responsive to the needs of each individual client" (Roth and Pilling, 2007; p18). Examples include the selection and application of the most appropriate method (at the most appropriate time) and capacity to adapt interventions in response to client feedback. Metacompetencies highlight the value of flexibility, adaptation and individualised application by the therapist, whereas much attention in the competency literature has focused on the value of adherence to protocol (eg Kazantzis 2003). The role of therapist competence in the effective application of CBT is reviewed and methods for incorporating the development of metacompetence in training programmes are presented. Kazantzis N (2003) Therapist competence in cognitive behavioural therapies: Review of the Contemporary Empirical Evidence. *Behaviour Change* 20 (1) 1-12 Roth A and Pilling S (2007) The competencies required to deliver effective cognitive and behavioural therapy for people with depression and anxiety disorders. Department of Health

### **Therapists' Competence in cognitive behaviour therapy: how do we define, measure and enhance it?**

Freda McManus & Sarah G Rakovshik, University of Oxford, Department of Psychiatry & Oxford Cognitive Therapy Centre

Cognitive-behavior therapy's (CBT) demonstrated efficacy has prompted calls for its increased dissemination to routine clinical practice settings. For the widespread dissemination of CBT to be successful in achieving effects similar to the original efficacy trials, there must also be effective dissemination of CBT training practices. However, as yet, CBT training is not evidence based. This review examines what can be learned from existing research into the efficacy and effectiveness of CBT training. Due to the paucity of research specifically investigating CBT training, CBT effectiveness and dissemination studies are also examined to glean information about potentially effective training practices. In order to draw conclusions about effective training practices, comparisons are drawn between studies according to the clinical outcomes that they achieved. Training approaches are compared according to dose and active training elements, and theoretical models of learning are applied to interpret the findings. The limitations of the existing literature are discussed, as well as recommendations for improving training research to meet the standards evident in treatment trials (e.g., random allocation, control conditions, self-report and blind assessment, adherence monitoring). Finally, the process of developing efficacious CBT treatment protocols is offered as a template for developing evidence-based CBT training protocols

## **Skills Classes**

### **From Report to Court: Psychology, Trauma and the Law**

Sarah Heke, Institute of Psychotrauma and Georgina Smith, The Haven (SARC) Paddington

Over recent years there has been considerable attention paid to the importance of dispelling myths and stereotypes surrounding the behaviour of complainants of violent crime. This is in conjunction with greater emphasis placed on understanding the psychological impact of trauma in order to explain these behaviours both in reporting crime and in the courtroom. There has been an overwhelming drive to improve both conviction rates and experiences of vulnerable and intimidated witnesses. The recently revised Crown Prosecution Service (CPS) policy guidance (2009) pledges it will not allow myths and stereotypes to influence its decisions and instructs prosecutors to robustly challenge such attitudes when in the courtroom. Judicial directions are currently being drawn up in order to address popular misconceptions about victims of sexual and domestic violence based on psychological evidence. These directives, as well as a noticeable increase in requests for professional statements, support the need for mental health professionals to be aware of and confident in their potential contribution to the criminal justice system. This workshop aims to improve confidence in the provision of specialist assessments, CBT treatment and statements for complainants of violent crime, by providing a model of joint working with legal professionals. Learning Objective #1: To provide a greater understanding of the interplay between psychological functioning post-trauma and the subsequent involvement with the criminal justice system. Learning Objective #2: Specific strategies for assessing and treating clients going through the criminal justice system using trauma-focused CBT. Learning Objective #3: Legal concepts, complexities and research on the provision of psychological



therapy with vulnerable and intimidated witnesses. Learning Objective #4: The provision of psychological evidence within the criminal justice system: Expert vs professional psychological reports, case notes and confidentiality. Didactic and experiential (group & case discussions). Dr Sarah Heke is a Consultant Clinical Psychologist and Director of the Institute of Psychotrauma, East London Foundation NHS Trust. Dr Georgina Smith is a Specialist Clinical/Research Psychologist at the Haven Paddington and Imperial College. They have provided training and lectured on the psychological impact of rape and sexual assault to the Metropolitan police and other constabularies, including the CPS. They have published in the area and presented at national and international conferences. Dr Heke is currently Secretary of the UK Trauma Group.

1. Conway, M.A. & Holmes, E. (2007). *Guidelines on Memory and the Law: Recommendations from the Scientific Study of Human Memory*. The British Psychological Society Press. Crown Prosecution Service. (2009).

2. Provision of therapy for vulnerable or intimidated witnesses prior to a criminal trial: Practice guidance. [www.cps.gov.uk](http://www.cps.gov.uk).

3. Jones, J.S., Alexander, C., Wynn, B. N., Rossman, L. & Dunnuck, C. (2009). Why women don't report sexual assault to the police: The influence of psychosocial variables and traumatic injury. *Journal of Emergency Medicine*. 36(4), 417-424.

This workshop is suitable for Clinical psychologists or other mental health professionals working clinically with complainants of crime and trauma (e.g. rape, physical and sexual assault, domestic violence) who are involved (or may be involved) with the criminal justice system. It aims to improve confidence in the provision of specialist assessments, CBT treatment and statements for complainants of violent crime, by providing a model of joint working with legal professionals

### Getting your Work Published: From Inspirational Idea to Editorial Acceptance

Michael Townend, University of Derby and Editor of *The Cognitive Behaviour Therapist* (tCBT)

Key Words: Publication, Research Assessment Framework, Scientist Practitioner, Empirically Supported Interventions

The notions of the scientist practitioner and empirically grounded clinical interventions upon which the current practice of cognitive behavioural psychotherapy is built assumes that practitioners are skilled in theory and research basis of cognitive behavioural psychotherapy, and the practical application of their integration in terms of clinical work. Practitioners who take such a view often seek to contribute to the development of the field by publishing their work. Getting an article published often ranges from being difficult through to infuriating. However, the effort can be very satisfying and rewarding both in terms of the review process and ultimately when the article is finally accepted and published. The motivation to write a paper for publication can be to disseminate work with an interesting or unusual case, learning from an audit, synthesise knowledge about models of services, and disseminate research findings or to write a teaching and learning article on how to carry out an established intervention properly. In addition to the desire to communicate, publishing an article might be a personal aim, a career goal or a requirement of a job role. In this workshop participants will be taken through the publication process from the initial inspirational idea to final editorial acceptance, the realities of the process, with reflection on common mistakes made and best practices being covered. The workshop will incorporate peer review and feedback so participants should wherever possible bring with them drafts of any paper already written, an outline of their proposed article or a statement of their intended paper or article. The workshop is aimed at new researchers perhaps expecting to be included in their Universities Research Assessment Framework submission or clinicians and post graduate students who either have a case study, audit or research study completed or close to completion that they wish to write up for publication. It would also be appropriate for clinicians or researchers and clinicians who want to consider writing up a paper on how to conduct a particular therapeutic strategy or technique. The BABCP with its publishing partner Cambridge University Press publishes two Journals. The *Scientific Journal Behavioural and Cognitive Psychotherapy* (BCP) and the more *Practitioner and Practice Focused journal the Cognitive Behaviour Therapist* (tCBT) each journal has a wide range of sections for publication type and form. Pre Workshop Reading Submission guidelines for BCP: <http://mc.manuscriptcentral.com/bcp>  
Submission guidelines of tCBT: <http://mc.manuscriptcentral.com/cbt>  
Salkovskis, P. M. (2002). Empirically Grounded Clinical Interventions: Cognitive behavioural therapy progresses through a multi-dimensional approach to clinical science. *Behavioural and Cognitive Psychotherapy*, 30(1), 3-9.

## Open Papers

### Professional Development and Service Delivery

Chair: Frank Wills, University of Wales Newport

**What are the key supportive elements and resources a service requires to deliver high quality CBT? The development of audit tool to define and measure the resources and support systems which ensure delivery of competent and effective practice.**

Martin Groom, Leeds Primary Care Mental Health Team

IAPT services are commissioned to deliver CBT to a specific standard. The CBT delivered should closely resemble that used in the randomised controlled trials underpinning NICE guidance. Roth and Pilling (2007) emphasise the importance of concrete specification of CBT competencies. This specificity facilitates evidence based practice and commissioning as those involved (commissioners, managers, supervisors, educators and clinicians) have a common framework to define and measure what should be delivered. However, competencies and specific procedures and skills cannot be divorced from the support systems and resources that ensure their delivery (Roth and Pilling, 2007). Unsurprisingly, Elkin (1999) identifies that when evidence-based therapies are used in routine rather than research settings, supportive factors such as training and supervision are not considered so important in the successful delivery of a service. This diminishes a services ability to deliver CBT to the quality specified. This paper describes a tool for IAPT and CBT services to audit what Roth and Pilling (2007) describe as the "support systems that help to ensure the delivery of competent and effective practice". The tool applies the principle of concrete specification to key supportive elements. For example, access to audio/video equipment, protocols to

facilitate work outside the clinic, and the quality and frequency of supervision. By defining, quantifying and measuring these key elements, services can identify specific strengths, as well as particular gaps between best practice and the existing situation. The tool contributes toward a framework for clinical audit, clinical governance and service planning and improvement. More generally it defines the key supportive and resource elements a service requires to deliver high quality CBT.

#### **Self-practice and Self-reflection (SPSR) as an alternative to traditional personal therapy in CBT training**

Craig Chigwedere, St Patrick's University Hospital/Trinity College Dublin, Brian Fitzmaurice, Trinity College Dublin/HSE (Ireland), Gary Donohoe, Trinity College Dublin, James Bennett-Levy, University of Sydney and Southern Cross University, Richard Thwaites, Cumbria Partnership NHS Foundation Trust, Ladislav Timulak, Trinity College Dublin

Personal therapy for the therapist (PTP) is an integral part of the training and practice in many psychotherapeutic modalities. There is a move in CBT practice in many European countries to embrace PTP. Therefore research into PTP and its equivalents is increasingly important. 26 CBT training related participants completed a shortened version of the SPSR workbook (Bennett-Levy and Smith, 1999). Participants summarised reflections on their experiences in emails, discussed them on an internet based discussion board and in a reflective practice group. Qualitative analysis of reflections and reflective group recordings derived two main categories 1) effect on the 'personal' self and 2) effect on 'therapist' self emerged. These had several sub-categories including empathy, applicability of model to self, increased knowledge, general felt effect, increased awareness and change. The personal effect of SPSR was not unexpected. Self-help CBT has proven efficacy (e.g. Gega, 2003). Of interest is the effect of the approach on the 'self as therapist'. Participants developed a deeper understanding of CBT and the interventions they used clinically, which supports previous SPSR findings (e.g. Bennett-Levy et al. 2001) and others. SPSR might be an alternative to traditional personal therapy for trainee CBT therapists. Its rationale might be easier for trainees to accept than personal therapy, because the focus is not on treating an identified pathology. Our numbers were small, our results are hard to generalise. More work is needed to identify the transfer of the identified gains to clinical practice and to compare SPSR and traditional therapy. References Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B. & Farmer, S. (2001) The value of self-practice of cognitive therapy techniques and self reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, 29, 203-220. Gega, L., Marks, I. & Mataix-Cols, D. (2003) Computer-aided CBT self-help for anxiety and depressive disorders: Experience of a London clinic and future directions. *Journal of Clinical Psychology*, 60(2), 147-157. Bennett Levy, J. & Smith, M. (1999) *Self-practice and Self-reflection Workbook*. (unpublished)

#### **Improving Access to Psychological Therapies "Top-up Training": A model and evaluation of effectiveness**

Gavin Clark & Roz Shafran, University of Reading, Lusía Stopa & Stuart Hunt, University of Southampton  
The Improving Access to Psychological Therapies (IAPT) programme has vastly increased the number of CBT practitioners working within the UK and intense supervision by qualified workforce within the service is one of its key elements. IAPT has provided curricula for High Intensity therapists, Psychological Well-being Practitioners and Supervision Training. However, there has been little guidance for the "Top-Up" component of the programme. The "Top-Up" programme was introduced in 2009 in recognition of the fact that many of the qualified workforce within the IAPT service providing field supervision required additional specific skills to maximise the effectiveness of their supervision. This presentation will describe the aims and format of the IAPT "Top-Up" programme within South Central SHA. The efficacy of the individual workshop components was assessed using a standardised measure of knowledge and clinical skills. Each workshop demonstrated a significant improvement in both knowledge and skills ( $p < .05$ ). Feedback from each of the subsequent monthly sessions following a workshop demonstrated the value of ongoing liaison between the IAPT service and training courses. It is concluded that the "Top-Up" programme is effective in increasing the knowledge and skills of the qualified workforce within the IAPT service and is an essential component of the programme.

#### **Recruitment into a guided online based CBT intervention for depression: Lessons learnt from the failure of a prevalence recruitment strategy**

Joanne Woodford, Mood Disorders Centre, University of Exeter, Paul Farrand, Mood Disorders Centre, University of Exeter, Chris Williams, School of Psychological Medicine, Faculty of Medicine, University of Glasgow  
Online Cognitive Behavioural Therapy (CBT) represents one of the recent significant developments in the way psychological interventions are delivered. Recommendations for the use of online CBT for mild-to-moderate depression and anxiety are made by NICE and are commonly used within stepped care models of mental health service delivery. Studies into online CBT tend to recruit via common media channels as opposed to through Primary Care. This has led to criticisms of studies using biased samples and the need to recruit through Primary Care. This paper describes the failure of a prevalence recruitment strategy within Primary Care to recruit into an RCT examining the effectiveness of a free online CBT intervention for depression, "Living Life to the Full" (Williams, 2007). During the 8 month recruitment period only 21 potential participants undertook the consent and initial screening process with only 7 of these being recruited into the study. Comparisons are made with the previous successful use of prevalence recruitment within Primary Care (White et al, 2007) resulting in over-recruitment. Key differences between these studies highlight potential issues in relation to the acceptability of online CBT for both GPs and participants and the need to adopt a more assertive approach to recruitment within Primary Care. Further discussion questions whether published rates of prevalence of depression are representative of rates recorded in GP databases. Given recruitment via media channels is successful, although unrepresentative of the general population, are these samples representative of those who find online CBT acceptable? This brings into question the need to recruit from Primary Care.

#### **Yada, yada, yada: Researching the missing bit of CT practice: A call for more practitioner research**

Frank Wills, University of Wales Newport

Practitioners in many professional fields are criticised for being reluctant to read and use research relating to their practice (Persons, 1995). Yet questions can also be asked about how fit for practitioner purpose any current research is. CBT research has excelled in developing valid and reliable problem formulations and in testing outcomes for treatment based on these formulations. Many research reports, however, read somewhat like this,

This is our model of the problem. This is CBT. Yada, yada, yada. The outcomes were good.' What is left out here are the twists and turns of actually carrying out treatment with different types of clients - the blood, sweat and tears of practitioners' experiences and crucially what they had to do to make therapy work. It seems entirely right that the overall effectiveness of CBT has been researched before efforts to look at how things proceed on the ground. It initially appeared that such process research would come in the fullness of time but it is still conspicuous by its absence. It may be that this type of research will never be a priority for most research centres. McLeod (2003) has argued that more use of 'grey literature', especially practitioner case reports, can help to close the gap between outcome research and everyday practice. Archives of carefully collated and indexed case reports and studies could be used for direct practitioner access and as sources of 'secondary data' for further research. Modern technology makes such archiving much more easily possible. More practitioner participation in research may also help to close the researcher/practitioner gap. As the number of practitioners of CBT grows alongside the growth of IAPT, there are likely to be increased demands for much more instruction on 'how to actually do it'. More practitioner reports, intelligently archived, could be a significant source of help for both practitioners looking for stimuli on how to work with a particular client and for researchers as they try to establish how practitioners do or don't make therapy actually work.

## Posters

### 1. Exercise DVD for Nottingham Pain Patients

Caroline Neal, Nottingham Back and Pain Team, Paula Banbury, Nottingham Back and Pain Team, Sarah White, Nottingham Back and Pain Team, Laura Waddington, Nottingham Back and Pain Team, Georgia Stone, Nottingham Trent University

The Nottingham Back and Pain Team have been providing self management group programmes for people with long term back pain since 2000. These follow the Cognitive Behavioural approach, and include individual CBT as required. Amalgamation with an established hospital pain management group in 2007 meant that a fresh look at services was required. Referrals are received from G.P.'s, Physiotherapists, Consultants, and Occupational Health professionals. Our patient group varies enormously in duration and severity of symptoms, social and employment circumstances and levels of distress due to pain. Some individuals who find a group setting challenging, whether due to communication difficulties or mood may benefit from additional support. Clinicians used a problem solving exercise to identify ways in which this patient group could be helped and treated. A DVD of manageable exercises and top tips from former patients was proposed, as a project to meet the following needs:

- Patients unable to access group treatment
- Patients undertaking treatment, for support and motivation and increased compliance, to aid self help and a regular habit of exercise at home

Team members worked in partnership with final year media students at Nottingham Trent University. They were given the brief to create a short DVD of exercises and tips for managing long term pain. Clinicians were filmed undertaking a selection of exercises to music, aimed at improving stamina, strength and flexibility. Additionally former patients were interviewed giving their 'top tips' for managing long term pain. An inlay card giving the team's tips for managing pain was also included. The DVD was produced in conjunction with Hospital Charitable Funds and is available free of charge to our patients along with our relaxation CD. This project will enable the team to evaluate the success of using different forms of media to reach and optimise treatment for those patients unable to access groups. In the future we plan to explore other media to support our patients and enhance programme delivery such as an audio package, information links from our website, and downloadable information podcasts. The DVD was launched to our current cohort of patients (Nov / Dec 2009), with accompanying audit form, due for completion in April 2010. Initial anecdotal feedback indicates that patients are accepting of technology and comment it improves their knowledge of specific exercises. Users have further commented it helps with motivation and continuing commitment to the self management approach for long term musculoskeletal pain.

### 2. The Implementation of Computerised Cognitive Behavioural Therapy (CCBT) in a service user-led, third sector Self Help Clinic

Nicky Lidbetter, Self Help Services, Manchester, UK., Dominic Seccombe, Self Help Services, Manchester, Kate Cavanagh, University of Sussex

Improving access to evidence based psychological therapies is a major agenda in international healthcare. This study explores the implementation of Beating the Blues, an evidence based computerised cognitive behavioural therapy (CCBT) program, as a treatment option offered by Self Help Services, a user-led organisation that co-ordinates groups and other self-help initiatives for people experiencing mental ill-health, discrimination, social exclusion and/or emotional problems in the North West of England. Research Objectives: What is the uptake, adherence and outcome for users accessing Beating the Blues in a Self Help Service? Is this a feasible model for implementing CCBT? 510 referrals for the Beating the Blues program were received over a 16 month period in routine care. The Patient Health Questionnaire Depression (PHQ-9) and Anxiety (GAD-7) Scales, the 10-item Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM), Work and Social Adjustment scale and patient experience questionnaire were also administered pretreatment and immediately on completing treatment. This study supports the demand for and benefits of a CCBT program for depression and anxiety in Self Help Services. Limitations are noted. The study supports the extension of this service to Self Help Services in other locations. Demographic and clinical characteristics of services users at assessment and user flow through the service are described. Completer and intention-to-treat analysis demonstrated statistically and clinically significant improvements on the PHQ-9 and GAD-7 measures. Fifty percent of service users engaging with two or more CCBT treatment sessions met criteria for recovery. Statistically significant improvements in general distress and functioning were also found. High service user satisfaction was recorded. This study supports the demand for and benefits of a CCBT program for depression and anxiety in Self Help Services. The study supports the extension of this service to Self Help Services in other locations.

### 3. Web-Cam based Cognitive Behavioural Therapy as Treatment for Anxiety: A New Service for Anxiety UK

Jessica Hinchliffe, Anxiety UK, Nicky Lidbetter, Anxiety UK, Cat O-Neil, Anxiety UK

Within society, a number of barriers can exist which may prevent many anxiety sufferers accessing vital help and support needed to improve their mental health. In a recent Anxiety UK survey it was identified that many individuals with agoraphobia and in some cases social phobia were missing out on service provision due to an inability to attend appointments for therapy due to their anxiety or due to extraneous influences such as child care. Web cam based CBT is proposed as a way to rectify these issues. Research suggests that using web based cognitive behavioural therapy (CBT) interventions is a beneficial as face-face therapy (Bouchard et al, 2004) and that web cam based CBT in particular is beneficial for sufferers of agoraphobia (Griffiths et al, 2006). Anxiety UK offers a therapy referral service to its members and in order to try and improve the accessibility of the services that we provide, web- cam based CBT was introduced in January 2010. Stringent guidelines regarding the usage of this have been adopted; these primarily concern assessment procedures and maintaining confidentiality within the organisation. It is hoped that offering web cam based CBT interventions in this manner will help to alleviate some of the issues, like those mentioned above, that can impact on the lives of anxiety sufferers. Four clients have accessed this service to date, presenting various conditions including agoraphobia. Pre and Post therapy assessment scores will be taken in order to assess the improvement in well-being and any decrease in overall symptomatology. Clients will also have access to Anxiety UK's Live Chat service whilst undertaking therapy as peer support service.

#### **4. Mind the Gap: Meeting the Needs of Moderate-Severe Anxiety Disorder Sufferers**

Jessica Hinchliffe, Anxiety UK, Nicky Lidbetter, Anxiety UK, Cat O-Neil, Anxiety UK

Anxiety UK is the UK's largest anxiety disorders charity that provides supports to individuals experiencing a range of anxiety disorders of differing severity. In spite of the varied and comprehensive services available on the NHS for anxiety sufferers (such as the rolling out of a national IAPT program) some individuals require additional support from non-NHS/statutory agencies. It seems that some individuals are unfortunately falling through gap within service provision particularly when their needs are both complex and wide ranging. 58% of Anxiety UK's membership is comprised individuals whose anxiety is classified as moderate to severe on the GAD7 clinical scale. In a recent Anxiety UK membership, feedback from members suggested that individuals accessed Anxiety UK's services in part because they had difficulty accessing NHS services; having more complex needs than which can be addressed at low intensity level, whilst not quite meeting the criteria for high intensity therapeutic interventions. Furthermore, 54% of respondents to a recent Anxiety UK membership survey stated that they felt either the same or worse than they did 10 years ago. This poster provides an insight into the qualitative experiences of individuals who have had contact with Anxiety UK and who have accessed one or more of the charity's therapeutic services (helpline/email support/therapy etc). 70% of members of Anxiety UK had accessed therapy through the NHS at some point but 40% had been left disappointed by the number of sessions provided or the level of intervention. These findings suggest that the needs of individuals experiencing moderate to severe anxiety are not necessarily being met through current statutory sector mental health provision. An awareness of the complex needs of anxiety sufferers when delivering interventions, particularly being mindful of those clients who may be missed by current clinical services.

#### **5. How good are you? Developing OSCE's addressing CBT Self-Help**

Joy Ross, Glasgow University, Michelle McCauley, Glasgow University, Chris Williams, Glasgow University

We are introducing Objective Structured Clinical Examinations (OSCE's) to assess CBT self help delivery within the Structured Psychosocial Intervention In Teams (SPIRIT) training in Glasgow. We describe the development of a range of OSCE's assessing core competencies: introduction, support and review. The OSCE's have been developed around the 'Plan, Do, Review' model of supporting CBT self help (Williams, 2009). Thirteen trainees participated in this pilot in three separate OSCE stations. Each station was allocated a clinical case with a trainee, actor and examiner. Both actor and examiner completed individual feedback forms for each station which were passed onto trainees following OSCE completion. Each station lasted 10 minutes. We developed and administered questionnaires to evaluate individual experiences of the OSCE to all involved. The responses were extremely positive and we gained invaluable insight into the delivery of this method of assessment. The SPIRIT approach can be used in high intensity and low intensity CBT and teaches healthcare professionals how to work within the 'Five Areas' model of low intensity intervention. The introduction of OSCE's provides a standardised method of assessment for the SPIRIT training and focuses on assessing skills used in practice that are objectively marked. Currently we are using the OSCE's in formative ways as a training aid, but intend to include it as part of the university assessment process. The data derived from these questionnaires are being quantitatively analysed comparing the experiences of the three groups of individuals involved in the OSCE. Result will be presented on the poster. This practical method of assessing the skills of those delivering low intensity CBT will encourage more standardised practice.

#### **6. How good do you need to be? Developing a Marking Scheme and Competency Standard for use in CBT Self-Help OSCE's**

Michelle McCauley, NHS Greater Glasgow & Clyde, Joy Ross, NHS Greater Glasgow & Clyde, Chris Williams, University of Glasgow

The Structured Psychosocial Intervention In Teams (SPIRIT) training is a university accredited course that teaches practitioners three core competencies: introducing, supporting and reviewing the use of CBT self help resources. Traditionally, competency in CBT training is assessed using video/audio recordings or observed practice, however, OSCE's offer a more standardised and objective assessment method that can address a wide range of skills. We report the pilot outcomes of 3 OSCE stations addressing the three competencies and describe the distribution of marks. Normal distribution, points of rarity in practitioner scores and professional judgement are all discussed as ways of determining appropriate "pass" marks. Findings from Kane (1994) and Angoff (1971) regarding competency and cut-off scores are described. Creating a consistent marking scheme and determination of a pass mark reflecting competence for these OSCE's objectively assesses some of the core competencies taught on the SPIRIT training. The development of an evidence based competency standard adds to the robustness of the training. Lessons are applicable for the development of OSCE's for the use in a wider range of CBT high intensity and low intensity training. Following the pilot (n=13) we will administer the OSCE's to a further round of trainees (n=70). By the BABCP conference, we will have a full data set for approximately 80 participants, from which we

will determine a standardised reflective marking scheme for the OSCE's. Determining clinical competency in terms of an approved marking scheme ensure that practitioners are competent in introducing, supporting and using CBT self help resources.

#### **7. Incorporating CBT Practice in the Acute Psychiatric Ward: The Emotional Coping Group**

Rosanna Black Josman, Mazra Mental Health Center, Carla Popescu, Mazra Mental Health Center, Christina Yogev, Mazra Mental Health Center, Helena Chernavsky, Mazra Mental Health Center

The practice of CBT in Israel is sporadic and not fully integrated into the service provision for the mentally ill. However an acute psychiatric ward in Northern Israel has been building a service within its existing system, promoting mental health through CBT. Following the recommendations of Clark and Wilson (2009), the ward provides an emotional coping group together with short term CBT therapy. The focus of this poster is to describe the group and its influence on the ward as a whole. The aim of the group is to help patients deal with overwhelming emotions such as anxiety and anger which often results in repeat hospitalizations. The group teaches emotional regulatory skills, distress tolerance skills, and new adaptive coping behaviours. The group is built around a six session protocol, developed especially for the group, which takes into account the relatively short hospitalization, cross diagnosis and the multi-cultural patient population. The group was set up in April 2009 and is held twice a week. In addition, different professional sectors have shown an interest in the group as have other wards in the hospital. CBT is not traditionally seen as the dominant therapy in the ward or in the hospital, however through the group, there appears to be a cognitive shift which may pave the way for the further development of a CBT service. Although the group has not been evaluated as to its effectiveness, it has certainly been incorporated into the busy routine of the acute ward.

#### **8. Is Self-Efficacy related to outcome in a Self-Help Anxiety Management Programme?**

Richard Cosway, NHS Lothian

Within NHS mental health services, models of stepped care have increasingly been applied to direct individuals to the level of intensity of psychological therapy appropriate for their difficulties. Little research, however, has addressed how this decision is made and how particular characteristics may affect the appropriateness of a particular psychological therapy for an individual. Some research has shown that the construct of generalised self-efficacy has been related to successful outcome in low intensity self-help interventions. In Edinburgh, a service of low intensity anxiety management classes (Stress Control; White, 1997) has been developed. Classes are available through self-referral and consist of six didactic sessions covering different areas of anxiety management. Participants were asked to complete pre- and post-programme questionnaires including the CORE and the DASS. To assess self-efficacy the Generalised Self-Efficacy Scale (GSES; Scholz, et al 2002) was also included pre- and post-programme. Preliminary results support previous research demonstrating the Stresspac classes were successful in helping to reduce anxiety. Anxiety level at the end of the programme was predicted by a combination of lower anxiety and higher self-efficacy at the beginning. Of the 120 participants who attended at least one session, 59 completed the programme and pre- and post- measures. Preliminary analysis demonstrated that anxiety levels were significantly lower at the end of the programme and post-programme anxiety could be predicted by both lower anxiety and higher self-efficacy at the start of the programme, accounting for 54% of the variance. Further statistical analysis is ongoing. This research suggests that low intensity CBT interventions may be more useful for those individuals with a higher self efficacy and milder anxiety severity

#### **9. A survey of Mental Health Service Staff: Their Knowledge and Implementation of the Recovery Model**

William Hallam, Cardiff and Vales University Health Board Benna Waites, Powys Teaching Health Board Amy Canning, Cardiff and Vales University Health Board

The concept of recovery is being increasingly adopted by mental health services in the U.K. It is embedded in policies, statements and position papers including: 'Making Recovery a reality' (SCMH Policy Paper, 2008) and 'Commissioning framework for health and well-being' (DoH, 2007a). However, the extent to which the Recovery Model is applied across the NHS is mostly unknown. This poster aims to give a snap-shot of the knowledge and the degree to which the recovery model is implemented within a Welsh NHS health board. 2 questionnaires: the Recovery Knowledge Inventory (Bedregal et al, 2006) and the Recovery Self Assessment Revised (O'Connell et al, in press) were administered to mental health staff (n=37). Results show that staff had a moderate knowledge of the recovery model but that they placed undue emphasis on symptom management and were worried about having overly high expectations for clients. Differences were found between teams, with inpatient services showing lowest knowledge scores. Staff perceived their services to be recovery orientated, especially in terms of respecting the choices made by clients. However, they were less confident whether service-users were involved in service development. 'Recovery' is a pan-theoretical model but one which may particularly complement a CBT approach. The CBT therapist within the NHS should be mindful of helping clients towards recovery-orientated goals such as: social inclusion, creative risk taking and empowerment. They should also hold an attitude that engenders hope and belief in positive change. Collaborative Empiricism and Agenda Setting are both platforms by which to engage in recovery-orientated practices.

#### **10. Perceptual Control Theory and Attendance of Therapy**

Oliver Schauman, University of Manchester

The high prevalence of non-attendance of therapy appointments is a problem from both a financial point-of-view and may also mean that people who need help for psychological problems are not successfully accessing it. Previous research has highlighted both demographic factors as well as personality variables that relate to control, such as internal locus of control and perceived control. Most importantly, increasing client control has been found to increase attendance of appointments. Control is thus hypothesised to be of crucial importance when accessing therapy and it also relates to many of the avoidance factors reviewed in the literature. Perceived need for psychological help, as well as perception of the care services has been distinguished in previous models of seeking psychological help. These models however lack a unifying insight into the concept of control highlighted in the literature. Perceptual Control Theory is hypothesised to offer such a unifying insight into the process. The framework suggested highlights both the personal goals relating to independence and how they relate to needing help, as well as control in the help-seeking process itself. Needing help is hypothesised to mainly relate to goals of

independence, while people who may perceive a need for help may still not access it because of the fear of losing control over the problem. The discrepancy between the preferred and expected amount of control in therapy is thought to reflect anticipation of the losing control as a result of seeking help. This is hypothesised to inhibit people who report needing help from actually seeking it. The study consisted of 132 students at the University of Manchester, who filled in an online questionnaire. The questionnaire consisted of personality measures relating to control, DASS21, as well as items concerning the preferred and expected amount of control over therapy. The questionnaire also enquired about the history of needing help as well as their current keenness to seek therapy. The findings support the hypothesis that people who may not perceive needing help to conflict with their personal goals of independence, may still not seek therapy if they fear losing control of the problem as a result of accessing it. The findings further highlight the importance of control in terms of seeking therapy and call for further investigation into the process by which people successfully attend therapy. People's personal goals, as well as client control should thus be taken into account in further research. It was found that high scores on depression, as well as low perceived control, predicted needing help. In addition, lower discrepancy between preferred and expected amount of control predicted more keenness to seek therapy in a subsample of the people who had reported needing help. The personality measures relating to control did not significantly predict keenness to seek therapy in the subsample. The findings suggest that client control is a pertinent issue in delivering successful therapy and that clinical services should be mindful of the people's need for sense of independence and control when seeking psychological help.

### **11. Should practical teaching in Psychotherapy form a Compulsory part of the Medical Students' Curriculum? The Students' Perspective**

Daniel Cox, Graham K, Howey A, Page G, Siese T, University of Bristol

**Introduction:** The notion that psychotherapy should form a taught aspect of medical student curricula has long been debated (Strauss, 1950). Support has been fostered by suggestions that psychotherapy will develop students' understanding of psychosocial components of care, non-compliance and negative transference whilst encouraging consideration of psychiatry as a future career. Others have argued that such complex theory with an arguably weak evidence base make the teaching of psychotherapy undesirable (Waterman, 2003). The questions have been posed, but the voice of medical students is yet to be heard. **Method:** We, as students, attended tutorials to develop a basic understanding of psychotherapeutic theory. Suitable patients were interviewed by a supervisor and consent for a course of student led psychotherapy gained. Students and patients were matched, before engaging in weekly psychotherapy followed by smaller group supervision for a mean of 25 sessions. **Results:** The project is ongoing - students have established strong and promising relationships with their patients, the supervisor and other members of the group. **Discussion:** Having gained a more holistic understanding of treating psychiatric patients and being exposed to a previously inaccessible aspect of psychiatry, we believe this experience is beneficial for our patients, our own emotional understanding and for our education. Nevertheless in contrast to some of the existing literature, we as students do not advocate the expansion of this time-consuming, logistically-difficult and specialised scheme as a compulsory element of education for medical students. Our reflections will illustrate that an already overstretched curriculum cannot support these rather intangible benefits.

### **12. The Presence and Future of IAPT**

Klaus Dieter Schultewolter, John Brooks & Glen Macklin, CBPS Ltd.

IAPT has become operational reality with benefits for clients with identified mental health needs in form of depression and anxiety through a ring-fenced government funding programme. This is non-recurrent funding and this makes the future of it uncertain. But there are not just challenges to overcome when the money for it will run out but already PCTs up and down the country making decisions to use ring-fenced money for other health services, channelling money away from IAPT projects. Further, the current IAPT reality is heterogeneous in another area as well: integration within renewed care pathways in depression; how does IAPT fit in with the new NICE guideline on depression (CG 90)? Does the critically reviewed evidence support and justify a continuation of IAPT? What is its future? Literature review on current IAPT projects using relevant search engines for local health economies; CBT evidence in EMBASE and MEDSCAPE as well as CG 90 NICE depression guideline (2009) Government funding for IAPT has not entirely been dedicated to developing and maintaining CBT based intervention for Depression and Anxiety, which has led to a heterogeneous picture of training and service delivery up and down the country. The reality for the individual person with identified needs is therefore the sad reality of "post code" health service availability. Further, critical review of evidence base for CBT as intervention for depression in particular demonstrates a strong case and features prominently within psychosocial interventions within the NICE depression guidelines (CG 90; 2009). Whilst this is strong independent endorsement of this form of intervention the future of it remains unclear in as much as provision and further development of CBT is funding sensitive. Does the body of evidence supporting CBT constitute a relevant drive for the development of IAPT to become a nationwide operational reality and not a statement of intent? Given the mismatch between the government funding and intent and the regionally different realities IAPT in its current form might be doomed in particular since the government funding is non-recurrent money. Whilst the positive endorsement of the evidence should render a question of whether or not to continue it nonsensical the reality looks rather sobering. An alternative funding pathway for it would have been the so-called practice-based commissioning (PBC) but despite ambitions outlined in "World Class Commissioning" PBC has not taken off nationwide and indeed seems to become a concept of the past with the change in economic climate and a possible change in government. A return to the "old" days of patchy availability of CBT seems not unlikely despite the robust appraisal of its necessity in its latest endorsement from NICE. The implications will potentially be very tangible for the individual practitioner who plans his / her psychotherapy career future based on IAPT and beyond. This will be equally relevant for people with identified mental health needs who will potentially again be left out standing in the rain. It will affect potential referrers and their everyday practice when they have to engage in repeated consultations without being able to provide the relevant intervention. For the remaining practitioners who are being provided with NHS funding for providing CBT they might well be overwhelmed with work and long waiting lists become a nationwide reality again. In consequence, this could very much hinder the further practical implementation of an evidence-based intervention and restrict the further development of it.

### 13. Screening of Conduct Problems for Prevention Programmes

Kallitsoglou Angeliki, Celia Beckett, Tamsin Ford, Stephen Scott, the Helping Children Achieve (HCA) Research Team

Effective prevention programmes need to accurately identify high-risk groups in the population (Lochman & Conduct Problems Prevention Research Group, 1995). A school population (n= 1,800) of 5-7 year olds from disadvantaged communities was screened for conduct problems during the Helping Children Achieve (HCA) trial, a four-intervention-programmes randomised-controlled trial designed to support parents with their children's behaviour and learning. Preliminary findings on the screening method's effectiveness to identify children at risk for developing conduct problems are presented. Differences in psychological and academic functioning between children 'at risk' or 'not at risk', for conduct problems, are examined. Parents and teachers completed the Strengths and Difficulties Questionnaire (SDQ), Conduct Problems scale and the DSM-IV Oppositional Defiant Disorder symptoms scale to identify children "at risk" for conduct problems. The SDQ Pro-social and Peer Problems scale, the Eyberg Child Behavioural Inventory (ECBI), the Parental Account of Children's Symptoms (PACS), Antisocial Behaviour scale and teacher ratings of children's reading level were also used. Children "at risk" for conduct problems were more likely to be boys and had significant problems in their relationships with their peers as well as poorer pro-social skills and reading difficulties compared to those "not at risk". In line with the ECBI and PACS measures, children "at risk" were also more likely to exhibit oppositional and antisocial behaviours than children in the normal population. Theoretical and practical implications of the screening method are considered.

## Therapeutic Techniques

### Keynote Address

#### Strengthening Couples: Treatment and Prevention of Couple Distress

Professor Kurt Hahlweg, University of Braunschweig, Germany

The quality of family life is fundamental to the well-being of the community. The stability of the family has a pervasive influence on the psychological, physical, social, economic and cultural well being of children and parents. Strengthening couple, parenting, and family skills has the potential to improve the quality of life and health status of children, our future generation. Over the last 30 years, approximately 100 clinical trials have demonstrated the efficacy and effectiveness of couple therapy and interventions to prevent relationship distress and divorce. However, the impact of these programs on a public health level is highly questionable. Few therapists and counsellors actually use evidence-based interventions; likewise, few couples actually use counselling or treatment services whenever they experience a deteriorating relationship. Therefore the most important question for the next ten years is: Are we ready to disseminate our effective interventions to the public? This paper describes the steps necessary to disseminate a public health model of couple therapy and prevention. E.g., do we have sufficient knowledge of risk and protective factors? Are there "ready to use" resources (e.g., treatment manuals, psycho-educational materials)? Are there effective training and supervision programs available? Do strategies exist that help to build sustainability? And: Do we have continuous quality control measures to monitor the ongoing implementation of the interventions? The field of couple therapy and prevention has made great strides over the past decades, and innovations continue to evolve as theoreticians, researchers, trainers, and clinicians employ recent findings to benefit couples and families.

## Symposia

### Clinical Applications of Compassion Focussed Therapy

Convenor: Mary Welford, GMW Mental Health NHS Foundation Trust

#### Clinical Applications of Compassion Focussed Therapy

Mary Welford, GMW Mental Health NHS Foundation Trust

Gilbert's Compassion Focused Therapy (CFT) and Compassionate Mind Training (CMT) has its scientific and theoretical roots in neuroscience models of emotion, and evolutionary psychology models of human motivation. Originally developed as an antidote to shame and self-attacking, clinicians and researchers are increasingly using this approach with distinct clinical populations. The approach is being used across the age spectrum, with groups as well as individuals and with staff teams. The use of CFT and CMT, with individuals meeting criteria for Borderline Personality Disorder, may be indicated for a number of reasons. According to DSM-IV (APA, 1994), individuals meeting criteria for Borderline Personality Disorder show long term difficulties with interpersonal relationships, self-image, mood fluctuations and impulsivity. Both environmental and genetic factors are considered to play a key role, with many individuals reporting early experiences of abuse, neglect, or actual, as well as perceived separation as young children. Shame and self attacking / loathing are also highly prevalent and, in contrast to very difficult life experiences (both past and present) individuals experience a jaw-dropping absence of self compassion. CFT aims to deshame individuals, in the context of both their past and present experiences. Such material is then used as a platform to motivate individuals towards developing self compassion. Finally it is hoped that engagement with a broad range of exercises promotes improved psychological wellbeing. This presentation will outline specific examples of work conducted with individuals meeting criteria for Borderline Personality Disorder. It will cover both individual and group formats. Brief qualitative and quantitative data will be provided.

#### Use of Compassion-Focussed Therapy with Pregnant Women and New Mothers Experiencing Perinatal Distress

Michelle Cree, The Beeches, Derbyshire Childbearing and Mental Health Service

NICE guidelines for Antenatal and Postnatal Mental Health (DoH, 2007) emphasised the importance of early and rapid psychological treatment for women suffering from mental illness in pregnancy and the early post-partum period due to the potentially serious impact of maternal mental illness upon the mother, fetus, and infant. Compassion Focused Therapy (CFT), with its focus on strengthening the soothing system rather than working with

the threat system has the potential to provide an effective and appropriate treatment for a number of psychological difficulties that occur or are exacerbated in the Perinatal period. In addition, as CFT aims to stimulate the soothing system, a system connected to oxytocin production, CFT may have a role in improving bonding difficulties between mother and infant. This presentation will examine the ways in which CFT has been adapted for specific use with pregnant and new mothers, and as an intervention for problematic mother-infant interactions.

#### **Compassion-focused group therapy for people with psychosis**

Christine Braehler, NHS Ayrshire & Arran, Ayrshire Central Hospital, Janice Harper, NHS Ayrshire & Arran, Ayrshire Central Hospital, Andrew Gumley, University of Glasgow

Compassion-focused group therapy for psychosis is an adaptation of Paul Gilbert's Compassion-Focused Therapy. At its heart is the development of compassionate relating to threats experienced in psychosis. Psychosis often has a devastating long-term impact on people's lives. Shame, entrapment, low self-esteem and stigma typically result in anxiety, depression, and social isolation, which significantly impair the quality of life of up to 75% of people with psychosis - often long after acute symptoms have remitted. The ongoing activation of psychological threats - such as fears of relapse, of coercive service responses; fears of being attacked, rejected or humiliated - can lead to the development of a defeatist, self-attacking or avoidant attitude, which blocks emotional recovery. Emotional resilience is developed through the gradual desensitisation to self-compassion using experiential exercises, interpersonal learning, the building of peer attachments and the integration of psychosis via narrative tasks. Drawing on the experience of a recently completed pilot randomized controlled trial, key aspects of the intervention and important clinical observations will be discussed.

#### **The application of a compassion focussed approach on acute inpatient wards**

Chris Irons, Inpatient Psychology Team, Mile End Hospital, London

Surveys have frequently found unsatisfactory patient experiences during inpatient psychiatric admissions. Some of the reasons highlighted for this include the lack of talking therapies, poor interactions/care from ward staff, and threatening and unpleasant ward environments. This presentation will look at how these experiences can be conceptualised and worked with from a compassion focussed approach, and will include: (i) a description of the adaptation of a compassion focussed therapy when working with people admitted to acute psychiatric units, many of whom may have short admissions, be highly distressed and at times, difficult to engage with; (ii) how a compassion focussed approach may be helpful in supporting staff in working more compassionately with their clients; (iii) how changes in the ward environment may bring about a less threatening and more soothing and calming environment for recovery; and (iv) what 'blocks to compassion' may exist on wards, and how these may be addressed.

## **Panel Discussion**

### **What is a Complex Case? Definition, Understanding and Treatment of Complex Cases**

Convenor: Robert Dudley, University of Newcastle

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Speakers: Nick Tarrier, University of Manchester  
Paul Gilbert, University of Derby  
Richard Moore, University of Cambridge

At one level we all know when we are working with a complex case. However, the term is seemingly a catch all for a host of presentations. In some settings complexity is equated with characterological problems, severe mental illness, or even a lack of response to our efforts to help a person get better. Yet this is a poor definition of potentially multiple processes and factors. This panel debate will help consider complexity in terms of unusual or co-morbid disorders, as well as presentations in the context of complicating social and physical health circumstances. Of course, complexity may also be a result of chronicity or result from less well understood processes like the capacity to feel compassion or take another person's point of view. This panel debate will consider the definition, causes, and contributors to complexity. By considering these and other notions of what constitutes complexity we can then begin to articulate key processes that need to be accounted for within a formulation that then guides subsequent treatment. The contributors to the debate bring experience as clinicians, trainers, supervisors and researchers. This session would appeal to researchers considering how to refine and improve models of disorders. Also, trainers, supervisors and services need to address issues of complexity as these presentations may not respond to our best efforts to help. It may actually be that they are excluded from services even though they are experiencing distress and disability. Of course, the debate will also be relevant to clinicians working with people with these complex presentations.

### **Metaphors and Stories in CBT: Grounded tools in working with Meaning and Perspective, or Flights of Fancy to engage our clients?**

Convenor: Richard Stott, Institute of Psychiatry

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Speakers: Richard Stott, Institute of Psychiatry  
Paul Salkovskis, Institute of Psychiatry  
Ann Hackmann, University of Oxford  
Paul Blenkiron, Hull York Medical School

The use of metaphorical language and stories in therapy has been advocated across many quarters (Blenkiron, 2010; Stott, Mansell, Salkovskis et al, 2010, in press; Hayes, Strosahl & Wilson, 1999; Kopp, 1995; Muran & DiGiuseppi, 1990). Metaphors and stories are frequently used by therapists to help clients understand abstract concepts, promote a change of perspective on a problem, and make fuller use of clients' experiential wisdom. There is much clinical appeal and anecdotal benefit in using such approaches, but relatively little scientific research to instruct us on how and when the use of non-literal language may be optimized in therapy for the benefit of our clients. Grappling with the appealing but elusive issue of therapeutic metaphor seems to touch at



the heart of our understanding of the distinction between 'clinical art' and 'clinical science.' Several important questions will be addressed by the members of the panel in this discussion. How is metaphor applied well, and how is it applied badly? What is the role of imagery both in our theoretical understanding and our application of metaphor? Is metaphor powerful by virtue of its ability to help us transform meaning, or by a deliteralising, 'decentering' function? Should we be developing our knowledge of the best, tried and tested, 'off-the-shelf' metaphors and stories, or instead be refining our skills at working with novel, spontaneously occurring metaphorical concepts (both client and therapist-generated)? Is it desirable to become more 'scientific' about therapeutic metaphor, and if so, which research questions would best advance us in this direction? Panel members will draw on their own experiences as clinicians, researchers and authors, and the experiences and insights of members of the audience will also be gratefully welcomed. This topic has direct implications for the everyday practice of CBT. Many clinicians use metaphor and stories in their work already, and they will encounter it routinely when listening to many of their clients' descriptions of their problems. The questions to be discussed by the panel will help elucidate the context and scientific basis of metaphor use in therapy, and help all participants think more closely about the nature and benefits of metaphorical language and stories.

## Skills Classes

### **Why Feeling Compassion can be Difficult: Desensitising to Positive Emotion**

Paul Gilbert, University of Derby

Compassion focused therapy distinguishes between activating positive affect and calming positive affects. Therapists rarely explore the fear of these two types of positive affects. For example, people might have meta-cognitive beliefs that if you enjoy yourself today then something bad will happen tomorrow, or they may have conditioned emotional memories of being hit or hurt unpredictably at times when they were having fun. This workshop will explore the functionalities of the fear of positive affect and in particular positive feelings associated with affiliation. We will explore some ideas of desensitising to positive affect through processes of clarification with clients, guided discovery and gradual exposure and specific compassion focused imagery exercises.

### **Broad Minded Affective Coping (BMAC): A New and Positive Technique for the CBT Tool Box**

Nick Tarrier, University of Manchester

This mini-workshop will describe a new cognitive-behavioural treatment Broad Minded Affective Coping (BMAC) based upon Frederickson and colleagues' 'broaden and build' theoretical model of positive emotions. Simply, negative emotions are threat-focused and survival based whereas positive emotions broadened thought-action repertoires and increase access to a much wider range of psychological resources. Thus constructive and positive cognition and behaviour are more likely to arise from the experience of positive emotional states. The majority of CBT interventions aim to remove or decrease negative emotions or behaviour, BMAC aims to increase positive experiences as a platform to increase positive behaviour and functioning. The theoretical underpinnings of, and the clinical procedures to, BMAC will be described. BMAC aims through the use of mental imagery to elicit positive past memories and the positive emotional states associated with them. BMAC can be used to amplify positive affect and as a tactical addition to cognitive behavioural treatments. Preliminary results indicate that it is clinically feasible and acceptable and applicable to people suffering a range of psychological problems and disorders.

Reference:

Tarrier, N. (2010) Broad minded affective coping (BMAC): a positive CBT approach to facilitating positive emotions. *International Journal of Cognitive Therapy*, 3, 65-78.

### **Teaching Core mindfulness skills in Mindfulness-based Cognitive Therapy (MBCT)**

Mark Williams, University of Oxford

MBCT combines Jon Kabat Zinn's Stress Reduction program with techniques from Cognitive Therapy in an eight week 'class' format for around twelve patients who are currently in remission. It aims to teach participants how to become aware of early warning signs of relapse, and to reduce tendencies to avoid these early signs. It includes several core meditation and mindful movement practices to help participants become more aware of moment-to-moment changes in the mind and the body. It also includes basic education about depression, and exercises from cognitive therapy that emphasise the links between thinking and feeling. Evidence suggests that MBCT is effective in reducing risk of relapse in patients with three or more previous episodes of major depression, is equivalent to long-term antidepressant use for those who stop taking medication under supervision, and can help those with treatment-resistant depression. MBCT is now included in the UK Government's National Institute of Clinical Excellence (NICE) Guidelines for prevention of recurrence in major depression. This class will involve guided practice in some core MBCT skills, as well as discussion of the aims and intentions of each. As a practice class, it will assume knowledge of the outcome evidence, and will not review this.

## Open Papers

### **Relationships and the Therapeutic Process**

Chair: Lyn Ellett, Royal Holloway, University of London

### **Trust and paranoia in the therapeutic relationship in CBT: Patients' perspectives**

Katherine Hall, Royal Holloway, University of London, Lyn Ellett, Royal Holloway, University of London, Paul Chadwick, Institute of Psychiatry, Kings College London

The therapeutic relationship is particularly important for people with enduring psychosis and may challenge beliefs about the (un)trustworthiness of other people that defines paranoia. Trust is regarded as essential for a good therapeutic relationship and has been emphasised in the literature on CBT for psychosis. Modifications to the structure and content of therapy have been suggested based on the clinical experience that trust can be difficult to build when working with people with paranoia. The aim of this study was to explore the meaning and

experience of trust in the therapeutic relationship from the perspective of clients with paranoia who are currently engaged in CBT. Eight participants with current paranoia who were engaged in CBT were interviewed using a semi-structured interview schedule. Topics covered in the interview included: clients' experience of the process of building trust in therapy; whether clients ever felt mistrustful of their therapist and the factors that led to this and clients' response to breakdown in trust within the therapeutic relationship. Interviews were transcribed and analysed using Interpretive Phenomenological Analysis. Seven superordinate themes were identified. These were: what the client brings to the relationship; trust as getting to know someone; reciprocal relationship between trust and progress in therapy; therapist qualities; the client's sense of agency and responsibility; mistrust and misgivings about the therapist; and therapy facilitating a change of trust with others. The study emphasises the active role of the client in developing trust. The implications of these results will be discussed in the context of advancing our understanding and treatment of paranoia in CBT. Although limited in its generalisability, the study has many implications for everyday application of CBT. For example, that the client must be considered an active agent in the therapeutic relationship. Emphasising responsibility the client has for therapy may encourage a sense of empowerment. These interviews also illustrated the ability for the client to hold two "realities" in mind and emphasised the active battle that clients experience in letting themselves trust their therapist. Although CBT formalises the process of questioning one's own thoughts, recognising the natural occurrence of such a process and utilising in therapy may be helpful. A cycle between trust and progress and therapy became apparent. Providing opportunities to recognise progress, including at the early stages of therapy, may be helpful in facilitating further engagement. Moreover, the application specific strategies were particularly important to the group in influencing their trusting behaviour outside of the therapeutic relationship. These to name a few potential implications.

#### **Trust and paranoia in the therapeutic relationship in CBT: Therapist perspectives**

Lyn Ellett, Royal Holloway, University of London, Caroline Lawlor, Royal Holloway, University of London, Paul Chadwick, Institute of Psychiatry

The development of an effective and collaborative therapeutic relationship is recognised as a crucial part of CBT. Developing and maintaining a therapeutic alliance with clients with distressing psychosis may be particularly difficult, especially if they are experiencing persecutory delusions. The aim of this study was to explore therapists' experiences of working with clients with paranoia, and how they develop and maintain a therapeutic alliance over the course of therapy. 10 clinical psychologists, all of whom had at least 2 years post-qualification experience of CBT for psychosis, were interviewed using a semi-structured interview schedule. Topics covered in the interviews included: therapist perceptions of what promotes trust in therapeutic relationships with clients with current paranoia; how therapists respond when trust breaks down in the therapeutic relationship; how therapists respond when clients incorporate them into their paranoid belief systems and consideration of phases of relationship building when working with clients with paranoia. Interviews were transcribed and analysed using Interpretive Phenomenological Analysis. Therapists discussed their beliefs about factors that contribute to trust and mistrust in the therapeutic relationship and how they respond to mistrust or ruptures when they occur. Accounts of being incorporated into paranoid belief systems were also described. The findings provide insights into therapists' experiences of working with clients with paranoia and some of the common difficulties experienced. The study also highlighted common conflicts experienced by therapists when working with clients with paranoia, as well as the techniques used by therapists to develop and maintain a therapeutic alliance in CBT for psychosis. Implications in terms of highlighting common difficulties that are experienced by therapists working with clients with paranoia, and how these can be managed.

#### **Attachment processes and their relationship to working alliance in the supervision of British clinical psychology trainees**

Joanne Dickson, University of Liverpool, Nicholas Moberly, University of Exeter, Yehuda Marshall, The Royal Oldham Hospital, James Reilly, University of Liverpool

Although the supervisory relationship is thought to be critical in the training of clinical psychologists, little is known about factors that facilitate or impede the supervisory alliance. This study tested whether attachment theory provides a useful way in which to understand the supervisory alliance. We conducted an internet survey of British clinical doctoral (DClinPsy) trainees (N = 259). Participants rated aspects of their supervisory working alliance, parental style during childhood, pathological adult attachment behaviours, and attachment style for themselves and their supervisors. Results showed that trainees' ratings of the supervisory working alliance were associated with perceptions of supervisors' attachment style, but not with perceptions of trainees' own attachment styles. Path analysis revealed support for a causal chain linking parental indifference, compulsive self-reliance, insecure supervisor attachment style and lower ratings of the working alliance. Our results broadly replicate data from American clinical trainees reported by Riggs and Bretz (2006) and indicate that attachment theory is helpful in understanding clinical supervisory processes in a British training context. Trainees exhibiting compulsive self-reliance may present particular difficulties for the development of strong working alliances.

#### **Decision making in stepped care for common mental health problems: health professional and patient experiences**

Judith Gellatly, The University of Manchester, Karina Lovell, The University of Manchester, Peter Bower, National Primary Care Research & Development Centre, The University of Manchester, Linda McGowan, The University of Manchester

Stepped care is designed to provide mental health treatment in the most effective and efficient way by providing patients with low intensity interventions in the first instance, only moving onto high intensity treatments if outcome is not 'successful'. However, there is a paucity of research about how health-professionals make treatment decisions and the patient experiences within this decision making process. Using qualitative interviews, this study aimed to explore health-professional and patient decision making in stepped care for anxiety and depression. A number of factors were found to have an influence upon the decisions that health professionals made. In particular, where patients did not 'fit' the stepped care model and service waiting lists were long, health-professionals felt the need to 'hold' patients who they considered inappropriate for their service. Consequently, patients were commonly receiving more treatment than the model recommends. Patients generally felt they had a choice about their treatment and were satisfied with their level of involvement,

however some felt choice was limited and their expectations of treatments did not match what they received. This often resulted in poor outcomes with some patients indicating they felt 'abandoned' following discharge. This study has highlighted a potential gap between the theory and implementation of stepped care. 'Holding' is a potential drain on resources, and has significant implications for the function of the model. The tension between the 'caring' values of health-professionals and the 'economic/public health' perspective underlying stepped care impacts upon its ability to maximise access to care and meet patient need.

#### **Investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis**

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

## **Posters**

### **23. Treating a 33-year old man with severe Learning Disability for Specific Phobia: Application of Cognitive-Behavioural Interventions**

Sirous Mobini, University of East Anglia

John is a 33-year old man with severe learning disabilities who was referred following concerns about his excessive fear of bees and wasps which has caused significant restrictions on his daily activities to the extent that he now mainly avoids going out with his support workers and prefer to stay indoors. He shuts all the doors and windows in summer. Occasionally, when he goes out in the evenings he covers his face with hat and wears rain coat in hot weather. Formulation John's fear of bees and wasps appeared not to have been caused by specific negative experiences. He seemed to have a vulnerability to anxiety, making him more susceptible to environmental stimuli. It was assumed that John might have developed his phobia of bees and wasps through watching T.V or receiving some negative information (e.g., "bees and wasps can kill us"). He developed a 'danger schema' (e.g., "bees and wasps are dangerous") which underpinned his negative automatic thoughts ('I don't like bees and wasps', 'bees and wasps bite me') triggered by seeing some environmental stimuli associated with bees and wasps (plants, trees, flowers, sunny days etc). Intervention To treat John's specific phobia a number of cognitive and behavioural strategies were adapted to his cognitive abilities and used in collaboration with his support workers. These interventions included some simple psychoeducation about bees and wasps using relevant pictures. Using pictures and visual prompts, John's emotions ('happy' vs 'scared') were linked to his negative automatic thoughts and his phobic behaviours (e.g., not going to the garden, shopping, café, etc). Exposure-based behavioural strategies were used to encourage John test his negative beliefs/assumptions about bees and wasps. Using visual prompts we looked at evidence for and against John's negative automatic thoughts. He was encouraged to go out with the help of support workers and see what would happen to him (mini-experiments). This helped John modify his negative beliefs/assumptions which lead to significant reductions in his anxiety levels, and hence increasing frequency of his adaptive behaviours. John's language and cognitive abilities were very limited. In line with this, it was important to adapt CBT techniques to his cognitive ability and use pictures and visual prompts to facilitate communication with him. It appeared that John was able to make use of the CBT session evidenced by his behavioural changes and his support workers' observations of John's behaviour at home and outside. Following 12 sessions of CBT work, John was able to go and sit in his garden in summer (this was the most difficult in hierarchy of feared situations). John allowed his support workers to leave the door and windows open in hot weather. He was able to go out with his support workers for shopping and do recreational activities (going to café and leisure centre, playing football with friends). He stopped covering his face with his hat which was a risky behaviour. He appeared to be more confident in himself and his support workers reported more positive attitudes in him. CBT techniques can be adapted and applied to people with severe learning disabilities.

### **24. Cognitive Restructuring of Negative Old memories of Parents was Effective in the Treatment of an Adolescent patient with marked Social Withdrawal**

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When Miss A visited our clinic for the first time, she was a high school student and expressed depressive mood, anxiety, insomnia, and marked social withdrawal. After several sessions, it was revealed that she had a problem of avoidant personality disorder which made her avoid social situations extremely. Nowadays, such extreme social withdrawal condition is often observed among adolescents or young adults in Japan. We assumed that she had two core beliefs related to her current problem. These were "I am inferior" and "other people reject me". Thus, she seemed to develop some assumptions such as "If people get close to me, they will discover the real me and reject

me” and “I should avoid social interaction in order not to let other people know real me”. Her coping strategies based on the assumptions eventually caused the difficulties and made her solitary and hopeless. As these core beliefs and assumptions seemed to come from interaction with her parents in her early life, treatment focused on restructuring the negative old memories of parents. The intervention included a task to talk about the negative old memories with her parents. The intervention focusing on negative old memories of parents was effective in this case. Her cognitive distortion of self and others was altered. After about seventy sessions, finally, she recovered from the social withdrawal condition. The treatment approach for this case seems to give some useful information to the therapists who treat patients with marked social withdrawal.

#### **25. Emotional Wellbeing during Refeeding: A Retrospective Case Series investigating the Relationship Wellbeing, Functioning and Mood in clients recovering from an Eating Disorder**

Sari Harenwall, The Retreat, Julia Coakes, The Retreat

Very little attention has been paid to emotional well-being in inpatient low weight populations and little is understood how this fluctuates during inpatient refeeding and treatment. This case series explores 4 clients' journeys to recovery during an inpatient stay in a CBT based unit. Of key interest in this paper is the relationship between refeeding, changes in body weight and changes in cognitions, social functioning and emotional wellbeing. Each client in this series has a severe eating disorder. Restriction of diet has led to them to become dangerously underweight. The clients were admitted to an inpatient CBT program which uses refeeding, dietetic education, CBT groups, individual CBT, and family support as its main interventions. This study explores correlations between weight change and emotional, social and cognitive functioning. Family support and attachments during recovery may affect outcome in inpatient adult clients with eating disorders. The treatment given to all the clients discussed here was comparable, but the psychological outcomes despite, good physical recovery seem to be affected by prior vulnerabilities and core beliefs. A weakness in this case series is the uniqueness of the intervention which may make generalisation to other services difficult. However, this has opened a new avenue of research into factors influencing psychological and physical recovery in low weight clients during inpatient refeeding. It was also noticed that clients with good social skills had a better psychological recovery. Poor social skills seem to be predictive of poor psychological outcome but not weight restoration. Two clients showed decreases in depression scores, and shape concern as their weight restored, whilst the other two showed increases in depression, and shape concern, during this process. It was noticed that the two clients whose mood and body image improved had supportive family relationships, and good attachments, and returned home at the end of treatment. The two whose mood lowered and body image issues increased had less functional attachments, and moved into independent housing at discharge. It is important at assessment to identify clients who may need extra interventions beyond the normal CBT approach. Family support may act as a resilience factor and positive predictor of outcome. It was also noticed that clients with good social skills had a better psychological and physical recovery. Poor social skills seem to be predictive of poor psychological outcome but not weight restoration.

#### **26. Yusuf: Possibilities for Multi-Disciplinary CBT**

Catherine Gardner-Elahi, University of East London, Gaby Parker, Tower Hamlets Community Health Services

Yusuf (a pseudonym) was referred to a Community Disability Rehabilitation Team with a neurological problem of unknown aetiology. He avoided walking long distances, restricted his activity, and experienced tingling and wobbliness. At home alone, he ruminated that he was a failure as a man and as a father. At assessment, he scored 27 on the BDI (Beck et al., 1996) and 30 on the BAI (Beck et al., 1988). This case was conceptualised drawing on a health anxiety model. At psychological assessment, Yusuf had been working with other Multi-Disciplinary Team (MDT) members for some time, gradually increasing his physical activity levels. Psychological intervention was primarily cognitive. It included: collaborative formulation using a cognitive behavioural framework; reframing his increased activity within this; and challenging ruminations. This case illustrates the challenge of multi-disciplinary health settings with varied waiting times. Experiences 'reviewed' within the model may not be as powerful as experiments experienced in vivo. One suggested solution is training for all team members in basic CBT frameworks for conceptualisation and intervention with simple anxiety difficulties. The CBT model could then also be used as a framework for consultation about cases, improving a key role for CBT therapists in an MDT setting. At ending, Yusuf scored 12 on the BDI and 14 on the BAI. He achieved 'User of the Month' status at his local disability gym, and stated that he had moved forward dramatically. Consultation frameworks for service delivery offer a way of tackling waiting list difficulties and addressing psychological problems as they arise in institutional settings. They have been used in educational psychology services. The proposed development extends these ideas to a health psychology setting, and suggests use of a cognitive-behavioural approach in consultation, supported by training for other staff. It could enable psychological services to be better integrated with other aspects of multi-disciplinary care.



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