Abstracts

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The Waterfront Conference Centre
Belfast
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Keynote Addresses

Clinical and Cost Effectiveness of Behavioural Activation versus Cognitive Behaviour Therapy for Depression: Outcomes from the UK COBRA Non-inferiority Randomised Controlled Trial

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

Methods: COBRA is a two-arm non-inferiority patient level randomised controlled trial, including clinical, economic, and process evaluations comparing CBT delivered by highly trained professional therapists with BA delivered by junior professional or para-professional mental health workers to establish whether the clinical effectiveness of BA is non-inferior to CBT and if BA is cost effective compared to CBT.

COBRA is the largest specific trial of BA vs. CBT internationally and is one of the largest trials of CBT for depression ever conducted. We have recruited 440 people with major depressive disorder randomised to either CBT or BA. Our primary outcome was severity of depression symptoms (Patient Health Questionnaire-9) at twelve months follow up with secondary outcomes of severity of depression at 18 months, and anxiety (General Anxiety Disorder-7 questionnaire) and health related quality of life (Short-Form Health Survey-36) at twelve and 18 months.

Our economic evaluation has explored cost-effectiveness in terms of quality adjusted life years using the EuroQol–SD measure of health-related quality of life and our process analysis has examined qualitative perceptions of therapies and both moderators and mediators of effect.

This keynote will report our results and explore the significance of them for the psychological therapy of depression including the merits or not of including BA as a first line treatment of depression.

Improving access to psychological therapies: an update on science, policy and economics

David M Clark, University of Oxford
No abstract given.

Chronic Fatigue Syndrome: The Trials and Tribulations of Outcome Studies

Trudie Chalder, King’s College London
Fatigue is best viewed on a continuum with fatigue as a symptom at one end of the spectrum and chronic fatigue syndrome (CFS) associated with profound disability at the other. Up to 75% of people with CFS also have a mood disorder. Over about 25 years worth of research trial findings show that both cognitive behaviour therapy (CBT) and graded exercise therapy (GET) are moderately effective treatments for CFS that are not associated with harm. In primary care briefer interventions for fatigue have been shown to be efficacious. Self-help books are available. The aim of this lecture is to describe the overlap between fatigue and emotion, the evidence for CBT and GET, the nature of the interventions and how they work according to recent meditational analyses and long term follow ups.
Intensive, brief, and effective treatments for anxiety disorders: A systematic review

Lars Goran Ost, Stockholm University, Swede

CBT for anxiety disorders are usually carried out in weekly 50-60 min. sessions for 10-15 weeks, both in research studies and in clinical practice. In the early 1980’s I developed the one-session treatment for specific phobias and today more than 30 RCTs, on both children and adults, have been published by researchers in various countries. This format has later been successfully applied in RCTs for Social phobia specific subtype (Hinto, 2011) and PTSD (Basoglu, 2007). In the other anxiety disorders there are examples of effective treatments which are brief compared to the original format: Panic disorder with agoraphobia in two sessions (Salkovskis, 2006), Panic disorder without agoraphobia in five sessions (Clark, 1999), Generalized anxiety disorder in five sessions (Durham, 2004), and Obsessive-compulsive disorder in 4-5 days (Whiteside, 2010; Havnen, 2014). Some of the advantages of brief treatment are that patients don’t have to travel to a therapist weekly for a number of weeks, the treatment can be more cost-effectively than standard treatment, the attrition risk is reduced, and it can simplify dissemination of evidence-based treatments. Some disadvantages are the intensive treatment may not be suitable for anxiety disorders requiring a lot of exposure in natural situations in order to test catastrophic beliefs, and that some insurance companies and administrative booking programs in health care do not approve of this format. The keynote will systematically review intensive and brief treatments for anxiety disorders and compare its efficacy with standard treatments.

Attachment and Caregiving in Psychosis: Current status and future directions

Andrew Gumley, University of Glasgow

Recovery from psychosis can best be conceptualised as a journey involving a number of core processes including developing a sense of connectedness; hope and optimism for the future; a sense of identity; having meaning in life; and empowerment. I will propose that interpersonal relationships are the window through which these recovery processes unfold and that developing understandings of recovery that are rooted in an appreciation of attachment and resilience can offer new perspectives on theory, research, clinical practice and service organisation. Attachment theory provides a framework to understand the interpersonal roots of emotional regulation, resilience and adaptation to stressful life events and experiences. Attachment theory also emphasises the importance of the interpersonal (and the caregiving context) as an environment for individuals’ development and growth. Optimal caregiving environments are characterised by two key dimensions: safe haven (for responding to threat and resolving distress) and secure base (for facilitating the curiosity, exploration, autonomy and empowerment). The presentation will provide a state of the art summary of the growing empirical literature on attachment and psychosis. This literature now comprises well over 30 studies and 2,500 participants. Based on our conceptualisation of this literature I will show how attachment theory can be used to (a) enhance strengths based approaches to Cognitive Behavioural Therapy for psychosis (CBTp), (b) to aid formulation and collaboration in CBTp and (c) cultivate service models that can attune to attachment needs of service users. I will illustrate these applications through a number of selected empirical studies and show how these studies can inform the development of new interventions and service models to promote empowerment and recovery.

Developing mental health services for traumatized refugees and asylum seekers – what should we be offering?

Kerry Young, Central and Northwest London Foundation Trust
Most countries in Europe have seen a dramatic increase in the number of asylum seekers arriving over the last few years. If the UK were to follow suit and offer to take their share, what sort of mental health services would we need to offer? In this presentation, I will discuss what we know about the mental health needs of refugees and asylum seekers. While estimates vary, we know that rates of depression and PTSD are elevated. Next, I will review the literature about how best to meet these needs and about what moderates good outcomes. Then, I will make concrete suggestions about what mental health services should look like for traumatized refugees and asylum seekers. Finally, I will try and share some of my enthusiasm for this amazing field of work in the hope that it will motivate others to join us.

**Mind Over Mood 2: The Challenges of Aligning Self-Help with Evidence-Based Practice**

**Christine Padesky, The Centre for Cognitive Therapy, USA**

There has been a rapid expansion in CBT protocols and practices since the first edition of Mind Over Mood was published in 1995. Our goals for the 2nd Edition of Mind Over Mood (MOM2) (Greenberger & Padesky, 2016) were to reflect the highest standards of evidence-based practice and, at the same time, offer an appealing and easy to use self-help workbook. Reaching these goals required rethinking the structure and content of MOM2 in ways we did not anticipate at the beginning of our four year effort. What we learned in the process offers helpful insights into current CBT practice as well as guidelines for integrating self-help into therapy.

This keynote highlights the practical and accessible solutions we derived to meet challenges such as: (1) MOM2 teaches readers to understand and manage a variety of moods, yet there are different treatment paths for each mood. How can a single book align with a myriad of evidence-based treatments and remain simple for readers to follow? (2) There are now many CBT therapies. We wanted to integrate classic CBT methods with evidence-based practices that emphasize acceptance, mindfulness, and positive psychology. How is it possible to meaningfully integrate multiple treatment perspectives and at the same time maintain a focus on step-by-step development of mood management skills? (3) Although self-help can be less rigorous than therapy, we wanted to encourage readers of MOM2 to follow evidence-based practices such as: regular completion of mood measures, rehearsal of skills until mastery is achieved, goal setting enhanced by motivational interviewing, and proactive relapse management. How can readers be enticed to follow such good treatment principles?

In learning how to solve these challenges we discovered that a self-help workbook can be aligned with evidence-based practice but only when the demands of each are fully understood.

**Prevention of mental health problems in early life: promises and pitfalls**

**Paul Ramchandani, Imperial College London**

There is huge potential to intervene early in life to prevent mental health problems from developing or becoming entrenched. It is in many ways so obvious a thing to do. However, the evidence for effective prevention in mental health is limited, some avenues of research are overlooked, and the potential for any harm is often ignored. I will describe some of these challenges, and outline some of the key early interventions used, including an ongoing trial of a video-feedback parenting intervention to prevent enduring behavioural problems in one and two year old children (Healthy Start, Happy Start: ISRCTN no: 58327365).

**Translating empirically supported treatment into evidence based practice for eating disorders**

**Carolyn Becker, Trinity University, USA**
Clinicians increasingly experience pressure to engage in evidence-based practice, which is often equated to delivery of empirically supported treatment (EST). Yet evidence-based practice actually consists of three components – only one of which includes ESTs. More specifically, in evidence-based practice, which is commonly conceptualized as a three legged stool, clinicians must incorporate each of the following into treatment: the best research available, including ESTs; clinical judgment; and patient values and preferences. This can be particularly challenging when patients present with high degrees of comorbidity. The aim of this talk is to consider each component of evidence based practice in the context of eating disorders. More specifically, this talk will review what randomized controlled trials do and do not tell us about the treatment of eating disorders. A primary aim will be to identify where research provides a good template for treatment versus areas where clinical judgment will have to play a larger role in the absence of clear data. Person’s case formulation approach then will be used to explore how clinical judgement can be integrated with ESTs to address gaps in research knowledge while simultaneously attempting to minimize the cognitive errors that often occur in human decision making. Lastly, this talk will consider what is known about the impact of patient preferences and values on treatment outcome and consider how this can be used to facilitate treatment given that patient values may change over the course of treatment.

**Theory of Emotion: Emotional Schemas and Psychopathology**

**Robert Leahy, The America Institute for Cognitive Therapy, USA**

The role of emotion has gained increasing importance in CBT. Research in cognitive social psychology indicates that affect forecasting (predictions about future emotional experience) is characterized by problematic heuristics that lead to over-prediction of durability and intensity and underestimates of mitigating factors and coping ability. This leads to time discounting about emotion—that is, over-emphasis on current experience while discounting future experience. In addition, even though emotions are “ephemeral”, more intense emotions are experienced as durable and these emotional experiences are used to predict future emotion. The Emotional Schema Model proposes that once the individual experiences an emotion, specific interpretations, evaluations and strategies are elicited. These include beliefs about the duration, controllability, uniqueness, shame, comprehensibility, and complexity of emotion and, in addition, problematic strategies such as avoidance, suppression, blaming, and validation demands. These beliefs and strategies may either escalate emotion or result in confirming beliefs that emotions need to be avoided. We will review research on how emotional schemas are related to depression, anxiety, dispositional mindfulness, psychological flexibility, metacognitive dimensions of worry, and personality disorders. In addition, we will review how beliefs about the emotions of others may lead to unhelpful responses to the emotions of intimate partners. Strategies for modifying these emotional schemas will be reviewed.

**What is Positive Behavioural Support (PBS)? Developmental disabilities and beyond**

**Richard Hastings, Warwick University**

10-15% of people with intellectual disabilities may engage in behaviours described as “challenging”, and similar behaviour problems are also seen in other settings such as mental health and dementia services. Practice has developed in developmental disabilities services to address challenging behaviour using a framework known as Positive Behavioural Support (PBS). In England, various documents emerging from the government Transforming Care programme (in response to the Winterbourne View scandal) recommend PBS should be included as a part of services’ response to “challenging behaviour”. However, there is confusion around what PBS is and an increasing emphasis on access to mainstream mental health services for people with intellectual disabilities. Therefore, everyone needs to understand PBS and how it might fit within services more widely. In this presentation, I will
focus on the theoretical model underlying PBS, its defining features, and consider the application of PBS beyond developmental disability services.

In search for therapeutic forgetting

Merel Kindt, Amsterdam University, the Netherlands

For years it was believed that after fear memory has been established, the memory trace is engraved into the physical structure of the brain. At the turn of this century, a major breakthrough in neuroscience was achieved with the discovery that once (fear) memories are retrieved, they may enter a labile, protein synthesis dependent state, rendering it amenable to change. This process of memory reconsolidation may provide a window of opportunity to weaken or even erase emotional memory in patients with anxiety disorders and other related disorders. A technology that erases the emotional impact of unduly intense fear memories would signify a true paradigm shift in the practice of psychotherapy. Pharmacologically induced amnesia has only been convincingly demonstrated for fears induced in the laboratory, basically in animals and healthy participants. In line with the fear-conditioning studies, we showed that disrupting the process of memory reconsolidation effectively transformed avoidance behaviour into approach behaviour in spider fearful individuals, without actually targeting the cognitive level of fear. As such, our findings also challenge one of the fundamental tenets of Cognitive Behavioural Therapy, where changes in dysfunctional beliefs are supposed to precede the behavioural modifications. Disrupting reconsolidation instead seems to act in a reverse order: it targets the emotional aspects and subsequently the cognitions may change. Along the same line, I will present several case descriptions in patients with other anxiety disorders and PTSD, who received only one or two Reconsolidation Intervention sessions. To illustrate that the translation from basic science to clinical practice is not self-evident, I will also present non-effective case descriptions. Even though the process of memory reconsolidation has the potential to actually erase excessive fear memory, we cannot observe the molecular and cellular processes in the human brain underlying either the presence or absence of memory expression. We can only infer the underlying neurobiological processes from the behavioural, physiological or neural read-outs of fear memory. Because there is no one-to-one relationship between these memory expressions and the underlying neurobiological processes, erasure of memory traces cannot be proven. However, by critically testing hypotheses that follow from the reconsolidation conjecture, we may gradually unveil some of the mysteries that underlie the plasticity of fear memory in humans.

Risk and Resilience: How can we prevent PTSD?

Jennifer Wild, University of Oxford

Posttraumatic stress disorder (PTSD) is the only disorder in DSM-V for which there is an external cause. It is the only disorder for which a behavioural ‘medicine’ could be administered after exposure to the central trigger to protect against developing the disorder. An enormous body of research has established risk factors for developing PTSD and emerging research has begun to evaluate resilience interventions aimed to protect individuals from developing the disorder. Unfortunately, the currently available resilience interventions are not very successful, possibly because they fail to target predictors of risk. I shall present results of our large-scale RCT of a widely available resilience intervention. I will also present programmatic research, in which we first applied an established cognitive model of PTSD persistence to the prediction of trauma-related disorders. Our aim was to identify pre-trauma risk factors for post-trauma PTSD and depression in a large sample of individuals regularly exposed to trauma. The talk will present the results of this prospective research as well as a number of novel experimental studies that demonstrate how we may successfully modify malleable predictors of risk with CBT to protect individuals from developing trauma-related disorders. The talk culminates with a presentation of how we
may protect emergency workers, individuals who risk their lives to promote our own physical health and safety, with an evidence-based preventative intervention.

Understanding and treating conflict related trauma - reflections on research and clinical practice from Northern Ireland

Michael Duffy, Queen’s University Belfast
The aftermath of the recent prolonged conflict in Northern Ireland has left a legacy of trauma-related illness. NICE guidelines recommend trauma-focused CBT (TFCBT) for the treatment of PTSD but how can these therapies be effective with PTSD linked to conflict and terrorism? This keynote will draw upon over 20 years clinical practice working with trauma linked to terrorism and conflict. The first question is whether psychological factors add to our understanding of predictors of PTSD among individuals exposed to potentially traumatic events. Previous meta-analyses by Brewin et al. (2000) and by Ozler et al. (2003) have identified a range of predictors of PTSD but the amount of variability in PTSD that they explain is modest. Ehring, Ehlers and Glucksman (2006, 2008) assessed a range of psychological factors specified in Ehlers and Clark’s [2000] cognitive model of PTSD and found that the cognitive factors were substantially more powerful in predicting PTSD. I will present 3 school and community studies that investigate whether the same psychological factors may be similarly powerful in predicting chronic PTSD following a terrorist bombing. The second question is whether TFCBT is effective for those who experience PTSD linked to trauma and conflict. I will present findings from 2 clinical studies of individuals with conflict related PTSD who were offered TFCBT based on the Ehlers & Clark (2000) model. In the first study following a terrorist bombing incident substantial and significant improvements in PTSD were observed, with pre to post treatment effect sizes in line with those reported for TFCBT in trials with non-terrorism related PTSD. In the second study patients were randomized to either immediate TFCBT or Wait list. Patients typically had chronic PTSD (range 3 months to 32 years) mostly resulting from multiple traumas. Half had failed previous psychological treatments for PTSD. In contrast to no improvement on the wait list, immediate CT was associated with significant improvement in PTSD, depression and social/work related disability, which was maintained at follow-up. This keynote will report how large surveys can be designed to inform clinical practice and how clinicians can adapt TFCBT for a chronic, multiply traumatized population in the context of ongoing threat.

Recent advances in assessing CBT competence

Freda McManus, University of Stirling
Effective assessment of Cognitive Behaviour Therapy (CBT) competence is crucial to the success of the current drive to expand CBT training and service provision, and to the widespread dissemination of CBT into routine practice. However, a lack of consensus about how CBT competence should be assessed has resulted in the use of numerous different methods, many of which have been widely criticised. This keynote will present the advantages and disadvantages of the various methods for assessing CBT competence within Miller’s (1990) framework for assessing clinical skill, in the context of ‘evidence-based training’ (Ravoshik & McManus, 2010).
Observational ratings of therapists’ in session performance using standardised rating scales is the ‘gold standard’ for assessing therapists’ ability to effectively apply their knowledge and skills within clinical practice settings (Barber et al., 2007; Muse & McManus, 2013). Given the need to further refine the rating scales that are currently available (Fairburn & Cooper, 2011; Muse & McManus, 2013; Muse & McManus, 2015), a BABCP funded initiative was to develop a novel CBT competence rating scale: the Assessment of Core CBT Skills (ACCS – Muse, McManus, Rakovshik & Thwaites, submitted). The ACCS aims to build upon existing tools (particularly the Cognitive Therapy Scale [www.beckinstitute.org] and the Cognitive Therapy Scale-Revised [CTS-R: Blackburn et al, 2001]) by providing a
behaviourally-specific rating scale with discrete items applicable across a range of CBT interventions and adult mental health problems, and serving as a developmental tool for providing formative feedback and engaging in self-reflection. Results from preliminary studies investigating the psychometric properties of the ACCS rating scale in ‘real world’ CBT training and routine practice contexts suggest that both the self-rated and assessor-rated versions of the ACCS demonstrate good internal consistency, inter-rater reliability, and discriminant validity. Thus the ACCS is suitable for use in clinical practice, training settings and research studies, and can be used as a self-rating tool as well as an assessor-rated tool. In addition, the ACCS was found to be correlated with, but distinct from the Revised Cognitive Therapy Scale (CTS-R), was comparable to the CTS-R in terms of internal consistency and discriminant validity, and may have advantages over the CTS-R in terms of inter-rater reliability. Thus the ACCS may provide an acceptable alternative to the CTS-R, with updated criteria and broader applicability.

**The puzzle of adolescent depression**

**Shirley Reynolds, The University of Reading**

Although adolescent depression is common and has long term adverse effects the treatments we offer are hard to access and only moderately effective. There is a need to develop and improve prevention, early intervention and treatment of depression when it develops in young people. Many depressed young people do not access effective treatment. This is due to multiple factors including lengthy waiting lists, high thresholds for accepting referrals, and poor recognition of depression in teenagers. Of those who are referred to child and adolescent mental health services, many depressed young people present with high levels of risk and self-harm and thus present a major demand to NHS Child and Adolescent Mental Health services (CAMHs). Even if we increase investment in CAMHS the treatments that we offer mean that many young people will not benefit.

This presentation will present recent research carried out in a joint University of Reading/NHS CAMHs research clinic. Our research focuses specifically on depressed young people. It is based on the assumption that adolescence is a distinct period of social, emotional, cognitive and neural development. Young people who are vulnerable to depression often lack core self-regulation and executive functioning skills and have significant deficits in reward processing. Irritability, low motivation, low self-efficacy and hopelessness present significant barriers to engagement. Thus our research and the treatments we offer should address the specific needs of this population and the specific characteristics of depression amongst this group. We have adapted Brief Behavioural Activation specifically for young people who are depressed. Brief Behavioural Activation is highly structured, involves parents, and elicits and builds on the ‘values’ held by young people to increase reinforcement and pleasure. There has been very limited evaluation of the effectiveness of Brief Behavioural Activation for depression in adolescents; I will present the results of a pilot study conducted in NHS CAMH and discuss a current project in which we are evaluating the effectiveness of delivering Brief Behavioural Activation in schools.

**Understanding suicidal behaviour**

**Rory O’Connor, University of Glasgow**

Suicide and attempted suicide are major public health concerns with complex aetiologies which encompass a multifaceted array of risk and protective factors. There is growing recognition that we need to move beyond psychiatric categories to further our understanding of the pathways to both. As an individual makes a decision to take their own life, an appreciation of the psychology of the suicidal mind is central to suicide prevention. Another key challenge is that our understanding of the factors that determine behavioural enaction (i.e., which individuals with suicidal thoughts will act on these thoughts) is limited. Although a comprehensive understanding of these determinants of suicidality requires an appreciation of biological, psychological and social perspectives, the focus in this presentation is primarily on the psychological determinants of self-harm and suicide. The
Integrated Motivational–Volitional (IMV) Model of Suicidal Behaviour (O’Connor, 2011) provides a framework in which to understand suicide and self-harm. This tripartite model maps the relationship between background factors and trigger events, and the development of suicidal ideation/intent through to suicidal behaviour. I will present a selection of empirical studies derived from the IMV model to illustrate how psychological factors increase suicide risk and what can be done to ameliorate such risk. The implications for the prevention of self-harm and suicide will also be discussed.

**Symposia**

**Developments in hoarding disorder**

**Assessment and treatment of Hoarding Disorder**  
*Helena Drury, South London and Maudsley NHS Foundation Trust*

Little is known about the reliability of informant (clinician or relative) ratings of hoarding severity, and whether or not individuals who self-identify with Hoarding Disorder (HD) differ from those who do not. Good correspondence was found between self- and informant-ratings, indicating that relative reports of hoarding severity are likely to be reliable. Higher hoarding severity and lower insight informant-ratings were made for individuals with HD who did not provide self-ratings, indicating that those who do not self-identify with HD may be the most impaired proportion of the HD population. Suggestions for engaging this hard-to-reach subgroup of HD individuals will be discussed. A number of studies have found that cognitive-behavioural therapy (CBT) is an effective treatment for Hoarding Disorder (HD), and a recent meta-analysis found that delivering CBT for HD in a group format had the same treatment outcome as individual CBT (Tolin et al., 2015). A treatment manual has been developing in the United States for group CBT for HD (Muroff, Underwood, & Steketee, 2014), but to date, no studies have reported on the use of this manual outside the USA, or in research groups not linked to the manual authors. Findings will be reported from a project examining the effectiveness and feasibility of group CBT for HD in routine clinical settings, which has not previously been investigated. We will also describe our reflections on running treatment groups for HD, and share what we have found helpful in using a group treatment for HD.

**Is cognitive analytic therapy (CAT) effective in treating Hoarding Disorder?**  
*Steve Kellet, University of Sheffield*

The evidence base for the treatment of Hoarding Disorder (HD) is entirely grounded in the CBT model and the need to research alternative models has been consistently stated. An adjudicated hermeneutic single case efficacy design (HSCED) was conducted to explore the efficacy of cognitive analytic therapy (CAT) in the treatment of one treatment resistant patient. Complex quantitative and qualitative outcome data was analyzed and combined to form a rich case record. Arguments for and against efficacy were identified and debated by two separate research teams (n=3) and presented to independent judges (N=3) for deliberation and delivery of a final verdict. Contradictions were present regarding outcome, with measures indicating both the presence and absence of change. Subsequently, all three judges returned a verdict in favor of the skeptic position, concluding that CAT was not efficacious. The results will be discussed in terms of (a) the promise offered by the CAT model and (b) viability of adjudicated HSCED as a complementary approach to supplement more traditional treatment efficacy designs.

**Exploring the occupational needs of individuals with psychosis who experience hoarding**  
*Erin McIntyre, South London and Maudsley NHS Foundation Trust*

Research regarding hoarding is limited, particularly addressing co-morbidities such as psychosis, and there is little evidence describing the role of occupational therapy. The project discussed in this presentation aims to bring occupational therapists into the dialogue
about the management of hoarding, exploring contributions specifically for those with psychosis, and how this complements existing research and practice. Findings will be presented on caseload evaluation of those in psychosis promoting recovery teams who have hoarding difficulties and clinicians’ experiences of hoarding in psychosis and views on effective approaches for intervention including occupational therapy.

**Using Q-method to highlight the experience of working with clients that hoard**  
*Steve Kellet, University of Sheffield*

Whilst we know quite a lot about the impact of hoarding on the person, we know much less about what it feels like to work with this client group. The aim of this project was to explore and illuminate professionals’ experiences of engagement and intervention with people that hoard - and to achieve this via using Q-method. Five semi-structured interviews were initially conducted with professionals with detailed experience of working with hoarding. The thematic analysis of the interviews identified key statements for a 49-item Q-set. The Q-sort was subsequently administered to public sector professionals with wide experience of working with people who hoard (N=36; fire-fighters, environmental health, housing and mental health). Organizational support and job-related wellbeing measures (anxiety/contentment and depression/enthusiasm) were also administered. Three distinct clusters of workers emerged: (a) therapeutic/client focused (b) shocked/frustrated and (c) pragmatic/task-focused. Therapeutic/client focused professionals were significantly more content and enthusiastic regarding their hoarding work. The results are discussed in terms of the evidence that professionals experience and approach their work with people that hoard in discrete and dissimilar ways. Service delivery and training implications will be also considered.

**Family impact of Hoarding Disorder**  
*Helena Drury, South London and Maudsley NHS Foundation Trust*

Hoarding Disorder (HD) is associated with substantial functional impairment for individuals with HD, but relatively little work has examined the impact on relatives of those with HD. Findings will be presented on the impact of HD on relatives in terms of carer burden, well-being and everyday functioning; factors associated with higher carer burden will also be discussed.

**Clinical Flexibility in the treatment of adult anxiety disorders**

**Treatment of perinatal anxiety disorders in practice**  
*Fiona Challacombe, Centre for Anxiety Disorders and Trauma*

This talk will review the available evidence on the treatment of a range of anxiety disorders presenting in primary care. The talk will discuss particular considerations in the treatment of such problems during pregnancy and the postnatal year including issues of diagnosis, risk and treatment flexibility in terms of both content and delivery. Preliminary data from a survey of mothers who experienced perinatal anxiety will be presented alongside discussion of the issues this raises in terms of effective identification of these problems and delivery of treatment.

**Flexibility in the delivery of CBT for Social Anxiety Disorder (SAD)**  
*Debbie Cullen, Centre for Anxiety Disorders and Trauma*

This talk will begin with an overview of the treatment for SAD based on the Clark & Wells model for social phobia, which is typically delivered in 12-14 weekly sessions. This will be followed by a brief review of the evidence base for treatment and some of the common barriers that clients report in terms of accessing standard treatment, including the challenges of attending regular weekly sessions. To increase the accessibility of this effective treatment and maximise engagement we have been piloting an ‘intensive treatment’ format, wherein a full course of CBT for SAD is provided over a 1-2 week period, with a number of follow up sessions in subsequent weeks. We will describe this intensive
treatment with illustrative case examples and present some promising outcome data alongside a discussion of the potential benefits and challenges of working in this way. We will also share our ideas about when flexing the treatment in this way works best and when standard treatment may be more beneficial.

**Treating compulsive rumination in the context of OCD**  
**Blake Stobie, Centre for Anxiety Disorders and Trauma**  
“Pure O”, OCD characterised predominantly by mental rumination, is widely perceived by sufferers and clinicians to be a difficult-to-treat subtype of OCD. This presentation will describe the content of common ruminatory themes using case examples for illustration, before considering ways of customising standard OCD treatment techniques (examining which concepts to draw out in formulations for people with rumination, and how to modify Theory A/B summaries when working with people with compulsive rumination) and additional techniques which can help people with compulsive rumination, including identifying and labelling worries, noting first and second level obsessions, metaphors and role plays.

**Challenging stuff: CBT for hoarding disorder**  
**Alice Kerr, Centre for Anxiety Disorders and Trauma**  
Previously listed in DSM-IV as a symptom of OCD, hoarding disorder is now seen as distinct from OCD within the DSM-V, albeit classed as an obsessive compulsive spectrum disorder. In this talk the features and diagnostic criteria of hoarding disorder will be outlined. The main components of CBT for hoarding disorder will then be presented relating to a case example including goal setting, formulation, visualisation and motivational exercises, reducing acquiring and working on discarding possessions. The work of Frost, Steketee and Muroff (from the USA) will be drawn upon, along with recommendations from our UK colleagues, Satwant Singh, Margaret Hooper and Colin Jones. Effectiveness of individual CBT will be considered and an audit of individual and group therapy conducted by our clinic also presented. Common obstacles in treatment will be discussed and how these were addressed within the case example. Service user testimonials for treatment will also be presented.

**How OCD can interfere with the process of CBT for OCD**  
**Alison Roberts, Centre for Anxiety Disorders and Trauma**  
This talk will briefly refer to the literature on treatment resistant OCD before presenting case material to demonstrate how OCD beliefs can interfere with the process of CBT for OCD. This will include descriptions of potential ways OCD can interfere with assessment, formulation, engagement, cognitive re-structuring, behavioural experiments, homework and ending therapy. Strategies that can be employed to predict, avoid or resolve these challenges will be described with an emphasis on using an understanding of OCD processes and idiosyncratic formulation as a guide.

**Mindfulness and CBT**

**Mindfulness for people with long-term physical conditions: Lessons, challenges and preliminary evidence from two IAPT services**  
**Costas Lambropoulos, Oxford Health NHS Foundation Trust (Healthy Minds, Buckinghamshire IAPT Service), Mary Kavanagh, Oxford Health NHS Foundation Trust (Talking Space, Oxfordshire IAPT Service); Charlotte Morris, Oxford Health NHS Foundation Trust (Healthy Minds, Buckinghamshire IAPT Service)**  
Abstract: Living with chronic physical conditions can be difficult and stressful. As many as 25% of those having to cope with illnesses such as diabetes, cardiac problems, rheumatoid arthritis and Parkinson’s disease experience depression, low mood, anxiety and chronic pain. Factors such as having to cope with the effects of medication and physical changes are compounded by psychological factors such as a sense of loss, anger and resentment, rumination about what the future may hold and impaired capacity to work and maintain relationships. So how can Mindfulness training help
We hope that the presentation will provide participants with the opportunity to
• Reflect on the rationale for MBCT with participants living with long-term physical conditions in an NHS setting
• Hear about our experience of running courses, including challenges and discoveries and also the experience of the participants.
• Discuss preliminary evidence
• Discuss and share their own experience of working with this population

For our preliminary evaluation we use qualitative data from the orientation/assessment interviews, mid-course reviews and end of the course reviews, as well as quantitative data based on outcome measures from the two IAPT services (TalkingSpace in Oxfordshire and Healthy Minds in Buckinghamshire).

Our preliminary evidence from both services suggests significant improvement in our outcome measures for those who established a regular practice during and after the mindfulness course. Similarities and differences between the two services in the delivery of the LTC MBCT courses will be discussed as well as the adaptations made to the mindfulness programme when working with people with long-term physical conditions. By the end of this presentation we hope that participants will have:
• An understanding of the factors to be considered when running an 8-week Mindfulness course specifically for people with long term physical conditions in an NHS setting.
• Ways of adapting materials, structure of sessions and mindful practice when working with this population.
• An understanding of the impact of the course on people with long-term physical conditions based on our preliminary evidence from Oxford and Buckinghamshire.

We hope that our presentation will promote mindfulness for people with long-term conditions and will help other IAPT services to make mindfulness courses more accessible to this population.

Testing a new cognitive model of tinnitus distress: results of path analysis
Lucy Handscomb, NIHR Nottingham Hearing Biomedical Research Uni; Laurence McKenna, Royal National Throat Nose and Ear Hospital, London; Deborah Hall, NIHR Nottingham Hearing Biomedical Research Uni; Derek Hoare, NIHR Nottingham Hearing Biomedical Research Uni; Gillian Shorter, Trinity College, Dublin

Tinnitus—noises in the ears or head—is a common condition which is known to be much more distressing for some individuals than for others (Davis and El Refaie, 2000). The reasons for these individual differences are not fully understood, but there is no direct relationship between loudness and distress (Andersson et al., 1999). A cognitive model of tinnitus distress has been proposed by McKenna et al. (2014). This hypothesizes that tinnitus becomes and is maintained as a distressing problem through a process of interaction between thoughts, emotional distress, attention, perceived loudness, beliefs and behaviour.

In order to investigate the predictions made by this model, a survey was compiled which consisted of nine published questionnaires (or parts of questionnaires) which measure tinnitus-related distress, thoughts, beliefs, attention and avoidance behaviour, perceived tinnitus magnitude and general emotional distress. The survey was completed (mostly online) by 342 members of the public with tinnitus. Respondents were divided into five categories depending on whether they rated their tinnitus as not a problem or a small, moderate, big or very big problem. Factor analysis was carried out on all the questionnaires and path analysis was then used to investigate relationships between different components of the model.

Comparison of mean questionnaire scores between categories found a clear tendency for scores to be higher amongst those who rated their tinnitus as a greater problem, except on the measure of control beliefs. This suggests that all the components of the model do contribute to tinnitus distress, with questions remaining about beliefs.

A satisfactory factor structure was identified for all of the questionnaires. Path analysis using the factor scores derived from all the factors identified found several adapted versions of the
cognitive model of tinnitus distress (testable using structural equation modelling techniques) to be an acceptable fit to the data. Certain elements of the model were shown to mediate or partially mediate between others.

This study supports and builds on existing evidence about psychological factors which contribute to tinnitus distress. It found the hypotheses contained within the Cognitive Model of tinnitus distress to be largely accurate.

CBT has been shown to be an effective way of reducing tinnitus distress (Hoare et al., 2011). A deeper understanding of the relative importance of different components of tinnitus distress and the connections between them will help to refine therapy so it can be more efficient and more effective. The model itself could also be a helpful counselling tool.

**Meditation, Mindfulness & Working Memory: general practice & specific techniques**

**Presenter: Josie Flight, Regent’s University London**, Amy Harrison, Regent’s University London

Research suggests meditation improves Working Memory (WM), which accounts for wider purported health benefits. WM refers to a cognitive model of a ‘central executive’ attentional control system with sub verbal-auditory and visual-spatial systems sustaining and manipulating information over short-time periods (Baddeley, 2000). A systematic review on meditation and WM highlighted 18 papers. Various explanations are offered for observed WM improvements: improved WM capacity (WMC) and attentional control (Heeren, Van Broeck, & Philippot, 2009; Kuo & Yeh, 2015; MacLean et al., 2010; Mazrek et al., 2013; Van Vugt & Jha, 2011); prevention of stress induced impairment (Banks, Welhaf & Sour, 2015; Jha et al., 2010); reductions in mind wandering (Mazrek et al., 2013; Zeidan et al., 2010; Zylowska et al., 2008); and prefrontal cortex neuroplasticity (Baird et al., 2014; Chambers, Lo & Allen, 2008; Moore & Malinowski, 2009). Only one article compared different meditation techniques (Jha, Krompinger, & Baieme, 2007); this found MBSR and Buddhism affected different WM attentional subcomponents.

Understanding more about mechanisms behind reported improvements might further aid clinical intervention developments like Mindfulness Based Cognitive Therapy (MBCT) (Williams, 2010). Therefore, the present study aimed to examine whether improved WM observed in meditation practitioners might also be explained by meditation techniques. Participants were an even split of genders (32 females and 33 males) and consisted of experienced meditation practitioners (n = 46) across three groups (Hinduism-inspired n = 18, Buddhist n = 14, and Mindfulness n = 14) and an IQ-matched control group (n = 19).

Participants completed three paper-WMC measures: the colour-word interference task (measuring attention) (Delis, Kaplan & Kramer, 2001), the symbol span test (measuring visual-spatial WM) and the logical memory test (measuring verbal-auditory WM) (Wechsler, 2009). IQ was estimated using the National Adult Reading test (Nelson & Willison, 1991). Three factorial MANOVAs and post-hoc tests were used to compare differences between meditation conditions and the control group.

Meditators outperformed controls across all WM tasks (p < 0.05), particularly in visual-spatial skills (p < 0.005), although effect sizes were small-medium (np² = 0.15). Significant differences were not seen between meditation groups (p > .05, ηp² = .11) or techniques (p > .05, ηp² = .18).

The research was limited by the cross-sectional design; failure to replicate Jha, Krompinger & Baieme’s (2007) findings might be due to the alternative study design. A future study could use standardised lab environments, consider computerised tests and a longitudinal, randomised study design. It would also benefit from neuroscientific testing such as functional magnetic resonance imaging to ascertain neural correlates. The study supports the idea that regular meditation, regardless of the technique used, induces improvements in WM. These findings might be important given the previously identified associations between WM and positive wellbeing. It is possible that the WM mechanism might contribute to explaining why meditation techniques prevent relapse from mental illness such as depression (Williams, 2010).
The study therefore might be of use to “third wave” Cognitive Behavioural Therapies, notably MBCT, for highlighting potential areas of development and also providing explanation to clients.

Mindfulness Based Cognitive Therapy compared to Relaxation Training for Chronic Tinnitus: Results of a Randomised Controlled Trial
Elizabeth Marks, University of Bath and Royal National Throat Nose and Ear Hospital, Laurence McKenna, Royal National Throat Nose and Ear Hospital; Elizabeth Marks, University of Bath and Royal National Throat Nose and Ear Hospital; Roland Schaette, Ear Institute, UCL

Tinnitus refers to auditory perception in the absence of external stimulation; Estimates suggest that 10 – 14% of the population suffer with prolonged tinnitus, and 1 – 2% develop clinically significant psychological distress as a result. Tinnitus does not resolve with medical or surgical intervention, so standard treatment focuses on sound therapy and managing psychological distress using interventions such as Tinnitus Retraining Therapy, Relaxation Therapy and CBT. More recent developments have focused on ‘acceptance based’ treatments, which represent a radical change from mainstream audiology practice. This has included mindfulness-base approaches such as Mindfulness-Based Cognitive Therapy (MBCT). Recent studies have found reported beneficial effects of mindfulness in tinnitus, but these have been from uncontrolled or small clinical trials. Here we describe the results from a randomized-controlled trial of MBCT, based on the standard UK approach, adapted to be specific to tinnitus and compared to an active control group (Relaxation Therapy) and a waiting period.

Patients reporting chronic and distressing tinnitus were assessed. 70 met eligibility criteria and were randomized to receive either Mindfulness Based Cognitive Therapy (MBCT) or Relaxation Training (RT). Both were group treatments, delivered over eight weekly, 2-hour sessions, by two clinical psychologists. Primary outcomes were changes in tinnitus-related distress (measured on the Tinnitus Questionnaire – TQ) and psychological distress (measured on the Clinical-Outcomes on Routine Evaluation - CORE-OM). Secondary outcomes included measures of anxiety, depression, tinnitus loudness, tinnitus catastrophizing, tinnitus acceptance and mindfulness. Participants completed measures at 5 time-points (8-weeks pre-therapy, week 1 and week 8 of therapy and at 1 and 6-month follow-up).

70 patients completed the study. Initial results of pre-post differences demonstrated significant improvements in both groups on primary and secondary outcomes. Between-group analyses showed that a significantly greater proportion of patients in the MBCT group (50%) reported clinically significant reduction in psychological distress compared to the RT group (21%) (X2= 0.02). There was a trend effect of the MBCT to be associated with greater improvement in tinnitus distress (TQ) compared to RT (p = 0.088). Compared to the RT group the MBCT group showed significantly greater reductions in tinnitus-catastrophizing and greater improvements in tinnitus acceptance. Further analyses are due to be conducted to measure outcomes at 1 and 6 months, and explore potential mediators and moderators of change, and these results will be presented.

MBCT and RT both led to significant clinical improvements in tinnitus-related distress and psychological well-being. Patients in the MBCT group showed some significantly greater changes than those in the RT group in a number of domains. This included changes in tinnitus acceptance and catastrophizing, cognitive and behavioural correlates of tinnitus which have previously been associated with long-term outcomes. We discuss the implications for these findings in future developments of treatments for chronic and distressing tinnitus.

Acceptance-based approaches in chronic health conditions are growing in popularity. This study, in demonstrating that MBCT is an effective and acceptable approach for tinnitus management offers further support to the inclusion of mindfulness-based interventions in audiological care.
Mental Imagery as a Therapeutic Target: From Lab to Clinical Application

Mental imagery affects subsequent automatic defense responses
M.A. Hagenaars, R. Mesbah, & H. Cremers; Utrecht University

Negative mental images are an important feature of several psychiatric disorders, for example posttraumatic stress disorder (PTSD). Moreover, mental imagery is used successfully in the main treatment strategies for PTSD. By activating mental images, basic alterations may be made in the memory of that event and associated emotional responses. The aim of the studies presented here was to examine whether mental imagery would also affect emotional responses to a future event. More specifically, it was tested whether mental imagery would affect later automatic heart rate responses to threat. Two experiments were done with different mental imagery scripts that were either related or unrelated to the pictures that were shown later (related-good ending, related-bad ending, unrelated, and no script). A passive viewing task followed with neutral, pleasant and unpleasant pictures. Mental imagery indeed affected later heart rate responses, with lack of bradycardia after the “pleasant” (related-good ending and unrelated) mental imagery scripts. These findings are discussed in the context of vigilance and freezing.

Taxing Distressing Autobiographical Memory Imagery Using Cognitive Tasks
A Stewart, C. Deeprose, & J. Andrade; Cognition Institute, Plymouth University

Distressing mental imagery plays an important role in a variety of psychological disorders and their treatment. A primary example is Posttraumatic Stress Disorder (PTSD), in which emotional distress is maintained by the re-experiencing of traumatic events in the form of intrusive memory imagery. Ongoing research suggests that such aversive imagery can be effectively attenuated if brought to mind while performing a cognitively demanding task, such as making bilateral eye movements. Concurrent task procedures like this are an active component of trauma focused interventions like Eye Movement Desensitisation and Reprocessing (EMDR) therapy, and have proven efficacious in attenuating distress in several disorders. The question that remains is how and why concurrent task interference can provide such therapeutic efficacy. The current study used a non-clinical sample to test a leading hypothesis: that eye movements reduce the ability to vividly maintain an emotional mental image in working memory. The vividness and emotional intensity of negative autobiographical memories was assessed before and after performing either a visual or verbal cognitive task during memory visualization. Results indicate that the general working memory load imposed by concurrent tasks may serve to reduce the vividness and emotional impact of distressing memory imagery. Implications for the working memory model of EMDR, future research, and potential clinical implications are discussed.

The phenomenology of mental imagery in social anxiety
S. Homer, J. Andrade, C. Deeprose; Cognition Institute, Plymouth University

Negative mental imagery is a key feature of posttraumatic stress disorder (PTSD) and a growing body of evidence has identified its prevalence in range of psychological conditions. Negative imagery is ubiquitous within cognitive models of social anxiety and experimental research has demonstrated that it has a causal role: visualising negative self-images is conducive to increased anxiety, lower social performance ratings and lower implicit self-esteem in social situations. Accordingly, several imagery-based interventions are emerging including concurrent working memory interference tasks (e.g. eye movements). The main study presented here aimed to update and further previous qualitative investigations into negative imagery in social anxiety. An in-depth exploration of the phenomenology of negative mental imagery in sub-clinical socially anxious samples was conducted using a computerised interview based on previous work. Results indicated that negative imagery was experienced regularly and intrusively; was usually related to a negative autobiographical memory; tended to be in the field perspective and was primarily visual,
somatic and/or auditory but could involve a range of sensory modalities. Implications for laboratory research and clinical application will be discussed.

**Imagery Interventions for Relapse Prevention in Dual Diagnosis: A Case Series Design**

**N. Guiney; Oxford University**

**Background:** Craving is a central feature of alcohol dependence. Higher levels of craving have been identified as a risk factor in alcohol dependence and a possible predictor of negative treatment outcomes. Current psychological approaches do not always address factors that trigger, maintain and reduce craving episodes. Intrusive imagery can play an important role in maintaining cravings. Despite this, there are limited interventions or guidelines to show therapists how to target craving imagery in a direct and meaningful way. In contrast, imagery interventions such as imagery rescripting have been utilised in reducing distress and in challenging unhelpful beliefs in a range of other disorders. This study explored whether imagery interventions would be effective in addressing unhelpful addictive beliefs/images and behaviours maintaining craving in alcohol dependence.

**Aims:** A pilot case series was designed to find out if imagery interventions (including imagery rescripting) could reduce craving and potentially play an important role in relapse management.

**Method:** A case series design was utilised to evaluate the application of imagery interventions in reducing craving, alongside treatment as usual (TAU) for three clients with a diagnosis of alcohol dependence and a co-occurring mood disorder.

**Results:** All three clients reported a reduction in craving by the end of treatment.

**Conclusion:** Adding imagery interventions to treatment as usual was successful in combating cravings in this small cohort and this success warrants further investigation.

**Promoting positive imagery in depression via a brief web-based cognitive bias modification training**

**A Picet; University of Geneva**

Recent research suggests that abnormalities in mental imagery may play an important role in the maintenance of depressed mood (Holmes, Blackwell Burnett Heyes, Renner & Raes, 2016). In particular, people with depression have been shown to be specifically impaired at generating vivid imagery of positive future events (Morina, Deeprose, Pusowski, Schmid, & Holmes, 2011). A recently developed cognitive training procedure called “imagery cognitive bias modification” (imagery CBM; Holmes, Lang, & Shah, 2009) aims to instil a more positive imagery bias through repeated practice in generating positive imagery of ambiguous information. Several studies have shown that imagery CBM could be efficient in reducing depressive symptoms. However, two recent randomized controlled trial of online imagery CBM have provided inconclusive results (Blackwell et al., 2015; Williams et al., 2015), suggesting that more research is required to identify which parameters of the technique could be improved to maximise active engagement with the online training task. The current study sought to test the efficacy of a refined, brief imagery CBM program consisting of 4 sessions delivered online to a sample of 101 participants with depressive symptoms. The effects of imagery CBM on depressive symptoms, anhedonia and interpretation bias were assessed immediately after the intervention and at two weeks follow-up. Results of this study and potential implications for future development of imagery CBM for depression will be discussed in this symposium.

**Memory consolidation and reconsolidation: implications for treatment**

**Targeting intrusive memories of trauma by disrupting memory consolidation: Feasibility of a simple cognitive-task intervention delivered in the emergency department**

**Lalitha Iyadurai, Department of Psychiatry, University of Oxford**

We currently lack preventive interventions for post-traumatic stress symptoms that could be delivered in the immediate aftermath of a traumatic event. Intrusive memories of trauma are distressing in their own right, are a hallmark symptom of post-traumatic stress disorder, and have transdiagnostic relevance across other disorders such as depression and
complicated grief. Laboratory studies with non-clinical participants have found that a simple
cognitive-task intervention, delivered soon after an experimental trauma (watching a film
with traumatic footage), can reduce the frequency of intrusive memories over the following
week (e.g. Holmes, James, Kilford & Deeprose, 2010; James, Bonsall, Hoppitt, et al., 2015).
The intervention involved a film reminder followed by playing the visuospatially-demanding
computer game “Tetris”. The intervention was hypothesised to disrupt the consolidation of
sensory trauma memories by competing for cognitive resources during a memory
consolidation window.
This research translated the cognitive-task intervention from the laboratory to a clinical
setting after real-world trauma: in a hospital emergency department with patients who had
experienced a road traffic accident. A randomised controlled trial (N = 71) tested whether
the cognitive-task intervention (a memory reminder followed by playing Tetris), compared
to a control condition (completing a simple written activity log), could reduce the frequency
of intrusive memories in the week after the accident. Post-traumatic stress symptoms,
anxiety and depression at one week and one month were also assessed, as well as
participant feedback at one month. Results showed that it was possible to reach patients
within a few hours of the accident (within a hypothesised timeframe for memory
consolidation). Compliance with the intervention was high and drop-out was low.
Participant feedback indicated that participants found playing Tetris very easy, very helpful
and minimally distressing. The implications of the study are discussed in relation to
developing novel, low-intensity preventive interventions after psychological trauma that
could be easily disseminated in a variety of contexts, from emergency settings to mass
disasters.

**Reconsolidation-based treatments for specific phobia: Long-term outcomes and
mechanisms of change**

**Jamie Elsey, Department of Clinical Psychology, University of Amsterdam**

Maladaptive memories are a core feature of several psychiatric disorders. The disruption of
memory reconsolidation thus holds great promise as a therapeutic tool. In a randomised
controlled trial of memory reconsolidation disruption as a treatment for arachnophobia, we
found a striking transformation of behaviour and attitudes towards spiders in the active
treatment group, which was sustained at one year follow-up. However, questions remain
regarding outcomes over longer timescales, and the precise treatment mechanism may have
implications for such long-term outcomes and relapse rates.
In this talk, I will present data from a three year follow-up of our original arachnophobia
participants. In addition, I will discuss the proposed mechanism of action for this treatment
in relation to standard pharmacotherapy and exposure-based therapies. Finally, I will
present a further treatment study, designed to test an alternative to the ‘reconsolidation
disruption’ explanation for the observed treatment effects: state-dependent retrieval failure.
We anticipate that a greater understanding of the long term outcomes and treatment
mechanisms in reconsolidation-based interventions for specific phobia will have
implications for the treatment of more complex psychiatric conditions.

**Changing minds by changing memories: Developing a reconsolidation-based cognitive
behavioural therapy for alcohol-related disorders**

**Sunjeev K. Kamboj, Research Department of Clinical, Educational and Health
Psychology, University College London**

Addiction involves frequently-reinforced drug-seeking and -taking behaviours, as well as the
formation of associations between environmental (drug-related) cues and drug-taking.
Consider the smoker with a 20-a-day habit: they will repeat the action of bringing a cigarette
to their mouth and inhaling tobacco smoke approximately 100,000 times in a year, with each
instance associated with relief. At the same time as this instrumental reinforcement,
Pavlovian associations are being formed between smoking and smoking-paraphernalia
(ashtrays, lighters, smoking buddies etc.). Moreover, this learning occurs across a variety of
contexts. As such, addiction-related learning is particularly robust and generalised, and
exerts a lasting influence on drug-seeking, attention, and subjective experiences (e.g. 'liking' and 'wanting'), even after prolonged abstinence.

Our studies have focused on developing novel experimental treatments for addiction-related problems. After outlining some failed efforts to improve the effects of exposure/response prevention using cognitive enhancing drugs in heavy drinkers and smokers, I will describe our recent studies on modification of alcohol memories via retrieval-dependent memory destabilisation and restabilisation (reconsolidation). By performing common cognitive-behavioural procedures during the reconsolidation window we found evidence for a distributed re-writing of alcohol memories, reflected in reductions in attentional bias, liking of alcohol, craving and alcohol semantic memory. Our experiments suggest that small changes to existing CBT procedures may enable generalized changes in motivational memory networks, and enduring reductions in relapse risk in addictive disorders. The next step is to develop these procedures into viable treatments for clinical populations.

Understanding and treating co-morbid fatigue, somatic symptoms, sleep and distress in young people

Sleep and fatigue in adolescents with depression
Shirley Reynolds, Charlie Waller Institute, University of Reading

Depression in adolescents presents as a very heterogeneous constellation of symptoms. To receive a formal diagnosis of depression low mood, or lack of pleasure, or irritability must be reported, as well as a minimum of 4 other symptoms. Typically adolescent depression is assessed informally via clinical interviews and questionnaires. When adolescent depression is identified a range of evidence based psychological therapies, including CBT, are available. However, despite our best efforts, outcomes from treatment are moderate at best and we urgently need to improve effectiveness. In this presentation I will present descriptive data on symptoms described by over 500 young people with a diagnosis of depression, assessed using a structured diagnostic assessment (the K-SADS). Sleep problems and fatigue were amongst the most common symptoms yet these are rarely tackled directly in psychological therapies for depression in adolescents. These data suggest possible approaches to developing interventions to prevent and treat depression amongst adolescents and highlight important avenues for research.

Mood in paediatric CFS/ME - what we know and what have yet to establish
Maria Loades, University of Bath

Chronic fatigue syndrome (CFS), also known as myalgic encephalomyelitis (ME) affects approximately 1 - 2 teenagers in every 100. It interferes significantly with their day-to-day lives. For example, on average, children and young people with CFS/ME miss one year of school. We think that about 1 in 3 children and young people with CFS/ME also have depression. Those with depression seem to be more disabled, experience more pain, and don't seem to recover as well from CFS/ME.

This presentation will aim to provide a brief introduction to CFS/ME, including issues around mood and differential diagnosis, before focusing on what we know about mood in paediatric CFS/ME. This will include data from the RECOVERY study, an observational clinical cohort study. Outcomes over 6 months in a specialist CFS/ME service will be compared for young people with CFS/ME and probable depression, to those without probable depression. A summary of a systematic review undertaken of treatments for paediatric CFS/ME and depression will be presented. The final aim of the presentation will be to summarise what we have yet to establish about mood in paediatric CFS/ME, identifying research avenues for the future.

The overlap between chronic fatigue syndrome and mood disorders
Trudie Chalder, King's College London, Kate Lievesley, Maudsley Hospital. London, and Katherine Rimes, King's College London
Previous authors have investigated the overlap and distinction between psychiatric disorders and CFS. Concurrent psychiatric disorders (mostly depressive disorders) are reported in between a quarter to a third of young people with CFS in the community, specialist treatment centre samples and those attending an immunology clinic. We assessed anxiety and depression in adolescents with CFS compared to an adolescent group with asthma and a healthy control group. There were significantly higher scores of anxiety and depression symptoms in the CFS group than the other two groups in the questionnaire study. Forty-four (51.8%) of the adolescents with CFS also met DSM-IV criteria for a psychiatric disorder (most frequently for anxiety and depression), as assessed by the Mini International Neuropsychiatric Inventory. Eight weeks later, depression was significantly associated with both fatigue and school and social adjustment in the CFS group, in the univariate analysis. Depression may lead to the maintenance of functional impairments associated with fatigue problems, particularly as depression is associated with reduced motivation and behavioural avoidance.

**Psychological Factors in Chronic Fatigue Syndrome & Irritable Bowel Syndrome: Similarities & Differences**

Hazel Carrick and Maria Loades, University of Bath

Chronic Fatigue Syndrome (CFS) and Irritable Bowel Syndrome (IBS) are debilitating conditions; associated with significant psychological distress and impairments in functioning. In both cases, the causes of these conditions are not fully understood. Current research suggests that a number of factors contribute to how these conditions are experienced over time. For example, levels of anxiety & low mood, beliefs about symptoms and behavioural responses to symptoms. This research study aims to investigate how these factors impact CFS and IBS in adults. A questionnaire battery was developed to measure these factors and has been completed by three groups: people with CFS, people with IBS and people without either of these conditions. The comparative findings, which will be presented, help us to understand the similarities and differences between CFS and IBS. These findings can help to inform psychological approaches for treating these conditions. This presentation will consider the findings in adults, and how these might apply to young people, as well as identifying targets for future research.

**Internet Delivered Cognitive Therapy for Social Anxiety Disorder**

An overview and main features of internet-based cognitive therapy for social anxiety disorder.

Richard Stott, King's College London

Cognitive therapy following the Clark and Wells (1995) model is a firmly established and effective treatment for social anxiety disorder (SAD), and recommended by NICE. An internet-based version of the treatment was developed to allow patients to engage in a full course of this treatment remotely, and without meeting their therapist in person. In theory, the internet promises rich advantages as a treatment modality; 24 hour availability, delivery of rich modular and multimedia content, sophisticated built-in tracking of symptoms and key cognitions, potential reduction in therapist contact time, and the lifting of any geographic restriction on patient locality. The practice of developing an internet treatment presents significant challenges, however, if such a programme is to aspire to match the leading face-to-face treatment in treatment efficacy. Such challenges include technical hurdles in implementing key features of the model, such as video-feedback, keeping patients engaged and adherent, and the formation of a healthy therapeutic alliance whilst working remotely. This talk will discuss how each of these challenges was addressed, and present an overview of all the key features of this internet-based cognitive therapy programme, which was first successfully piloted (Stott et al, 2013), and subsequently subjected to a rigorous randomized controlled trial.

**Internet vs face to face cognitive therapy for social anxiety disorder, a randomized controlled trial**
David M Clark, University of Oxford
Randomised controlled trials have shown that face to face cognitive therapy based on the Clark and Wells (1995) model is a highly effective treatment for social anxiety disorder, which compares favourably with alternative treatments such as group CBT, exposure therapy, psychodynamic psychotherapy, interpersonal psychotherapy, and medication. In a new randomised controlled trial we investigated whether a therapist assisted Internet version of the treatment that required 80% less therapist time might be equally effective. 102 patients with social anxiety disorder were randomised to face to face CT, Internet-based CT or a wait list control condition. The two versions of treatment were rated as equally credible by patients and established equally high levels of therapeutic alliance. Ratings of the competence with which face-to-face therapy was delivered indicated that it was implemented in an optimal fashion. Outcomes were assessed using a range of self-report measures, independent assessor ratings, and a behaviour test. Patients were followed up for 12 months after the end of treatment. Results for the main outcome measures will be reported, including recovery rates using IAPT criteria.

Seeing is believing: internet-based video feedback for social anxiety disorder
Video feedback is an effective component of cognitive therapy for social anxiety disorder (SAD) and helps patients to gain a more realistic impression of how they come across to other people. In Clark and Wells (1995) cognitive therapy for SAD, video feedback is used throughout therapy with patients typically watching a video recording of themselves in session three. In this talk, we present data of N=50 patients who received internet-based cognitive therapy for SAD (iCT-SAD). As part of the iCT-SAD programme, patients first had a conversation with a stranger remotely via the webcam function in two conditions, one with and one without the use of their safety behaviours. The iCT-SAD programme video recorded the conversation such that the video recording captured the patient and also the conversational partner based in the therapist’s office. Patients then completed a module on how to watch their conversation on video before watching a playback of the experiment on their own. Results reveal that video feedback delivered remotely as part of iCT-SAD led to significant reductions in social anxiety. Patients rated themselves as looking significantly less anxious, performing significantly better, and rating their main social fear (e.g., sweating, blushing, running out of things to say) as significantly less visible than they had predicted before they watched themselves on video. These results suggest that video feedback may be successfully delivered as part of iCT-SAD. Attention will be given on how to conduct video feedback as part of iCT-SAD, what difficulties may arise and how to address them.

“The flexibility of the internet has been perfect to fit in with my life”: Service user perspectives on internet-based cognitive therapy for social anxiety disorder
Nick Grey and Harriet Rankin, South London and Maudsley NHS Trust and King’s College London
Acceptability of internet treatments is an important issue. Service users’ views are essential to support development and adaptation of such programmes. Independent assessors interviewed 35 people after they completed Internet-based cognitive therapy for SAD (iCT-SAD) and 33 people who received face-to-face cognitive therapy. Patients who received iCT-SAD also completed a questionnaire on the usefulness of different modules, communication methods, and technologies in the programme. The semi-structured interviews asked about the advantages and disadvantages of their treatment modality, how their initial expectations compared with the reality of therapy, and what needed to be improved. Common themes were identified across both groups, such as the importance of behavioural experiments, as well as themes idiosyncratic to internet therapy, such as the value of independent learning and 24/7 access to resources. Implications for adoption and dissemination of iCT-SAD are highlighted.
“If I don’t add anything online I can’t be judged or criticised”: How people with social anxiety disorder think and behave online and implications for internet-based treatments

Emma Warnock-Parkes, University of Oxford, Harriet Rankin, Richard Stott, Elizabeth Woodward & David M Clark

Previous studies have found that people with social anxiety disorder (SAD) express a preference for technologically mediated communication, implying the internet could provide patients with a less threatening social environment in order to build relationships or even access treatment. However, this would only be likely if patients were actively interacting online, self-disclosing and not engaging with thoughts and behaviours that typically interfere with their relationships in face-to-face communication. Unfortunately, research into the cognitive and behavioural processes that maintain SAD has focused on face-to-face interactions and so our understanding of how patients think and behave online is limited.

This talk will present data from 20 patients with SAD and 20 matched controls who completed a semi-structured interview and questionnaires about their experiences of using social media. Patients reported that they experience more anxiety, negative automatic thoughts, self-focused attention and safety seeking behaviours online compared to controls. These findings have implications for the delivery of internet treatments and the online therapeutic relationship. Key online negative thoughts and safety behaviours will be discussed and the talk will focus on the clinical implications for treating patients in an online environment. Case examples of how to help patients overcome common online fears and safety behaviours, that might otherwise interfere with internet therapy, will be presented.

Novel forms of CBT for distressing voices: Developing evidence for symptom-focused therapy?

The almost demise of the tooth-cleaning brigade: Brief coping strategy enhancement for distressing voices delivered in a low cost clinic model

Clio Berry, University of Sussex

Coping Strategy Enhancement (CE) is a brief (4-session) form of the evidence-based intervention for psychosis developed in the 1990s by Tarrier and colleagues (1993, 1998). The effectiveness of CSE is being assessed within the real-world clinical environment of a secondary care mental health service. This paper will present uncontrolled outcomes from approximately 60 patients and offer reflection upon the size and meaning of effects; focusing on change in distress and patient-reported outcomes.

GiVE it a go! Guided self-help CBT intervention for Voices Evaluated

Cassie Hazell, University of Sussex

Access to CBT for psychosis is poor. One approach to addressing the issue of access is to create brief, low intensity interventions; and such interventions have been found to be effective (Hazell et al, 2016). We have developed an 8-session guided self-help CBT intervention for distressing voices. The ‘GiVE’ intervention is based on the Overcoming Distressing Voices self-help book (Hayward, Strauss & Kingdon, 2012), with an accompanied workbook produced specifically for this project. This talk will discuss the therapy protocol, and how this was developed in partnership with clinicians and lived experience experts. We will also share the initial results from a pilot randomised controlled trial, as well as some qualitative feedback from those who were the first to receive this novel therapy.

Don’t react – choose how to relate to distressing voices: Findings from a Pilot RCT of Relating Therapy

Mark Hayward, Sussex Partnership NHS Foundation Trust

Voice hearing is a common and distressing experience and patients report distress reduction to be a priority. Relating Therapy adopts a symptom-specific and mechanism focused approach to the reduction of voice-related distress. We conducted a pilot RCT within a single mental health centre in the UK. Twenty-nine patients (18+ years) with persistent and distressing voices, irrespective of diagnosis were randomly allocated to receive either
Relating Therapy and Treatment-as-usual (RT) or Treatment-as-usual alone (TAU). Assessment of outcome was completed pre-randomisation (T0), 16 weeks post-randomisation (T1) and 36 weeks post-randomisation (T2). The primary outcome was the Distress scale of the Psychotic Symptoms Rating Scale - Auditory Hallucinations (PSYRATS-AHRS) at T1. Twenty-five patients (86%) provided complete datasets. Compared with TAU, RT led to reductions in voice-related distress in the large effect size range across T1 and T2. No adverse events were reported. Our findings suggest that Relating Therapy might be effective for reducing voice-related distress. A larger, suitably powered phase 3 study is needed to provide a precise estimate of the effects of Relating Therapy for voice-related distress.

**Can we be mindful of voices? Findings from a randomised-controlled trial of a group mindfulness-based intervention for distressing voices**

Clara Strauss, Sussex Partnership NHS Foundation Trust and University of Sussex

Background: Group Person-Based Cognitive Therapy (PBCT) (Chadwick, 2006) integrates cognitive therapy with a mindfulness-based approach. The therapy was specifically designed for people experiencing distressing psychosis or other currently distressing mental health conditions. This is the first fully powered randomised controlled trial of PBCT.

Method: One-hundred and eight participants meeting diagnostic criteria for a schizophrenia spectrum condition and hearing subjectively distressing voices were randomised to receive either 12 sessions of group PBCT and Treatment As Usual (TAU) or TAU only.

Results: There was no significant effect on the CORE, the primary outcome. There were however significant between-group post-intervention beneficial effects on voice-related distress, perceived controllability of voices and recovery. Additionally, PBCT participants reported significantly lower levels of post-intervention depression, with this effect maintained at the six-months follow-up.

Conclusions: Findings show that group PBCT can have beneficial effects on key dimensions of the voice hearing experience, support recovery and have lasting effects on depression. The facilitators and barriers to implementing these findings in a specialist NHS Voices Clinic will be discussed.

**Development and impact of Stress Control - a Low Intensity – Cognitive Behavioural Therapy programme**

Paddy Love, Belfast Health and Social Care Trust & Liz Shaw, Belfast

The outcomes and benefits of the Stress Control Programme are well documented and widely reported by students who attend classes. The Belfast Health and Social Trust have been delivering Stress Control Classes since January 2013 and routinely collect qualitative data from students on their experience of classes. The SC Programme has been now implemented across all the Health and Social Care Trusts in Northern Ireland who have worked in close collaboration to implement, deliver and evaluate the programme outcomes. The findings indicate significant improvement in people’s well-being. This presentation will give the delegates a brief account of student feedback on their experience of SC across Northern Ireland.

Liz Shaw, a SC Student, will then share her experience of attending a Stress Control Class. In particular she will give a personal account of what led to her attending Stress Control Classes, the impact it has had in transforming her life and what life has been like after Stress Control. Her personal journey was featured on the Saturday Morning Magazine Programme on Radio Ulster with John Toal and is now used routinely by Jim White in his delivery of Stress Control Training.
Estimating the efficacy and effectiveness of Stress Control via a mixed methods analysis.

William Mowlds, Clinical Psychologist, Northern Health and Social Care Trust

Stress Control (SC), a brief psycho-education course, was piloted in the Northern Health and Social Care Trust to increase access to psychological therapies, in line with Northern Irish mental health service statutory drivers. The following will summarise findings regarding outcomes from two separate studies across 12 iterations of SC.

Study One (Mills et al., 2016)

The efficacy of SC was gauged in a robust manner with clinical significance testing. In addition, this study aimed to elucidate what prompted access and the experiences of attendees at SC. 170 adults attended SC over six iterations of the course of whom 93 completed pre and post questionnaires, which included the Depression Anxiety Stress Scales – 21. This captured demographic details and qualitative feedback which was subject to a mixed-methods analysis. SC attendees reported significant decreases on depression, anxiety and stress sub-scales post-intervention. Moreover, 38.71% (n=36) of attendees who completed SC exhibited clinically significant improvement afterwards on one or more subscale.

Study Two (McMullan et al., in preparation)

Study Two examined if attendance at ST impacted upon psychological wellbeing utilising The Warwick-Edinburgh Mental Well-being Scale (WEMWBS), a scale developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. 121 adults attended SC over six iterations of the course of whom 54 completed pre and post questionnaires. Pre WEMWBS scores (M=38.41, S.D=.95) were significantly lower than post WEMWBS scores, (M=46.85, S.D=.84), t(53)= -6.8, p< 0.01, d= 0.92. This indicates wellbeing levels have increased from pre to post. The effect of SC on WEMWBS score can be considered large ( > 0.8), d=0.92). Reliable change index was calculated and 50% of the sample can be considered to have clinically reliable significant changes in their pre and post scores. Although there was a large effect size, it can be seen that both the pre and post scores are below the population average of 51 (Forero et al, 2014). There was no significant interaction between the effects of SC on wellbeing and gender (F(1, 52)= .009, p=.926), age (F(2, 51)= 1.252, p=.295), and SES (F(3, 44)= .197, p=.295). This suggests that SC had an equal effect on males and females, age groups, and SES groups.

Conclusion

SC attracted people in need of mental healthcare input and affected quantifiable change within those people’s lives, whilst satisfying statutory demands for service delivery in an accessible community context. Recommendations to increase engagement with those traditionally ‘hard to reach’ for psychological services are provided, which, if implemented, have the potential to achieve further compliance with Northern Irish mental health statutory drivers.

Effectiveness of stress control classes: A multi-service practice research network study

Mike Lucock, University of Huddersfield and South West Yorkshire Partnership NHS Foundation Trust

The Stress Control (SC) programme (White & Keenan, 1990) is routinely provided in Improving Access to Psychological Therapies (IAPT) Services in England at step 2 in the stepped care model. SC is a group-based didactic intervention that teaches anxiety and depression coping skills. The content is similar to other CBT-based self-help interventions but it is often delivered to large groups in community settings, thereby potentially improving access and acceptability. I will describe a multi-service evaluation of the clinical and organisational effectiveness of stress control classes in IAPT services. Clinical outcomes for 4,451 participants in 163 stress control interventions delivered across five IAPT services were analysed by calculating pre-post treatment anxiety (GAD-7) effect sizes (Cohen’s d). Overall and between-service effects were compared to published efficacy
benchmarks. Multilevel modelling was used to examine if variability in clinical outcomes was explained by differences in service, group and patient-level (case-mix) variables. The findings were fed back to service users who attended SC in one of the IAPT services and they gave their views of their experiences and suggestions for future service improvements and research.

The pooled GAD-7 effect size for all services was $d = 0.70$, which was consistent with efficacy benchmarks for guided self-help interventions ($d = 0.69$). One service had significantly smaller effects ($d = 0.48$), which was explained by differences in group treatment length and case-mix, including socioeconomic context and initial severity. There was evidence of variability of outcomes between groups, explaining up to 3.6% of variance in treatment outcomes. Service users' views included the value of taking a friend or family member to the classes, ways to engage and retain attenders and the importance of alternative therapy options for those who do not find SC classes acceptable or helpful. The presentation will consider the implications of the study for the role of SC classes in stepped care service model.

**Stress Control: evaluating the effectiveness of a Flemish adaptation using a matched control design**

**Tom Van Daele, Thomas More University College**

Traditional therapies for a variety of reasons are inaccessible or unappealing to certain individuals. Low Intensity Cognitive Behaviour Therapy (LI-CBT) has sought to address cost, with other problems such as stigma and accessibility in psychological service delivery. There is therefore a need for equitable and effective allocation of resources, together with the extension of access to mental health services for people traditionally ‘hard to reach’. This goal has been innovatively addressed by a LI-CBT initiative, Stress Control. The current study aims at consolidating the evidence base for a Flemish Stress Control adaptation, both in the short and long term. We were more specifically interested in how the intervention performs in the real-life context of communities, resembling common practice. This provides a more accurate view of intervention effectiveness in everyday life.

Two groups (intervention group N=47; matched control group N=47) completed self-report questionnaires on stress, depression, anxiety, worrying, and stress management skills pre- and post-intervention, at six months and at one year follow-up.

An overall decline was found for all symptoms in the intervention group (linear trends ps < .05), whereas stress management skills remained stable. Clinically significant and reliable change for almost 30% of participants confirmed these findings. No such change was found for the control group. The strongest effects occurred for those participants who presented themselves with higher levels of initial symptoms.

In conclusion there were substantial indications that the intervention had long-term effects on participants’ stress, anxiety and depression, especially for those who reported higher initial symptoms and as far as up to one year after the intervention. It furthermore also showed that the effectiveness of ‘interventions in the field’ that focus on self-registering community dwellers should be interpreted carefully. The heterogeneous groups they attract might not only include people who participate in order to obtain an immediate reduction of high symptoms, but also those who have low level symptoms and follow the course in order to prevent future symptoms. Especially the latter group could be responsible for an underestimation of intervention effectiveness if they are not specifically taken into consideration, as this might cause floor effects.

**Psychological Care with Offenders - What are we Offering?**

**Adapting a community IAPT model to reach into a local prison: using step 2 and step 3 interventions to treat common mental health problems in the prison population**

**Heather Bolton: South London and Maudsley NHS Foundation Trust**

Common mental health problems have a high prevalence in prison settings and are often intertwined with offending behaviour and substance misuse. Prison can be seen as an
opportunity to identify and treat such problems in a population who tend not to seek psychological support. This presentation outlines the way that a community IAPT model has been adapted to fit the needs of a prison population. After giving a background to the service, its operation and challenges to working practice, case examples will be explored. This has the aim of demonstrating how CBT (and the stepped care model) can be adapted to meet the needs of a prison population.

**Introducing an IAPT clinic into a Female Probation setting**  
**Toby Chelms. Northpoint Wellbeing (Leeds IAPT)**  
Following a pilot study within IAPT Leeds in 2012 it was identified that women in the probation services would be more likely to engage with therapeutic services in a female-only environment. An IAPT clinic was therefore introduced at Together Women’s Project Leeds. I will detail the learning from this clinic via anecdotal experiences and audits to explore how IAPT services can integrate within Probation to improve access to this hard to reach Client group.

**The Stepped Care approach within a Prison setting**  
**Helen Watson, Nottinghamshire IAPT/Prison Healthcare**  
This talk will explore (via case studies) the role of the IAPT Stepped Care model within a prison setting focusing on a Client’s journey through Steps 2 and 3 of the model as well as the practical obstacles to the establishment of the service. This will explore the greater model of prison healthcare and how this is applied and managed across the North of England.

**The use of Methods of Levels Therapy (MOL) in Prison**  
**Vyv Huddy. University College London**  
The majority of young people detained in custody meet criteria for at least one mental health problem. Untreated psychological distress in young men is a risk factor for future offending, aggressiveness, adult mental health problems and increased societal costs into adulthood. The evidence guiding best practice for CBT practitioners working in prisons is sparse. There are few clinical trials of CBT in the setting and those that have taken place report substantial modifications to routine practice. The prison setting presents a range of challenges to the frequency and duration of therapy required by traditional CBT. Clients also “import” complex problems, which creates dilemmas for therapists when pinpointing the focus of intervention. The Method of Levels (MOL) approach to cognitive therapy circumvents key obstacles of the setting by 1) focusing on present moment perceptions 2) giving clients control over appointment scheduling 3) a focus on distress rather than symptoms and 4) taking a transdiagnostic approach. A case example is presented that illustrates these characteristics of MOL and how the approach may be implemented in a category C prison. This example suggests that MOL has potential for wider implementation in prisons and other secure settings.

**What makes a difference in CBT for anxiety disorders and couple distress?**

**Combining the use of Prazosin with evidence based psychological approaches for the treatment of nightmares within PTSD**  
**Debra Malkin, Lancashire Traumatic Stress Service, Amanda Parkinson, Lancashire Traumatic Stress Service; Debra Malkin, Lancashire Traumatic Stress Service; Gita Bhutani, Lancashire Traumatic Stress Service; John Holland, Lancashire Traumatic Stress Service; David Keane, Lancashire Traumatic Stress Service**  
The Lancashire Traumatic Stress Service (LTSS) has been committed to the combination of psychological and pharmacological approaches to the treatment of Post-traumatic stress disorder (PTSD) to deliver optimal outcomes for service users since it was established in 2008. There is increasing evidence regarding the off-label use of the alpha blocker Prazosin for the treatment of nightmares. Published studies focus on Prazosin used in isolation and show
that when treatment is discontinued the nightmares return. Following literature review, a treatment protocol was devised that combined Prazosin with psychological approaches aimed at addressing the nightmares. It was suggested that by tackling the nightmares via psychological approaches could deliver a permanent resolution. The use of Prazosin was of benefit in supporting clients in engaging with psychological approaches by enabling better sleep. The focus of this work was therefore to use Prazosin in combination with psychological approaches to lead to the resolution of nightmares associated with PTSD.

This study utilized both quantitative and qualitative methods to establish whether this combined approach would lead to the resolution of nightmares in PTSD. The client group offered this treatment had severe or extreme complex PTSD and scored highly in the Clinician Administered PTSD Scale (DSM-IV) for sleep disturbance and distressing dreams. They were assessed for their clinical appropriateness for treatment with Prazosin prior to commencement and then titrated to a suitable dose in response to efficacy and side effects. A behavioural sleep management programme was introduced for all patients and strategies were introduced to help clients re-orientate themselves on waking from nightmares. A range of psychological interventions were used to address the nightmares including Imagery Rehearsal Therapy, EMDR and Trauma focussed CBT. Treatment was stopped once psychological therapy had been completed and in agreement with the client and treating clinicians. A range of scales were utilized to establish the success of treatment.

Of the non compliers one was due to side effects of medication however psychological therapy continued. For the other external factors caused him to disengage from the service and so post scores were not available. The initial results have shown that this approach provides relief from this distressing symptom of PTSD both in the short-term and after the Prazosin is withdrawn. Those treated have described a positive impact on their quality of life and have achieved long term benefits in some cases enabling them to be discharged from mental health services completely. It has also been shown that the benefits can be achieved at doses much lower than those used in previously published trials. Some clients report feeling too overwhelmed to begin discussing the content of trauma related nightmares particularly as they are sleep deprived. Prazosin helps to reduce the frequency and intensity of the nightmares and hence prepares the way for patients to engage in this work. The addition of Prazosin to the psychological intervention enabled clients to sleep better, resulting in them feeling more able and willing to engage with psychological therapy. This approach has now been used in 30 cases with extremely positive outcomes and the service continues to develop this work further so that the wider population may benefit in the future.

Social Anxiety in Adults with ADHD: A result of Cognitive Bias?

Andrew Merwood, University of Bath, Ailsa Russell, University of Bath; Amy Watts, AWP NHS Foundation Trust; Kobus Van Rensburg, NHFT; Philip Asherson, King’s College London;

Around 30% of adults with attention-deficit/hyperactivity disorder (ADHD) experience social anxiety (Kessler et al, 2006), higher than the estimated 12% prevalence among adults from the general population (Kessler et al, 2005). This indicates that adults with ADHD are more likely to experience fear in social or performance situations, yet the reasons for this remain unclear.

A cognitive-behavioural model is widely accepted as accounting for the development and maintenance of social anxiety among adults from the general population (Clark & Wells, 1995), with cognitive-behavioural therapy (CBT) recommended as the first-line treatment for social anxiety disorder (NICE, 2013). Conceptually, the same model should also apply when working with adults with ADHD, however it has been argued that CBT may require adaptation to take account of genuine deficits in social skills experienced by those with ADHD (e.g. Young & Bramham, 2012).

To date, no studies have examined the range of distressing cognitions and behaviours specific to social anxiety that are experienced by adults with ADHD, meaning the extent to
which this population might benefit from CBT for social anxiety is unknown. Consequently, the aims of the present study are:

1. To compare adults with ADHD and social anxiety (ADHD+SA) to adults with ADHD without social anxiety (ADHD-SA) and adults without ADHD or Social Anxiety (controls), to determine the frequency and intensity of distressing beliefs and behaviours implicated in the development and maintenance of social anxiety.

2. To compare the ADHD+SA, ADHD-SA and control groups for the presence of functional impairments and levels of psychological wellbeing.

3. To examine associations between social anxiety and ADHD symptoms, to determine whether increasing ADHD severity is associated with greater levels of social anxiety, including distressing beliefs and behaviours.

4. To capture qualitative descriptions of how social anxiety manifests among adults with ADHD and what kind of strategies are used to cope with this distress.

A mixed-methods approach was used to collect quantitative and qualitative data. The quantitative component used a between-subjects design to compare the three groups (ADHD+SA, ADHD-SA, controls) across a range of outcome measures, with data collected using online questionnaires. The qualitative component involved interviewing adults with ADHD+SA to understand how and why they believe their social anxiety manifests and how they cope with it.

Data collection for this study is currently underway and due to for completion in May 2016. Results will be reported in this talk. Results will be discussed in relation to the existing literature on social anxiety and adult ADHD, paying particular attention to the clinical utility of identifying social anxiety cognitions and behaviours among adults with ADHD and the potential benefits and/or pitfalls of using CBT as an intervention with this group.

This research will help practitioners to identify when to use CBT with adults who have ADHD and are experiencing social anxiety. This will be of relevance to those working in specialist services (e.g. adult ADHD teams) and those working in general adult mental health.

What happens when the stabilisers come off? Exposure with and without safety-seeking behaviours in spider phobic students

Robertta Bowie, Salomons Centre for Applied Psychology, Blake Stobie, South London and Maudsley NHS Trust; Fergal Jones, Salomons Centre for Applied Psychology

Salkovskis (1996; 1991) has argued that safety-seeking behaviours (SSBs) are crucial in the maintenance of anxiety disorders, as they prevent disconfirmation of threat-related cognitions. More recently, reductions in anxiety during exposure after using SSBs has led some (Milosevic & Radomsky, 2008; Sy, Dixon, Lickel, Nelson & Deacon, 2011) to advocate for judicious use of them, to counteract high refusal and drop-out rates and allow access to exposure therapy which might otherwise be declined. Some of the studies examining judicious SSBs have been hampered by methodological issues including the absence of control groups and follow-up analyses (e.g. Morgan & Raffle, 1999; van den Hout, Reininghaus, van der Stap, & Engelhard, 2012), which the present study seeks to address.

33 student participants who scored high on spider phobia questionnaires and low on a spider behavioural approach task were randomly allocated to one of three groups: exposure without the use of SSBs, exposure with the use of SSBs, and a control group. Participants took part in a non-direct behavioural approach task (BAT1 i.e. a task in which they did not have to actually touch the spider) to establish their baseline ability to approach spiders. The two active groups then participated in a 60 minute exposure session, either with or without SSBs. 7-14 days later, participants from all groups were invited to a follow-up session, in which they were requested to complete BAT1, this time without the use of SSBs. All participants were then invited to undertake a second, behavioural approach task (BAT2) that required direct contact with a spider. 

The SSB group demonstrated significant improvements on BAT1 whilst using SSBs (although the exposure group performed significantly better than the SSB group). At follow-up and without the ability to use SSBs, the SSB group scores on BAT1 (approaching a spider without
touching it) worsened significantly. On BAT2 (touching the spider), none of the 11 SSB participants completed the task (9 of the 11 SSB participants refused to attempt it), compared with 8 out of 11 participants in the exposure group who managed to complete it. The SSB and control groups did not differ significantly on the BAT2 (spider touching) task. The findings are consistent with some previous studies which have shown that participants using SSBs may show initial progress but then deteriorate (Hood et al., 2010; van den Hout et al., 2011). Advantages of the present study include an emphasis on ecological validity, the use of a control group, follow-up data collection, and the use of two behavioural approach tasks to explore both the longer-term effects of using SSBs, and the extent to which change generalises when using SSBs. The possibility of allegiance effects, the lack of a blinded data collector, and the use of a student sample are weaknesses of the present study. The debate about the judicious use of SSBs is topical and highly clinically relevant and we believe that this clinically relevant piece of research adds to it. This study highlights the importance of examining follow-up data and the ability to approach feared situations without the use of SSBs in future research into whether SSBs can be applied in a judicious manner. It highlights to clinicians the potential problems associated with advocating the use of safety-seeking behaviours, and therefore has broad relevance to clinicians treating anxiety disorders using CBT.

Emotional Distress after a Relationship Dissolution: A Cognitive Behavioural Model
Sylvia Buet Gonzalez, Queen's University Belfast

Emotional and behavioural responses to relationship dissolution vary from individual to individual. Cognitive theory proposes that this variability is the result of the interplay and the reciprocal effects present between cognitions (including processes such as selective attention and memory), emotions and behaviours (Frijda, 1993; Lazarus, 1993; Lewis, 1996; Parkinson, 1997).

Many studies have approached the possible effects of static (intrinsic to the relationship) or demographic factors such as duration of the relationship, time since breakup, initiator status of the dissolution, being involved in a new relationship, gender, education, and so forth on how people experience distress after a relationship breakup. Other studies on relationship dissolution have focused on one or a small number of cognitive or behavioural variables e.g. ruminative processes (Duck, 1982; Saffrey and Ehrenberg, 2007), coping strategies (McCarthy, Lambert, and Brack, 1997), or attributions made about the dissolution (Stephen, 1987). However, research outcomes for post-dissolution emotional distress have not yet been integrated in a CBT model. Instead, dozens of variables have been found associated with relationship breakup maladjustment. It would be beneficial for clinicians and researchers alike to know the relative importance of such variables in order to plan better treatments for those who find it difficult to adapt to a relationship dissolution.

The aim of this study was to investigate the impact of cognitive, behavioural, static, and demographic factors on emotional distress measured by the Inventory of Complicated Grief (ICG-19-Adapted, Pringerson et. al., 1995) after relationship dissolution among an internet sample of panellists.

Forty-eight predictors of post-dissolution distress were used to perform three multiple regression analyses. The first one examined the importance of behavioural factors such as avoidant and proximity seeking strategies on emotional distress. A second multiple analysis was conducted to investigate the impact of sixteen cognitive variables. Finally, a hierarchical multiple regression was performed in four blocks to compare the relative of importance of 1) demographic, 2) static, 3) cognitive and 4) behavioural factors on post-dissolution distress. A 120-item questionnaire was administered to a sample of 255 participants who were recruited from an online participant pool through Socialsci.com.

Behavioural factors (avoidance and proximity seeking strategies) explained 57% of the variance in emotional distress while seven of the sixteen cognitive variables examined accounted for about 79%. However, when all forty-eight variables were computed in the four blocks of the hierarchical regression, using a BCa Bootstrap 95% confidence intervals, demographic factors explained about 9% (R2) of the variance in post-dissolution emotional distress and static factors about 12%. The most important contribution was made by
cognitive behavioural variables (R² = 65%). The final model consisted of five cognitive and two behavioural significant predictors which accounted for about 85% of the variance. The final model consisted of five cognitive and two behavioural significant predictors which accounted for about 85% of the variance. There are implications of these results for the assessment, case conceptualisation, and cognitive-behavioural treatment of individuals who are not adjusting adequately to a relationship breakup.

**Sudden gains in individual CBT for panic disorder**

**Dean McMillan, University of York**

A proportion of people receiving Cognitive Behavioural Therapy (CBT) experience “sudden gains” during treatment in which their symptoms improve rapidly and persistently between two consecutive therapy sessions. Sudden gains have been widely studied in CBT for depression and have been observed in over 35% of clients (Tang & DeRubeis, 1999). Clerkin et al. (2008) investigated sudden gains in group CBT for panic disorder and found that 20% of participants showed a sudden gain at session two or later and that those who experienced a sudden gain had significantly lower levels of panic symptoms at the end of therapy.

The aim of the current study was to investigate sudden gains in individual CBT for panic disorder and determine the relationship between sudden gains and catastrophic misinterpretations of panic symptoms in the previous session, in order to better understand the mechanisms of this intervention. A further aim was to identify the therapeutic strategies that preceded sudden gains.

**Method:** Service users who received CBT for panic disorder within four IAPT settings in the UK completed questionnaires before and after every session. Diagnosis was confirmed with the Mini-International Neuropsychiatric Interview. The Panic Disorder Severity Scale (PDSS) was administered at the start of each session in order to identify sudden gains in panic symptoms. A modified version of The Agoraphobia Cognitions Questionnaire was administered at the start and end of each session to identify changes in catastrophic misinterpretations. Participants also completed brief questionnaires at the beginning and end of sessions to identify behavioural changes and learning points.

**Results:** Data was collected from 64 service users, of which 60 participants met our inclusion criteria. Preliminary analyses revealed that twenty four (40%; 24/60) of the participants demonstrated one or more sudden gains in panic symptomatology, as measured by the PDSS, according to the sudden gain criteria specified by Tang and DeRubeis (1999). Sudden gains tended to occur early in therapy, and were most likely to occur in session three (11/24, 46%). Participants who made a sudden gain were more likely to have a lower PDSS score at the end of therapy, compared to those who did not make a sudden gain (p < .001). Furthermore, we found a significantly greater level of cognitive shift in the pre-gain session compared to a control session (the session prior to the pre-gain session). This suggests that cognitive change in participants’ key cognitions may be responsible for sudden gains. The results demonstrate a change in misinterpretations of panic symptoms prior to a sudden gain and support Clark’s (1986) cognitive model of panic.

**Implications for clinical practice of CBT** The implications of these results for understanding possible change mechanisms in CBT for panic disorder and for delivering CBT for panic disorder will be discussed.

**New interventions to motivate lifestyle change**

**Images of desire: The role of mental imagery in motivation**

**Jackie Andrade, School of Psychology, Plymouth University**

Elaborated Intrusion theory explains how drug and food cravings involve embodied sensory imagery of consumption, simulating the desired experience and conveying the pleasure or relief of the real thing. This paper briefly reviews the substantial body of evidence showing that imagery and emotion are closely linked and that frequent, vivid images of consumption are associated with cravings for substances such as alcohol and nicotine, and with their
actual consumption. Research in the laboratory and the field shows how blocking the working memory processes that support imagery weakens cravings and reduces unhealthy choices. In particular, visuospatial working memory loads, which target visual imagery, reduce substance cravings relative to auditory loads. Because craving images are proximal and concrete, they tend to be highly vivid, dominating experience and driving out intentions to abstain. We argue that vivid, episodic imagery for functional goals can strengthen motivation by increasing desire for those goals and simultaneously competing with imagery for shorter-term temptations. For example, participants were more strongly motivated to achieve a personal goal after 2 minutes of vividly imagining why and how they would achieve their goal than after the same time spent verbally narrating the same information. Data from two further studies show how such imagery can strengthen motivation and change behaviour: a single session of imagery training reduced unhealthy snacking in participants wanting to lose weight (Andrade et al., 2016) and increased physical activity in gym members wanting to get better use from their gym membership, compared with information and advice. We conclude that motivational interventions will be more effective if they incorporate training in mental imagery of pathways to functional goals.

Using mental imagery to increase behavioural activation in depression
Fritz Renner, MRC Cognition and Brain Sciences Unit, Cambridge, UK
Depression is associated with reduced engagement in behavioural activities. A wide range of activities can be promoted by simulating them via mental imagery. Mental imagery of positive events could thus provide a route to increasing adaptive behaviour in depression. This paper reports a study to test whether repeated engagement in positive mental imagery can increase behavioural activation in participants with depression, using data from a randomized controlled trial (Blackwell et al., 2015). A total of 150 participants were randomized to a positive imagery intervention or a non-imagery control condition, completed via the internet over four weeks. Behavioural activation was assessed five times up to six months follow-up using the Behavioural Activation for Depression Scale (BADS). Participants in the positive imagery condition showed significantly greater increases in BADS scores compared to those in the control condition. Mental imagery simulation of positive activities may provide a means to promote behavioural activation in depression.

Functional Imagery Training: A technology-assisted approach to building and maintaining motivation
David Kavanagh, Centre for Children’s Health Research and Institute for Health and Biomedical Innovation, Queensland University of Technology, Australia
Mental imagery has strong links to affective reactions, including desires for both functional and dysfunctional goals. Elaboration of desire imagery competes with concurrent visuospatial tasks for capacity-limited working memory. These findings provide opportunities to build functional desires through imagery and use that imagery to interfere with dysfunctional desires. Functional Imagery Training (FIT) assists participants to use episodic imagery about incentives for behaviour change and about effective strategies, to elicit and enhance motivation and guide functional behaviour. Habitual practice of this imagery is trained by linking imagery rehearsal with everyday behavioural cues such as hand washing, and using a smartphone app for additional reminders. This paper explains the key elements of FIT and describes results from two uncontrolled trials applying FIT to Alcohol Use Disorder.

Functional Imagery Training for weight loss
Linda Solbrig, School of Psychology, Plymouth University
Two thirds of UK adults are overweight or obese and at increased risk of chronic conditions such as heart disease, diabetes and certain cancers. Obesity is a risk factor mental health problems, particularly depression. Basic public health support is limited to information and advice. Motivational interviewing is effective but long-term benefits are small. This paper presents results from early-phase development of Functional Imagery Training (FIT) as a novel, theory-based intervention for weight loss. A qualitative study using thematic analysis
of four focus group discussions (N=24) found that all groups spontaneously raised the issue of wanting motivational support for losing weight and increasing physical activity. They felt apps had a role in providing such support but disliked calorie counting and fitness apps that required a lot of input from users. All groups wanted help with behavioural elements such as setting and reviewing goals and were positive about FIT as a means of achieving this. In a second study, 22 participants with BMI > 25 took part in a 3-month open-label pilot trial of FIT for weight loss. Data from the 17 participants who completed the trial showed a mean reduction of 4.16kg from a baseline mean of 83.52kg to 79.36kg at 3 months (SD 3.03; 4.87% of baseline bodyweight; Cohen’s d = 1.37). All but four participants showed at least the 3-5% reduction in weight deemed to be clinically meaningful, and none gained weight. Waist circumference reduced by a mean of 8.59cm (8.32%; SD 6.02; Cohen’s d = 1.39). These data show the promise of FIT for motivating and supporting behaviour change.

New technologies for motivating behaviour change
Joana Galvão Gomes da Silva, School of Psychology, Plymouth University
This paper presents innovative uses of technology to support motivation, using motivational interviewing scripts developed specifically for remote delivery. Two qualitative studies with 20 participants each explored the usability and acceptability of a motivational interview delivered by a human video counsellor and by a NAO robot programmed with Coreography software. Participants were recruited for having a goal to become more physically active. Scripts aimed to develop discrepancy, evoke solutions and promote self-efficacy using open-ended questions, affirmation, reflection, and summarising. Everyone received the same questions, which were carefully designed to fit the developing dialogue regardless of the participant’s response to the preceding question. For the video counsellor interview, participants reported that voicing their physical activity goals aloud during the interview was helpful but were somewhat frustrated by the lack of personalisation in the sense that the counsellor could not respond to their specific concerns. Voicing goals aloud when talking face-to-face with the robot was also helpful. Participants positively appraised the non-judgemental aspect of the interview and how it gave space to articulate their motivation for change, for example: “Hearing myself talking out loud made me feel as if I was chatting to myself and truly sorting out issues - without anyone else poking their nose in.” Additionally, participants liked the novelty of the robot. This novelty led them to discuss their interview with others, thereby rehearsing their goals and strengthening their motivation to achieve them: “...It played on my mind during the past week and I told others about the robot which made them ask about the goals set during the interview.” These findings show the potential to deliver a brief motivational intervention that is fully-automated, applicable across a range of behaviours, and acceptable to participants.

Adults with Medically Unexplained Symptoms

Teaching GPs cognitive and behavioural skills: General knowledge and confidence
Meenal Patel and Trudie Chalder, King’s College London
Persistent Physical Symptoms (PPS), otherwise referred to as medically unexplained symptoms, are common in primary care. Patients presenting PPS will likely have gone through extensive investigations, referrals, and treatment which can become problematic for both the patient as well as the general practitioners (GPs). Successful methods are required for managing PPS; however a recent study showed that GP trainees were not confident in working with PPS, leading to increased anxiety and frustration. In 2011, a meta-analysis suggested that mental health professionals were better placed to deliver therapy but that consultation rates could be tackled by GPs trained specifically in communication skills. They also argued that because many patients are not willing to receive psychotherapy that medical health specialists should be trained to provide some treatment. PRINCE Primary is a cluster randomised control trial and is part of a programme that aims to intervene at both patient and GP level. GPs in London will be given formal training in applying CBT approaches so that they are able to use them during routine appointments with patients with PPS. The CPD accredited training will address GP attitudes, knowledge,
and confidence towards PPS, and will include role plays, videos, optional ongoing supervision, and prompt sheets. Patients who participate will also be given self-help materials which include a series of leaflets and an animation describing a patient experience with chronic pain. The GP training will be assessed (before and after) in terms of satisfaction, knowledge of PPS, and confidence in diagnosing and managing these symptoms. Open-ended questions will be used to elicit feedback about the workshops. This study will contribute to the current literature by providing an insight to the feasibility of training GPs in cognitive and behavioural skills in primary care. We will describe the training and share some early insights into GP’s perceptions.

A Transdiagnostic approach to persistent physical symptoms: The description of a trial protocol and intervention
David McCormack, South London and Maudsley NHS Trust, Claire Willis, South London and Maudsley NHS Trust, Fabio Simao, South London and Maudsley NHS Trust, Trudie Chalder, King's College London
Persistent physical symptoms can have a significantly negative impact on the people who experience them. They often adversely affect the individual’s activities of daily life, including occupational functioning, and can place a strain on their relationships with friends and family. Emotional problems, such as marked anxiety and low mood, are commonly associated with persistent physical symptoms. There is evidence to suggest that a complex interplay of the symptoms, and the negative impact that they have on psychosocial functioning, the persons thinking and behaviour, can play a role in maintaining and/or contributing to the physical symptoms (Deary, Chalder and Sharpe, 2006).

There are few effective evidence-based treatment for persistent physical symptoms. However, there is growing evidence that cognitive and behavioural therapies may be effective. At the Institute of Psychiatry, Psychology and Neuroscience, King's College London, we have developed a transdiagnostic approach to understand and treat such persistent symptoms. We are currently carrying out a randomised controlled trial of a tailored form of cognitive behaviour therapy which has shown promising results in our specialist clinic at the Maudsley Hospital. A description of this approach, the intervention under investigation and the trial protocol, will be presented.

Health anxiety in CFS/ME: mutual maintenance?
Jo Daniels, University of Bath
CFS/ME is a complex and debilitating condition which is difficult to treat successfully; current rehabilitative treatments achieve only moderate effect sizes. A recent large scale RCT (White et al. 2011) reported a high prevalence of anxiety in CFS/ME, a confounding factor likely to influence the success of treatment. While CBT is considered an effective treatment for anxiety disorders (NICE, 2014) no treatment trials have utilised a CBT approach designed to target secondary issues such as anxiety disorders, as well as CFS/ME. The CHAMP trial (Tyrer et al. 2013) report successful outcomes for the treatment of co-morbid health focussed anxiety in a large sample of patients with medical disorders however CFS/ME was not included within this population.

Emerging evidence suggests that prevalence of health focussed anxiety in CFS/ME could be as high as 69% (Daniels et al. submission), which is significantly lower than the 24.7% reported across medical disorders (Cella et al. 2013). This is unsurprising, given the complex nature of CFS/ME, the often protracted process of diagnosis by exclusion, and the lack of a clear medical explanation for the aetiology of CFS/ME.

Early theoretical models of CFS/ME (Wessley, 1991) share theoretical similarities with the cognitive model of health anxiety (Salkovskis & Warwick 1986). This may bear relevance to the apparent high health anxiety rates in CFS/ME: interpretation of physical sensations, vigilance to bodily variations and behaviours informed by fear of deteriorating health are key features in both CFS/ME and health anxiety. This paper presents the notion that CFS/ME and co-morbid health focussed anxiety present a unique but not uncommon clinical challenge which may confound successful treatment. Furthermore, it is suggested that in as
many at 69% of CFS/ME cases, health anxiety and CFS/ME mutually maintain one another, requiring a transdiagnostic approach to optimise outcomes.

Based on this premise, the novel treatment of a single case of CFS/ME with co-morbid health anxiety was trialled, targeting both physical symptoms and anxiety related symptoms (Daniels & Loades, in submission). In this preliminary study, positive outcomes are reported following eight treatment sessions and maintained at one year follow up. The treatment approach is presented and clinical and theoretical implications are discussed.

The long term follow-up of the PACE trial: CBT and GET in CFS/ME patients
Trudie Chalder, King's College London

Background The PACE trial found that, when added to specialist medical care (SMC), cognitive behavioural therapy (CBT), or graded exercise therapy (GET) were superior to adaptive pacing therapy (APT) or SMC alone in improving fatigue and physical functioning in people with chronic fatigue syndrome 1 year after randomisation. In this pre-specified follow-up study, we aimed to assess additional treatments received after the trial and investigate long-term outcomes (at least 2 years after randomisation) within and between original treatment groups in those originally included in the PACE trial.

Methods The PACE trial was a parallel-group randomised controlled trial of patients meeting Oxford criteria for chronic fatigue syndrome who were recruited from six secondary care clinics in the UK between March 18, 2005, and Nov 28, 2008. Participants were randomly allocated to receive SMC alone or plus APT, CBT, or GET. Primary outcomes were fatigue measured with Chalder fatigue questionnaire score and physical functioning with short form-36 subscale score, assessed 1 year after randomisation. In this long-term follow-up, we sent postal questionnaires to assess treatment received after the trial and outcomes a minimum of 2 years after randomisation. We assessed long-term differences in outcomes within and between originally randomised groups.

Findings Between May 8, 2008, and April 26, 2011, 481 (75%) participants from the PACE trial returned questionnaires. Median time from randomisation to return of long-term follow-up assessment was 31 months (IQR 30–32; range 24–53). 210 (44%) participants received additional treatment (mostly CBT or GET) after the trial; with participants originally assigned to SMC alone (73 [63%] of 115) or APT (60 [50%] of 119) more likely to seek treatment than those originally assigned to GET (41 [32%] of 127) or CBT (36 [31%] of 118; p<0·0001). Improvements in fatigue and physical functioning reported by participants originally assigned to CBT and GET were maintained. Participants allocated to APT and to SMC alone in the trial improved over the follow-up period compared with 1 year. There was little evidence of differences in outcomes between the randomised treatment groups at long-term follow-up.

Interpretation The effects of CBT and GET seen at 1 year were maintained at long-term follow-up a median of 2·5 years after randomisation. Outcomes with SMC alone or APT improved from the 1 year outcome and were similar to CBT and GET at long-term follow-up, but these data should be interpreted in the context of additional therapies having being given according to physician choice and patient preference after the 1 year trial final assessment. Future research should identify predictors of response to CBT and GET and also develop better treatments for those who respond to neither.

Clinical Roundtable Dental anxiety in young people: time for new solutions

Anticipatory anxiety about dental treatment is common amongst children and young people, and often founded in cognitions about the controllability of events in the dental surgery, the likelihood of pain and the lack of relevant coping strategies. These thoughts are often maintained by the views expressed by family and friends, as well as a failure to challenge the reality of the beliefs since dental attendance is relatively infrequent and often avoided. This session brings together experts in CBT of dental anxiety and young people (Tim Newton, Chris Williams, Cathy Creswell), Dentists and Dental Public health researchers (Zoe
Marshman and Jenny Porritt) to discuss experiences of the co-development of free-access CBT self-help resources. These aim to provide young people and their carers with a framework to explore their beliefs about dental treatment, and to discuss their concerns with the dentist. The book resource developed has been tested for acceptability amongst young people attending for dental treatment, and amongst the treating dentists. Speakers will draw on the qualitative interview experiences with dentists, young people and their families, and also point to the findings of a Research for Patient Benefit (RfPB) funded study evaluating the use of a self-help booklet designed for teenagers with dental anxiety. Key issues will be discussed including the challenge of:

1. Engagement of avoidant teens, using an approach that gives them a sense of control
2. The need for a new language of engagement by dentists
3. The importance of including anxious and avoidant parents who can pass on their own anxieties to the young person.
4. To discuss the appropriate settings for such interventions

Improving Access to Psychological Therapies – An Update (1)

IAPT: the fantasy of homogeneity and the reality of variability?
Steve Kellett, University of Sheffield
The IAPT programme was established to deliver the NICE guidelines for depression and anxiety. The guidelines assume that providing patients with access to the relevant evidenced based treatment (low and high intensity cognitive behavioural therapy in this context) will produce outcomes that are equivalent with those found in the original trials. This talk will focus on what factors can introduce variability of outcomes between IAPT workers and also between IAPT services. The first two datasets will illustrate systematic variability between the outcomes of achieved by PWPs, the third will focus on variability of outcomes between PWPs, counsellors and CBT therapists and the final dataset variability between services from an IAPT practice research network. The factors possibly creating difference will be debated and the issue of whether variability is a ‘bad issue’ discussed.

Training High Intensity Therapists in Behavioural Couple Therapy: Dissemination, Outcomes and Increasing Patient Choice
Sarah Corrie, Central and North West London NHS Foundation Trust & Royal Holloway University of London, Donald H. Baucom, University of North Carolina at Chapel Hill, Michael Worrell, Central and North West London NHS Foundation Trust Central and North West London NHS Foundation Trust & Royal Holloway University of London, Melanie S. Fischer, University of North Carolina at Chapel Hill, Jennifer M. Belus, University of North Carolina at Chapel Hill
Behavioural couple therapy (BCT) is an efficacious intervention for treating depression for individuals in a committed, romantic relationship, and is included in the NICE guidelines as a treatment for Major Depressive Disorder. The majority of adults who are depressed are in committed relationships, and their partners often are eager to assist their loved ones in overcoming depression. However, frequently partners do not know how to help. By providing BCT as a treatment option, depressed clients have a choice in how they approach their depression, and their partners can learn how to provide assistance in constructive ways.
Central and North West London NHS Foundation Trust, in partnership with Professor Don Baucom from the University of North Carolina (one of the originators of this NICE recommended therapy), has been providing training to High Intensity Therapists as part of the expanding IAPT Programme since 2011. Clinical outcome data have demonstrated that graduates of the training are able to provide effective treatment in routine practice that results in high recovery rates for depression in the identified client, as well as improvements for the partner.
This presentation describes the steps taken to further disseminate the training in order to ensure that BCT is delivered by an appropriately skilled workforce. The most recent clinical outcome data are also presented. Key points of learning as well as next steps are discussed.

**CYP IAPT and the transformation of CAMHS**  
**Anne O’Herlihy, NHS England**  
CYP IAPT has come to be the organising context for one of the pillars on which the initiative to transform CAMHS now rests. This presentation will consider how the values of CYP IAPT have been adopted in service transformation and will contribute to significant changes in the delivery of mental health services in England.

**Severe Mental Health Difficulties**

**The nature of trauma matters: The impact of betrayal trauma on dissociation, insecure attachment and symptoms in people with psychosis**  
**Filippo Varese, University of Manchester**, Josie Davies, Lancaster University; Sandra Bucci, University of Manchester; Katherine Berry, University of Manchester; Andrew Moskowitz, Aarhus University; Jane Simpson, Lancaster University  
Research suggests that specific features of traumatic experiences (e.g. the “type” of traumatic experience e.g. interpersonal vs non-interpersonal traumatic events) might exacerbate the risk for and severity of psychotic symptoms, possibly via several psychological processes (dissociation, insecure attachment representations). In this cross-sectional study we focused on the role played by betrayal trauma i.e. adversities characterised by high levels of interpersonal closeness (such as being physically assaulted by someone the victim felt very close to, e.g. a family member) relatively to traumas characterised by low levels of interpersonal closeness. We hypothesised that exposure to betrayal trauma will be more predictive of psychotic symptoms, insecure attachment and dissociative experiences compared to “low betrayal” adversities.  
One-hundred participants with life-time self-reported diagnoses of psychotic disorders and/or psychotic experiences that required mental health support completed an on-line battery of questionnaires assessing betrayal trauma (the Brief Betrayal Trauma Survey, Goldberg & Freyd, 2006), positive and negative psychotic symptoms (the Community Assessment of Psychotic Experiences; Stefanis et al 2002), insecure attachment (the Psychosis Attachment Measure; Berry et al, 2996) and dissociation (the Dissociative Experiences Scale Revised).  
Correlational analyses revealed robust associations between trauma and positive (but not negative) psychotic symptoms, insecure attachment (in particular avoidant attachment) and dissociative experiences – in all cases these bivariate associations were significantly larger for events characterised by high levels of betrayal compared to low-betrayal trauma events. In separate multiple regression analyses, adversities characterised by high-betrayal trauma significantly predicted these outcome variables, whereas the effect of low-betrayal experiences was not significant.  
Our findings suggests that adversities characterised by high levels of interpersonal closeness and betrayal might be particularly important predictors of both psychotic experiences and the alleged psychological mediators of the trauma-psychosis link. Our findings bear implications for future research into the psychological and social underpinnings of psychosis, and for the assessment and formulation of distressing psychotic experiences in clinical practice. &nbsp;  
The importance of considering traumatic experiences in clinical assessments and formulation in people with psychosis is increasingly recognised. Our findings tentatively suggest that clinicians should be particularly mindful of traumatic experiences characterised by high levels of interpersonal closeness and betrayal, and should carefully explore these experiences, associated sequelae (e.g. attachment representations and dissociation) and links with appraisals and characteristics of presenting psychotic complaints as part of cognitive behavioural interventions for psychosis.
Is there a relationship between childhood trauma and bipolar disorder? Evidence from a meta-analysis of case-control and epidemiological studies

Filippo Varese, University of Manchester; Sandra Bucci, University of Manchester; Warren Mansell, University of Manchester; Jasper Palmier-Claus, University of Manchester

Childhood trauma has been linked to increased risk of developing a number of mental health difficulties, including (amongst others) psychosis and major depression. In recent years, a growing number of studies have also examined the association between potentially traumatic experiences in childhood and bipolar disorder, with suggestions that emotional abuse and neglect may convey greater risk of developing bipolar symptoms than other adversities (e.g. sexual abuse; e.g. Etain et al. 2013). To clarify the size and significance of the link between childhood trauma and bipolar disorder, we carried out a systematic review and meta-analysis of all case-control and epidemiological (prospective and cross-sectional) studies that examined this association.

A database search (Medline, Embase, PsychInfo, Web of Science) was carried out to identify studies which tested the association between bipolar disorder and childhood trauma (i.e. sexual abuse, physical abuse, emotional abuse, emotional neglect, bullying and parental death before the age of 19). We screened the literature to select quantitative studies that allowed comparing exposure to childhood trauma between 1) individuals with bipolar disorder and non-clinical controls and 2) individuals with bipolar disorder and psychiatric controls with either diagnoses of psychosis or major depression.

19 eligible studies contributed to the analysis. People with diagnosis of bipolar disorder were 2.63 times (CI: 1.99 -3.47) more likely to have experienced trauma in childhood compared to non-clinical controls. In subgroup analyses examining specific types of trauma, bipolar disorder was significantly associated with all childhood adversities considered in this review, with the notable exception of parental loss (OR = 1.16, CI: 0.75 - 1.79). The effect of emotional abuse appeared particularly robust relatively to other types of trauma (OR = 4.04, CI: 3.12-5.22). The analyses contrasting bipolar disorder to psychiatric controls revealed that trauma exposure was similar in people with bipolar and psychosis diagnoses, but that trauma may be more prevalent in bipolar compared to major depression.

Our findings suggest that childhood adversity is associated with bipolar disorder, with effects of a similar magnitude of those detected in previous meta-analysis considering other severe mental health difficulties (e.g. psychosis; Varese et al. 2012). Our findings also provide tentative support for the apparent importance of childhood emotional abuse in the context of bipolar, but further prospective research is needed to clarify explanatory mechanisms and pathways of influence.

Given the high levels of childhood adversity in bipolar disorder, practitioners should carefully and routinely enquire about their clients’ past adverse experiences, including emotional abuse. Identification of childhood adversity should then lead to its integration into personalised formulations of clients’ difficulties and the provision of appropriate support and interventions in clients who may be struggling with trauma-related difficulties.

Psychological Therapy in Acute Mental Health Settings: a Meta-Analysis

Charlotte Paterson, Edinburgh Napier University; Thanos Karatzias, Edinburgh Napier University & Rivers Centre for Traumatic Stress, NHS Lothian; Paul Hutton, University of Edinburgh; Sean Harper, NHS Lothian; Adele Dickson, Edinburgh Napier University

There is evidence to suggest that psychological therapies for severe mental health problems in the community can be beneficial (Wykes, Steel, Everitt & Tarrier, 2008; Stafford, Cooper, Simplicio, Blackwell & Holmes, 2015; Turner, Van der Gaag & Cuijpers, 2014; Khoury et al., 2013). Furthermore, recent NICE guidelines recommend the use of psychological therapy in the acute phase of mental health care (NICE, 2014). Consequently, there is now demand for increased provision of psychological therapies in acute mental health inpatient services (Mind, 2010, 2013). However, research investigating the effectiveness of psychological interventions in this context remains varied and with mixed results.
The present review and meta-analysis discusses the available evidence base and the effectiveness of psychological therapy in the acute mental health inpatient context. A total of 22 studies were identified and included in the review. The primary outcomes for investigation were post treatment and follow-up Positive and Negative Symptom Scale (PANSS) total score in the meta-analysis. Potential mediating factors of effectiveness were also explored within post treatment PANSS scores (study quality (i.e. use of randomisation and blinding), probable contact with a therapist in the control group and therapy type).

Secondary outcomes were the number of readmissions during follow-up period and end of treatment depression and anxiety symptom presentation.

Initial findings suggest psychological therapy in addition to treatment as usual (TAU) has a small to medium effect on overall psychotic symptoms at post intervention when compared to TAU alone. However, study quality and probable contact with a therapist in the control group moderate this effect. Therapy type, on the other hand does not moderate the effect of treatment. This small to medium effect is sustained at follow-up. Psychological therapy in addition to TAU also has a medium effect on the number of readmissions during the follow-up period.

Initial results suggest the addition of therapy contact in general to TAU is more effective than TAU alone in reducing psychotic symptoms at end of treatment and longer term (6-12 month follow-up). They also suggest readmissions are reduced during a 6-12 months follow-up period when patients have access to psychological therapy during an acute inpatient stay. Our findings suggest further work is required to assess the effectiveness and efficacy of psychological therapy in acute mental health services, in particular the long-term effect and economical value. This review also highlights symptom presentation as a common primary outcome measure of effectiveness, while coping or self-efficacy is less commonly used. The implications of this and final results of all analyses (including effects of psychological therapy plus TAU on symptoms of depression and anxiety) will be presented and discussed at the conference.

Our findings imply that access to psychological therapy within acute inpatient services should be increased.

**Anger, Violent Fantasies, and Violent Behavior among Discharged Psychiatric Patients**

**Ray Novaco, University of California, Irvine, Michael Russell, Pennsylvania State University; John Monahan, University of Virginia**

Substantial research finds anger to have dynamic bearing on violence risk and involvement in multiple psychiatric disorders. The violent behavior of psychiatric patients before, during, and after hospitalization is associated with anger, controlling for background factors and various forms of psychopathology. The pathways by which anger is linked to violence remain to be disentangled. As recurrent anger is accompanied by rumination and anger often springs from grievances derived from unresolved conflicts, imagined violence or violent fantasy is a potential pathway.

The interrelationship between anger, violent fantasies, and violent behaviour was examined in present study analyses conducted on the MacArthur Violence Risk data set (Monahan et al. 2001), which involved civil commitment patients in three US metropolitan areas, who were assessed during hospitalization and on community follow-ups. Recent studies with that data set have shown anger, assessed by the Novaco Anger Scale (NAS) in hospital, to be significantly related to other-directed and self-directed violence in the community, controlling for many covariates (e.g., Sadeh & McNeil, 2014; Swogger et al, 2012). Previous research (Grisso et al. 2000) has shown that NAS scores are highly related to imagined violence in hospital. The present study concerned 1136 patients assessed in hospital and at 10-weeks and 20-weeks regarding anger (NAS) and violent fantasies (Grisso, Schedule of Imagined Violence, SIV); Violent behavior data were obtained for those two community follow-ups.

The imagined violence and anger measures have high stability across assessment time points. Cross-lagged panel analyses found anger in hospital to be predictive of violent fantasies (SIV) at 10-weeks (controlling for SIV in hospital); imagined violence in hospital was predictive of anger (NAS) at 10 weeks (controlling for NAS in hospital); and anger at 10
weeks was predictive of violent fantasies at 20 weeks (controlling for their previous assessments). With the repeated measures data, multi-level models (individual and aggregate) were run to further examine interrelationships of anger, violent fantasies, and violent behavior. We found that patients show significantly more anger when they report violent fantasies compared to themselves when they report no violent fantasies. The relationship between violent fantasies and anger over time is significantly stronger for some patients than for others, and it is particular so for patients who engage in violent behavior. The effect of current SIV is within-person, and suggests that individuals show greater levels of anger when they imagine violence compared to themselves when they do not imagine violence. The effect of SIV frequency is between-person, and suggests that individuals who image violence more frequently experience more anger on average than those who imagine violence less frequently. The significant interaction between current SIV and violent history suggests that those with a violent history experience stronger surges in anger when they imagine violence compared to those without a violent history.

Our findings have important implications for violence risk assessment and for targeting anger treatment with regard to ruminative processes and the development of violence scripts. Both the imagined violence and anger assessments were obtained by self-report (validated), so they are clinically accessible, and they flag dynamic psychological variables that raise violence risk for patients in the community. Anger and imagined violence are conjoined in ruminative processes. Rumination is routinely addressed in CBT therapy for anger, but there should be an enhanced treatment module when imagined violence is involved. Similarly, CBT for anger has always had imagery components for cognitive reframing, arousal reduction, and behavioural coping skills, but augmentation is needed for countering imagined violence and its scripting.

Clinical Effectiveness of Combining DBT with CBT and Third Wave Therapies

Overview – DBT, CBT and Third Wave Therapies
Fiona Kennedy, Consultant Clinical Psychologist & Director of GreenWood Mentors Ltd.

DBT is a dialectical integration of behavioural science and Zen Buddhism. As this blending of wisdom from both Eastern and Western traditions is also a feature of ACT and CFT, it could be argued that there is much that is compatible between these approaches in helping people to manage their lives. On the other hand, there are key elements that distinguish each therapy: while DBT offers interventions to enhance self management skills, emotional regulation and behaviour control balanced by self validation and acceptance, CBT focuses to a greater degree on cognitive functioning, ACT emphasises personal values around which to organise change, and CFT works on developing emotional resilience by promoting compassionate emotional experiencing and improving the self to self relationship. Fiona Kennedy is a Consultant Clinical Psychologist & Director of GreenWood Mentors Ltd. She will present an overview of the differences, similarities and potential for integration of these approaches. She will then demonstrate integration of DBT & ACT in clinical, training and consultancy work.

The Decider – A Skills Manual for living a more skillful less impulsive life
Michelle Ayres & Carole Vivyan, CBT Therapists, Health and Social Services Guernsey.

The Decider programme was developed as a response to clients with impulsive behaviours in Guernsey, an area where the full DBT programme was prohibitively expensive and impractical to implement. The developers identified 32 CBT and DBT informed skills which they considered to be key elements of both therapies, and brought together in their manual called The Decider. This reference card and therapist manual which gives the client & therapist the flexibility to develop an intervention plan tailored to the needs of each client. It provides client handouts with illustrations and detailed explanations for the clinician on how to present each skill using a fun, creative and interactive style.
Combining Compassion Focused Therapy to a DBT programme in Derbyshire

Catherine Parker, DBT Therapist, Derbyshire Healthcare NHS Foundation Trust

Developing self compassion can be difficult for BPD clients with harsh & abusive histories. In a pilot project devised in consultation with Prof Paul Gilbert in 2008, the North Derbyshire DBT Team extended their range of DBT interventions promoting self-validation and reducing unjustified guilt, by adding a CFT module targeting self critical and shame reactions, to their standard DBT skills programme. The results led them to integrate a component of CFT into the teaching of their Coping with Emotions Group (a condensed version of the standard DBT skills programme), as well as into their individual work with clients in their standard DBT programme.

Studies conducted by other researchers over the last 5 years have indicated that this is a promising combination, demonstrating how raising self compassion might affect key mediators of BPD symptoms such as emotion dysregulation. In 2014 Marsha Linehan extended the Mindfulness handouts in her new manual to include Loving Kindness meditation. The experience of combining these therapies, along with the clinical benefits and challenges, will be addressed by Catherine Parker, DBT Therapist, in her presentation on the North Derbyshire DBT Service.

A DBT skills and trans-diagnostic individual formulation based approach for IAPT: Comprehend, Cope and Connect.

Isabel Clarke, Consultant Clinical Psychologist, Southern Health NHS Foundation Trust

With a recovery rate of around 50%, IAPT services need to confront the question of the ‘other’ 50%. Hampshire IAPT (italk) identified the characteristics of this group: current issues complicated by past trauma, longstanding relationship and attachment problems, and history of service contact. The SHA commissioned the development of an approach to tackle these challenges.

Comprehend, Cope and Connect builds on a model successfully piloted in Acute Services to introduce psychological working throughout that sector (Araci & Clarke 2016). The individual, emotion focused trans-diagnostic formulation identifies vicious circles to be broken. This requires facing and managing as opposed to avoiding emotion, hence the central role for mindfulness and other DBT emotion management skills. It also involves other third wave approaches such as compassionate mind to heal the conflicted self-self relationship and ACT style values work to foster motivation to work actively on change.

The approach is being delivered through four individual formulation and goal setting sessions followed by 6 group sessions focused on individual arousal, behaviour, emotion and attention management skills, followed by 6 sessions on skills pertaining to relationship with self and others. Isabel Clarke, Consultant Clinical Psychologist, developed this programme and will present early evaluation data.

Predictors of PTSD onset and response to treatment: new findings for preventative interventions

Cognitive mechanisms and responses to trauma: Data from recent prospective longitudinal and treatment studies.

Richard Meiser-Stedman, University of East Anglia, Tim Dalgleish, MRC CBU; Patrick Smith, KCL; Anna McKinnon, Macquarie University; Clare Dixon, University of Bath

An emerging literature suggests that cognitive appraisals pertaining to trauma have a role in the onset and maintenance of post-traumatic stress disorder (PTSD) in youth, in a manner consistent with cognitive models of PTSD proposed for adult populations. However, some of this literature have methodological issues, and several theoretical issues remain unaddressed. This issues include how cognitive processes play a role in the onset of PTSD, the specificity of trauma-related appraisals in driving PTSD (e.g. how strong a role do they...
play in other psychopathology, such as depression), and whether they directly worsen PTSD symptomatology (or work indirectly, e.g. through increased levels of rumination or safety-seeking behaviours).

This paper will present data that relates to these questions from three studies: a prospective longitudinal study of 8-17 year olds (n=226) interviewed at two and eight weeks following a single event trauma (e.g. assault, road traffic collision); a randomised controlled trial of cognitive therapy as an early intervention for PTSD in youth (n=29); and a pilot study of cognitive therapy for youth with PTSD following multiple trauma (n=9). In each study structured interviews were used to assess for the prevalence of acute stress disorder and PTSD, while questionnaires were used to assess putative psychosocial and cognitive mechanisms. A mixture of statistical methods (i.e. correlational analyses, regression modelling, mediation analysis, group-based trajectory modelling) will be used to explore the effects of negative trauma-related cognitive appraisals on the development of and recovery from PTSD. Implications for the management of trauma-exposed youth will be discussed.

Pretrauma predictors of PTSD and depression in emergency workers
Jennifer Wild, University of Oxford, Kirsten Smith, Erin Thompson, Francine Bear, Miriam Lommen and Anke Ehlers
It is unclear which potentially modifiable risk factors best predict post-trauma psychiatric disorders. We aimed to identify pre-trauma risk factors for posttraumatic stress disorder (PTSD) or major depression (MD) that could be targeted with resilience interventions. Newly recruited paramedics (N=453) were assessed for history of mental disorders with structured clinical interviews within the first week of paramedic training and completed measures to assess hypothesized predictors. Participants were assessed every four months for two years to identify any episodes of PTSD and MD; 386 paramedics (85.2%) participated in follow-up interviews. Thirty-two participants (8.3%) developed an episode of PTSD and 41 (10.6%) an episode of MD during follow-up, but in all but 9 cases (2.3%) episodes had remitted by the next assessment. At two years, those with episodes of PTSD or MD during follow-up reported more days off work, poorer sleep, poorer quality of life, greater burn-out; and greater weight-gain for those with PTSD. Consistent with theories of PTSD and depression, analyses controlling for psychiatric and trauma history identified several pre-trauma psychological predictors (cognitive and coping styles, response to stressful memories, social support). Logistic regressions showed that rumination about memories of stressful events at the start of training uniquely predicted an episode of PTSD, and perceived resilience uniquely predicted an episode of MD. Participants at risk of developing episodes of PTSD or depression could be identified within the first week of paramedic training. Cognitive predictors of episodes of PTSD and MD are promising targets for resilience interventions.

Early in-session predictors of outcomes for cognitive therapy for PTSD
Francesca Brady, University College London, Emma Warnock-Parkes and Anke Ehlers, University of Oxford
Trauma-focused cognitive behaviour therapy is effective in treating posttraumatic stress disorder but non-response rates range between 25% and 50%. Results of previous research on patient characteristics predicting outcome are inconsistent and mainly focused on demographic and diagnostic variables. This study examined whether behavioural predictors of poor treatment response can be observed in early sessions. It was predicted that greater patient perseveration, lower expression of thoughts and feelings and weaker therapeutic alliance would be associated with poorer outcomes. We also explored the relationships of patient behaviours with therapeutic alliance and the efficiency and competence of treatment delivery. Audio or video recordings of the initial treatment sessions of 50 patients who had shown either good (n = 34) or poor response (n = 24) to cognitive therapy for PTSD (CT-PTSD, Ehlers & Clark, 2000) were blindly coded for patient perseveration, expression of thoughts and feelings, therapeutic alliance, efficiency and competency of treatment delivery and therapist competence. Poor responders showed more perseveration and less expression of thoughts and feelings in the initial session. Patient perseveration and low expression of...
thoughts and feelings were associated with poorer therapeutic alliance and compromised treatment delivery. Patients with these behavioural characteristics may benefit from additional treatment strategies. Limitations of the study and implications for clinical practice are discussed.

Predictors of PTSD from conflict related community and school based studies - implications for therapy
Michael Duffy Queen’s University Belfast
Meta-analyses of PTSD predictors (Brewin et al. 2000; Ozler et al. 2003) have identified a range of predictors but the amount of variability in PTSD that they explain is modest. Studies by Ehring, Ehlers and Glucksman (2006, 2008) found that cognitive factors specified in Ehlers and Clark’s [2000] cognitive model of PTSD were substantially more powerful in predicting PTSD. This presentation will consider these factors in predicting chronic PTSD linked to civil conflict. Three studies will be presented:
1. A community study of adults (n = 3131) found that highest rates of PTSD symptoms and probable casesness (58.5%) were observed among people who were present when a bomb exploded but elevated rates were also observed in people who subsequently attended the scene (21.8% probable casesness) and among people for whom someone close died (11.9%). Predictors of PTSD highlighted by Brewin et al. and Ozler et al. accounted for 42% of the variance in PTSD symptoms among people directly exposed to the bombing however predictors derived from the cognitive model accounted for 63%.
2. In an adolescent study 14 – 18 (N= 2221) increased exposure to a car bombing was associated with increased psychiatric morbidity. The combined pre and peri trauma risk factors highlighted in previous meta-analyses accounted for 20% of the variance in PDS scores but the amount of variance accounted for increased to 56% when the variables highlighted in the Ehlers and Clark's cognitive model for PTSD were added. The best predictors of PTSD were specific aspects of the trauma (‘seeing someone you think is dying’), what you are thinking during the event (‘think you are going to die’) and cognitive mechanisms employed after the trauma.
3. In a large study of younger school children 8-13 (N = 1945) direct exposure to the same traumatic event was associated with higher levels of probable PTSD and psychological distress. Significant predictors of increased IES scores included being male, witnessing people injured and reporting a perceived life threat but when co-morbid anxiety and depression were included as potential predictors anxiety remained the only significant predictor of PTSD scores.
This presentation will discuss the therapeutic implications of these findings for psychological therapies.

Undercontrolled or Overcontrolled—That is The Question: Using Evidenced-Based Transdiagnostic Theory to Guide Clinical Decision-Making

Using Evidenced-Based Transdiagnostic Theory to Guide Clinical Decision-Making
Tom Lynch, University of Southampton
Most evidence-based therapies have been tested on non-chronic and non-comorbid populations. Yet, a significant proportion of people fail to benefit from treatment—due to chronicity, co-morbidity or pre-existing personality problems. Major research funding agencies think similarly (e.g., NIMH RDoC, Wellcome Trust-UK, MRC-UK)—reflected by initiatives prioritizing transdiagnostic models of psychopathology and treatment interventions targeting shared genotypic/phenotypic features across spectrums of disorders rather than focusing solely on diagnosis.
The aim of this presentation is to provide an overview of the theoretical and empirical basis underlying a novel socio-emotional model of psychopathology that can help guide clinical-decisions pertaining to ‘what works best for whom’. The theory outlined in this talk is supported by 20+ years of translational treatment development research—plus, large-scale studies examining comorbidity, revealing two superordinate style of coping: undercontrolled (externalizing) and overcontrolled (internalizing) to precede the
development of chronic and difficult-to-treat mental health problems. A novel thesis linking neuroregulatory theory to the communicative functions of emotions will be proposed. Treatment strategies emphasizing our tribal nature as a species and the importance of accounting for social-signaling deficits when working with chronic conditions will be discussed—based on observations that our species survival depended on being able to signal cooperation to unrelated others and work together in tribes.

When Emotional Overcontrol Looks Like Borderline Personality Disorder: Issues in Misdiagnosis
Heather O’Mahen, University of Exeter, Roelie Hempel, Thomas Lynch University of Southampton

Only 30–50% of depressed patients who receive treatment for depression will achieve full remission and those with chronic or complex depression are least likely to benefit from treatment. This may be due, in part, to the fact that current treatments are not designed for chronic and complex patients. Further, current treatments focus on problems of undercontrol, rather than overcontrol. Excessive self-control is critical to address because it has been linked to social isolation, aloof interpersonal functioning, maladaptive perfectionism, disingenuous emotional expression and severe mental health problems like anorexia nervosa, obsessive-compulsive PD and refractory depression. Radical Openness Dialectical Behaviour Therapy is a new, transdiagnostic treatment designed to address problems in overcontrol. The REFRAMED trial (registration number: ISRCTN85784627) is a multi-center randomized controlled trial for treatment resistant depression, comparing 7 months RO-DBT to treatment as usual (TAU).

A key issue in providing appropriate treatment for those suffering from depression is being able to accurately assess whether the individual struggles with issues of overcontrol or undercontrol (e.g., Borderline Personality Disorder, BPD) as diagnostic errors are commonplace. For example, the presence of self-injury is commonly assumed to indicate the presence of BPD—yet, self-harm is markedly frequent in among disorders typifying overcontrol; distinguished by its relatively non-mood dependent, premeditated, and private nature.

The aim of this presentation is to use baseline assessment data from the REFRAMED trial to identify key areas of diagnostic misinterpretation in individuals with refractory depression and emotional overcontrol. A total of 1514 patients were referred to the trial, 913 were screened, 444 were assessed, and 250 were randomized. Data from weekly consensus diagnosis meetings led by two clinical psychologists and a psychiatrist were independently coded by two raters. Inter-rater reliability, frequency counts of diagnostic areas, and qualitative reports of consensus decisions will be reported. Preliminary results based on 19 analyzed cases thus far (out of 40) indicate that the most commonly discussed OC symptoms that masquerade as borderline symptoms are 'Impulsivity in at least two areas that are potentially self-damaging' (79%), 'Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior' (84%), 'Chronic feelings of emptiness' (83%), and 'Inappropriate, intense anger or difficulty controlling anger' (68%).

Our data indicate that during acute periods of distress, problems with emotional overcontrol can mimic emotional undercontrol. A life-history course of symptoms in individuals with refractory depression can help to correctly specify problems and the importance of differentiating common assessment errors in order to improve treatment decision-making will be discussed.

Assessing Overcontrolled and Undercontrolled Personality: The Brief Self-Control Trait Rating Scale
Dion Seretis, Roelie Hempel, Thomas Lynch, University of Southampton

With the increasing recognition that severe and chronic mental disorders often reflect one of two differing overarching personality or coping styles—i.e. overcontrolled and undercontrolled coping—the need for appropriate assessment instruments has also increased. While previous studies have used existing measures to capture these coping styles, most self-control scales assume a linear relationship between self-control and
psychological well-being, whereas we propose a quadratic relationship in which you can have too much of a good thing: too much self-control can decrease psychological well-being. We will present psychometric data on a new self-report measure that takes this quadratic relationship into account and aims to measure both undercontrol (UC) and overcontrol (OC). This measure has been designed with clinical settings in mind, aiming for a brief yet sufficiently reliable and valid measure that is both sensitive and specific.

The item pool for the Brief Self-Control Trait Rating Scale was developed via an iterative process, based on an initial peer review by clinicians familiar with the biosocial model for overcontrol (Lynch et al.) followed by a panel review of three experts in overcontrol including Dr Thomas Lynch. This resulted in 180 items that aimed to capture the eight dimensions of OC. The sample consisted of 291 undergraduate and postgraduate students. Of these, 84 had very high rates in our random response scale (5-items), resulting in a final sample of 207 (83% F, 17% M). An Exploratory Principal Component Analysis (PCA) with Varimax rotation yielded a 7 factor solution. Each of these dimensions were factor analysed separately to determine whether they tapped into a single dimension or measured more than one. A second PCA was conducted aiming for scales’ independence (correlation<.5). A three-component solution was considered to give the best fit of the PCA with Orthogonal (Varimax) rotation, which explained 54.17% of the variance. The KMO measure for sampling adequacy gave a high value of 0.755. Bartlett’s test indicated that the assumption of specificity was met (chi-square=866.66, p<.001).

The three factors retained can be described as Disinhibition (Cronbach’s α=0.812), Fearfulness-Detachment (α=0.758) and Compulsive Striving (α=0.733 (α=0.0782). OC patients are expected to score low on Disinhibition but high on the other two factors. Overall, the measure is a very good fit and has high reliability scores. Preliminary findings on convergent and divergent validity of the subscales indicate that the scale does not correlate with either Positive or Negative affect/Neuroticism, has a negative correlation with Disinhibition (SNAP-2) and positive correlations with subscales that measure depression, anxiety, perfectionism, rumination, deliberation, and punctiliousness.

**Preliminary Outcomes applying Radically Open-Dialectical Behavior Therapy (RO-DBT) to adolescents with Anorexia Nervosa**

**Mima Simic, Catherine Stewart, Katrina Hunt, Institute of Psychiatry, King’s College London**

Family-Based Therapy (FT-AN, Eisler, 2013) for treatment of Anorexia Nervosa (AN) in adolescence has a good evidence base, but concern remains for those who transition into chronic presentations or who may overcome their eating disorder but remain at risk for depression, anxiety or social isolation. This talk will present preliminary data from a new service development at the South London and Maudsley National and Specialist Child and Adolescent Eating Disorder Service using a new transdiagnostic treatment for overcontrolled disorders known as Radically Open-Dialectical Behavior Therapy (RO-DBT) applied to adolescent AN patients. The rationale for this new approach is based on research linking AN in adults to problems of overcontrol; e.g., constrained, conforming, obsessional, rigid, and perfectionistic behavior found in AN has been repeatedly shown to occur prior to the onset of AN.

In contrast to other eating disorder treatments for AN, RO-DBT posits that overcontrol is primarily a problem of emotional loneliness—secondary to low openness and social-signaling deficits. Improved social connectedness is one of the main treatment targets in RO-DBT. Self-report data from a sample of 46 adolescent AN patients enrolled in RO-DBT will be presented. Preliminary findings reveal that Social Connectedness is significantly positively correlated with Anticipatory Pleasure (r=0.58) and Temperament (r=0.79), while significantly negatively correlated with Risk Aversion (r=0.57), Inflexibility (r=0.62), Perfectionism (r=0.53), Workaholism (r=0.39), Punctiliousness (r=0.35) Disinhibition (r=0.32), Ambivalence over Emotional Expressions (r=0.64), Lack of Perseverance (r=0.45) and Lack of Premeditation (r=0.45). A mediation analyses further shows that Temperament and Anticipatory Pleasure significantly predict Social Connectedness (F = 25.1, p < .001), but this relationship is not mediated by Ambivalence over Emotional Expression Perseverance.
or Premeditation in this sample. The talk will also include a brief overview of recommended measures for assessing overcontrol in adolescent AN patients and families. Finally, qualitative data pertaining to the acceptability of RO-DBT for adolescents with AN will be presented.

Breaking Down Clinical Myths: Not All Violent Offenders Are Cut From the Same Cloth
Laura Hamilton, Rampton Hospital. Roelie Hempel, Thomas Lynch, University of Southampton

Despite good intentions to understand violent offenders and intervene to prevent violence, our understanding of the type of violence associated with moral certitude, planning ahead, revenge, and punishment of transgressors remains poorly understood. Contrary to common assumptions that all (or most) violent offending stems from poor impulse control, emotion dysregulation, and low distress tolerance (i.e., undercontrolled coping) the aim of this presentation will be to present novel data supporting a growing consensus linking excessive self-control (i.e., overcontrolled coping) to serious mental health problems—including violent offending. Prior research has shown that overcontrolled violent offenders tend to be socially-isolated individuals—their acts of violence, though often occurring only once, are disproportionately more extreme (e.g., mass killings) and planned compared to the violence of undercontrolled offenders. The idea of excessive self-control in a forensic population remains under-studied and under-recognized, with the vast majority inmates receiving treatments designed for undercontrolled problems.

The aim of this presentation will be to challenge prevailing conceptualizations of violent offending based on preliminary findings from a maximum-security forensic hospital in the UK (Rampton Hospital). Results from a sample of 39 overcontrolled (OC) and 54 undercontrolled (UC) forensic psychiatric in-patients will be reported. Findings confirmed a priori hypotheses positing greater anger inhibition and social-isolation as characteristic of OC offenders. OC offenders reported significantly lower anger experience and expression ($t=-2.94, p<0.01$ and $t=-3.15, p<0.01$ respectively), but higher anger control ($t=2.26, p<0.05$). In addition, OC offenders felt significantly more socially detached from others ($t=-1.64, p<0.05$), and treating professionals rated OCs as significantly less gregarious and fun ($t=-2.84, p<0.01$), and more isolative and withdrawn ($t=3.34, p<0.01$) than UC offenders. Moreover, results suggest that approximately 42% of violent offenders in this setting are best characterized as overcontrolled (not undercontrolled as they had been previously). Future directions and treatment implications stemming from these findings will be discussed.

Delivering cognitive behavioural interventions for suicide prevention in acute settings: key issues and complexities

Understanding psychiatric staff views and beliefs about working with suicidal inpatients: findings from a qualitative investigation and implications for delivery of inpatient psychological therapy.
Yvonne Awenat, The University of Manchester

Consideration of stakeholder issues is recognised to be important for successful implementation of research. Given the paucity of existing literature depicting programmes of psychological therapy for suicidal inpatients in the UK a preliminary investigation of mental health staff experiences of working with suicidal inpatients was carried out primarily to guide research implementation practices. Twenty qualitative interviews with a range of staff whose role involved working with suicidal inpatients were thematically analysed. Study findings illuminating staff views and beliefs about suicidality and suicidal inpatients will be presented drawing out some implications for the delivery of inpatient psychological therapy.

Rising to the Challenge of Suicide Prevention in Inpatient settings: Case examples.
Daniel Pratt, The University of Manchester

Whilst the number of suicide deaths of psychiatric inpatients has decreased over recent years, arguably such deaths are the most preventable of all due to the close proximity of staff
throughout the 24 hour period. Although NICE guidelines recommend CBT for suicidal patients there are many challenges to delivering psychological therapy in the inpatient setting. This paper will draw on some case examples outlining our experiences of the barriers we encountered in delivering inpatient suicide prevention therapy (CBSP). Possible ways forward and methods of overcoming such barriers will be discussed.

**The evaluation of cognitive behavioural approaches for suicide: a pilot trial in an inpatient setting.**

**Gillian Haddock, The University of Manchester**

Suicide is a major cause of preventable death, and suicidal behaviour is prevalent in acute psychiatric wards. People admitted to acute psychiatric wards often experience repeated episodes of suicidal behaviour, causing great distress and heavy use of NHS services. There is little research investigating effective psychological treatments for suicidal patients in inpatient settings although previous research has found support for psychological therapies which specifically target suicidal behaviour. This paper describes a single blind RCT of cognitive-behavioural suicide prevention (CBSP) versus treatment as usual. The primary objective was to explore whether CBSP was feasible to deliver and acceptable on acute inpatient psychiatric wards. Secondary objectives were to assess the impact of the intervention on suicide behaviour and ideation and functioning.

Participants experiencing recent suicidal ideation were identified on acute psychiatric wards and were invited to participate. Those providing consent were assessed on a range of assessments and randomly allocated to receive either CBSP or treatment as usual over 6 months. Participants in the CBSP group were offered up to 20 sessions delivered whilst on the ward and continued into the community if the participant was discharged. Blind assessments of outcome were carried out at 6 weeks and 6 months following consent to participate.

Findings in relation to suicidal ideation, affect, psychological variables thought to relate to suicide and functioning will be presented.

**The therapeutic alliance when working with people with suicidal thoughts in inpatient environments.**

**Emma Evans, Manchester Mental Health and Social Care Trust**

One of the factors shown to be associated with positive outcomes in psychotherapies is a good therapeutic alliance (TA). Whilst this has been researched across a range of therapeutic modalities and client groups, little research has explored the TA when working with suicidal patients on inpatient wards. Currently an on-going single blind randomised control trial is exploring the efficacy and feasibility of providing Cognitive Behavioural Suicide Prevention (CBSP) therapy to suicidal inpatients. Within the context of this trial, we aimed to explore the nature of the TA between psychological therapist and inpatient from both perspectives and examine how it relates to suicidality and to the progress of therapy in the inpatient environment.

Participants were recruited from psychiatric inpatient wards across the North West of England and were randomly allocated to treatment as usual or TAU plus Cognitive Behavioural Suicide Prevention (CBSP) therapy. The intervention was up to 20 sessions over 6 months during the inpatient phase and then continued into the community if the participant was discharged. Those receiving therapy were asked to complete the Working Alliance Inventory (WAI) in session four and at the end of therapy (6 months). In addition, therapists completed the WAI at both time points.

Data describing the TA from the therapist and patient will be presented and its relation to severity of suicidal thoughts and behaviours will be discussed. The implications for delivering therapy in this environment will also be discussed.

**Use of technology in CBT in Ireland**
“Pesky gNATs! – A computer assisted Cognitive Behaviour Therapy Intervention for Young People with Anxiety or Depression

Gary O’Reilly, University College Dublin, David Coyle, Department of Computer Science, University of Bristol

This paper will describe Pesky gNATs a computer assisted Cognitive Behaviour Therapy (CBT) intervention for young people aged 9 years or older experiencing anxiety or low mood. Pesky gNATs has three components: 1. A computer game that delivers a child friendly CBT intervention. The game is played in session by a young person along-side a mental health professional. The game has multiple levels, each delivering a single component of a customized developmentally appropriate CBT intervention, designed to be the equivalent of a standard treatment session in length to play. 2. A mobile App - freely available to any young person playing the game to download to their smartphone or tablet. The Pesky gNATs App supports the young person’s application of the CBT ideas they learn in session to their everyday life at home and school. 3. An on-line training suite for mental health professionals so they can train in how to use our programme and then download it to their work computer. There are a number of innovative features of Pesky gNATs. These include: 1. It is designed to deliver a de-stigmatising fun developmentally appropriate adaptation of CBT to young people aged 9 years and older. 2. Pesky gNATs has measures of psychological functioning and outcome built into the game that are automatically administered and scored (Revised Children's Anxiety and Depression Scale; the Clinical Outcome Rating Scale, and the Session Rating Scale). 3. Pesky gNATs has a mobile App to assist a young person transfer in-session learning to their everyday life at home, at school or in their community. 4. An on-line training system to ensure the easy availability of Pesky gNATs to mental health professionals at their location.

A preliminary randomised controlled trial of Mindful Gnats: a mindfulness computer game and app for children.

Conall Tunney, University College Dublin

Introduction: In recent years mindfulness-based interventions have grown dramatically in popularity. This rise in growth has coincided with the growth of mobile and gaming technologies, leading to a variety of mindfulness computer programmes and apps becoming available, for both adults and young people. However, little is known about the efficacy of these programs. The present study is a preliminary trial of a mindfulness-based intervention called Mindful Gnats, a desktop computer game and smartphone app designed to teach mindfulness skills to children. Method: A 2x3 (group x time) randomised controlled design was employed. 156 normally functioning school children were randomised to either a 6-week Mindful Gnats intervention or control group. Participants were assessed at pre, post and 4-week follow-up. 119 children were retained across all time points and included in final analyses. Results: No significant differences were observed between groups on the primary outcome measure of mindfulness, or the secondary outcome measures of metacognition, rumination or worry. Both intervention and control groups significantly improved across time on each of the secondary outcome measures, indicating a confounding variable not controlled for in the design. Discussion: The potential future applications of Mindful Gnats and the challenges of teaching mindfulness will be discussed. Conclusion: The present study represents an important first step in the literature exploring the utility of technology as a medium for offering mindfulness skills to children.

A Randomized Controlled Trial of an internet-delivered treatment: its potential as a low-intensity community intervention for adults with symptoms of depression.


Internet-delivered treatments for depression have proved successful, with supported programs offering the potential for improved adherence and outcomes. Internet
interventions are particularly interesting in the context of increasing access to interventions, and delivering interventions population-wide. The study was a randomized controlled trial of an 8-module internet-delivered cognitive behavioral therapy (iCBT) program for adults with depressive symptoms (n = 96) compared to a waiting-list control group (n = 92). Participants received weekly support from a trained supporter. The primary outcome was depressive symptoms as measured by the Beck Depression Inventory (BDI-II). The program was made available nationwide from an established and recognized charity for depression. For the treatment group, post-treatment effect sizes reported were large for the primary outcome measure (d = 0.91). The between-group effects were moderate to large and statistically significant for the primary outcomes (d = 0.50) favoring the treatment group. Gains were maintained at 6-month follow-up. The study has demonstrated the efficacy of the online delivered Space from Depression treatment. Participants demonstrated reliable and statistically significant changes in symptoms from pre- to post-intervention. The study supports a model for delivering online depression interventions population-wide using trained supporters.

Preventing depression: examining the benefits of depression-focused iCBT for participants who do not meet clinical thresholds


Depression is widely understood as a common condition affecting a significantly large portion of the population and has become a public health priority. There are those who suffer with depressive symptoms that do not meet criteria for clinical diagnosis. Individuals with subclinical symptoms are more likely to go on to develop clinical depression. Internet-delivered CBT (iCBT) interventions for the treatment of depression have accumulated significant empirical evidence, but currently there is little known about the potential effects of such interventions for those presenting with subclinical symptoms. The current study will examine what, if any, changes do participants in the sub-clinical range of depression symptomology perceive as a result of completing the SilverCloud iCBT Space from Depression Programme. Eight participants met inclusion criteria which involved a score of 13 or below on the BDI-II. Evaluation involved the use of semi-structured telephone interviews using the Client Change Interview Schedule (Elliot, Slatick, & Urman, 2001) with minor modifications to reflect the participants’ engagement with an online intervention. Qualitative analysis is being carried out on the data using a descriptive-interpretive framework. Results will be presented. Internet-delivered CBT interventions that help to prevent depression onset could have a large public health impact.

Psychological disorders in young people

A pilot study exploring the effectiveness of treating anxiety disorders in community paediatrics using parent-delivered cognitive behaviour therapy

Jenny Smerdon, The Lifetime Service, Catherine Lane, The Lifetime Service; Jackie MacCallam, The Lifetime Service; Marianne Roberts, The Lifetime Service; Laura Baker, Bristol Children’s Hospital

Parent-delivered CBT for children with anxiety has been found to be both effective and efficient in reducing anxiety in children within mental health services (Thirlwall et al, 2013). This intervention has not yet been piloted in a community paediatric setting, where anxiety is often experienced by children with life limiting conditions or their siblings and can interfere with treatment adherence, decision making and reduce quality of life (Barlow & Ellard, 2004, Lane, 2014). As professionals working within the limited resources of the health service, adequately addressing such anxiety can be challenging. Training parents to help reduce their children’s anxiety may make the experience of the child’s illness more manageable for families and empower the family to address these difficulties themselves as they arise. By combining elements of evidence-based practice and family-centred
care, offered in a time-limited and resource-effective way, it is hypothesised that this programme may be of benefit within paediatric settings. Families known to a community nursing and psychology service for children with life limiting and life threatening illnesses were invited to take part in a pilot study evaluating the effectiveness of an evidence-based parent-delivered CBT programme for child anxiety. 13 families agreed to participate and were contacted by one of 5 Clinical Psychologists or Trainee Clinical Psychologists within the service. The programme consisted of an assessment session, 8 therapy sessions (4 face-to-face and 4 telephone) and a follow up session.;Parents completed pre- and post- measures, including the RCADS (child and parent), GAD7, PDQ9, Brief Parental Self-Efficacy Scale (parent) and Goal based outcomes (GBO). Preliminary results will be presented, including differences between pre- and post- scores on the above measures, and parent feedback about the programme. To date, early results demonstrate a reduction in child anxiety as measured on the RCADs (parent and child scales) and an average of a 7 point shift in progress towards goals (from 2/10 to 9/10) as measured on the GBO. 100% of the participants so far reported finding the programme helpful and would recommend it to a friend. Reductions in scores for parental GAD7 and PDQ9 scores and increase in parental self-efficacy were also found. Results suggest that the programme may be an effective and efficient method of addressing anxiety difficulties experienced by children with a life limiting illness and their siblings within a paediatric setting. Further research is needed to confirm this. Providing parents with the skills to use to support their children with anxiety in future may prevent further referrals to psychology for anxiety-related conditions, increasing the cost-effectiveness of the programme. Secondary benefits may include an increased sense of empowerment and self-efficacy for parents, reduced anxiety and distress around medical interventions thus improving treatment adherence, and parents generalising the strategies acquired in order to manage their own anxiety and coping ability. Programmes such as these offer an effective stepped care approach to psychological therapy, and increase accessibility to psychological interventions where resources are limited.

The psychological impact of children’s social support use following a traumatic event

Clare Dixon, University of Bath, Sarah Halligan, University of Bath; Rachel Hiller, University of Bath; Sarah Lobo, University of Bath

A child’s exposure to a traumatic event (e.g. road traffic accident, assault) places them at increased risk of a range of psychological difficulties, including the development of posttraumatic stress disorder. However, little is known about the factors which contribute to persistence/remission of initial symptoms. Children employ a number of coping strategies following a trauma and meta-analytic studies have identified perceived social support as a strong predictor or PTSD risk. However, children’s actual use of support, i.e. where, why and how children seek support following a trauma and the barriers to seeking support are unknown. This longitudinal study will aim to address this gap in the literature by exploring what supports children utilise after a trauma, what factors might influence this and how the use of social support might influence the development of PTSD?

Participants are approximately 90 children aged 6-13 years, and their parents, who attended emergency departments following the child’s experience of a single-incident trauma (e.g. road traffic collision). The parent and child completed assessments within 4 weeks of the trauma and again at 3 months. Parents completed demographic information and questionnaires assessing their own symptoms of PTSD, other psychopathology and parent-ratings of child symptoms. Children completed questionnaires assessing symptoms of PTSD, mechanisms of PTSD (e.g. memory, appraisals), other psychopathology and perceived social support. No measures were identified which look at what support children actually use, the reasons they seek support and barriers to support. A measure was developed to look at this. Parents also rated their own perspectives of their child’s support needs and their ability to manage this.
This study is in progress with data collection due for completion in March 2016. The results described children’s actual use of social support following a trauma and relationships between children’s support seeking and demographic (e.g., age, gender, parental psychopathology) and trauma characteristics (e.g., trauma type, trauma severity). The main analysis explored whether social support use at 4-weeks predicted symptoms of PTSD at 3 months and whether support use influenced specific trauma mechanisms and symptoms e.g., memory or appraisals.

The results of this study will help to us to find out more about social support following trauma and the potential impact this could have on the development and maintenance of PTSD in children. The results could also help us to think about how we inform those in the system around children to support them and the impact this could have. This research could help to inform early intervention work about how support could be promoted and best used following a trauma. It will also help to provide some insight into where children may have sought support, and their appraisals about support, prior to attending more formal support services, such as CAMHS.

**Flexibility in the face of complexity**

Sophie Bennett, UCL Institute of Child Health, Roz Shafran, UCL Institute of Child Health; Sophia Varadkar, Great Ormond Street Hospital for Children NHS Foundation Trust; Isobel Heyman, Great Ormond Street Hospital for Children NHS Foundation Trust

Children and young people with physical illnesses are at greater risk of developing mental health disorders, such as anxiety, depression and disruptive behaviour disorders, compared to children and young people who do not have a physical illness. However, the mental health disorders are often not detected or treated with evidence-based treatments. Clinicians may either not refer, or CAMHS teams may decline the referral because they consider that the presence of a physical illness makes them ‘too complex’ for standard evidence-based interventions, such as CBT for anxiety or depression, or parenting groups for disruptive behaviour. Many children and young people have comorbidities (for example disruptive behaviour in the context of anxiety, or anxiety and depression). Modular interventions are one way to maintain fidelity to evidence-based treatments, whilst allowing flexibility in the face of complexity. Session by session outcome monitoring allows the therapist to focus on the primary goal/presenting symptom.

The Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct (MATCH-ADTC) was completed with families of children and young people with behavioural difficulties, anxiety and/or depression, in the context of neurological and/or neurodevelopmental disorders. Goal monitoring and outcome measures were completed weekly and emailed to the therapist before each session. This allowed the therapist to switch modules where it was clear that other symptoms were interfering with the course of therapy or when goal priorities changed. Conversely, the therapist continued with the primary module where progress was maintained and the primary goal priority remained constant.

Six clients, all with comorbidity, completed the modularised intervention (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems). Symptoms for the primary goal/intervention target reduced between pre and post-intervention for all participants. In most cases, only one module was required, despite the presence of comorbidity. Tracking real-time progress through the use of routine outcome measurement allowed the therapist to ensure that there was progress towards goals and that symptoms were reducing through treatment.

The modular intervention, informed by session by session outcome monitoring, was effective in these six cases. The treatment protocol was not adapted to account for the physical illness and therefore is a treatment that most CAMHS clinicians should be able to deliver.

In these cases, complex presentations did not necessitate complex intervention. Routine outcome measurement was key in ensuring flexible delivery of the protocol.

**Super Skills for Life**: Transdiagnostic prevention programme for the anxiety and depression in children
Cecilia Essau, University of Roehampton
Super Skills for Life (SSL) is a CBT-based transdiagnostic prevention programme that also behavioural activation, social skills training, and uses video-feedback and cognitive preparation as part of the treatment. It consists of 8 group sessions, each lasting for 45 minutes.

The main aim of this study is to examine the feasibility and efficacy of the SSL in reducing anxiety and depressive symptoms, and in enhancing self-esteem and social skills. A total of 61 children participated in the study. All these children have been identified by their teachers as having problems with anxiety and/or depression. They were given a set of questionnaires to complete before and after the training, and about an average of 6 months at a follow-up period; video-recordings were also taken during these three assessment periods. The questionnaires were used to measure anxiety and depressive symptoms, cognitive dysfunction, psychosocial impairment, self-esteem, and social skills.

Results, based on self-report measures, indicated that children who participated in the SSL showed a significant reduction in anxiety and depressive symptoms, cognitive dysfunction, and psychosocial impairment. Behavioural indicators of anxiety during the 2-minutes speech task decreased, indicating that the independent raters observed behavioural change in the children from pre-treatment to follow-up.

This study provides empirical evidence for the utility of the SSL in reducing anxiety and depressive symptoms among children.

Young people’s understanding of CBT: socialisation to the model and its relationship with clinical outcomes
Cara Roberts-Collins, University of Bath, Gerwyn Mahoney-Davies, University of Bath
Children and adolescents experience high levels of anxiety disorders and depression. The NICE guidelines recommend CBT to treat these disorders, and there is emerging evidence to support the use of CBT for children and young people. Research has identified prerequisites to engage in CBT, including the ability to understand, discriminate between, and understand the relationships between thoughts, feelings and behaviours. In order to engage in these skills, young people are required to have an awareness of their own emotions, and to be socialised to (or understand) the CBT model. However, there is no evidence to suggest whether socialisation is an important factor in CBT with young people.

This study therefore aimed to develop a tool to measure socialisation, and to explore whether socialisation to the CBT model is related to treatment outcome.

Young people (aged 11-18 years old), with and without a diagnosis on the autism spectrum, who had attended CBT took part in the research. They completed an interview about their experiences of and their socialisation to CBT and a thought, feelings and behaviours (TFB) task. Clinicians were asked to rate socialisation to CBT, the young person’s improvement since attending therapy, and report RCADS treatment outcomes scores and therapeutic alliance.

It is hypothesised that the young people who are better socialised to the CBT model will have better treatment outcomes, which will also be correlated with therapeutic alliance.

Results will be available prior to the BABCP conference.

Use of the newly developed TFB task and implications for clinicians working with young people (both with and without a diagnosis of autism) will be discussed. Areas for further research will also be identified.

This research aims to develop a tool (TFB task) for clinicians to use in their everyday clinical practice of CBT, to help identify how socialised the young person is to the CBT model. This research will also examine young people’s personal experiences of attending CBT; an area which has been identified by young people themselves as extremely important.

Understanding developmental norms in reasoning biases across adolescence: A longitudinal study
Rachel Slavny, Royal Holloway, University of London, Pote, Royal Holloway, University of London
The current study evaluates how reasoning biases develop longitudinally over one year in a community sample of adolescents. Research has established that various reasoning biases are associated with psychopathology in young people (for e.g. Waite, Codd & Creswell, 2015; Schwartz & Maric, 2014), although to date few studies have explored how these biases change across this developmental period. The lack of research makes it difficult for therapists to integrate knowledge of developmental norms into formulations and treatments. Recently presented cross-sectional data revealed that overgeneralising, mindreading, threat interpretations and negative attributions were significantly higher in late adolescents (14-17 years) compared to early adolescents (10-13 years) when psychopathology was controlled for (Slavny, R. & Pote, H., 2015). The current study aimed to explore whether similar developmental increases are detected utilizing a longitudinal design.

Seven reasoning biases were explored longitudinally in a community sample (N=104) over a year during early adolescence (11-13 years) using self-report questionnaires. Baseline psychopathology was measured and controlled for as a covariate. Longitudinal data will be presented, describing developmental changes in seven reasoning biases over time.

Limitations of existing cross-sectional studies are addressed by utilizing a longitudinal design, including the reduction of cohort differences and by exploring systematic individual change over time. Interesting longitudinal results are presented and discussed in relation to previous cross-sectional findings. Understanding typical developmental changes in reasoning biases across adolescents will aid therapists to develop individualized, developmentally sensitive formulations which inform their work and guide age appropriate interventions.

What happens when you don’t have IAPT? Northern Ireland’s response to the development of Psychological Therapies within limited resources

Review of the Implementation of Psychological Therapies Strategy in Northern Ireland
Rodney Morton, Health and Social Care Board (HSCB), Head of Improvement within the Directorate of Social Care and Children’s Services.
Rodney will outline how the DHSSPS Psychological Therapies Strategy has been implemented in Northern Ireland. This will include a discussion on development of the Northern Ireland Mental Health Triple Aim Strategy:
1. Building a Culture of Early intervention through the establishment of Primary Care Talking Therapy Hubs. These hubs aim to improve access to talking therapies and lifestyle support for people who have common mental health needs (anxiety depression stress etc.). These hubs are underpinned by a community development approach and involve a consortium of community and voluntary sector providers working in partnership with statutory mental health services to better meet the mental health needs of the local population.
2. Building and strengthening a recovery culture and improving access to evidenced based psychological care. This has been achieved through the development of the new mental health care pathway. The pathway, is a single document, which describes the experience that people with mental health care needs can expect and the key standards directing the delivery of all mental health care across Northern Ireland. This pathway has been supported through the publication of the “You in Mind Talking Yourself Well” A Guide to Mental Health Psychological Therapies.” This guide aims to outline the range of therapies which should be available across all mental health services. Importantly, the pathways establish a platform for redefining how services are shaped to restore hope, opportunity, recovery, control and personal responsibility. In support of the care pathway, Recovery Colleges have been established across Northern Ireland. These recovery Colleges adopt an adult learning approach to mental health recovery. This involved bringing together people with lived experience and professionals who co-deliver therapeutic...
educational programmes. The colleges enable people during and post treatment, to discover personal talents and develop new skills for life, which in turn have opened opportunities for volunteering, further education, and entering or returning to employment.

3. Building a Culture of Effectiveness through building system capacity and capability.

This has been progressed through the implementation of a new “Working Together Learning Together Mental Health/Psychological Therapies Training Framework”, and adoption of the Choice and Partnership Framework and the development of a New Managed Care Data System designed to enable reflective practice in the evaluation of outcomes.

The Introduction of CBT techniques to an Acute Mental Health Inpatient setting: A Quality Improvement Initiative

Colette Reynolds, Cognitive Behavioural Psychotherapist South Eastern Health & Social Care Trust & Ann Domican, Mental Health Nurse

A frequent complaint by service-users of psychiatric inpatient units is the absolute unavailability of talking therapy at precisely the time when they have some time and space to make sense of their situation (Clarke & Wilson, 2009). In a region where IAPT has yet to be implemented this is even more of a problem. Within limited resources commissioners and Trusts have needed to more carefully target training (DHSSPSNI, 2010). In Northern Ireland this has meant training and up skilling the existing workforce. This creation of a more psychologically literate workforce across mental health treatment areas is growing and as a result patients, who have for too long been fobbed off with a mixed bag of eclectic 'clap trap', are now more likely than ever to be treated using evidence based treatments delivered by appropriately trained, accredited psychotherapists.

This paper and presentation outlines the preliminary results of the experimental use of Behavioural Activation (BA) techniques in an acute mental health inpatient unit and represents part of a Trust "Safety Quality and Experience "(SQE) project. One fully qualified Mental Health Nurse training to be a BABCP accredited Cognitive Behavioural Psychotherapist designed and is overseeing the project with the help of another Registered Mental Health Nurse who was undertaking low intensity CBT training.

The specific objective of this improvement project was to commence behavioural activation on a mental health inpatient ward for depressed clients and measure the outcome using standardised outcome tools. Behavioural activation was chosen because its theory of pathology and change is well specified in the literature (Dimidjian et al., 2006; Mazzucchelli et al., 2009; Kanter et al., 2012). Behavioural activation’s potential strengths in terms of parsimony and portability make it an ideal treatment in terms of staff training. The assumption behind behavioural activation’s direct behaviour change approach is not that behavioural factors are the only factors that are relevant to depression but that depression is a multisystem disorder and behavioural change is a direct and pragmatic method for affecting those systems. Thus, research has shown that both important cognitive changes and neurobiological changes occur after a successful course of treatment (Jacobson et al., 1996; Dichter et al., 2009). Behavioural activation’s theory in fact dovetails well with neurobiological research and is therefore easily accepted as an adjunct to psychopharmacological inpatient treatments. In addition, its flexibility, adaptability make it an ideal treatment option which is portable enough to be used in a rapid patient turnover population found in modern inpatient units. Curran et al (2007) and Hopko et al (2003) support the assertion that BA is particularly well suited for inpatient environments. In addition, Folke et al (2015) suggest that Behavioural Activation is actually a highly transferable inpatient treatment for persons with a variety of psychiatric disorders.

The process included baseline measurement using standardised outcome scales, psycho-education, the development of a BA formulation to assist the patient in understanding how their illness may be maintained by behaviours that are understandable but that may only work in the short term. In addition, the Valued Living Questionnaire was used to ensure treatment was receptive to the patient’s particular cultural values when defining activation
targets, including culturally, spiritually and personally meaningful targets (Hughes, Herron and Younge (2014). The results suggest a positive correlation between activity and improved mood and the patients that have been involved in the project have provided useful feedback. In addition, clinical scores have shown that the use of BA in an inpatient unit is indeed an effective intervention which can be successfully applied to difficult to treat acutely ill populations.

Mental health Services for Older people Community Team CBT Skills Training (A Quality Improvement Project)

Joanne Younge, Associate Specialist Psychiatry of Old Age, South Eastern Health & Social Care Trust & Clinical Lecturer CBT Queens university Belfast

Although CBT is recognised as the psychological therapy with the greatest evidence base, recommended in the NICE guidelines for mental disorders and identified as a service deficiency in the N.I. Assembly inquiry into suicide (2008) and the Bamford review of Mental Health (2005), which has led to the development of N.I. Psychological Therapy Strategy (2010), there is a lack of psychological therapy provision, particularly for older people. CBT has a place in all tiers of the stepped care model from primary to secondary care and all staff should have psychotherapeutic skills, however there has been a lack of training and investment to date locally, in the absence of IAPT.

South Eastern Health and Social Care Trust runs a Safety, Quality, Experience training program in collaboration with the Institute for Healthcare Improvement, where staff receive training in these areas and identify an improvement project relevant to the needs of their service. The presenter, Dr Joanne Younge, identified that the vast majority of Mental Health Services for Older People (MHSOP) community staff had never had CBT skills training so a short program of CBT skills training (25 hours over 6 months) was developed and provided by BABCP accredited Cognitive Behavioural Psychotherapists. In keeping with quality improvement philosophy, objectives were set and the impact of the training was measured using process measures, balancing measures and outcome data by completion of ‘Plan-Do-Study-Act’ (PDSA) cycles:

Objectives: To improve perceived knowledge, skills, confidence and frequency of use of key CBT skills to good category; to improve objective CBT knowledge test scores to >60% and have practice implementation for 80% trainees following training.

Methods: At baseline and following training staff completed a subjective questionnaire rating their knowledge, skills, confidence and frequency of use of key CBT skills on a five point scale and an objective CBT knowledge test. Balancing measures of morale, workload manageability and job satisfaction were also rated before and after training. During training monthly data was collected on practice implementation e.g. goal-setting and use of patient outcome measures (PHQ-9, GAD-7).

Results: Staff ratings (good or better category) of: CBT knowledge improved from 34% to 100%; CBT skills from 14% to 100%; and confidence in use of skills from 14% to 98%.

Frequency of use of CBT skills (at least sometimes) improved from 33% to 88%. Objective test scores improved from 7% to 82% average, with 100% achieving >60%. Staff perceptions of workload manageability, job satisfaction and morale all improved (36% to 72%; 18% to 63% and 18 to 45% were rated good or better at baseline and following training respectively). Patient outcomes also showed improvement- average PHQ-9 scores dropped from 16 to 9.75 and average GAD-7 scores dropped from 11.3 to 6.3.

Quality improvement methodology is presented as a novel, pragmatic way to help evaluate training programs in action. Challenges to sustained quality improvement are discussed.

1. National Institute of Health and Care Excellence. Available at: https://www.nice.org.uk/


Building the Network
Geraldine Hamilton, Head of Health & Wellbeing Services, Victims & Survivors Service Northern Ireland (VSS)
In this presentation, Geraldine will outline the successes, challenges and outcomes of building a Talking Therapy Consortium across the City of Belfast. A particular focus will be on the integration of Primary Care, Community, Statutory and Voluntary Organisations in the delivery of the talking therapies. Geraldine is now on secondment with the VSS, an Arms’ Length Body funded by the Office of the First and Deputy First Minister to fund and deliver trauma therapies and support to victims and survivors of the conflict/Troubles, and will outline the work being taken forward to build capacity, pathways and best practice within the sector.

Regional Evaluation of Stress Control Classes across Northern Ireland
Paddy Love, Senior Cognitive Behavioural Psychotherapist, Belfast Health and Social Care Trust
The waiting list for Mental Health Services and Psychological Services in particular are excessive, with many Health and Social Care Trusts in Northern Ireland reporting that they are frequently not meeting the waiting time directives of 9 and 13 weeks respectively. It could be argued that the Services are over reliant on the traditional approach of one to one therapy. In addition many clients are reluctant to partake in group therapy for psychological therapy due to the concerns of confidentiality and stigma. The provision of an alternative approach to psychological therapies delivery using low intensity, quick access and readily available Stress Control Classes, delivered by CBT Therapists throughout Northern Ireland, has proven to be highly successful and is well received by students, practitioners and service managers alike. The anonymity and carousel approach with no need to register is highly popular among the stress control students. It allows the hard to reach population the opportunity to dip in and out of classes and gain some insight into how stress is maintaining their problems. For Mental Health Services Practitioners, Stress Control Classes offer an additional option to the traditional menu of psychological services provided to their clients and is used before, during and after mental health interventions are provided. In this presentation, Paddy Love will present on the evaluation and feedback of the provision of Stress Control Classes across Northern Ireland. The uniqueness and strengths of a small psychological therapies community which has led to strong collaboration and co-working will be emphasized. The outcomes and data collated for one set of classes using the DASS 21 scale from the Belfast Health and Social Care Trust will be shared. More recent data collated using the Warwick and Edinburgh Well-being scale will also be reported upon. The delegates will also gain an appreciation of the development of Stress Control Classes in Northern Ireland and the various approaches to delivery, advertisement and co-operation among therapists which had resulted in the establishment of Stress Control NI.

Dissemination at home and abroad

Training ‘trauma experts’ in IAPT: Results from a training evaluation
Hannah Murray, Traumatic Stress Service, South-West London and St George’s NHS Trust
PTSD is often considered a difficult problem to treat by IAPT clinicians, and clinical outcomes in IAPT are well below those found in clinical trials. A recent training initiative aimed to intensively train IAPT staff in trauma-focused CBT and to provide an additional
Can the Internet help in overcoming common barriers to disseminating CBT to underdeveloped countries?

Ahmed Ismail, Kent and Medway NHS Trust and Social Care Partnership Trust

There is a need to develop more affordable and scalable methods of training CBT skills than current expensive methods. In the past few years, many empirical research papers in the developed world have concluded that the Internet could be an effective method of training psychotherapy skills. A recent randomised controlled trial in Sudan provided further evidence supporting the effectiveness of Internet based training. The trial evaluated the effectiveness of Internet-based training versus live workshop training in improving Sudanese mental health practitioners CBT theory, assessment and formulation skills. Thirty-six participants were randomly assigned to (a) 3 hours-long live workshop, (b) online multimedia recorded lecture of same content and duration. Participants were rated on: (1) performance on a video-recording of a standardized role-play of a CBT assessment, (2) ability to construct a CBT formulation of simulated patient, and (3) participants’ satisfaction and acceptability of the training. The results suggest that the two training methods improved participants’ ability to apply the skills learned from the training in clinical simulation and to construct a CBT formulation. Participants allocated to the internet-based training performed better on measures of CBT assessment and formulation skills than those allocated to the live workshop. There were no statistically significant differences between the two groups in the acceptability and feasibility of the training.

This study suggests that Internet-based training could be an affordable and effective method of training that might help to disseminate CBT to developing countries like Sudan and may be useful in training clinicians with little knowledge or prior experience in CBT. An update will also be provided on efforts to set up a Diploma-level CBT training programme in Sudan.

Supervisor Competence Scale: a pedagogic tool in supervisor training and education

Anna Tornquist, SAPU Education centre, Stockholm Sweden

The Supervisor Competency Scale (SCS) is a tool systematically developed by the Oxford Cognitive Therapy Centre aiming to balance ease of use with comprehensibility in capturing key supervision competencies and core skills. This presentation builds on an earlier analysis of its psychometric principles for group supervision of CBT trainees by trialing it on supervision-course for psychotherapists. Students produced self-ratings for recordings of individual supervision. The sessions were also rated using the SCS by two independent assessors. This presentation will discuss the result of this validation, and will compare the measure’s psychometric properties when used for group and individual supervision sessions. Trainees’ evaluation of the scale will also be presented, with data on what students report to have learnt by using the form and how they consider this has affected their skills as supervisors.

Socratic Methods: What do we mean and how is this measured?

Sarah Rakovshik, Oxford Cognitive Therapy Centre (Oxford Health NHS Foundation Trust)/ University of Oxford

What exactly do we mean when we talk about Socratic Methods? Are we referring to a particular line of questioning? Is this the same as Guided Discovery? A Socratic approach to therapy is often a difficult skill for CBT trainees to acquire, and even experienced therapists continue to hone these skills throughout their career. This talk examines the results of using a new Socratic Methods rating item, developed at OCTC, to assess the skills of students on the PG Diploma in CBT at the University of Oxford and the University of Newcastle. The presentation will highlight the similarities and differences between this item and the Guided Discovery item on the CTS-R, and will look at the development of students’ ability to use this approach during their core CBT training.
Panel Discussion – When the past is in the present: disorder specific presentations with Trauma in the past

Colette Kearns, St Patricks Mental Health Services, Dublin
All panel members will present briefly a case of a disorder specific presentation where there is trauma experience in the past requiring trauma specific interventions.
Chigwedere will present a case of Dissociation, where Schema therapy interventions were used.
Kearns will present three cases of OCD where there are traumatic memories from the past within the maintenance cycle. Imagery rescripting is used in treatment.
O’Connell will present a case of BDD/Social phobia where there have been traumatic bullying experiences. The trauma work involved will be described.
Hill will present a case of complex Eating disorder where treatment involves CBT-E and Imagery rescripting.
Questions will then be asked by the chair on interventions used and outcomes achieved.

What sorts of CBT interventions can be delivered in schools?

“Living life to the Full” within St Andrews and St Bride’s High School
Lyndsay Malley, Principal Teacher of Pupil Support
Within St Andrew’s and St Bride’s High School in East Kilbride, Scotland we have implemented CBT interventions in a range of different ways through use of the Living Life to the Full programme. The aim was to develop staged intervention strategies to address the growing number of children who present in school with difficulties in relation to self esteem, self image, stress, anxiety, exam pressure, social problems, health concerns and for children who are challenged with mental health difficulties. The programme has been embedded in different ways, through class lessons, group work, individual E therapy sessions and a Peer Mentoring project, which involved S6 pupils delivering a workshop called ”Why does everything always go wrong?” to educate younger students on unhelpful thinking and how it can inhibit your progress and alter your feelings and behaviour. This presentation will share the results from evaluations of these supports in relation to children developing skills and strategies to use in times of need.

Universally delivered CBT in a Scottish secondary school setting: a pilot feasibility study
Karen Mackenzie, University of Glasgow
There has been widespread interest in developing school-based interventions to promote mental health in children and young people. Living Life to the Full (LLTTF) is a series of Cognitive Behavioural Therapy (CBT)-based booklets and accompanying 8 classes to improve coping skills in adults. An adolescent version of LLTTF was recently developed. This project aimed to evaluate the feasibility of this CBT programme for adolescents within a Scottish secondary school setting.
Third year (13-14 year old) secondary school pupils from four Religious, Moral, Citizenship and Education (RMCE; equivalent to PHSE) classes (n = 105) were allocated to two conditions: a comparison arm, RMCE-as usual (‘RMCE-AU’), and intervention arm, ‘LLTTF’. A pretest-posttest, within and between groups design was utilized comparing pre- and post-outcomes on four standardised measures (Strength & Difficulties Questionnaire, Locus of Control Scale, Rosenberg Self Esteem Scale and Self-efficacy Scales). Weekly feedback was also gathered from the intervention group to determine acceptability and usefulness of the LLTTF materials.
This talk will share the results of this pilot study and comment on the feasibility, acceptability and utility of an early intervention CBT course for adolescents in Scottish secondary school settings.
Building Emotional Health and Well-being across the whole school; staff and students
Jo Elliott Head of PSHE and Lara Nicholson Sixth Form Student King's School Honiton
Exeter
Five Secondary schools in Devon were awarded a Character Education Grant from the
Department of Education in England. The aim was to give students the opportunity to
develop their skills to prepare them for life. Kings School school focused on improving
emotional health and well-being with close consultation with students. Mixed ability classes
of 14/15year olds were taught lessons from the Living Life to the full programme alongside
mindfulness activities. A whole school initiative utilized sixth form students in a peer led
programme implemented during tutorial periods. A Teen Health group run by the students
for the students organized week long activities with a theme of being happy. The effects have
been overwhelmingly positive.

The feasibility and acceptability of a pilot project embedding social and emotional
wellbeing interventions within 5 schools in the South West of England.
Catherine Gallop, University of Exeter
Approximately three children in every class experience mental health difficulties, which can
have a large and chronic impact on young peoples’ attainment, development and functioning.
Building wellbeing and resilience in young people can have a positive impact on both the
development and course of these difficulties and schools are well placed to support young
people in developing these skills and abilities.
Furthermore, recent national policy (e.g. future in Mind) has stressed the importance of a
joined up system of care to support young people’s emotional and mental health and central
government has recently launched schemes to support joined up working with staff in
schools and CAMHS. Several service specifications now point to the need for the skilling up
and supporting of school staff in addressing the emotional well being agenda. The CYP IAPT
service transformation programme, which has involved the training and skilling up of staff
working with children with mental health difficulties, has included the Enhanced Evidence-
Based Practitioner programme. This draws on the evidence base in low intensity CBT
interventions, as a way of skilling up a wider range of staff to deliver CBT in universal
settings. The University of Exeter has developed a very successful EEBP programme in the
South West of England, and has also been working with local schools to identify ways of
extending the usefulness of low intensity CBT models across the whole school curriculum.
As part of a government-funded schools initiative to promote Character Education and
Wellbeing, the University of Exeter has worked very closely Chris Williams’s Five Areas
organization and five secondary schools in the South West of England on a project to deliver
an 8-session version of Living Life to the Full programme. Clinical psychologists from the
university helped key staff within the schools to pilot delivery of the individual class
sessions, and each school has independently planned the ongoing implementation of Living
Life to the Full and its materials.
This talk will review the acceptability and feasibility evidence for the delivery of this project,
consider the associated strengths and difficulties associated with it, and highlight learning
outcomes for the future.

Improving Access to Psychological Therapies – An Update (2)

Improving Access to Psychological Therapies for People with Psychosis and Bipolar
Disorder: The Story so Far
Alison Brabban, NHS England, Tees, Esk and Wear Valleys NHS Foundation Trust,
Durham University
With the introduction of the new EIP Access Standard there is an expectation that everyone
with a first episode of psychosis will have access to NICE recommended psychological
therapies. This is a significant challenge, since previous audits have revealed that less than
10% of people with psychosis receive these interventions from an adequately trained
therapist. This presentation will go through the steps that have been taken to bridge this gap and to ensure there is an adequate workforce in place equipped to deliver CBTp and Family Interventions. The lessons learnt and the next steps in implementing psychological therapies for those with a diagnosis of psychosis, bipolar disorder and personality disorder will be explored.

**Ageing Access to IAPT Services: Some things done and some things still to do**

*Steve Davies, NHS England, North Essex Partnership University NHS Foundation Trust*

The development of evidence-based psychological therapies for older people has lagged behind those for younger cohorts due to overt ageism but also because of a number of more subtle barriers. But the number of people over 65 now using Improving Access to Psychological Therapies (IAPT) services has risen from less than 2% of this population to more than 7%. Even better, the recovery rate in IAPT is around 47% in the general population but 57% among people over 65. So when older people get access to IAPT they get better. Considering the multiple challenges of late life this may well represent a substantial contribution to improving the health of the nation.

Psychological work with older people is the same and different, as with any other such work. The IAPT programme has allowed a considerable expansion of the availability of CBT and other evidence-based therapies to the whole population, including older people. This means that a significant minority of the population has been exposed to effective psychological interventions that would not have been the case otherwise. However, significant challenges to consistent and comprehensive access remain. Self-stigmatisation and self-exclusion from services remains a problem. Access for older old people, particularly those over 90, remains patchy. Access for ethnic minority elders is ongoing issue, coupled with problems with access to psychological services generally.

My contention is that the IAPT programme has represented a public good in the lives of older people. But the aspiration is for IAPT to grow old gracefully by continuing to improve access to psychological therapy for all people facing the challenges of late life.

**Developments in Behavioural and Cognitive Therapies for Adults with Intellectual Disabilities**

**Improving the Quality of Behavioural Support Plans through Service Development Initiatives**

*Jill Chaplin, Northumberland, Tyne & Wear NHS Foundation Trust*

**Background:** Behavioural support plans (BSP) are an important tool in the delivery of interventions for people with intellectual disabilities and challenging behaviour. Considerable clinical effort and resources in services are invested in BSP development. Although there is existing research on BSP quality, few studies have addressed the outcomes of attempts to improve BSP quality in applied settings.

**Method and materials:** In the present study, we used the Behaviour Support Plan Quality Evaluation II (BSPQEI; Browning-Wright et al., 2003) and evaluated the quality of the BSP for adults with intellectual disabilities and severe challenging behaviour before and after the implementation of a coherent service development plan (SDP). The SDP was informed by previous research and an initial audit.

**Results:** We found significant improvements in BSP quality over time. However, the proportion of BSP rated as ‘good’ after the implementation of the SDP was still very small.

**Conclusion:** The service developments may require longer to bed in and/or amended implementation to improve the proportion of BSP rated as higher quality.

**Mindfulness-Based Intervention for Parents of Adults with Intellectual Disabilities: Outcomes from a Randomized Active Treatment Controlled Trial**

*Richard Hastings, University of Warwick*

**Background:** Despite the number of recent studies focused on mindfulness based interventions for parents of people with intellectual and developmental disabilities (IDD),
only 2 studies have included active treatment control groups. Both of those studies have focused either exclusively or primarily on parents of children and youth. The purpose of the current study was to compare clinical outcomes for parents of adult children with IDD randomly assigned to either a mindfulness based or support and education focused parent intervention.

**Method:** Parents seeking adult services for their children age 16 and up with IDD were recruited to participate in a parent intervention project. Participants were randomly assigned to one of two parent groups: (1) the mindfulness based intervention group; and (2) the support and education intervention. Parents were randomly assigned to Group 1 (n= 26) or Group 2 (n=20). Participants completed Time 1 baseline ratings, Time 2 post-intervention ratings, and Time 3 ratings, at 3 months follow-up.

**Results:** ANCOVA indicated a significant main effect of group assignment on depression and stress scores at Time 2. In both cases, the reductions in psychological distress were in favour of the mindfulness intervention. There was no significant main effect of group assignment on other study measures including mindfulness processes. Analysis of follow-up data suggests the maintenance of putative intervention gains.

**Discussion:** Using a robust, randomized, attention-controlled design our data suggest a benefit of mindfulness based intervention for parents of adults with IDD. The study has also highlighted important feasibility data, including the challenges of recruiting parents of adults with IDD across a large metropolitan area.

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**The Evidence for Behavioural and Cognitive Therapies for Adults with Intellectual Disabilities – Never Mind the Quality, Feel the Width?**

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

**Background:** Recently NICE has reviewed the evidence concerning interventions for challenging behaviour and mental health problems in people with intellectual disabilities (ID). NICE then produced clinical guidelines which are systematically developed statements to assist clinicians and service users in making decisions about appropriate treatment. They are derived from the best available research evidence and are intended to improve the process and outcomes of healthcare.

**Method:** The evidence identified in the NICE guidelines to support behavioural and cognitive interventions for people with ID is described along with the key recommendations concerning treatment for behavioural and mental health problems in this population. A more inclusive analysis of the quantity and quality of the evidence to support interventions for challenging behaviour is presented to highlight the complexity of decision-making about appropriate treatment in this heterogeneous population.

**Results:** The quality of the evidence identified in the NICE guidance to support behavioural and cognitive therapies for people with ID is generally considered to be limited. However, a broader review of the literature suggests that, in terms of challenging behaviour, there a weight of evidence available to support behavioural interventions for particular groups of service users; and whilst the quantity is limited, the quality of evidence to support cognitive behavioural interventions for some service users is reasonable.

**Conclusions:** The NICE approach to identifying and rating research evidence is rigorous but quite rigid and can lead to what some might consider somewhat narrow recommendations. A broader approach to reviewing evidence leads to more nuanced conclusions about the effectiveness of behavioural and cognitive interventions for people with ID.
Sean Harper - NHS Lothian, Ruth Lennon - NHS Lothian, Charlotte Paterson - Edinburgh Napier University

Objective: A cross diagnostic, psychological model of intervention (based on Clarke and colleagues model) has been applied in an acute adult mental health service alongside treatment as usual (TAU). The model offers individual therapy and CBT based ‘third wave’ group therapy to patients. It also offers Mentalization Based Therapy (MBT) skills based training and basic CBT skills training to all ward staff. Furthermore, weekly group reflective practice and clinical supervision is available for staff. The aim of the study is to evaluate the effectiveness of this model plus TAU in comparison to TAU alone.

In addition one of the group therapies (a cross diagnostic emotion regulation (ER) group) has been evaluated using both quantitative and qualitative methodologies

Method:

Effectiveness of the model is being measured in two wards (intervention and control) using patient data (LOS and readmission data), standardised clinical outcome measures (CORE-10 and Brief Symptoms Inventory) and a theoretical measure (Mental Health Confidence Scale) at 3 data collection points (pre treatment, post treatment and 6 month follow-up).

The six session ER skills group was developed and piloted within an acute inpatient mental health setting. The group was an open, rolling group piloted over a 5 month period, with two sessions delivered per week. Participants completed pre and post group ratings of emotion regulation (DERS, REQ-2), acceptance (AAQ-II) and distress (CORE-5). Participants also completed ratings of emotion regulation (visual analogue scales), acceptance (AAQ-II) and distress (CORE-5), at each group session. A mixed method design was employed, which included a multiple single case series design and qualitative exit interviews with eight participants. Qualitative interviews aimed to explore the acceptability and feasibility of the intervention. Case series and qualitative data were triangulated where possible.

Results

The ER group research is complete and descriptive data indicate high group attendance rates and low attrition rates. Group level analysis indicates large effect sizes for changes on the DERS and REQ-2 (internal functional subscale), and moderate effect sizes for changes on the CORE-5 and AAQ-II following the intervention. Case series data indicate sustained change occurred on at least one measure for four participants. Qualitative themes triangulate findings related to acceptability of the group; change in ER strategies and increased emotional acceptance.

The larger scale evaluation of the applied psychology model has encountered considerable challenges in the process which has resulted in the development of a revised research protocol aiming to provide a more informative assessment of effectiveness. The challenges and protocol adaptations will be presented for discussion.

Conclusion:

The pilot ER group study indicates that the intervention is feasible and acceptable, with preliminary evidence identifying potential clinical benefits. The challenges in evaluating the wider scale applied psychological model in an acute inpatient environment are presented for further discussion.

Implementing a whole system psychological approach in 4 acute services across one Trust

Isabel Clarke. Southern Health NHS Foundation Trust

The Emotion Focused Formulation (EFFA) model, which is used to link an individual formulation based understanding of mental health issues in terms of coping with overwhelming emotion, to psychological interventions delivered by the whole team across four acute services, both inpatient and community, will be presented. Results from two papers evaluating this initiative will follow.

Paper 1. Quantitative: Evaluation of the service one month after data collection, illustrates operation and level of uptake across different professional roles. The programme was evaluated by assessing psychological distress (CORE-10) and confidence in self-management (Mental Health Confidence Scale) of participating
service users before and after intervention. Results showed improvement in self-management skills and facilitation of recovery.

Paper 2. Qualitative. Staff perspectives on the initiative were explored in 10 interviews, analysed using thematic analysis. Results. Staff welcomed the opportunity for involvement in the delivery of psychological interventions and could see results for individual service users. Impact on the whole service was less evident.

**Changing the Narrative with people who present in crisis across the acute and rehabilitation care pathway**

*Kate Oldfield Principal Clinical Psychologist Community Enhanced Recovery Service and Linda Wilkinson, Consultant Clinical Psychologist/Professional Lead for Inpatient and Community Services*

Isabel Clarke’s emotion focused formulation was used to develop a whole service model of crisis management by firstly, using this approach with service users to have a shared understanding of the crisis and develop a care plan with shared responsibilities with the team, of ways to cope with emotional distress. Secondly, for the team involved with the service user to use this as a team formulation/shared understanding in team supervision. Finally for the whole system to learn from and integrate psychologically informed care to provide containment, interventions and compassionate care in high-risk environments.

Results: using both Quantitative and Qualitative methodologies, initial results are positive in terms of the approach, providing containment and a broader psychological understanding for the service users in crisis and across staff teams in a Home Treatment Team, Enhanced Community Recovery Team and the Acute mental health wards. This approach allows the teams to map unhelpful team responses, preventing disengagement and escalating of the risks for the service user.

**A new model of acute care across inpatient and PICU services; training our new ward teams**

*Anna Preston, Surrey and Borders Partnership NHS Foundation Trust*

This study examines the impact of a new care model in inpatient and PICU services, including those services which are located within a new state-of-the-art inpatient psychiatric unit in Surrey. Emotion-Focused Formulation (developed by Isabel Clarke) forms part of the three-strand model. The adoption of a solution-focused approach and an emphasis on the reduction of physiological arousal comprise the other two strands.

Training sessions for each of our seven new ward teams in Surrey were based on a 12-hour shift, and involved the use of actors in order to re-create a ward environment. Trainers and observers provided feedback and coaching to ward staff who were observed in delivering day-to-day tasks which they would be delivering within the real-life ward setting. Training took place within an empty ward environment in order to enhance sense of reality. Recovery focus, staff stress and burnout, leadership skills and team-working are all examined in the evaluation of the new model. Service-user experiences of the EFF have been positive, and the implementation of the new model within the PICU setting have led to improved service user and staff experiences.

**Third wave therapies: exploring mechanisms of change using qualitative methods**

*James McFadden, School of Psychology, Trinity College Dublin, Louise Kinsella, St Vincent’s University Hospital, Dublin, Charlotte Wilson, Trinity College Dublin*

Background: A recent randomised controlled trial examined the effectiveness of group mindfulness based cognitive therapy, group mindfulness based self-compassion therapy, and audio-delivered mindfulness based self-compassion therapy for people with psoriasis. This qualitative study explored participant experiences of change across these interventions.
Methods: 19 participants were interviewed approximately 10 months post-intervention. Template analysis was used to develop a hierarchy of themes.

Results: Eight first-order themes emerged: (1) absorbing the message; (2) present focused attention; (3) awareness; (4) facing difficult thoughts and feelings; (5) relaxation; (6) acceptance; (7) identification of problematic patterns; and (8) doing things differently. Many common processes were observed across the interventions, although points of contrast in participant experiences were found under the themes facing difficult experiences, and doing things differently, particularly in terms of how participants responded to self-criticism.

Conclusion: The findings indicate many shared and contrasting change processes in mindfulness based cognitive therapy and mindfulness based self-compassion therapy. They also provide detail about the ways participants of both interventions developed compassionate ways of relating to themselves and others, including findings that suggest that some participants may benefit from interventions directly aimed at developing an understanding and means of responding to self-criticism.

From isolation to integration: Clients’ experiences of Dialectical Behaviour Therapy
Amy Cadden, School of Psychology, Trinity College Dublin, Patrick Finan, Leitrim Adult Mental Health Services, Co Leitrim, Charlotte Wilson, Trinity College Dublin

Dialectical behaviour therapy (DBT) is an empirically validated intervention for borderline personality disorder (BPD). However, there is a significant gap in the literature between research demonstrating the effectiveness of DBT, and studies exploring what it is that makes DBT effective. This study aimed to address this gap through exploring the process of change in DBT from the perspective of clients who completed the intervention. Qualitative methods have been documented to facilitate the depth of description required to fully explore clients’ experiences. Grounded theory methodology was therefore applied to ten interviews. An interpretive theory of participants journey through DBT was developed which identified a number of core change processes: Universality within the group, the therapeutic relationship, the power of increased understanding, and the use of behavioural skills. Primary perceived outcomes related to self-sufficiency and self-acceptance. Results are considered in the context of furthering the understanding of change mechanisms within DBT.

Mindfulness and compassion in the treatment of people with psoriasis: what are the common mechanisms of change and what are the differences?
Aiveen Dillon, School of Psychology, Trinity College Dublin, Catherine Jackman, Cheeverstown House, Dublin, Charlotte Wilson, Trinity College Dublin

The present study aimed to explore service users’ experiences of a mindfulness group intervention.

Method Fifteen participants with a diagnosis of a mild or moderate disability and mental health difficulties including anxiety and depression who had attended the mindfulness group were recruited from an intellectual disability service. Semi-structured interviews focused on the positive and negative aspects of attending the group and comparisons between group and individual therapy.

Results Thematic analysis was used to interpret the data. Four superordinate themes and ten subthemes emerged. The four superordinate themes were ‘I liked taking part,’ ‘The hassle of being in the group,’ ‘I liked both,’ and ‘It’s helped me.’

Discussion The results highlighted that participants found the mindfulness group to be beneficial and reported that psychological distress decreased as a result of attending. The participants also reported positive aspects regarding the process of attending the group. The clinical implications of the group are discussed as well as directions for future research.

Developing CBT competency: What happens in training and beyond

Developing CBT competency: looking for patterns in CBT skill subsets acquisition
Sharon Pettit, University of Southampton
The UK government’s Improving Access to Psychological Therapies (IAPT) initiative resulted in expansion of post-graduate diploma training programmes in cognitive behaviour therapy (CBT). Since then there has been a growing literature on both assessment of therapist competency, and evaluation of training. What is less clear is whether there is any pattern to the development of trainee therapists CBT competency. Which CBT skill subsets do they learn first, and which do they find most challenging? This presentation will summarise an evaluation of CBT training for High Intensity (IAPT) therapists on a post-graduate diploma programme. It will specifically examine the effect of training on four skill subsets, and will discuss implications for trainers and supervisors.

Supporting the dissemination of Behavioural Couple therapy. Assessing therapist competence and developing supervisors

Rita Woo & Sarah Corrie, Royal Holloway CNWL

This paper describes ongoing efforts to disseminate Behavioural Couple Therapy within the IAPT programme in England. Initial empirical evidence has indicated that it is highly feasible to train individual CBT therapists in BCT and that they are able to provide this intervention in routine care resulting in good recovery rates where one or both of the partners are depressed. Current developments include the creation of training curricula and processes to develop new BCT supervisors who are in a position to effectively support new BCT therapists and to sustain BCT in the service setting. Additionally, this paper will describe the development of a new measure of BCT competence, the BCTS-D, which is being piloted and evaluated as part of ongoing training activity.

What IAPT CBT High Intensity Trainees do after Training

Sheena Liness, IoPPN, King’s College London

Little is currently known about the retention of IAPT CBT trainees, or the use of CBT skills acquired on the course in the workplace after training has finished. The IAPT High Intensity CBT Course at the Institute of Psychiatry, Psychology & Neuroscience (IoPPN), King’s College London (KCL) conducted a follow-up survey of past CBT trainees (n=212) across 6 cohorts (2008-2014 intakes). A response rate of 92.5% was achieved. The vast majority of IAPT trainees continue to work in IAPT services post-training (79%) and to practice CBT as their main therapy modality (93%). Sixty-seven percent have become CBT supervisors. Some NICE recommended treatment procedures that are likely to facilitate patients’ recovery are not being routinely implemented across IAPT services. Key findings will be presented. The results have implications for the continued roll out of the IAPT programme, and other future large scale training initiatives.

How are levels of CBT knowledge and skills retained after training. A follow up study of trainees from an employer based short basic skills course and a university based PG Diploma course

Michael Duffy, Queen’s University, Belfast

A strong evidence base for Cognitive Behavioural Therapy has led to an expansion of CBT training in universities and service provider agencies. In response to the concept of stepped care training is provided for staff to provide:

a- less intensive mental health interventions such as guided self-help and
b- more intensive treatments to meet requirements for accreditation as Cognitive Behavioural Therapists.

These developments pose the question of how staff can be facilitated to apply appropriate CBT concepts, models and techniques as part of their normal practice and to retain and develop knowledge and skills over time.

Method: This presentation follows up two cohorts of trainees:

1. Participants in short Cognitive Behavioural Therapy skills training programme provided in a Community Mental Health setting with mentor support
2. Graduates from 2 university courses, a “low intensity” PG Certificate course and a “high intensity” BABCP accredited PG Diploma course.
Approaches to working with perinatal anxiety and depression

**ACORN: Feasibility and acceptability of a low-intensity intervention for antenatal anxiety**
Heather O'Mahen, University of Exeter

Dr. O’mahen will present results from the ACORN trial, which compared a low-intensity intervention for antenatal anxiety to treatment-as-usual. The intervention consisted of 3 group-based sessions with women and their partners, delivered by a midwife and a psychological provider. This was followed by self-help materials on preparing for parenthood, and one postnatal session. Women were recruited at their 12 week scan by a research assistant. Women who scored 7 or more on the GAD-7 were offered participation in the trial. Outcome measures included number of sessions attended, qualitative interviews about the acceptability of the intervention, and measures of symptom reduction, including the GAD-7, EPDS, Dyadic Adjustment Scale, the Postnatal bonding scale, and birth outcomes. Implications for brief treatments for antenatal anxiety that are embedded within the antenatal care framework and incorporate father participation will be discussed.

**A pilot RCT for treatment of postnatal OCD**
Fiona Challacombe, Centre for Anxiety Disorders & Trauma, South London & Maudsley NHS Trust & King’s College London

There is increasing recognition that perinatal anxiety disorders are both common and potentially serious for mother and child. OCD can be triggered or exacerbated in the postpartum, with mothers reporting significant effects on parenting tasks. However, there is little evidence concerning their effective treatment and the impact of successful treatment on parenting. 34 mothers with OCD and a baby of 6 months old were randomized into either time-intensive cognitive behaviour therapy (iCBT) or treatment as usual (TAU). iCBT took place after randomization at 6 months postpartum and was completed by 9 months. Maternal symptomatology, sensitivity in mother-infant interactions and parenting were assessed at baseline and reassessed at 12 months postpartum. At 12 months attachment was also assessed using Ainsworth’s Strange situation procedure. A healthy control group of mothers and infants (n=37) underwent the same assessments. iCBT was successful in ameliorating maternal symptoms of OCD (ES=0.92–1.09). However, mother-infant interactions were unchanged by treatment and remained less sensitive in both clinical groups than a healthy control group. The distribution of attachment categories was similar across both clinical groups and healthy controls with approximately 72% classified as secure.

**Advancing the IAPT programme**

**Stress Busters - a community mental health course for older adults**
Ann O’Hanlon, Northern Ireland Centre for Health and Well-being (NICHAW)

More people than ever before are reaching old age, and with this demographic change comes an urgency to add quality of life and health to increased longevity. A significant barrier to quality of life and health are high levels of depression, loneliness and anxiety, often exacerbated by stigma, and a lack of information about these conditions. The current project aimed to evaluate the effects of a 6-week group psychoeducational course with adults aged 60+ years living in Northern Ireland. Ten groups have been in process to date involving around 5-15 men and women per group. For each group, participants completed surveys at baseline, and sessionally. Measures included the Patient Health Questionnaire (PHQ-9) (Spitzer et al, 1999) the GAD-7 (Spitzer et al, 2006), and a newly developed measure of emotional health specifically developed for this group. Each week a different mental health condition was discussed in order to provide information and break down stigma. In addition to behavioural activation, participants were also encouraged and upskilled towards greater self-care and more compassionate self-talk.
Results reflect improvements on all measures. Pre- and post- assessments measures of anxiety and depression decreased, and measures of positive affect, understanding, and compassion improved. Improvements were also maintained at 3-months and 6 months for a random subgroup who were followed-up. Participants valued structured opportunities for informal learning, support, and information. Initial success from graded interventions generated enthusiasm for further behavioural and social activation, which includes formalising a monthly Stress Café meetup group for continuing peer support post intervention. For older people, group interventions offers a clinical and cost effective way to manage time and resources.

- Older people are an important and growing group that are in need of supports to promote greater health and well-being
- A psychoeducational CBT intervention can effect improvements in levels of depression, anxiety, loneliness, happiness, and understand.

**An evaluation of the effectiveness of a ‘rolling’ low intensity CBT group programme in an IAPT service**


Abstract: The Improving Access to Psychological Therapies (IAPT) programme endeavours to increase accessibility of evidence-based psychological support (Whitfield, 2010) and reduce waiting times for treatment (NHS England, 2014). Group CBT interventions are currently recommended by NICE to treat mild to moderate Depression (NICE, 2009) and Generalized Anxiety Disorder (NICE, 2011). A “rolling” group format allows immediate access to treatment for patients deemed appropriate at assessment. There has been little research to date evaluating the effectiveness of this format for providing low intensity CBT interventions in primary care psychological services.

This service evaluation examined the outcomes of two six-week, low intensity CBT rolling groups in an IAPT service: Stress and Worry (worry management) and Mood Boost (behavioural activation). The rolling format allowed participants to join a course within one week of their initial assessment, with a new aspect of the topic covered each week for six weeks. The courses were offered as a ‘stand-alone’ low intensity treatment or as a waitlist intervention for further treatment (usually one-to-one CBT).

Participants included all course attendees over a 12 month period who had complete outcome measures (PHQ-9 and GAD-7) at their assessment and their final course session for either Stress and Worry (n=205) or Mood Boost (n=136). Recovery rates were calculated using a subset of attendees who were within the clinical range at assessment. Reliable improvement rates were calculated using all participants, regardless of their initial score. Both rates were subsequently determined for participants who had completed the full six sessions. Recovery rates for participants who did not go on to receive high intensity treatment were also calculated.

The recovery rate for the Stress and Worry course was 41.0%, and 58.5% of participants showed reliable improvement. For those who attended all six sessions, the recovery rate was 52.7% and reliable improvement was 58.1%. For Mood Boost, the recovery rate was 28.4%, with a reliable improvement rate of 47.8%. For those attending all six sessions, the recovery rate was 31.4% and reliable improvement was 53.7%.

When excluding those who completed further high intensity treatment, the recovery rates were 45.0% for Stress and Worry and 29.3% for Mood Boost. For participants attending all six sessions, the recovery rates were 61.1% and 33.3% respectively. The Stress and Worry course showed recovery rates that were on par with the overall IAPT recovery rates (41%) for the London Commissioning Region during a similar time period (HSISC, 2014). For those attending the full Stress and Worry course, recovery rates exceeded the national IAPT recovery rate target of 50%. Although the Mood Boost course had less successful recovery rates, almost half of the course attendees showed reliable improvement, suggesting that this course may be more useful as a waitlist intervention than as a stand alone course of treatment.
These courses appear to be a promising format for delivering prompt access to CBT treatment while having a meaningful impact on symptoms of depression and anxiety. This group format can allow IAPT services to meet waiting time targets and improve patient experience.

**Impact of a Progressive Stepped Care Approach in an Improving Access to Psychological Therapies Service: An Observational Study**

Lisa Boyd, TEWV, Emma Baker, TEWV; Joe Reilly, Durham University

The national Improving Access to Psychological Therapies (IAPT) programme advocates stepped care as its organizational delivery, (Clark 2011, Gyani, Shafran, Layard, & Clark 2013), yet there is limited evidence regarding the efficacy of stepped care as a service model, heterogeneity of definition, and differences in model implication in both research and routine practice. (e.g. Richards &amp; Borglin 2011 Richards et al 2012). NICE guidelines appear to advocate a mixed model of matched and pure stepped care, and given the apparent variety of definition in organizational delivery, outcome comparison in terms of effectiveness of model is difficult. (Richards, Bower, Pagel, Weaver, Utley, Cape, Pilling, Lovell, Gilbody, Leibowitz, Owens, Paxton, Hennessy, Simpson, Gallivan, Tomson Vasilakis. 2012).

Despite sound evidence of the efficacy of low intensity interventions (e.g. Bower; Kontopantelis, Sutton, A Kendrick; Richards; Gilbody, Knowles, Cuijpers; Andersson, Christensen; Meyer, Huibers; Smit; Van Straten, Warmerdam, &nbsp;Barkham, Blich, Lovell, and Liu, 2013), there appears to be a perpetuation of the notion that severity and complexity should only be treated by a high intensity intervention, through the continuation of a matched care model, yet no psychotherapy treatment is found to be more superior than another, (Barth, Munder, Gerger, Nuesch, Trelle, Znoj, juni, Cuijpers 2013), and not enough is known about what works for whom to aid the matching of treatment decision. (Richards et al 2012). In the absence of understanding precise treatment factors optimal for recovery, it may be useful to better understand the impact of a service delivery model, and whether different models achieve different outcomes.

This study aims to contribute to the discussion regarding the stepped care definition and delivery, and explores the impact on clinical outcomes where different types of stepped care have been implemented within the same service. An observational cohort study, analyzed retrospective data (n= 16,723) over a 4 year period, in a single IAPT service, where delivery changed from one type of stepped care model to another.

We compared the outcomes of treatment completers with an allocated/matched care model and a progression/pure stepped care model. We also explored the assumption that patients who score severe on psychological measures, and therefore are potentially complex, would achieve better outcomes in a matched care model. Outcomes in each model type were compared, alongside baseline factor variables. All cohorts were subject to chi square tests and logistic regression to explore the predictive effect of variables. A significant association was observed between a recovery outcome and model type, with patients 1.527 times more likely to recover in the progression/pure stepped care delivery model. Details of the results are discussed including an analysis of baseline factors such as patient characteristics and psychological measure initial severity score, and their relationship with a recovery outcome.

Alongside methodological limitations the discussion builds on the exploration of factors linked with better outcomes, the clinical, service design and delivery implications, and future research.

With a progression stepped care model of service delivery, more patients can be treated with a lower intensity intervention, even with initial severe presentations, ensuring that only those that need high intensity CBT or equivalent are stepped up. This provides services with an effective clinical model that is efficient and potentially more cost effective.

**Improving Access to Psychological Treatment in Primary Care through Transdiagnostic Cognitive Behavioural Group Therapy**
Hafrún Kristjánsdóttir, Reykjavík University; Jón Friðrik Sigurðsson, Reykjavík University; Paul Salkovskis, University of Bath; Baldur Sigurðsson, Landspítali - University Hospital of Iceland; Engilbert Sigurðsson, University of Iceland

Background: The development of initiatives to improve access to psychological therapies has been driven by the realisation that untreated anxiety and depression are both very common and costly to individuals as well as society. Effective and efficacious treatments, mostly in the form of cognitive behavioural therapies (CBT), can be used in ways which enhance their acceptability and accessibility. In recent decades numbers of group CBT treatment options have been developed to improve cost efficiency. The vast majority of these therapies have been disorder specific. In the last few years there has been growing interest in transdiagnostic therapies, but in spite of the growing interest, group therapies have largely remained diagnosis specific.

Objectives: The overall aim of this research was to evaluate the effectiveness of an Icelandic transdiagnostic cognitive behavioural group treatment (TCBGT) protocol. Two studies were designed to achieve this aim: I) Evaluate the effectiveness of the Icelandic TCBGT and the impact of comorbidity on treatment outcome, and II) evaluate the treatment effects of TCBGT on disorder-specific symptoms and what (if any) differences would be observed in the treatment effects with regard to general as opposed to disorder specific symptoms measured pre- and post-TCBGT

Method: In study I the participants were 281 adult patients in primary care with diagnoses of depression and/or anxiety disorders. They underwent five-weeks of TCBGT. Differential effects of treatment according to diagnostic groups and number of diagnoses were evaluated. Study II was conducted on 101 adult patients with diagnoses of depression and/or anxiety disorders, who underwent a six-week TCBGT. Treatment effects for general and disorder specific symptoms were compared.

Results: The results of study I showed that pre-post differences were significant and the treatment (TCBGT) was not different in terms of effectiveness for both anxiety disorders and depression. Neither number of diagnoses nor diagnostic groups affected the outcome. In study II it was shown that pre-post differences were significant and the treatment effects were not different for both general as well as disorder-specific symptoms.

Conclusion: The Icelandic TCBGT protocol is feasible for a wide range of mood and anxiety disorders in primary care and the treatment delivers similar effects on general and disorder-specific symptoms. The results indicate that low intensity transdiagnostic group therapies may be a feasible way to improve access to psychological therapies for members of the public, e.g. in primary care.

The results indicate that low intensity transdiagnostic group therapies may be a feasible way to improve access to psychological therapies for members of the public, e.g. in primary care.

Investigating professional issues: training, supervision and research

The Heterogeneity of Clinical Supervision Models for Psychotherapies: A Content Analysis
Chloe Simpson-Southward, University of Sheffield, Glenn Waller, University of Sheffield; Gillian Hardy, University of Sheffield

Clinical supervision for psychotherapies is widely used in both clinical and research practices. It is often assumed that supervision ensures adherence in therapy and positive client outcomes. While there is actually very little empirical research in this area, there are numerous models of supervision. This paper discusses which aspects of supervision are consistent across models, which are not, and which aspects of supervision we would expect to be included but are not.

To investigate what these models tell us about the process of supervision, a content analysis of over 40 commonly used models was conducted.

Overall, models tend to focus on the formative (learning and development) aspects of supervision, but there is less focus on the normative (managerial and ethical) and restorative (emotional) aspects. Looking at the individuals involved in the therapeutic triad, models mainly focus on the therapist, then the supervisor, and only around half of the
models specifically focus on the client. This lack of client focus is reflected in the assessment aspects of the models. While evaluation is recommended by many of the models, only five mention directly assessing the progress of the client. Finally, although almost all models cite research, none are directly based on a piece of empirical research. While we might expect clinical supervision and supervision models to contribute to positive client outcomes, findings indicate that models actually have very little focus on the client. In addition, these models are not directly based on empirical research. As there is such little focus on the client, perhaps we cannot rely on supervision models to ensure positive therapeutic outcomes within clinical practice.

Implementation of a measure of expected engagement in an IAPT sample: Initial Findings
Phillippa Harrison, University of Sheffield, Gillian Hardy, University of Sheffield; Michael Barkham, University of Sheffield
Cognitive Behavioural Therapy (CBT) and Counselling for Depression (CfD) are both effective interventions recommended as treatments for moderate to severe depression. IAPT provides both types of intervention but with no formal guidelines for PWP s on how to decide which one to refer a patient to. There is evidence that pre-therapy expectations can be used as an effective tool for matching patients to the most effective therapy. Patient expectations are sometimes taken into account by PWP s but may not be based on sufficient patient knowledge of the core goals and methods used in each intervention. Furthermore, stigma and reputation associated with a certain treatment may influence expectations. Engagement with therapy is a strong predictor of drop out but there is little research on expected engagement, although measuring credibility and expectancy is commonplace. The aim of the study is to determine whether there are significant differences in expected engagement with CBT and CfD components when their therapeutic orientation is unknown. A further aim is to explore whether expected engagement differs from overall expectations of and preferences for CBT and CfD. An initial sample of 50 IAPT patients stepped up to step 3 treatment completed a measure of expected engagement with CBT and CfD components. Participants completed the questionnaire at screening prior to therapy as part of the PRaCTICED trial. The questionnaire consisted of 15 therapeutic components taken from the Cognitive Therapy Scale Revised (CTSR), The Person Centred and Experiential Psychotherapy Scale (PCEPS) and the Sheffield Psychotherapy Ratings Scale (SPRS). Participants were asked to rate each component for how much it would engage them with therapy if they were to receive it. Results to be included when data collection complete in May. A high expected engagement score for one therapy over the other would indicate that some therapies suit patients more than others. If expected engagement with therapeutic components differs to overall expectations and preferences, this could indicate that current measures are not capturing all of the information required to match a patient to the most effective therapy. CBT has become widely known amongst laypeople. However, this had led to some misconceptions about the treatment involved. If an individual is unlikely to engage with the methods and core goals of CBT, this could increase the likelihood of drop out from treatment which is a drain on resources for those who would benefit from this approach. By implementing a therapy matching tool prior to therapy, it is possible to predict who is likely to benefit from CBT and to provide those who are unlikely to benefit with an alternative therapy that may better suit them as an individual.

Describing CBT trained mental health professionals' views towards and motivation for BABCP accreditation.
Ben Parkinson, Glasgow Caledonian University, University; Raymond Ndengeya, University of the West of Scotland; Dougie Marks, University of the West of Scotland
Abstract: The large-scale dissemination of Cognitive Behavioural Therapy (CBT) has made the issue of quality control and clinical governance of psychological therapies more salient. Increasingly CBT trained mental health professionals are seeking non-compulsory
accreditation with the British Association for Behavioural and Cognitive Psychotherapies (BABCP), even though, many already have statutory regulation and voluntary self-regulation traditionally being a divisive issue within the field of counselling and psychological therapies.

The aim of this study was to describe CBT trained mental health professionals' views towards and motivation for BABCP accreditation.

Seven CBT trained mental health professionals [six mental health nurses and one occupational therapist] were recruited in Scotland during early 2015. Qualitative data was collected from participants using face-to-face semi-structured interviews. Interviews investigated participants' views towards and motivation for BABCP accreditation and used verbatim transcripts and inductive Thematic Analysis to identify themes.

Thematic Analysis generated five major themes and twelve minor themes. Participants saw BABCP accreditation as having personal value and recognise the benefits of accreditation from a career development and CBT therapist identity perspective. However, some participants reported an absence of motivating factors and experienced barriers with the accreditation process. Specifically, the personal administrative burden and the lack of appropriate clinical supervision appear the main barriers for participants seeking BABCP accreditation. These elements can potentially cause ambivalence and frustration amongst some CBT trained mental health professionals when considering BABCP accreditation.

This study illuminates our understanding of CBT trained mental health professionals views towards and motivation for BABCP accreditation. Specifically, it highlights the challenges faced by some qualified and experienced CBT trained mental health professionals seeking BABCP accreditation. The barriers faced by some CBT trained mental health professionals include: a potential lack of motivating factors; difficulty overcoming the administrative burden of the application process; and difficulty accessing suitable clinical supervision, with appropriate levels of live supervision. These findings suggest it is a pertinent time to consider strategies for supporting aspiring CBT trained mental health professionals with BABCP accreditation. These strategies could include using e-portfolios for the application process and establishing a database of CBT supervisors familiar with the BABCP requirements and a willingness to provide regular live supervision.

Conclusions:

CBT trained mental health professionals see the value in BABCP accreditation from a career development and CBT therapist identity perspective, but report barriers and an absence of motivating factors when considering BABCP accreditation. CBT trained mental health professionals aspiring for BABCP accreditation might benefit from using e-portfolios to reduce the administrative burden associated with BABCP accreditation. Likewise, creating a database of CBT supervisors available to support CBT trained mental health professionals through the accreditation process and provide the necessary live supervision might facilitate the accreditation process.

Barriers and facilitators to engaging people in clinical trials: qualitative analysis from three psychological therapy trials for bipolar disorder

Sarah Peters, University of Manchester; Rebecca Sutton, University of Manchester; Lisa Riste, University of Manchester; Rita Long, Lancaster University; Steve Jones, Lancaster University

Engaging patients and service users in mental health trials can be challenging. Poor recruitment and high attrition has implications for the feasibility and generalizability of findings. However, patient perspectives of experiences of clinical trials and barriers and solutions to staying involved remain largely unrepresented. The aim of this qualitative study...
was to examine the perspectives of people with bipolar disorder who had been invited to take part in a randomized controlled trial (RCT). 

A secondary analysis of transcribed semi-structured qualitative interviews with service users who had been invited to take part in one of three RCTs of psychological therapy for bipolar disorder was undertaken. The sample of 50 participants comprised service users from a group psychoeducation trial (n= 18); a trial of cognitive behavioural therapy for comorbid anxiety (n= 17) and for co-morbid alcohol use (n= 15). Data were organised within NVivo and subjected to thematic analysis.

Analysis revealed factors that impacted upon their engagement with research. Taking part in a clinical trial involved an active decision by the service user to understand and manage their illness, to be part of and help a community, and to access psychological treatment. Feeling valued by the research team was central to engaging and remaining within the trial, as was their understanding of the mechanics of clinical trials.

Investing at the outset in ways of ensuring potential and actual participants feel engaged with the trial process and team is likely to increase recruitment and reduce attrition, and thereby improve the feasibility and robustness of clinical trials for people with mental health problems.

The current evidence base for CBT is limited by the types of participants who engage with clinical trials. Ensuring the patient voice is part of how trials are set up will increase the generalizability of findings and hence ensure research-informed developments in CBT meet the needs of those in clinical services.

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**Clinical Skills Classes**

**Developing, Testing and Evaluating Complex Interventions: a Health Services Research Methods Workshop**

David A. Richards, Professor of Mental Health Services Research, University of Exeter Medical School, Exeter, UK

Scientific background and description of skills class:

Most modern health care interventions are now seen as 'complex interventions' – activities that contain a number of component parts with the potential for interactions between them which, when applied to the intended target population, produce a range of possible and variable outcomes. Furthermore, recent reports on avoidable waste in the conduct and reporting of research have re-emphasised the need for guidance to help researchers make appropriate methodological and practical choices. Some of the sources of waste, such as inefficient priority-setting, failure to take account of what is already known, poor design and incomplete reporting, are matters that all researchers should take seriously.

Given that an estimated 85% of all research funded and undertaken can be regarded as 'waste', that it takes around 17 years for effective treatments to be routinely implemented, and that disinvestment in ineffective treatment is rarely achieved, researchers and clinicians require methodological developments that take into account changing values and attitudes related to the situation of patients receiving health care.

In this workshop participants will consider how to initiate programmatic research that can develop, test, evaluate and implement clinical findings whilst also minimising the potential for research waste.

Key learning objectives:

1. Be familiar with the theories and concepts that underpin complex interventions research methods in healthcare provision
2. Understand sources of, and methods to reduce, waste in research practice
3. Understand the importance and challenges in undertaking mixed methods evaluations of health care interventions
Training modalities
Presentation, discussion, group activities

2-3 key references

Implication for everyday clinical practice of CBT
CBT prides itself as an evidence based psychotherapeutic discipline. However, along with most other medical and health care interventions, much research evidence is neither developed properly nor implemented as developed. In many ways, research conduct in CBT does not meet the current methodological or reporting standards of modern health services research practices. A sharper focus on the process of developing evidence using up to date approaches to complex interventions research methods will help reduce waste and deliver better quality evidence for CBT practice.

Brie description of presenter(s)
David A. Richards is Professor of Mental Health Services Research at the University of Exeter Medical School. For many years he has been at the forefront of national and international efforts to improve access to treatment for those suffering from high prevalence mental health problems such as depression. A nurse by professional background, he is a UK National Institute of Health Research Senior Investigator, President of the European Academy of Nursing Science and chair of the European Science Foundation REFLECTION Research Network Programme, an interdisciplinary European Faculty of researchers, equipped to design, plan and implement programmatic, mixed methods and complex interventions research. He has frequently challenged the research community to reduce waste in their work by refocussing their research activity towards clinically relevant programmes, driven by the uncertainties of clinical practice and the real concerns of the public, patients and clinicians.

Beyond reliving in PTSD treatment: Advanced skills for overcoming common obstacles in memory work

**Hannah Murrary and Sharif El-Leithy, Traumatic Stress Service, South West London & St Georges NHS Trust**

Good evidence exists for PTSD treatments in which memory-focused techniques such as imaginal reliving and prolonged exposure play a significant role. However, the evidence base is sparse for complex presentations of PTSD, for example where trauma has been experienced in early life, or is prolonged and severe. There are gaps in our understanding of how to adapt existing protocols to apply these treatments effectively with complex cases in routine clinical settings. Revisiting the principles and theories underlying treatment can help us generate novel, and adapt existing, techniques to overcome these difficulties.

This workshop will bring together cognitive models of PTSD and memory, core CBT principles, and advanced therapeutic techniques to solve commonly encountered obstacles in PTSD treatment, such as overwhelming affect, difficulties connecting with feelings and memories, head-heart lag and problems identifying target memories in multiple trauma presentations.

Objectives
- Identify common obstacles in working with trauma memories
- Apply principles from existing cognitive models of PTSD to formulate these problems
- Understand how diverse memory techniques can be conceptualised using these models
- Learn practical ways to implement these techniques creatively while maintaining fidelity
to cognitive models.

Training Modalities

The workshop will complete Kolb's learning cycle using case material to present clinical examples of commonly encountered problems in PTSD treatment, theoretical frameworks to conceptualise these problems, generate solutions using a broad range of memory and experiential techniques, and give opportunities for participants to practice and reflect on using these techniques in their own work.

Four key problem areas will be explored. For each area, a range of clinical examples will be presented, and generated from participants' experiences. Fundamental principles will be applied to understand these difficulties; and how techniques from a range of models can be adapted to address the conceptual obstacles. Practical examples and tips on how to implement these techniques will be given, and participants will be invited to reflect on and role-play how they will apply similar strategies to their own cases.

References


Leaders

Drs Hannah Murray and Sharif El-Leithy are Clinical Psychologists based at the Traumatic Stress Service in South-West London. Between them they have 25 years of experience in working with complex cases of PTSD using trauma-focused CBT and supervise, teach and research widely in the field.

Implications

The workshop will equip therapists working with PTSD and other trauma-related difficulties with principles, conceptual frameworks and practical skills to overcome commonly-encountered obstacles.

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**Behavioural Management of Migraine and Tension-type Headache**

**Paul Martin, Griffith University, Australia**

The workshop is based on an updated version of an approach first published in a book (Martin, 1993). The approach follows a cognitive behaviour therapy tradition that has been shown to be highly effective (Martin et al., 2007), and is driven by a functional model of headaches. The workshop begins with an introduction to headache and migraine – diagnostic types, prevalence and associated disability, and peripheral and central mechanisms. The research literature on behavioural treatment of headache will be briefly reviewed. The focus will then be on assessment and treatment and includes education, relaxation training, cognitive therapy, and our approach to trigger management called ‘Learning to Cope with Triggers’.

Objectives

1. Participants will understand the traditional medical approach to migraine and tension-type headache, the diagnostic criteria for these disorders, and danger signs that prompt referral to a neurologist.
2. Participants will understand the functional model of headaches as an alternative to the traditional approach and how it can be used for guiding psychological assessment and treatment.
3. Participants will have acquired knowledge of the headache research literature.
4. Participants will have learnt general assessment methods and more specialised assessment methods, and when it is appropriate to use them.
5. Participants will have learnt how to carry out treatment methods.
Training Modalities

The content of the workshop will include a discussion of the relevant research literature, presentation of a model to guide assessment and treatment, description of assessment techniques and treatment techniques. Case studies will be used to illustrate the approach. Each section of the workshop will involve discussion between the participants and presenter. As the presenter has 40 years of experience in the headache domain, as a researcher, clinician and educator, he is in a good position to vary the workshop according to the wishes of the participants. For example, a greater focus on children if that is what the participants would like. If even some of the participants have experience treating headaches or a cognate disorder such as chronic pain, then the experience of these participants can be incorporated into the workshop.

References


Implications

An article published in Lancet in May 2015 identified headache disorders as the third cause of disability worldwide. Behavioural interventions for headaches are highly effective. For example, in an RCT of our approach there was a reduction of 68% in headaches from before to after treatment, and the reduction had increased to 77% at 12-month follow-up. This is in contrast to pharmacological approaches that achieve a reduction of less than 30% as well as being associated with adverse side effects and high medication over-use potential. The irony is that a tiny proportion of headache sufferers receive behavioural interventions. This workshop will prepare the registrants to carry out such interventions.

Professor Paul Martin has been engaged in research on headache and migraine since completing his doctorate at Oxford on this topic in the mid-1970s. Over the last 40 years, his research program has included laboratory studies and RCTs supported by funding from the National Health and Medical Research Council. He has also seen patients with headache and migraine in his clinical practice throughout this period on three continents. He presents a workshop on this topic most years to the postgraduate students in clinical psychology, and has presented 20 workshops at national and international conferences (Australia, USA, Canada, Denmark, Italy, Thailand).

We know what you did last summer (and it wasn’t always CBT): how to notice and minimise therapist drift

Blake Stobie, South London and Maudsley NHS Trust and Glenn Waller, University of Sheffield

Background

Clinician fidelity to evidence-based treatment protocols is routinely monitored in clinical trials, but suboptimal clinician deviations in the deliveries of treatments for obsessive compulsive (Stobie et al., 2007), eating (Tobin et al., 2007) and other disorders have been reported by both clients (Stobie et al., 2007) and clinicians (Kosmerly et al. 2015). Waller’s (2009) paper provides a thorough overview of the causes of therapist drift along with proposed solutions, and experts in the field (Shafran et al., 2009) have also proposed improving training and dissemination to bridge the gap between the map of research
findings and the territory of clinical practice.

This skills class evolved from the presenters’ observations that teaching clinicians about drift often results in low mood or defensiveness (neither of which may be particularly helpful in motivating change or better adherence!). Empirically derived techniques become more meaningful to clinicians when they are linked to case examples: how to implement these techniques becomes more understandable when demonstrated live; and this improves still further when clinicians experience and experiment with this themselves. The primary aim of this skills-based workshop is to use the presenters’ clinical case materials, examples from supervision and experiential exercises to illustrate how these problems apply to all clinicians, and to consider how best to minimize the effects of our own bias and unhelpful behaviours.

Objectives
By the end of the workshop, participants should be able to:
(1) Relate the theoretical principles of therapist drift to their own clinical practice and experiences
(2) Have practiced generating practical strategies for tackling this drift
(3) Normalise drift without accepting it
(4) Have a framework for bringing and addressing drift issues routinely in supervision

Training Modalities
Discussion
Presentation of case and supervision material
Role play

References

Leaders
Blake Stobie is a Consultant Psychologist at the South London and Maudsley Trust. Blake leads a team offering outpatient CBT to people with “treatment resistant” OCD who have not made or maintained gains from multiple previous evidence-based treatments. Glenn Waller is a Professor in the Department of Psychology at the University of Sheffield, where he has a particular interest in the translation of evidence-based approaches into real-life clinical settings, and a Consultant Clinical Psychologist specializing in the treatment of eating disorders. Glenn has published 250 journal articles, and two books on the treatment of eating disorders.

Implications
This skills class is applicable to the clinical work and supervision of all CBT practitioners. The focus is on recurrent problems which occur in the delivery of treatment and strategies for addressing these. We hope that the case material and implications for supervision will appeal to a broad audience, who will find the points helpful in improving their practice.

Understanding and managing dissociation in PTSD

Adele Stevens and Sam Akbar, Forced Migration Trauma Service, Central West London NHS Trust

Background
The workshop is based on Elbert & Schauer’s (2010) paper which outlines a psychophysiological understanding of dissociation in response to traumatic events. This provides a theoretical model for understanding the dissociative symptoms people often experience after traumatic events, as part of a PTSD symptom profile. Elbert & Schauer (2010) propose that traumatic situations trigger a defence cascade, a coherent sequence of six fear responses that escalate as a function of the appraisal of the threat and perpetrator together with appraisals of the individual’s ability to defend themselves against this threat. The cascade of defence stages a survivor has gone through during the traumatic event will repeat itself every time the fear network or trauma memory, which evolved peri-traumatically, is activated again (i.e. re-experiencing symptoms and during memory processing as part of trauma focused therapy). When a parasympathetically dominated “shutdown” was the prominent peri-traumatic response during the traumatic incident, comparable dissociative responses may dominate when the traumatic memory is reactivated. This model of dissociative PTSD symptoms leads to a number of strategies that can be used by clients and therapists doing trauma focused therapy. This is especially helpful with clients who have experienced type II traumas (i.e. prolonged and repeated trauma) where dissociation can often be part of the PTSD symptom profile. In the workshop we will provide a clear description of the defence cascade which will enable clinicians to explain this to clients as part of PTSD psychoeducation. This serves to normalise these often confusing symptoms for clients and can reduce shame associated with certain responses that may have occurred during a traumatic event. This also helps provide a rationale for using symptom management strategies targeting dissociation. The session will focus on ‘what’ clinicians can do to help clients manage dissociation and ‘how’ they can do this. We will describe and role play the strategies which will make this a clinically useful and practical session, providing attendees with clear strategies they can use in their clinical work.

Objectives
The main objectives are:
1. Provide attendees with psychophysiological understanding of dissociation in PTSD which they can use in their clinical practice, both directly as part of PTSD psychoeducation and indirectly to formulate and manage dissociation.
3. Develop attendees confidence using these strategies through demonstration by the facilitators and opportunity for attendees to role play and facilitators will help problem-solve any questions which arise from this.

Training Modalities
There will be a smaller didactic component but the focus will be on developing clinical skills for working with dissociation in PTSD so there will be demonstrations by the workshop leaders and opportunity for role play.

References

Leaders
Adele Stevens works as a Clinical Psychologist in the Forced Migration Trauma Service and Berkshire Traumatic Stress Service. She holds full BABCP accreditation and completed a CBT PGDip at the Institute of Psychiatry. She has also worked as a CBT supervisor and visiting lecturer on PGDip for Evidence-based Psychological Treatment (HI IAPT course) at the Charlie Waller Institute. Sam Akbar works as a Clinical Psychologist at the Forced Migration Trauma Service. Prior to this she worked in a Community Recovery Team. She holds full BABCP accreditation and has also completed intermediate and advanced level training in Acceptance and Commitment Therapy.

Implications
Many clients with PTSD experience dissociative symptoms. This is even more common in
clients who have suffered repeated or prolonged traumas and present with complicated and complex PTSD. This skills session aims to equip clinicians working with clients with PTSD with a clinically useful evidence-based explanation of these symptoms, which is de-shaming and helpful for clients. This explanation provides a rationale for engaging clients in symptom management and grounding strategies which will help them to effectively manage dissociation. This also facilitates engagement in memory processing as part of trauma focused CBT, as well as other evidence based approaches to PTSD (EMDR and NET).

Building shame resilience in OCD

Tara O’Donahue and Lisa Williams, South London and Maudsley NHS Trust

Background

Objectives
- Understanding and working with shame in OCD populations
- Using CBT and CFT techniques to help reduce shame
- Helping clients to build shame resilience and compassionate flexibility.

Training Modalities
- Role play
- Video
- Experiential
- Case discussion

References

Implications
Understanding that shame doesn’t just lie within our clients but within us all. The workshop will help therapists understand the need for common humanity across populations to reduce shame experiences promoting acceptance and compassionate flexibility impacting positively on clients, staff, families and communities as a whole. Therapists will gain skills and insights to help formulate and clinically work with and build shame resilience.

Leaders
Tara is a senior CBT and CFT psychotherapist specialising in assessment and treatment of OCD at the national Specialist unit for OCD alongside Dr David Veale- The Anxiety Disorders Residential Unit, The Royal Bethlem, South London and Maudsley. The unit was recently part of the channel 4 series ‘Bedlam’. She has published an article with Dr David Veale focussing on behavioural change (featured in BABCP journal) and has presented about OCD nationally for the BABCP, Derby University and Oxford Therapy centre.
Lisa Williams is a senior CBT and CFT psychotherapist who has worked for over 15 years in mental health services including primary and secondary care. Lisa now specialises in the assessment and treatment of OCD at the national Specialist unit for OCD alongside Dr David Veale- The Anxiety Disorders Residential Unit, The Royal Bethlem, South London and Maudsley.
Lisa also works at Canterbury Christchurch University as an honorary lecturer and runs CBT and CFT workshops both nationally and internationally

‘What if the bad men come back?’ Assessing and Formulating Child and Adolescent Trauma that is ongoing

Alistair Black, Police Rehabilitation and Retraining Trust

Background
Ideally the evidenced based treatment of child and adolescent trauma occurs in a safe secure setting where the impact of the past can be addressed. Increasingly however those treating children and adolescents who have experienced traumatic incidents are being faced with the challenge of the distinct possibility that the traumatic event may reoccur. This raises specific complications in how CBT cases that are subject to on-going risk are formulated and therefore treated. This workshop will focus on these ‘at risk’ child and adolescent populations and the challenge of ‘untangling’ what is a ‘real’ risk and what is symptom driven perception. Participants will specifically explore how to develop bespoke formulations that take into account current threats, avoidance versus safety needs and future catastrophising and realistic fears. Focus will also be placed on setting realistic goals for treatment in the ‘at risk’ context.

Objectives
Participants will -
- Discuss a working definition of complex trauma in children and adolescents.
- Examine trauma from a past, present and future perspective within the CBT model using a timeline model.
- Use the 'Bottle Model' of trauma to provide an age appropriate treatment rationale for the understanding and treatment of on-going trauma.
- Discuss Autonomic, Behavioural and Cognitive symptoms within a triple I model of risk impact - Immediate, Intermediate and Indefinite.
- Identify challenges that need to be incorporated into the CBT treatment plan in the at risk context including distinguishing between vigilance and hyper vigilance, when does safety planning become a reinforcer and setting up safe behavioural experiments. The impact of parental psychopathology and their safety behaviours will also be explored.
- Produce realistic behavioural goals that are contextually appropriate and flexible if required.

Training Modalities
Training modalities will include, didactic, case presentation, case discussion and a small group formulation exercise.

References

Leaders
Dr Alastair Black is Consultant Psychotherapist - Head of Psychological Therapies at the Police Rehabilitation and Retraining Trust in Northern Ireland which provides treatment for officers, spouses and children who have been impacted by terrorist threat and violence. He is a BABCP accredited Therapist, Trainer and Supervisor. Alastair is Honorary Consultant Psychotherapist to Beechcroft Regional Child and Adolescent In-Patient Unit and also provides consultations to out-patient CAMHS staff who treat children often within high risk environments. He has provided consultations to the UN and the MOD regarding the on-going impact of terrorist related trauma and has consulted on a recent CBT project with child soldiers in the Congo. He lectures at Queen's University Belfast Educational Child and Adolescent Psychology Doctorate programme.

Implications
This workshop is relevant to any CBT clinician who works with children and adolescent populations who find themselves developing psychological symptoms but who continue to live in at risk environments. These risks may be internal within the family unit or external within the broader community. This workshop may have particular relevance to those working within Refugee populations, Armed Forces families, those experiencing on-going school bullying or those living within geographical areas of high threat of violence.
Jennifer Wild, University of Oxford

Scientific background and description of skills class:
Post-traumatic stress disorder (PTSD) is a common problem that develops in some people after trauma and is linked to high rates of comorbidity, chronic disability, and long-term health care costs. Trauma-focused cognitive behavioural therapy (TF-CBT) has an established evidence base and numerous guidelines recommend this approach as a first line treatment for the disorder. A core component of TF-CBT is working on the trauma memory, an often daunting prospect for clients, so that it may be updated. Exciting advances in technology allow novel methods of approaching trauma memories in TF-CBT that may facilitate a client’s readiness to work on them, access new information to update them, as well as new methods to sustain gains. Our research shows that digital methods help some clients make gains sooner than when no such methods are used in treatment.

Key learning objectives:
1. To learn how to use stimulus discrimination with digitised sounds and images to work with dissociation before working on trauma memories
2. To learn audio methods for helping your clients tell their trauma story
3. To learn how to use google street view to visit the site of a trauma remotely, practise stimulus discrimination, and update trauma memories with new information
4. To learn how to create still images to capture new information and help to update traumatic imagery
5. To learn how to use smartphones to sustain gains

Training modalities:
Video demonstration
Lecture
Role play

2-3 key references

Implication for everyday clinical practice of CBT
Working on trauma memories is an essential component of TF-CBT. This workshop will demonstrate the latest methods in how to work on trauma memories safely and effectively making use of everyday technology. Facilitating work on trauma memories is essential for helping clients to recover from PTSD.

Brief description of presenter(s)
Dr Jennifer Wild is a Consultant Clinical Psychologist and Associate Professor of Clinical Psychology at the University of Oxford. Her clinical research focuses on treatment development for PTSD and social anxiety disorder. Jennifer has a special interest in developing brief interventions to modify predictors of risk for emergency workers. She has recently completed the first large-scale prospective study of predictors of PTSD and depression in newly recruited ambulance workers, a study funded by the Wellcome Trust. She has collaborated and worked with Mind, the mental health charity, to evaluate a new resilience intervention for emergency workers and is currently analyzing the data from this important trial, the first of its kind. Jennifer is dedicated to raising awareness of common mental health problems and effective treatments. She regularly appears in the media giving expert advice on trauma-related problems. Most recently, she designed a programme for the BBC to illustrate key components of cognitive behavioural therapy for anxiety. In the programme, she treated five people with severe height anxiety, successfully helping them to overcome their fear of heights and embrace a life they dreamed of living. The programme, Vertigo Road Trip, aired on BBC One, attracting 2.2 million viewers.

Positive Behavioural Support and High Quality Behaviour Support Planning – Applications Beyond Developmental Disability Services
Jill Chaplin and Richard Hastings, University of Warwick

Regardless of diagnosis, setting or demographic, many people present with behavioural challenges that others find difficult to understand and manage. Positive Behavioural Support (PBS) is an evidence based approach that has emerged from the field of developmental disabilities. A PBS framework has potential benefits for many vulnerable groups. PBS is a multi-component framework which evolved from a synthesis of applied behaviour analysis, normalisation/social role valorisation and person centred values. PBS utilises both educational and systemic models, to improve the quality of life of an identified person whilst minimising behaviour that challenges. To deliver PBS, a written Behaviour Support Plan (BSP) is needed describing the personalised intervention, the data informing that intervention, and an analysis/formulation of the problems. Research suggests that the quality of BSPs is often very poor. However, training staff to identify the components of a high quality BSP, as part of a structured PBS Care Pathway can lead to significant improvements.

This class will describe the policy context, evidence base and core components of Positive Behavioural Support. A core developmental disabilities Positive Behavioural Support Care Pathway and its application to forensic and children’s services will be shared. Using case examples, participants will be taught to use a recognised quality audit tool, the Behaviour Support Plan Quality Evaluation Tool (BSPQEII) to rate the quality of BSPs. The application of PBS and BSPs beyond developmental disability services will be discussed.

Key learning objectives:
1. Participants will be able to identify the core components of Positive Behavioural Support
2. Participants will understand the purpose and main elements of a Behaviour Support Plan
3. Participants will be able to use the BSPQEII to rate the quality of a range of BSPs.

Training modalities
Presentation
Case Studies
Discussion
2-3 key references


Implication for everyday clinical practice of psychological interventions
High quality Behaviour Support Planning can be utilised across a range of services and settings to address challenging behaviour. The key to successful outcomes is an individualised treatment plan.

Brief description of presenter(s)
Jill Chaplin leads Positive Behavioural Support training and development for one of the largest mental health/learning disability NHS Trusts in the UK. She is an experienced clinician who is also trained to masters level in Applied Behaviour Analysis and is certified as a Behavior Analyst through the international accrediting body – the Behavior Analyst Certification Board. Jill has also carried out research on the quality of Behaviour Support Plans used in clinical practice.
Richard Hastings has carried out research on challenging behaviour and contributed to the UK evidence base for Positive Behavioural Support (PBS). Recently, he has been a core member of the Positive Behavioural Support Academy in the UK – producing a range of resources defining PBS for the UK context, and PBS tools for people with a learning disability, family carers, service providers, and commissioners/care managers.

**Tribe Matters: Using Radical Openness Social-Signalling Skills to Enhance Treatment Engagement and Outcome**

**Tim Carey, Centre for Remote Health, a joint centre of Flinders University and Charles Tom Lynch, University of Southampton**

When compared to other species, humans are not particularly robust—at least when it comes to pure physicality—i.e. we lack sharp claws, horns, thick hides, or protective fur. Yet since we have survived (and thrived), our physical frailty is proof that our survival depended on something more than individual strength, speed, toughness, or technological know-how. We survived because we developed capacities to work together in tribes and share valuable resources with other members of our tribe who were not in our immediate nuclear family. This required finding a means to ‘signal cooperation’ and ‘bind’ genetically diverse individuals together in such a way that survival of the tribe could override older ‘selfish’ response tendencies linked to survival of the individual.

Robust research has confirmed that signalling matters when it comes to psychological well-being—e.g. chronic inhibition or disingenuous expression of emotion has been linked to social isolation, poor interpersonal functioning, and severe and difficult-to-treat mental health problems, such as anorexia nervosa, autism disorder, chronic depression, and obsessive-compulsive personality disorder.

Based on 20 years of research, two NIMH funded randomized controlled trials with refractory depression (RCTs), two open-trials targeting adult Anorexia Nervosa, one non-randomized trial targeting treatment resistant overcontrolled adults, and an ongoing multi-center RCT in the UK (REFRAMED; funded by EME-MRC) the aim of this talk is to provide a brief overview of some of the theoretical foundations underlying a new transdiagnostic treatment approach for disorders of overcontrol—known as Radically Open-Dialectical Behavior Therapy (RO-DBT; in press Guilford Press). Novel approaches designed to facilitate social connectedness will be introduced—including nonverbal social-signaling skills linked to the mirror neuron system and the establishment of trust, behavioral strategies designed to activate a neurobiologically-based social-safety-engagement system, and new radical openness mindfulness skills involving self-enquiry and ‘outing oneself’ that signal a willingness to learn from what the world has to offer—using slides, handouts, video clips, and role plays.

**Working with transgender & gender non conforming individuals**

**Saju Padakkara, Leeds Gender Identity Service**

Background

Mental health professionals need good understanding of gender diversity in order to help Transgender and gender non conforming individuals. The evolution in terminology in this field has been rapid and many professionals needs to update their knowledge to appreciate non binary gender identities. There is increased psychological co morbidity, partly due to social stigma, discrimination, marginalization and transphobia. They also experience psychological conflicts with regard to self acceptance, coming out and living fully in their true gender. Clinically the clients may present with low self esteem, depression, social anxiety, body dysmorphic concerns, eating disorders, self harm and addictions. Presence of autistic spectrum disorders is not uncommon. Clients may have had negative experience from health care professionals and this may affect their engagement in therapy. This workshop will aim to give CBT therapists confidence to work with this client group in non pathologizing and affirming ways.
Objectives
By the end of the workshop, participants will be able to
1. Distinguish between interrelated constructs of sex, gender identity, gender role and expressions
2. Assess gender identity and gender dysphoria by reviewing client’s gender history
4. Develop a respectful therapeutic relationship through reflecting on own biases
5. Adapt therapy models for co occurring psychological disorders without pathologization

Training Modalities
There will be a short didactic presentation to cover basic constructs and evolving terminologies and treatment overview in the field.

An experiential component to look at therapists attitudes and beliefs about gender variant clients.

Case vignettes will be used for an interactive discussion. Whole group discussion at the end of the session to generate guidelines for gender affirmative practices, using a strength based enabling approach.

References
WPATH (World Professional Association for Transgender Health) (2011): Standards of Care for the health of Transsexual, Transgender and Gender Nonconforming People. (accessible from www.wpath.org)

Leaders
Dr Padakkara Saju is a Consultant Psychiatrist working in Leeds Gender Identity Service. The service which is within the NHS sees more than 160 clients in a year. In addition to this role, Dr Saju works as a Medical Psychotherapist working in an NHS secondary care psychotherapy service with therapists from different modalities. He works as a CBT therapist in this setting. He also holds MSc in Family Systemic Therapy and interested to integrate helpful aspects of both models, particularly focusing on the strengths and resources within the client.

Implications
Psychological co morbidities in transgender population is high. CBT can address most of these co morbidities, but the model needs to be adapted given these clients experience their difficulties in a specific context around gender, self identity and expression. The distress is often the result of individual vulnerabilities coupled with real world social discrimination. A overly individual focus with deficit orientated/ pathologizing approach is harmful. The skills class would help CBT therapists with current knowledge to help these clients better, using a broader formulation and therapeutic interventions.

CBT 4u: How to be a more effective (and happier) therapist

Paul Blenkiron, Tees, Esk and Wear Valleys NHS Foundation Trust

Background
Is it possible to achieve your potential and have a rewarding career as a cognitive behavioural psychotherapist? What beliefs and behaviours lead clinicians to feel overworked and undervalued? Do you always apply the advice you offer colleagues and clients to yourself? If not, why not?

CBT is a flexible self-help approach that NICE consistently recommends as a first line treatment for many mental health conditions. The same principles also have a growing evidence base for effectiveness in the field of occupational health (Bamber et al, 2006). CBT can help professionals to deal with problems at work that can affect their performance and well-being.
This session will be of interest to all those who practice CBT - from beginner to advanced clinician. It will address common workplace difficulties including job stress, organisation change, demotivation, anger, relationship conflict and high self-expectations (Blenkiron 2010).

Objectives
This workshop aims to help therapists:
1) Apply the core principles of CBT to their own personal and professional development
2) Identify more helpful ways of thinking and reacting to workplace situations
3) Become more effective, motivated and happier clinicians

Training Modalities
The session will use a variety of teaching styles, including interactive presentation, case examples, small group exercises and a quiz.

References

Leaders
Paul Blenkiron is an NHS Consultant Psychiatrist in York with 15 years’ experience integrating CBT within daily practice. He is an accredited member of the BABCP, CBT Tutor for North Yorkshire and a national CBT trainer for the Royal Colleges of Psychiatrists and GPs. Awarded a NICE Fellowship in 2011, Paul acts as advisor to England's first National Books on Prescription scheme. He is Honorary Reader at Hull York Medical School, and author/co-author of over 100 publications, including the books CBT for Occupational Stress in Health Professionals, Stories and Analogies in CBT (now translated into Chinese) and The Female Mind.

Implications
This session will help therapists develop behavioural self-therapy (using time effectively, being assertive), cognitive self-therapy (developing more useful beliefs, managing professional guilt and perfectionism) and mindfulness (personal awareness) at work. There are wider benefits of this approach in helping practitioners to build on their strengths, set valued career goals, and achieve a ‘good enough’ work-life balance.

Adapting MBCT for adolescent clinical populations, including those with neuro-developmental disorders-implications for a CAMHS service delivery model

Brenda Davis, Brighton & Hove CAMHS, Sussex Partnership NHS Foundation Trust

Background
There is now an emerging evidence base for the effectiveness of adapted MBCT for child and adolescent clinical populations (Burke et al- 2010, Ames et al -2014), both for mood disorders and for co-morbid neuro-developmental disorders(Bogels-2008, Zyłowska-2008, Beer-2012) However, the mechanisms of change for this client population, and how they might differ from adult clinical populations, are still being explored, as well as their longer term effectiveness (Greenberg et al-2012, Harnett et al-2012).

In Brighton & Hove CAMHS, we have now been delivering and developing the MBCT group programme for over 4 years as part of our core service delivery model, as a means of enhancing and consolidating recovery when clients are no longer in an acute phase, and facilitating discharge. The workshop will present, both didactically and experientially, how we have adapted the content of our group programme in line with both the evidence base and our own quantitative and qualitative outcome data, with very encouraging positive post group results. It will also explore some of the proposed key elements that affect change, particularly those involved in the long term maintenance of skills/recovery.
Objectives
At the end of this class participants will be able to:
• Identify some of the main ways in which MBCT can be adapted to make it accessible to adolescent clinical populations
• Have experienced how and why some of these adapted practices may be effective
• Explore some possible ways in which MBCT could be used in their own services

Training Modalities
Experiential learning of key practices, role play, presentation of outcome data including video feedback, small group inquiry

Skills Class

References

Leaders
Brenda works as Consultant Psychology Lead for Brighton & Hove CAMHS, within Sussex Partnership NHS Foundation Trust, and also leads Sussex CAMHS-wide on CBT and MBCT, services for young people with Autistic Spectrum Disorders, and for young people with psychological problems associated with long term health conditions.
Brenda is a member of the Board of the BABCP, and committee member of the Child and Family SIG of the BABCP. As such, she has represented the BABCP on the CYP IAPT expert reference group.
Brenda trained as an MBCT teacher in 2011 and MBCT supervisor in 2014, and has been delivering, developing and evaluating an adapted MBCT programme for adolescent clinical populations since 2011.

Implications
The final part of the class will explore how participants might use the MBCT practices identified in the workshop, within/as part of their clinical service delivery models

Poster Presentations

Diagnosis-specific CBT as a stepping stone to transdiagnostic CBT: a single-case experimental design

Megan Cowles, University of Bath, Jim Nightingale, South Gloucestershire Psychological Therapies Service
Panic and agoraphobia, social anxiety, depression, uncontrollable worry, difficulties with emotion regulation, suicidality, self-harming behaviours and a history of bulimia
CBT model of panic was used to help socialize the service user to CBT before progressing to a transdiagnostic approach. It was hypothesised that similar processes were happening across diagnostic categories involving memory, attention, reasoning and behaviour. These
were collaboratively represented in a simple thoughts-emotions-behaviours maintenance cycle with a developmental hypothesis. Panic reduced to non-clinical levels by end of treatment, which was maintained at 6 week follow-up. Depression, anxiety and social phobia scores reduced. Self-harm and bulimic behaviours no longer present by end of treatment and follow-up. Overall this case found using panic-specific CBT as a stepping stone to tCBT was acceptable to both client and therapist, allowing a shared frame of reference that enabled a broader range of issues to be addressed than might have been typical within treatment based solely on the panic model. It is not clear if the approach impacted positively or negatively on either panic or other outcomes compared to panic formulation alone, but the approach used in this case did lead to panic remission and some indications of more marginal benefit in a broader range of problems. To this extent it suggests that further exploration of the approach is warranted. Limitations are discussed. In cases where panic is part of a presentation it is recommended that clinicians consider starting by looking at panic before moving on to look at problems more cohesively.

The potential use of mindfulness practice to improve the mental health and wellbeing of students in tertiary education: lessons for health and social care undergraduates.

Michael Kelly, Middlesex University
It has long been acknowledged that university students experience increased levels of academic and psychological distress when compared with the general population (Stallman, 2010). This often results in many not completing their courses (Andrew et al, 2008) and with far reaching consequences for their overall physical, mental and academic wellbeing (Stroeber & Rambow, 2007). Despite being an elevated risk, research on help seeking behaviours has found that the most distressed individuals are those less likely to seek help, a phenomena known as the help-negation effect. Between 45% and 65% of students experiencing mental health problems do not seek help, often preferring informal support from family, friends, self-help books and the internet (Ryan et al, 2010). It is appropriate therefore to introduce interventions which promote positive emotions in tertiary institutions (Stallman, 2012) and ones which are brought to the student, rather than students having to present in crisis. Mindfulness aims to teach individuals a broad range of formal and informal techniques which they can apply in the course of their day. Through the provision of a supportive group experience, it aims to strengthen relationships amongst participants and has the potential to mitigate against the full range of social and existential stressors experienced by participants, and in this case students (Rosenzweig et al, 2003). Amongst the general population the literature has shown that mindfulness can reduce rumination (often seen in depression), anxiety and distress, whilst participants report a greater sense of wellbeing and better coping and adjustment to change (Fouruer et al, 2013), the very things which many students experience at university. There is therefore potential for mindfulness to be used as an intervention with students. Following a literature review the lead applicant will contact the School of Health and Education’s Nursing and Social Work Societies, as well as the student voice leaders representing the different undergraduate cohorts within the school. They will be advised about the project, given an information sheet and asked to liaise with their respective cohorts about the project. A focus group will then be held with the societies and the student voice leaders to collect data on the student population’s perspectives on their understanding of mindfulness, student wellbeing and how mindfulness and wellbeing could be applied within the context of their current studies. This will include an exploration of understandings of mindfulness and wellbeing within different cultural contexts. Their view on the project will also be sought so that potential barriers to engagement by students with the project can be discussed and resolved, with particular attention paid to students at high risk of attrition and those least likely to engage.
A feasibility study will then be undertaken to assess whether the mindfulness intervention, in it’s standardised format, is appropriate to the student group and to determine whether
changes need to be made to the intervention so that it meets the needs of the Middlesex student population. In order to achieve this two pilot intervention groups will be undertaken with second year students, one with the social work students and one with the nursing students. Second year students will be chosen for the feasibility arm of the study so as not to reduce to number of potential participants in the main arm, The main arm of the study will be focused on first year students as attrition rates are the highest in this particular cohort at Middlesex.

The intervention groups will be held separately for ease of timetabling (an issue in previous studies) and to determine whether there are individual differences in approach which need to be considered with the respective cohorts. Data will be collected on a range of health and mindfulness scales to determine effectiveness (PHQ-9, GAD-7, Freiberg Mindfulness Inventory, Mindful Attention Awareness Scale). Participant feedback will also be gathered via an end of intervention questionnaire. The findings of the feasibility study, including issues arising, will be feedback to the aforementioned student focus group to help identify strategies which they and the students feel may help to overcome barriers to participation, or to make changes to the intervention so that students are able to benefit maximally from the intervention. Amendments can then be made accordingly for a larger cohort study.

CBT with a military veteran for combat-acquired PTSD

Rachel Paskell, University of Bath; David Wilcox, Avon and Wiltshire Mental Health Partnership NHS Trust

Mr A presented to a specialist veteran's service for symptoms of Post Traumatic Stress Disorder (PTSD) and associated low mood from combat experiences whilst in the military. Mr A reported experiencing night terrors and flashbacks where specific incidents from his ‘tours’ were replaying, triggered by sensory stimuli at work as a civilian and when he heard screaming children. He was left exhausted and with a sense of guilt for days after the re-experiencing. It was affecting his ability to work, his relationships and leading him to have thoughts of taking his own life.

Mr A was referred by a charity having tried to seek help for some time through the NHS and privately. At each stage he had found services he approached were unable to help him because they felt ill equipped to understand the military aspect of his presenting problem. This process had reportedly exacerbated his low mood and is a common occurrence in those referred to the specialist veterans' service.

Following recommendations from national clinical guidelines we offered Mr A a course of trauma-focussed CBT to improve his understanding of his experiences in the context of cognitive behavioural theory; provide him with grounding and stabilisation techniques that he could practice and use; engaged him in processing the memories and working with his beliefs related to those memories. Throughout it was important to support Mr A to engage in work and relationships as having an income, independence, a role and supportive relationships were all protective factors for him.

Mr A understood that the work would not be about removing his difficult memories but helping him to manage them and alter his relationship with them to make them less intrusive and less traumatic in present and future.

Outcome data will be available before the conference. Data have been collected pre-intervention, throughout the work and will also be collected at the end, with the intention to include follow-up data. Data have been collected using the Improving Access to Psychological Therapies phobia scales, the Work and Social Adjustment (WaSA) scale, the Patient Health Questionnaire (PHQ-9), Generalised Anxiety Disorder (GAD-7) scale, Dimensions of Anger Reaction Assessment, the Alcohol Use Disorders Identification Test (AUDIT-C), the Impact of Events Scale - Revised (IES-R) and the Dissociative Experiences Scale - II (DES-II).

Outcome data from the measures used will be presented and discussed with qualitative feedback from Mr A about the therapeutic process and his perceived outcomes.
Adding to the awareness of combat acquired PTSD and its treatment using trauma-focussed CBT as military veterans are increasingly presenting to NHS and private practice for such interventions.

**Case Report: Anorexia Nervosa, Interpersonal Anxiety and Low Self-Esteem; Support for Fairburn's Protocol using Idiosyncratic Vicious Flower Formulation**

**Rochelle Barden, University of Bath**


Fairburn et al's (2003) CBT formulation and treatment protocol. Vicious flower formulation also used with client.

No longer suffering from Anorexia Nervosa or Interpersonal Anxiety. Weight increase. Improved self-esteem.

CBT techniques such as guided discovery, collaboration and the use of the vicious flower enabled the client to engage in CBT for Anorexia Nervosa. The use of the maudsley model (Treasure et al., 2015) by the multidisciplinary team, which was instigated alongside the individual CBT with the client, also enabled positive outcomes. 

The client presented in this case study stated that the most effective components of the treatment were the components focused on Interpersonal Anxiety and Low Self Esteem; this case report therefore supports the addition of addressing these additional maintaining factors which Fairburn et al's (2003) protocol suggests. The case report also answers the research question “How can Fairburn's protocol be used collaboratively with young people (YP) who formulate the problem in a different way to Fairburn’s model?” by presenting clinicians with the option of using idiosyncratic ‘vicious flower’ formulation’s which include all the same factors as Fairburn et al’s (2003) formulation, but have the client’s main concerns in the middle (e.g. in this case interpersonal anxiety and low self-esteem was in the center of the clients vicious flower formulation).

**Everyday experiences of intrusive thoughts and images in individuals with a diagnosis of bipolar disorder**

**Rosie Oldham-Cooper, University of Bath, James Gregory, University of Bath; Warren Mansell, University of Manchester**

Recent advances in our understanding of the development and maintenance of bipolar disorder have highlighted the importance of intrusive cognitions (e.g., Holmes, Geddes, Colom & Goodwin, 2008). To date, much of the evidence relies on retrospective recall of intrusive thoughts and imagery (e.g., Gregory et al, 2010; Holmes et al, 2011; McCarthy-Jones, Knowles & Rowse, 2012; Ivins et al, 2014). However, this approach is potentially problematic, as retrospective recall could be affected by current mood state, the amount of time that has passed since the experience, and events occurring since that could alter or bias the memory.

The present study seeks to contribute to the current literature by exploring whether it is possible to assess intrusive verbal thoughts and mental images as they occur in individuals with bipolar disorder and healthy controls, using ecological momentary assessment.

Participants are asked to record their intrusive verbal thoughts and mental images over a 7-day period using a brief twice-daily diary measure.

Data collection is expected to finish in early April 2016.

The study could begin to address the question of whether individuals are able to report on intrusive verbal thoughts and mental images as they occur, and could lead to the development of more appropriate measures for assessing such phenomena. The comparison of individuals with and without a diagnosis of bipolar disorder will allow for further exploration of whether intrusive thoughts and images are reported to occur at a greater rate or intensity in individuals with bipolar disorder compared to healthy controls.
The findings could set the scene for future studies to begin to routinely assess intrusive thoughts and images ‘online’, and the associated appraisals and shifts in affect and behaviour that are posited to play an important role in the development and maintenance of symptoms in bipolar disorder. This growing research literature has the potential to contribute to the development of new and improved cognitive-behavioural treatments for bipolar disorder in the future.

**Helping Veterans Whatever Their Needs May Be: Developing services in partnership across Scotland**

**Sharon Fegan, Veterans 1st Point Scotland**, Lucy Abraham, Veterans 1st Point Scotland; Linda Irvine, Veterans 1st Point Scotland; Dave Carson, Veterans 1st Point Scotland; Sharon Fegan, Veterans 1st Point Scotland; John Wills, Veterans 1st Point Scotland

Veterans F1rst Point Lothian (V1PL) is a Health & Well-being service created in 2009 in response to the expressed needs of veterans identified in a focus group. It provides a one-stop shop for veterans and their families to address difficulties that impact on their ability to engage in healthy lifestyles due to illness and/or welfare problems. It is staffed by Veteran peer support workers and multi-professional mental health staff.

In 2014 £2,560,586 was awarded to NHS Lothian by the Armed Forces Covenant to develop the model across Scotland in partnership with service users and charitable and NHS organisations. The project has a number of objectives to achieve with the main aim being to establish VIP centres across Scotland to provide a single point of access for the armed services, reservists and veterans’ communities.

Focus groups were held in participating Health Board areas to inform the development of services in local areas. Currently the Teams are in varying stages of development including recruitment, induction and delivering services.

Focus groups, comprising mainly veterans, but occasionally family members and carers, were held in participating Health Board areas during which a series of key questions were explored primarily based upon individuals’ experiences of accessing help and support. The groups were audio-recorded, transcribed and reviewed to identify salient issues, both generally for veterans, and specifically for any local issues. The outcomes helped to inform the development of services.

The Focus groups identified the themes of “Available, Comprehensive and Effective” as essential components in service provision for Veterans. These map closely onto the themes of “Accessible, Co-ordinated and Credible” which were identified as important components in the original 2009 focus group. The Focus groups also identified a 4th theme related to “The veteran’s journey and aspects around help-seeking”. This is related to Veterans experiences in military service which impact upon their identification of difficulties, decision to seek help and knowing who to ask or where to go for help.

Services have been established in areas and venues identified by Veterans as most accessible. The first point of contact is with a Veteran PSW who has shared experience of the military and who co-ordinate services with the Veteran. Clinical input is delivered by staff that work within NHS governance structures and provide only evidence based interventions – credible. All staff understand the impact of military culture and experience in Veterans.

Additionally, each V1P service will undergo clinical evaluation by Queen Margaret University and engage in qualitative research to identify why this model works Veterans across Scotland will have access to evidence-based treatments, especially CBT, near to their home area.

More than 50% of referrals are self-referral which increases the likelihood of engagement. A key feature of the model is Veterans as Peer Support Workers who can support the client before, during and after clinical input thus reducing treatment length.

The V1P model compliments the CBT model in that as the service is being continually evaluated and informed by the Veterans then it too is continually adapting and improving in line with need.
The model crosses diagnostic, age and socio-economic borders delivering CBT to those who need it

“To boldly go: Pushing the boundaries of low-intensity cognitive-behavioural therapy to close the treatment gap for Armed Forces veterans and veteran family members”

Tess Bloomfield, University of Exeter, Ashlea Jeffs, University of Exeter; Ed Watkins, University of Exeter; Paul Farrand, University of Exeter
Closing the gap in the treatment of common mental health problems is an aim of the Improving Access to Psychological Therapies (IAPT) programme implemented across England. However difficulties remain in closing the treatment gap for Armed Forces veterans (Iversen & Greenberg, 2009). Barriers to engagement specific to this population have been identified (Zinzow, 2012). This poster overviews data arising from an ongoing service evaluation of Hidden Wounds, a community based, low intensity psychological service provided by Help for Heroes, adapted to meet the needs and preferences of Armed Forces veterans or family members of veterans. Additionally, the poster highlights the development of bespoke interventions for problem drinking and anger management for this population. Service evaluation is being conducted from September 2014 to May 2016 to investigate engagement and service use of Armed Forces veterans or veteran family members with Hidden Wounds. Service acceptability will be examined by an interview based qualitative sub-study with thematic analysis. Data analysis will report on referrals into the service, suitability for treatment, onward referral pathways, treatment completion, and recovery rates. Comparisons will be drawn between Hidden Wounds and national IAPT data to examine service efficacy. The research will report on the extent to which Hidden Wounds has succeeded, in its first 18 months, in addressing the treatment gap identified within psychological services for veterans. Additionally, it will comment on future considerations for developing veterans’ mental health services. Identifying ways of overcoming barriers to psychological treatment for Armed Forces veterans and their dependents. Informing the existing evidence base regarding the prevalence of mental health problems experienced by Armed Forces veterans.

A pilot study of a brief self-distancing and perspective-broadening training package for Bipolar Disorder

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When caught up in emotion, it is by stepping back (or decentering) that we see the situation from another perspective. Individuals with emotional disorders, however, struggle to do this (Fresco, Segal, Buis & Kennedy, 2007). Research has shown that improving an individual’s ability to step back from their emotions and take perspective is possible and can have beneficial effects on depressive symptomatology (Hill, Dunn, Hoppitt & Dalgleish, submitted). The prospective study aims to investigate whether the same Self-distancing and Perspective-Broadening [SD-PB] training package can improve these abilities in individuals with both depression and mania (Bipolar Disorder [BD]), and whether this reduces symptomatology.

Research questions
Does the SD-PB training reduce 1) depressive or 2) BD symptomatology in individuals diagnosed with BD?
Does the SD-PB training change the ability to 3) decenter or 4) perspective-take in individuals diagnosed with BD?
This pilot study will adopt a small N design with an “A-B” phase methodology.
Participants with a diagnosis of BD (but in a euthymic state at the time of testing) will be asked to fill out daily mood measures of symptomatology for two weeks. Following this, the SD-PB training will commence, which comprises of two face-to-face sessions and one week of daily homework, during this time participants will be asked to continue to fill out daily mood measures of symptomatology. An online follow-up will take place two weeks later.

We will be presenting the results which will consist of visual inspection of the data and Simulation Modelling Analysis. In particular we will be focusing on the daily mood measures of symptomatology.

This study will allow conclusions to be drawn regarding whether the SD-PB training package can bring about changes in symptomatology for individuals with BD. In addition to this, it will contribute to the emerging decentering literature and be able to inform us as to whether it is possible to improve the ability to decenter in individuals with BD. As well as contributing to the research field, the study will allow us to discuss whether a larger trial is feasible and the future of the SD-PB training package in a clinic setting.

The training package uses components of mindfulness and CBT in a distilled and compact way. It could one day be used for individuals on a waitlist, in remission, and in conjunction with standard CBT.

The use of virtual reality technology in the treatment of Emetophobia: A Single Case Study

Anna Smith, South London and Maudsley NHS Trust; Patrick Davey, South London and Maudsley NHS Trust

This case considers the use of virtual reality technology as an adjunct to standard cognitive behavioural therapy for emetophobia. Therapists working with emetophobia may be limited in what they can achieve with standard exposure techniques. Increasingly, virtual reality technology is being used to augment CBT treatment of specific phobias (Morina, Ijntema, Meyebroker & Emmelkamp, 2015). As yet there is no published data on the use of virtual reality in emetophobia treatment.

TP is a 27 year old male with severe emetophobia. He was treated in the Anxiety Disorders Residential Unit (Bethlem Royal Hospital) using standard cognitive behavioural approaches. TP made good gains in treatment. There were certain aspects of exposure that we were not able to recreate in the clinic setting (e.g. vomiting into a toilet). At his one month follow up he was shown a ‘virtual’ vomiting video using a Samsung Gear VR headset. The video was filmed from a first person perspective to recreate the experience of vomiting into a toilet bowl, with accompanying sounds.

Following presentation of the videos TP’s rating of anxiety about vomiting and avoidance of vomiting reduced. He also showed an overall reduction in standardised measures of vomit phobia.

TP found the intervention tolerable and it seems there is potential for building the use of virtual vomiting into standard emetophobia treatment. Further research needs to consider the timing of the video intervention and the scope of this technology in emetophobia treatment.

Potential to improve outcomes for individuals with emetophobia. This technology offers patients the opportunity to access many more of their feared and avoided situations than would be available in traditional CBT. The increasing availability and flexibility of the technology means that it could be accessed across all types of settings, including primary care psychological therapy services.

A Novel Cognitive Domain in OCD: Beliefs about Losing Control, OCD Symptoms, and the Mediating Effect of a Control Mismatch

Jean-Philippe Gagné, Concordia University; Adam S. Radomsky, Concordia University
Individuals with obsessive-compulsive disorder (OCD) often report concerns about a potential loss of control over their thoughts and behaviour. Still, the associations between beliefs about losing control and OCD symptoms are not well understood. Interestingly, control cognitions have been implicated in various disorders including OCD. For instance, one’s sense of control and desire for control, along with any discrepancy between the two (a “control mismatch”), may play a role in the development and maintenance of the disorder. We hypothesized that focusing on this control mismatch could shed light on the links between beliefs about losing control and OCD symptoms.

A preliminary inventory assessing beliefs about losing control was developed (α = .95) and completed by undergraduate student participants (N = 501). Even after taking into account symptoms of depression, anxiety, and stress, regression analyses indicated that this domain of beliefs predicted both higher levels of OCD symptoms (β = .39, p < .001) and a more pronounced control mismatch (β = -.42, p < .001). Critically, a mediation analysis suggested that a control mismatch explained the relationship between beliefs about losing control and OCD symptoms, b = .58, 95% BCa CI (.05, .16), κ² = .09.

Although experimental research is needed to establish causality, it is possible that beliefs about losing control may be a risk factor for experiencing a control mismatch, which also results in attempts at increasing one’s perceptions of control through compulsions. Beliefs about losing control should be explored in more detail, and potentially targeted during CBT. Results suggest that beliefs about losing control are possibly directly associated with OCD symptoms and the development of a control mismatch. Thus, it might be essential to target such beliefs during cognitive-behavioural therapy for those diagnosed with OCD, and not only the three currently identified domain of maladaptive beliefs -- responsibility/threat estimation, perfectionism/certainty, and importance/control over thoughts. Challenging beliefs about losing control during cognitive-behavioural therapy may potentially decrease the manifestation of OCD symptoms like compulsions (which may be performed to increase perceptions of control in the first place).

Validation and psychometric analysis of a novel measure: The Depressive and Obsessive Reassurance Seeking Scale (DORSS)

Rachael Neal, Concordia University, Adam Radomsky, PhD, Concordia University

Reassurance seeking (RS) is an understudied behaviour in obsessive-compulsive disorder (OCD) but has been examined extensively in depression, wherein individuals seek reassurance about self-worth/social bonds (Coyne, 1976). In OCD, RS is motivated by general threats (e.g., locks) and social threats (e.g., relationship security), and may be obvious/overt, or subtle/covert (e.g., studying others’ reactions; Kobori & Salkovskis, 2013). Nevertheless, existing measures of OCD-related RS focus on overt, anxious/obsessive RS. We therefore conducted validation analyses of the Depressive and Obsessive Reassurance Seeking Scale (DORSS), a novel, 30-item self-report measure of overt and covert, anxious/obsessive and depressive RS.

Data from undergraduate students in Montreal, Canada (N = 813, Mage = 23.5 (SD = 12.1) years, 85.1% female) were subjected to an exploratory factor analysis (EFA). After 10 items were removed due to low or complex associations, four RS factors accounted for 54.59% of the variance and are interpreted as follows: 1) Overt-Anxious/Obsessive, 2) Covert-Anxious/Obsessive, 3) Overt-Depressive, and 4) Covert-Depressive. The 20-item DORSS has excellent internal consistency (α = .93), with the factors being acceptable – good (α = .77 – .88). In addition, the factors show convergent validity with existing measures of anxious/obsessive-compulsive symptomatology (rs = .32 – .66), and depressive symptomatology (rs = .41 – .47), while the scale shows divergent validity with a measure of self-esteem (r = -.42).

Overall, the DORSS is a promising measure of OCD-related RS, and a confirmatory factor analysis is underway to establish model replicability. Results will be discussed in terms of cognitive-behavioural formulations of RS in OCD.
Perhaps due to research suggesting that individuals with OCD are principally motivated to seek reassurance by the desire to reduce perceptions of general threats (e.g., whether the door is locked; Parrish & Radomsky, 2010), existing measures of the behaviour place relatively little emphasis on the possibility that it could also be motivated by desires to confirm social bonds or increase comfort about one’s relationships, despite this being commonly endorsed by individuals with OCD a reason they seek reassurance (Parrish & Radomsky, 2010). Additionally, while it is recognized that individuals may seek reassurance either openly (e.g., with direct questions) or more subtly (e.g., by making a statement about the safety of an object and waiting to see if anyone disagrees), existing measures of reassurance seeking place little emphasis on covert reassurance seeking. As such, validating a comprehensive measure of both general threat-based RS and social threat-based, obvious and subtle RS with a large sample could improve the current understanding of factors that increase the likelihood of reassurance seeking. Further, being able to obtain a more complete assessment of factors related to an individual’s reassurance seeking may help clinicians identify the most central targets for intervention, thereby potentially increasing the efficiency and efficacy of the intervention.

**Writing Supervision Records: a chance for reflective practice?**

**Joanna Stace, Newcastle University / Independent Practice**

Clinical Supervision (CS) protects standards, supports staff development and quality improvement, and has formative, normative and restorative functions. The formative (skill-building) function is particularly important during training. CS appears to add a beneficial reflective ingredient to training which enhances learning.

The CS Record used by Newcastle University trainees is designed with the intention of promoting reflection. Learning can be maximised by supporting trainees to reflect from different perspectives, making processes explicit through constructing a ‘story’ about the learning (CS) process.

Literature about the role of reflection in CBP training is sparse. Several authors suggest reflection is an important skill to acquire, however some express concern that making reflection a course requirement may be counter-productive and many educators find themselves trying to promote reflection in the face of resistance. It behoves teaching staff to promote reflection as effectively as possible. This research project aims to describe trainee approaches to writing CS Records, to allow this.

Semi-structured interviews will be carried out with current trainees on the CBT course at Newcastle University. An interpretive phenomenological analysis (IPA) approach will be used, to describe and interpret individual experiences in a way that allows for general understandings to be developed. Thematic analysis will be used to derive themes from verbatim interview data.

At the time of submission, this study is still in progress; Full results will be available by the time of Conference.

This study begins filling a gap in knowledge about how CBT trainees approach writing their CS Records. By describing their approaches, and linking this description to the Theory of Planned Behaviour (Ajzen, 1991), a theory-driven approach can be taken to supporting teaching staff to promote the development of reflection.

We know that reflection - the intentional focusing of attention, inherent in writing - is a behaviour which can be improved through training and practice. We also know that reflection is an essential skill for effective CBT practice, particularly in work with complex cases. The results of this study will help promote the use of theory- and evidence-base teaching practices in teaching reflective skills in CBT.
The Emotional Impact of Failing to Resuscitate a Loved One Following a Witnessed Out-of-Hospital Cardiac Arrest.

**Rhian Lewis-Cuthbertson, Swansea University; Phillip Adrian Evans, Abertawe Bro Morgannwg University Health Board; Ahmed Sabra, Abertawe Bro Morgannwg University Health Board; Kais Mustafa, Abertawe Bro Morgannwg University Health Board; Karen Evans, Abertawe Bro Morgannwg University Health Board**

Witnessing a failed resuscitation attempt of a loved one following an out-of-hospital cardiac arrest may place individuals at high risk of experiencing negative psychological outcomes including post-traumatic stress disorder (PTSD) (Compton et al., 2009). However, little is still understood about how this experience may impact emotionally on individuals and their bereavement process, particularly if the relative who witnesses the event does not attempt CPR themselves.

Relatives of deceased, non-traumatic, non-paediatric out-of-hospital cardiac arrest victims who have died on arrival at, or within the Emergency Department are being contacted via mail approximately 1 month after the event. Physical presence and details of CPR delivery are gathered from patient notes and preliminary questions following initial contact. In-depth, semi-structured interviews are being conducted, transcribed and analysed using Interpretative Phenomenological Analysis (IPA) between 1-3 months post-bereavement.

Preliminary analysis of 5 male and female participants aged between 18 and 67 reveal evidence of post-traumatic symptoms including flashbacks, intrusive thoughts and avoidance behaviours. Emergent themes reflect the life-changing impact of witnessing this event which may include living with the guilt of not having attempted resuscitation. Changes in identity, difficulties coping (including self-harm and suicidal thoughts) and support needs were also prominent. On-going data collection and analysis will more clearly define super-ordinate and sub-ordinate themes.

Preliminary results for this study suggest that the psychological costs of failing to engage in CPR of a loved one may be profound and benefit from psychological intervention. CBT has already been identified as an effective technique for helping bereaved individuals to come to terms with their loss in a therapeutic setting, but the incorporation of such techniques into an information based leaflet specifically tailored to this event may be a cost-effective and potentially beneficial intervention in the future.

A Case Study of an Adolescent with Health Anxiety and OCD, treated using CBT

**Cara Roberts-Collins, University of Bath**

The case of an adolescent female (aged 15-years old) presenting with significant levels of health anxiety and obsessive compulsive disorder (OCD) is described. The sparse research evidence base for adolescents with health anxiety proposes a challenge in the treatment of such mental health difficulties.

Similarities were drawn between health anxiety and OCD in terms of their development and maintenance. An adult cognitive behavioural model of health anxiety was adapted and integrated with evidence based Cognitive Behavioural Therapy (CBT) for children and adolescents with OCD. These models were used to collaboratively conceptualize the young person’s presenting difficulties. The intervention consisted of 13 weekly CBT sessions.

A single case experimental design using routine outcome measures was used to assess the effectiveness of the intervention. Scores on the Short Health Anxiety Inventory (SHAI) and the Revised Child Anxiety and Depression Scale (RCADS) reduced from above to below the clinical cut off for health anxiety across the course of therapy, suggesting a reduction in health anxiety and improved overall emotional wellbeing. The intervention also showed a significant qualitative impact on everyday functioning including school work, friendships, family relationships and a reduction in visits to the GP.
This case study demonstrates the positive outcomes that can be gained by using CBT to treat health anxiety and OCD, and the benefit of using a single case experimental design to gather important evidence for the use of CBT for health anxiety for young people. It also highlights the need for further research in health anxiety in young people including the need for evidence based treatment for health anxiety for young people, and the development of disorder and age specific measures.

This case study has implications for clinicians working within community Child and Adolescent Mental Health Services (CAMHS) in demonstrating the value of using the CBT framework to work with adolescents to reduce symptoms of health anxiety, OCD and overall distress. It also highlights the importance of adapting adult CBT models to the appropriate developmental level, and the possibility that health anxiety is not often recognised within CAMHS services due to lack of appropriate measures for young people.

Goal achievement and low mood: The role of mental imagery and implementation intentions

Lisa Keane, University of Bath, James Gregory, University of Bath

Research, particularly in the area of sports psychology, suggests that those who vividly imagine themselves carrying out a task (referred to as mental imagery; MI) demonstrate enhanced performance and task achievement (Knäuper et al., 2011). The creation of concrete plans for when and where individuals plan to carry out tasks, known as implementation intentions (II) have also been demonstrated to result in the enhanced achievement of goals e.g. healthy eating (Gollwitzer, 1999).

We are interested in whether these techniques can be successfully used within clinical practice as it is well accepted that withdrawal from activity and goals contributes to the maintenance of depression. We know that those people who complete and engage in between-session homework, amongst other important factors, tend to do better in therapy. Here we investigate whether participants presenting to primary care services with primary low mood who engage in MI or II tasks are more likely to complete short-term personal goals than a control group.

An experimental design with random allocation to three groups has been employed (MI, II or control). Following the identification of three personal goals, those allocated to the MI or II group are facilitated to mentally imagine the completion of their goals, or to devise concrete plans for when/where their goals will be completed. Participants complete a follow-up a week later to establish the number of goals achieved.

Group differences will be identified using logistic regression.

Clinical implications of findings will be discussed in detail.

The outcomes of the research will help to establish and refine the 'active' ingredients of therapy, particularly in relation to setting homework tasks.

Exploring the experiences of service-users in an innovative acute care service - the intensive support programme

Kellie Louise Jacques, Southern Health NHS Foundation Trust, Jane Birrell, Southern Health NHS Foundation Trust; Kellie Louise Jacques, Southern Health NHS Foundation Trust; Isabel Clarke, Southern Health NHS Foundation Trust; David Araci, Southern Health NHS Foundation Trust;

The Intensive Support Programme (ISP) is an innovative approach to providing psychological services within acute care. It is a 'whole-service' approach in which the development of a psychologically-informed workforce and environment is equally as important as the direct provision of psychological and behavioural coping skills to individuals in crisis (Durrant, Clarke & Wilson, 2007). It places the service-user at the centre of their care, with the focus of treatment being derived from an emotion-focused formulation. Relevant coping skills are then taught largely through group sessions, using third-wave CBT approaches (Hayes, Strosahl, & Wilson, 1999). Individual support with
skill-development is incorporated into routine contacts with members of the multidisciplinary acute care team.
The approach has been implemented widely across one NHS Foundation Trust in the south of England. Initial analyses of the quantitative data show promising results for the effectiveness of the approach in reducing distress and increasing confidence in managing one's mental wellbeing (Araci & Clarke, in submission; Birrell, Jacques & Rutherford, 2015).

The current study aims to explore the subjective experiences of service-users who have participated in the programme. Semi-structured interviews were completed with 12 service-users who had received a formulation and attended group sessions in two acute hospitals within the same Trust. Topics covered within the interviews included which parts of the programme service-users found helpful, which parts were less helpful, and the continued application of skills after completion of the programme.

The data is currently being transcribed and will be analysed using thematic analysis in accordance with the guidelines described in Braun & Clarke (2006). The results will be presented and the findings will be critically evaluated in order to determine conclusions that may be drawn about the effectiveness and acceptability of the approach.

Recommendations for further research and for developments to the ISP approach will be made.

The findings of this study may have implications for the way that third-wave CBT approaches (Hayes, Strosahl, & Wilson, 1999) are delivered through the ISP. We hope that any recommendations for developments to the programme will help to make these CBT approaches more accessible to individuals under the care of acute mental health services.

Self-Compassion and Social Anxiety in Adolescents

Ciara Gill, NHS Lanarkshire, Lindsey Watson, NHS Lanarkshire; Charlotte Williams, NHS Lanarkshire; Chan Stella, University of Edinburgh

An emerging concept in the field of clinical psychology is self-compassion i.e. compassion we can direct towards ourselves (Gilbert, 2014). Preliminary evidence suggests that low self-compassion may contribute to the development and maintenance of social anxiety in an adult population (Werner et al., 2012). Despite wide recognition that social anxiety arises in adolescence and can be a pre-cursor to the development of other psychological disorders, the relationship between self-compassion and social anxiety is yet to be explored in an adolescent population.

316 community-based adolescents, aged 14-18, completed 7 validated psychometric questionnaires assessing levels of: self-compassion; social anxiety; fear of negative evaluation; self-focused attention; cognitive avoidance; depression and generalised anxiety. Self-compassion was found to be inversely related to social anxiety, r = -.551, p < .0001, 95%CI [-.62, -.48], with fear of negative evaluation and cognitive avoidance, but not self-focused attention, partially mediating this relationship. Self-compassion was found to be a unique predict of social anxiety, explaining additional variance when depression and generalised anxiety were controlled for.

Results suggest that the degree to which adolescents are self-compassionate at times of social distress or when faced with social situations may be an important factor in the development, maintenance and treatment of social anxiety. Similarly, the above study expands our understanding of the concepts underlying social anxiety, specifically in adolescents, for whom social anxiety is extremely prevalent. It is hoped that the above research may highlight associations in need of further investigation and inform the development of compassion focused adaptations or interventions for this population.

Consideration of an individual's level of self-compassion may aid clinicians to adopt additional techniques and tasks to enhance the effectiveness of currently available interventions. Recent evidence has shown that self-compassion can be increased with practice (Gilbert & Proctor, 2006) and that Compassion Focused Therapy can provide a framework in which to focus other psychological interventions. It is proposed that
recognition and consideration of self-compassion and the affiliative system may lead to increased effectiveness of CBT interventions.

**Overgeneral autobiographical memory and executive function in adolescent depression**

**Jeni Fisk, University of Reading.** Shirley Reynolds, University of Reading; Judi Ellis, University of Reading Depression in young people is a very serious mental health problem. Much research has indicated Overgeneral autobiographical memory (OGM) in the development and maintenance of depression, and as a potential intervention strategy (Hitchcock et al., 2014). The CARFAX model (Williams et al, 2007) suggests three cognitive processes cause and maintain OGM; rumination, functional avoidance and reduced executive functioning. These core mechanisms have been rarely examined, especially in depressed adolescents. The aim of this study is to test the CARFAX model in a community sample of adolescents. Adolescents with low (N= 29) and high (N=29) levels of depression symptoms were identified via the Mood and Feelings Questionnaire ((MFQ; Costello & Angold, 1988). Participants completed the Rumination scale (RRS), the WASI to assess IQ, the Autobiographical Memory Test, and three Executive Functioning tasks. As predicted significant differences were found between high and low depression groups on OGM. Consistent with the CARFAX model, young people with high depression scores also had higher rumination and poorer executive functioning compared to adolescents with low depression scores. There was no evidence of functional avoidance; memories of adolescents with elevated depression were significantly more negative. These data suggest that problems with working memory, verbal fluency, and rumination, but not functional avoidance, are associated with OGM in adolescents with elevated symptoms of depression. Participants reported symptoms of depression similar to those reported by clinical samples, suggesting that results may generalise to a clinical population. The results of this study partly support the CARFAX model in depressed adolescents. Results could lead to the development of new strategies to prevent or treat depression in young people by addressing memory difficulties. For example, interventions that promote aspects of executive functioning e.g working memory, may help overcome problems of retrieving specific (rather than general) autobiographical memories. It is also important that clinicians are aware that symptoms of depression are associated with problems performing cognitive tasks; this may also impact on a young person’s ability to engage with some of the cognitive demands of CBT.

**Can considering staff and services users’ views of acute mental health wards provide insight into the adverse behaviours exhibited by service users?**

**Ailsa Munro, Manchester Mental Health and Social Care Trust.** Charlotte Huggett, Manchester Mental Health and Social Care Trust; Gillian Haddock, The University of Manchester Over 103,800 service users spent time on mental health inpatient wards during 2014-2015 (HSCIC, 2015). While wards can be safe and therapeutic environments, incidents of self harm and harm to others can be common creating challenging environments for service users and staff (Rose et al 2015). With high rates of admissions and incidents reported, it is important to consider service user and staff views of this environment and explore possible relatedness. It is hypothesised that negative views on the ward environment will be related to higher patient rates of harm to self and others. Participants included service users and staff on acute mental health wards in one NHS trust in the North West of England. Service users were aged between 18-65 and had experienced suicidal ideation in the previous 3 months.
Staff/service user views on the quality of the ward environment were collected using the self-report Views of Inpatient Care (VOICE) and Views of Therapeutic Environments (VOTE) which assess themes including care, activities, environment and safety. Harm to self and others were captured prospectively over 6 months by incident reports completed by Trust Staff. Data on frequency of harm to self and others will be presented and correlated with staff/service user scores on the VOICE and VOTE. Need for effective risk management and the emphasis placed on learning from previous incidents make it important to identify possible underlying factors behind adverse behaviours. Understanding more about staff and service user views and adverse behaviours could have important consequences for developing ways of managing risk, improving safety and increasing staff morale in inpatient settings. It could have implications for the delivery of treatment within inpatient settings, including talking therapies such as CBT.

Evaluating & Improving OCD-UK’s Conference: Collaboration Between People with Personal Experience and Professionals

Hazel Carrick, University of Bath; Paul Salkovskis, University of Bath

OCD-UK is a charity, led by people with personal experience of OCD. It runs annual conferences with the aim to promote understanding of OCD and its treatment. Conference organisers had recognised that their methods for evaluating conferences did not provide sufficient information to determine whether this aim was achieved or not. The present study undertook a systematic evaluation of OCD-UK’s 2014 conference. First, OCD-UK collaborated with Clinical Psychologists in Training from the University of Bath to develop a new questionnaire. Second, this was completed by 91 attendees (including 50 sufferers and 41 carers) pre and post conference. Regardless of group, changes in scores showed that the conference was successful in increasing attendees’ confidence in their: understanding of OCD; knowledge of treatment options and evidence-base; ability to discuss treatment concerns with professionals. Additionally, over the course of the conference the following beliefs weakened: pessimism about the ability to overcome OCD, perceived poor past progress and perception of OCD as a biological illness. Contrastingly, beliefs about perceived need for psychological therapy to overcome OCD strengthened. However, beliefs about perceived poor past therapy did not change pre to post for either sufferers or carers. Findings were discussed in relation to their possible implications for enhancing sufferers and carers’ experiences of accessing and engaging with treatment. This present study illustrates how professionals can work alongside organisations led by people with personal experiences to address the unhelpful beliefs about OCD that can act as a barrier to accessing and engaging with CBT. This may have wider implications for CBT for other mental health conditions.

Modifying therapist beliefs about OCD: The impact of an OCD-UK Professionals Conference Day

Emma Stephens, University of Bath; Josie Millar, University of Bath; Paul Salkovskis, University of Bath

Although on paper people with Obsessive-Compulsive Disorder (OCD) are offered appropriate treatment, something about how this is undertaken in practice appears to be leaving many feeling like their problems are not well understood. One potential explanation for this discrepancy is that many mental health professionals may hold biases and unhelpful beliefs about OCD and its treatment, which could negatively effect therapeutic alliance, adherence to evidence based treatment, and subsequent outcomes. This research has
focussed on a one day professionals conference provided by national charity OCD-UK, which prides itself on being run by and for people with experience of (OCD). Inspired by reports of unhelpful treatment experiences from people experiencing OCD, OCD-UK planned a new additional day for professionals at their 2014 conference. Consultation with OCD-UK; professionals; and people with personal experience of OCD helped to shape the topics provided on the day. Presenters included Prof Paul Salkovskis, Prof Mark Freeston, and OCD-UK members with personal experience of OCD. Pre and post evaluation questionnaires were designed through a process of consultation with key members of OCD-UK and included therapist confidence ratings and a questionnaire exploring beliefs about OCD and treatment. The results showed that attendees' overall confidence in understanding and treating OCD had increased significantly over the day (pre: M=7.47; SD=3.65; N=30; post: M=11.10; SD=2.26; N=30), t(29)= -7.72, p<.001. Attendees of the conference day reported significantly increased confidence in all of the five factors measured, such as confidence in evidence based treatments and completing risk assessments of intrusive thoughts. Attendees also reported significantly increased confidence in having insight into the experience of OCD, and it is highly likely that the talks offered by people with personal experience played an important part in this. The professional sample were found to hold varied beliefs about OCD, some of which are likely to be unhelpful in maximising treatment effectiveness, such as belief in OCD as a largely biological rather than a psychological problem, or one that is chronic and linked to an individual's personality. Encouragingly, the conference day appears to have shifted some of these beliefs to a more positive stance, significantly increasing optimism about treating OCD (pre: M=80.14; SD=13.11; N=24; post: M=84.84; SD=11.60; N=24), t(23)= -3.38, p=.003), and decreasing belief of OCD as a biological problem (pre: M=-18.80; SD=14.54; N=32; post: M=-25.73; SD=11.87; N=32), t(31)= 4.04, p<.0001). These results are encouraging in suggesting that relatively brief training interventions can significantly alter professionals' confidence and understanding of some of the more frequently troublesome areas of OCD treatment, such as intrusive thoughts unfortunately being viewed as evidence of actual risk (Glazier et al, 2013), as well as ensuring a good understanding of the evidence base to avoid therapist drift and increase likelihood of successful treatment. The conference evaluation also suggested that professionals highly regarded the day, with excellent feedback and over 95% of attendees rating the day as 'good' or 'very good'. Highlights the need to be aware of the impact on treatment of any unhelpful therapist beliefs regarding OCD e.g. as 'hard to treat' in comparison with reality suggested by evidence base. Identifies role of training in potentially reducing such negative beliefs and also role that individuals' with personal experience can provide in educating and improving clinical practice.

Schema (Mode) therapy and is use with paranoid personality disorder a case discussion

Colin Hughes, Queens University Belfast

Clients with personality disorder have commonly been considered as particularly difficult to treat, they were viewed as clients who could not be helped or at best achieved low success rates (Arntz and van Genderen, 2009). The reasons for this are complex however at the heart is how they see and interpret their world. The reason for this is as Beck (1990) has postulated is as due to the way we are all 'programmed', this programming can be seen by the way we behave. Observable behaviour is shaped by the interplay between genes and environment, this involves cognitive processing (Davidson, 2000). In response to this programmed development Young et al (2003) highlight the importance of schemas, 'schemas' are developed in childhood specifically in the case of those with personality disorders 'maladaptive schemas' are developed. These are defined as a negative perception of oneself, others, and the environment which is pervasive and gives meaning to each experience (Beck et al, 1990, Young, 1994). Information is
interpreted in accordance with these schemas which are stable and resistant to change, only schema concordant information is processed the associated meaning is therefore in line with the underlying schema (Sempertegui et al 2013). To date the greatest amount of work has been applied to borderline personality disorder however according to Bamelis et al (2014) the use of Schema therapy has been shown to be effective in the treatment of paranoid, histrionic, and narcissistic personality disorders. The aim of this paper is to demonstrate the use and effectiveness of Schema therapy (mode approach) as proposed by Arntz and van Genderen (2009) when used with a client with a diagnosis of paranoid personality disorder. This approach conceptualise clients as being under the sway of five modes or aspects of the self, the goal is to reorganise this structure. To facilitate this there are four core mechanisms, limited reparenting, experiential imagery, cognitive restructuring, and behavioural pattern breaking. These approaches are used during three treatment phases, bonding and emotional regulation, schema mode change and development of autonomy (Kellogg and Young, 2006).

**Method:** The Young (1999) Schema Questionnaire long form version two was administered at the beginning, middle and end of 18 month of treatment along with the PHQ-9 (Kroenke et al, 2001) and GAD-7 (Spitzer et al, 2006).

**Results and conclusions**

In the present case study the results of the Young’s Schema questionnaire showed significant reductions across all items specifically mistrust/abuse, entitlement, insufficient self-control and vulnerability, according to both the PHQ-9 and GAD-7 significant improvements were also identified with depression and anxiety ratings.

While the majority of research has been conducted with clients with borderline personality disorder the results would suggest and in line with Bamelis et al (2014) work this approach is also effective for other types of personality disorder. In this case the use of the schema modal approach was effective in the reduction of symptoms and an overall improvement in the ‘paranoid’ diagnosis. It is recommended this approach is further developed and research conducted to establish the validity and reliability of this approach for the treatment of paranoid personality disorder.

While further research is required this provides a potential treatment approach for those clients with severe and enduring complex problems which is evidenced based and effective. In addition for already experienced and well supervised therapists this approach can be applied with minimal additional training, therefore making this approach cost effective.

**Treating Adolescent Health Anxiety using the Adult Cognitive Behavioural Model: A Case Study**

**Andrew Merwood,** University of Bath, Lauren Russouw, North Bristol NHS Trust

‘Molly’, an adolescent girl aged 15 years, was referred to Child and Adolescent Mental Health Services (CAMHS) with a low body weight and concerns that she may have an eating disorder. She was also experiencing symptoms of anxiety and daily headaches with no medical explanation. These difficulties began following the death of Molly’s older cousin. Careful assessment indicated that Molly did not have an eating disorder and her difficulties were instead conceptualised as health anxiety using the adult cognitive-behavioural model (Salkovskis & Warwick, 1986). The formulation placed particular emphasis on Molly’s interpretation of the meaning of her headaches and on her use of safety-seeking behaviours, including reassurance seeking, when anxious. The primary intervention was six sessions of CBT for health anxiety, adapted from an adult treatment protocol (Salkovskis, 1989). A within-series experimental design was used to evaluate the effectiveness of therapy. Data were collected pre and post intervention using the Revised Child Anxiety and Depression Scale (RCADS) and the Short Health Anxiety Inventory (SHAI). Results revealed a reliable change in Molly’s symptoms of anxiety and depression in her symptoms of health anxiety. This change was maintained at one-month follow-up, however some caution must be taken when interpreting these results since Molly received a diagnosis of a physical illness (Coeliac...
disease) during the course of therapy. Qualitatively, Molly reported that therapy had helped her to recognise and challenge anxiety.

This case study highlights the utility of the adult health anxiety model when working with adolescents who are worried about their health. To the best of our knowledge, no such case studies have been reported previously. Although the results must be interpreted with caution, they will be of relevance to CBT practitioners working within CAMHS. Health anxiety is a common problem but can be difficult to detect in the presence of ongoing health complaints. This case study indicates that health anxiety can be worked with using CBT in the presence of a physical illness and shows that the adult CBT model of health anxiety can be applied in adolescence.

Integrating mental health services into schools for refugees and asylum seekers in the North West

Jennifer Hall, Freedom from Torture; Carl Dutton, Alderhey CAMHS

The North West of England had the highest proportion of dispersed asylum seekers in the whole of the UK from June 2014-June 2015. Due to this, the numbers of asylum seekers is rapidly rising in the North West. Funding issues means that the third sector organisations offering psychological services for asylum seekers and refugees in the North West of England are sparse and it is widely recognised that this client group is not represented within the NHS. Due to this, a collaboration was set up between Freedom from Torture (a human rights charity; formally Medical foundation for the Victims of Torture) and statutory Child and Adolescent Mental Health Services, Alderhey CAMHS, in the North West to see if a community based approach, working into schools was feasible. CBT focussed consultancies were offered to teachers and a Tree of Life group incorporating CBT aspects was set up.

Evaluation of the service consisted of focus groups with teachers and children which were analysed qualitatively. The feedback of the service was very positive and was organised into different themes, which are discussed. The results from this study suggests that community focussed mental health services using adapted CBT techniques, and collaboration between statutory and third sector organisations is essential to begin to address the needs of asylum seekers and refugees. Recommendations are given for future collaborations and ways of working for the NHS and voluntary sector. Adapting CBT can be useful for school based consultations and group work with refugees and asylum seeking children in the North West of England. Other ways how the NHS and third sector organisations can collaborate in the future to best meet the needs of this client group are discussed.

Disseminating low intensity CBT working across a large Mental Health Trust

Denise Carroll, NHS GG&C; Donna Mackenzie, NHS GG&C, Anne Wills, NHS GG&C, Joanne MacLoed, NHS GG&C, Cheryl McCamley, NHS GG&G

In Scotland health is a devolved issue led by the Scottish Government Health Department. This means that there are different policies for the delivery of mental health care North and South of the border. One key difference is that the focus on the development of new teams with a new workforce in England and Wales (IAPT- Increasing Access to Psychological Treatments) has not been adopted in Scotland. Instead, health care delivery in Scotland is informed by the Matrix - a document that informs evidence-based service development and delivery across the health boards in Scotland. Each local area can decide its own policy and programmes of health delivery- informed by the Matrix. One of the recommended approaches for low intensity working is the Structured Psychosocial InteRventions In Teams (SPIRIT) approach, used in Glasgow and some other health Boards. NHS Greater Glasgow and Clyde is Scotland’s largest mental health Trust. It funds the SPIRIT team - including four seconded part-time trainers and a part-time administrator working to
build capacity in the workforce to deliver low intensity CBT-based interventions for anxiety and depression.

The aim is to increase the capacity within the workforce to meet the Scottish Government target of 18 weeks from referral to treatment for Psychological therapies. There are wider benefits from enhancing the psychological mindedness of practitioners, and encouraging application across teams.

SPIRIT has been established for over 13 years (2002) in Glasgow, training practitioners from across the range of adult and older adult mental health teams. All adult and older adult teams have received the training, as well as Occupational health and alcohol services. The course teaches key elements of CBT based on the five areas assessment model developed by Professor Chris Williams of the University of Glasgow and provides a recovery-focused intervention for use by practitioners with patients. Training systematically works through the content of the Overcoming depression and low mood and (Williams 2013) as well as how to use the linked online site at www.llttf.com.

The training is delivered as 8 x 3.5 hours interactive workshop sessions plus three x1.5 hour-long sessions of Practice and Review. Each session uses a range of training styles including taught theory, case discussion, and group work. An accompanying skills log encourages self-reflection/self-practice (Bennett-Levy tasks, as well as a log of use of key elements of the course with patients.

Linked workbooks and worksheets are freely available throughout the health Board with access to print worksheets and workbooks copies via the Staffnet site. Staff access the SPIRIT training via the online Staffnet site (centrally funded) with the approval of the local NHS manager.

A novel component is that teams as well as individuals are invited to attend training. This allows teams to reflect on processes of referral, assessment and implementation issues in a way that individuals alone might struggle to achieve.

Well over 1000 members of staff have completed training to date, with 469 staff trained in the last 2 years. Focusing on these latter staff, course completion rate is 87% awarded the final certificate (indicating attendance and portfolio completion) 60% have been nurses, 10% Occupational therapists and 30% a mix of other disciplines. Over 85% of the participants had more than 2 years experience.

The quality of training delivery and course content is routinely evaluated by the Training Acceptability Rating Scale (TARS) (Davis, Rawana & Capponi, 1989; Milne & Noone, 1996) administered at the end of the eight core workshop sessions. The TARS questionnaire is split into 2 sections addressing Content of training (rated &gt;91%) and Teaching process (rated &gt;80 %) by attending staff. In addition the quality of trainers has been consistently rated favourably, with 70 – 90%.

SPIRIT continues to provide training of an evidence-based intervention to build capacity in a workforce to deliver low intensity CBT-based intervention for patients with depression and anxiety. Participants value the training which enhances their knowledge and skills as well as providing a common language and intervention for all staff in local CMHT’s.

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Examining the impact of social exclusion on state paranoia and self-reported and implicit self-esteem in a non-clinical sample

Corinna Stewart, National University of Ireland, Galway, Ian Stewart, National University of Ireland, Galway, Monika Pilch, National University of Ireland, Galway, Yvonne Barnes-Holmes, Ghent University, Belgium

It is now widely accepted that paranoia is on a continuum, with paranoiac thoughts commonly occurring in the general population (Freeman et al., 2005). An important implication of this continuum perspective is that researching non-clinical paranoia may inform our understanding of clinical paranoia. As both social stress and self-esteem are relevant to paranoia (Kesting & Lincoln, 2013), recent research has examined the effect of social stress on paranoia and self-esteem in non-clinical samples. Findings indicate that social stress (e.g., social exclusion) is associated with increases in sub-clinical paranoia and decreases in self-esteem (e.g., Kesting et al., 2013; Westermann et al., 2012). The current study expanded on this research by investigating whether social exclusion is associated with changes in implicit self-esteem, in addition to self-reported self-esteem and paranoia.

Eighty-six participants from the general population completed measures of trait and state paranoia, self-esteem, and implicit self-esteem. They were then randomly allocated to the exclusion or inclusion condition of Cyberball – a virtual ball-toss game that has increasingly been used to examine social exclusion. Afterwards they completed the same measures again. Implicit self-esteem was examined using the Implicit Association Test (IAT) and Implicit Relational Assessment Procedure (IRAP). A growing body of research has demonstrated the value of the IRAP in clinical research and its utility in parsing out individual-specific responses to stimuli pertinent to clinically-relevant phenomena (Vahey et al., 2015). That is, while the IAT provides an overall bias score, the IRAP produces four individual bias scores, with each measuring a distinct aspect of the topic of interest (i.e., self-esteem: Me-Positive, Me-Negative, Others-Positive, Others-Negative).

Results confirmed that social exclusion was associated with increased state-paranoia and decreased self-reported self-esteem. Excluded participants also demonstrated decreases in implicit self-esteem on the IAT. A more complex pattern of responding was observed on the IRAP; while there was a trend towards significance for reduced ‘Me-Positive’ scores following exclusion, the most notable changes were on ‘Others-Positive’ scores, with both included and excluded participants demonstrating significant ‘Others-Positive’ biases post-Cyberball. Interesting trends were also observed on ‘Others-Negative’ scores, with excluded participants demonstrating changes in responding from disagreeing to agreeing ‘Others-Negative’ from baseline to post-Cyberball.

This study corroborates results from previous studies and extends this research by investigating the effect of social exclusion on implicit self-esteem. Based on the IRAP data, it would appear that decreases in self-esteem on the IAT following exclusion were driven by increases in ‘Others-Positive’ scores (rather than changes on ‘Me-Positive’ or ‘Me-Negative’ scores). Thus, the IRAP may provide a more fine-grained analysis of particular responses towards the self and others that comprise self-esteem. Furthermore, these findings highlight the need for future studies to examine how exclusion affects responding towards others. This study draws attention to the importance of examining responses to others and the self following aversive interpersonal experiences and provides some suggestions as to how schemas regarding the self and others might develop following such experiences. It also highlights the need to support individuals to cope with social stress.

Implementing Group Behavioural Activation in an acute inpatient setting

Martina Gibbons, Trinity College

Depression is set to become the second largest cause of disease burden by 2020 Behavioural Activation (BA) theory proposes that depression is maintained through high levels of avoidance and low levels of reinforcing activity. The corresponding mechanism theory is that using BA techniques to increase activation will lead to a subsequent increase in positive
reinforcement, which will decrease depressive symptoms (Martell et al, 2001). In this paper we attempt to review BA literature relevant to its psychopathology and mechanism models, paying particular attention to attempts to measure activation as conceptualized within BA treatments.

Based on the results of 6 BA groups delivered as part of a new inpatient service this presentation will report the outcomes of the intervention and examine a range of factors influencing its implementation. Particular attention will be paid to the acute unit context, modifications made to the number of group sessions delivered, the populations seen (in terms of demographics, symptom severity and duration), the timing of change shown on outcome measures.

The therapist ran 8 groups of Behavioural activation over an 8 week period and collected data using BDI 11 AND BAI ALSO BADS short version on a weekly bases . The Therapist also got verbal feedback from the patients the outcome was very positive with all participants showing good clinical &nbsp;outcomes.

In summary it is challenging providing group inpatient Behavioural Activation treatment &nbsp;in a complex group of patients &nbsp;with mixed diagnoses More studies needs to be carried out to give validity to this work.

However our small study showed that the group did provide very positive outcomes with very good feedback from the patients involved in the group.

Inpatient behavioural activation works very well as the study has shown even in a mixed diagnostic group of acutely ill in patient population.

Long term physical health conditions- mental health awareness training for practice nurses

Denise Carroll, NHS GG& C, Anne Wills, NHS GG&C, Chris Williams, University of Glasgow

The acute (physical care) hospitals in NHS Greater Glasgow and Clyde (NHS GG+C) are leading a new programme to empower and equip nursing staff working in primary care in the detection and support of people with depression. A new mandatory online wellbeing assessment tool is used by district nurses with any patients identified as experiencing a long-term physical health condition. It incorporates four key questions taken from the PHQ9 and the GAD7 questionnaires (including the two Whooley questions which have been shown to be helpful in identifying depression in older adults).

A linked staff training programme has aimed to increase depression/anxiety awareness, and skills in assessment, and we report the impact and effectiveness of the training programme here.

A 3 hour training session was developed and delivered by SPIRIT (Structured Psychological Interventions in Team) Trainers. The training aimed to build confidence in discussing common mental health problems and was delivered by 5 part-time seconded staff train staff throughout NHS GG+C in low intensity CBT skills. Content included the impact of anxiety and depression, core symptoms (presented as a CBT vicious cycle using the five areas assessment approach (Williams 2001), plus skills-based training and practice in how to complete, sum and feedback the longer PHQ9 and GAD 7 questionnaires when needed.

Finally, a short risk management reminder was included.

To date, 187 practice nurses have attended 13 standalone training sessions (37% of a practice nurses within NHSGG&amp;C). Overall 98% stated the training improved their understanding of mental health and 96% identified it had helped them develop work related skills. 91% stated it had increased their confidence and 100% of responders expected to use what they had learned in their clinical practice. If accepted for presentation we will have date including full Training Acceptability Rating Scales (TARS Milne et al) plus qualitative feedback from district nurses.

The depression and anxiety awareness training aimed to improve confidence in discussing and explaining mental health issues in patients with long term physical health conditions. The use of screening questions, supplemented by a simple to use CBT framework plus validated questionnaires (PHQ9 and GAD 7) has proved acceptable and popular. It has
helped staff understand patient needs more, and improved confidence by providing a structured approach to discuss the impact of illness. This training also provided an opportunity to promote information regarding further training and resources available within NSGCC&C including sign-posting to the free access www.lltf.com website as a support for their patients. Depression and anxiety are commonly present in those with long-term physical health conditions. It is associated with emotional distress, but also worsens medical outcomes (more admissions/readmissions, longer length of stay in hospital and worsened function). By raising confidence in having conversations about low or anxious mood, staff have felt empowered to provide a more integrated and whole person support. Bosanquet K, Mitchell N, Gabe R, Lewis H, McMillan D, Ekers D, Bailey D, Gilbody S. (2015). Diagnostic accuracy of the Whooley depression tool in older adults in UK primary care. Journal of Affective Disorders. Aug 15;182:39-43. doi: 10.1016/j.jad.2015.04.020.<br>Williams CJ (2001). Overcoming depression and low mood: a five areas approach. Hodder Arnold: London

Clinicians’ internal states influence the use of CBT techniques

Zachary Parker, University of Sheffield, Glenn Waller, University of Sheffield
This presentation focuses on how clinicians’ internal states (i.e., anxiety and attitudes) affect their delivery of cognitive-behavioural therapy (CBT). &nbsp;Two hundred and four clinicians from various mental healthcare fields who work with anxious clients took part in the study. &nbsp;Each completed a novel measure of negative attitudes towards CBT, and measures of self-esteem, anxiety, and techniques used in the treatment of an anxious population. &nbsp;Clinicians’ negative attitudes and anxiety were differently associated with the use of CBT and other therapeutic techniques. This presentation will explore clinical implications and potential means to improve delivery of therapy. These findings suggest that clinicians’ attitudes and emotions play different roles in our failure to deliver the optimum treatment to clients.

Cognitive Restructuring and Graded Behavioural Exposure for Delusional Appraisals of Auditory Hallucinations in Paranoid Schizophrenia

Pawel Mankiewicz, East London NHS Foundation Trust, Colin Turner, Lincolnshire Partnership NHS Foundation Trust
The prevalence of diagnostic comorbidity between psychosis and anxiety disorders has been found to be considerable. Cognitive models of psychosis suggest that anxiety does not arise directly from positive symptoms of schizophrenia but rather from an individual interpretation of such experiences. In the United Kingdom, cognitive-behavioural therapy for psychosis (CBTp) has been recommended within clinical guidelines as a psychological treatment of choice for those diagnosed with schizophrenia. However, despite empirical evidence supporting CBTp, the treatment provision remains infrequent and not routinely available. This case describes a successful implementation of CBTp. Sixteen sessions were delivered to a 40-year-old male with diagnoses of paranoid schizophrenia and comorbid anxiety, focusing primarily on cognitive restructuring of paranoid appraisals of auditory hallucinations and behavioural experiments employed progressively via graded exposure to anxiety-inducing stimuli. Standardised measurements, behavioural frequency sampling, and subjective data were collected to evaluate the client’s response to the delivered structured CBTp. Standardised measurements, behavioural frequency sampling, and subjective data indicated a considerable reduction in both paranoia and anxiety. Also, the client’s psychosocial functioning improved substantially.
This report indicates that the treatment may help those with experiences of psychosis and comorbid anxiety reach a significant improvement in their quality of life and offers an encouraging and innovative perspective on direct engagement with the content of paranoia and voices at the onset of therapy.

The original contribution the reported case attempts to make to the clinical and research literature concerns the delivery method of CBTp strategies and the particular way through which the substantial psychosocial improvements were achieved, rather than the outcomes themselves. CBTp interventions have traditionally focused on the enhancement of cognitive and behavioural abilities to cope with psychological distress among individuals experiencing psychosis, as a primary therapeutic focus. This case report appears to demonstrate that, in some cases, particularly among those individuals that are able to build a functional therapeutic rapport, the actual content of auditory hallucinations and paranoid delusions needs to be directly engaged with, analysed, and collaboratively restructured in order to produce an initial alleviation in comorbid distress. Such alleviation would allow the subsequent behavioural interventions to expose an individual to anxiety-inducing stimuli, encourage interpersonal interaction, and produce a sustained improvement in one’s psychosocial functioning.

Student self-practice self reflection of CBT: The facilitator’s experience

Martina Gibbons, Trinity College Dublin Highfield healthcare; Craig Chigwedere, Trinity College Dublin St Patricks Hospital, Brian Fitzmaurice, Trinity College Dublin Health Service Executive, Martina Gibbons, Trinity College Dublin Highfield Healthcare, . . . .

Self-practice of CBT techniques has not historically been part of the CBT training and accreditation culture. Recent developments have shown that self-experience of CBT techniques enhances therapist development. Self-practice and self-reflection, based on Bennett-Levy’s declarative and procedural and reflective (DPR) model (Bennett-Levy, 2006) is developing an impressive body of evidence. Participants report personal and professional impacts (Bennett-Levy et al., 2001), with particular chances to interpersonal perceptual skills, in a way that is distinguishable from training per se (Bennett-Levy et al., 2003), for both novice and experienced therapists. Though a manual has now been published (Bennett-Levy et al., 2015), the research so far has focused on participants’ experiences, neglecting the facilitators. If SP/SR practice is to be improved, we need to learn from the experiences of both the participants and facilitators. The current study aimed to address this gap in the research by taking a qualitative approach to the understanding the experiences of SP/SR facilitators. Results suggest that this is a different role with different challenges and conflicts to the usual supervisory or trainer role.

A qualitative approach will be used to understand the facilitators experience out come not concluded as research is not concluded as yet.

The potential implications are that more experienced therapists will use SP/SR in their practice to support them and reduce burn out and stress.

Angry, Anxious or Traumatised? The Benefit of IAPT in Probation

Toby Chelms, Northpoint Wellbeing (Leeds IAPT)

Using the poster format I intend to present a case study of a Client who was referred to the clinic I work at in Probation within Leeds IAPT.

The Client presented with problematic drinking and anger and was not benefiting from conventional input (Counselling and Anger Management). Through a CBT conceptualisation we were able to establish the root cause of the problems actually being PTSD from an incident in prison which had led to social anxiety, depression, anger and problem drinking as symptoms. This moved us to a conventional CBT PTSD IAPT model.

The Clients drinking reduced, they were able to return to social activities, begin to consider work, work better with social services and the benefits agency, engage better with probation...
and most importantly for them live a much more harmonius life with their Partner and Child free from flashbacks, matched triggers and startle responses.

This work demonstrates how simply placing an IAPT clinic within a Probation setting can help Clients who seem 'problematic' to probation and can often end up returning to offending or prison due to their mental health needs not being met.

I hope that this presentation could help encourage other CBT Practitioners to explore the possibilities in their locality of working in a similar setting.

Working with clients’ narratives: Socratic questioning in qualitative methodology

George Varvatsoulias, Newham College University Centre

In this presentation, I employ clients’ statements coming from sessions I had with them, which will be focused on how Socratic questioning triggers better knowledge on self-understanding. In line with the above, symptomology of conditions could be offered further exploration; goals agreed could be relevant to clients’ understanding of their conditions; interventions discussed could be focused on accommodating constructive changes in the domains of cognition, emotion, and behaviour.

The aim of this study is to introduce a theory that can include qualitative methodology understandings to CBT Socratic questioning statements focused on narrative analysis perspectives. Cognitive behavioural therapy (CBT) approaches clients’ mental states through the process of guided discovery. Guided discovery is a skill of the so-called ‘Cognitive Therapy Skills-Revised’ and it is placed at the very heart of every CBT session. We can’t have a session on CBT without this particular skill which enhances and progresses knowledge on the client’s case both for the person in question and the practitioner.

For guided discovery to be introduced there is the need of a dialogue between the practitioner and the client in which a better understanding is gained on clients’ thoughts, emotions and avoidant behaviours—the three basic elements to a CBT assessment. The dialogue outlined by guided discovery is a century-old one, the technique of which can be tracked back to the writings of Plato where there can be found detailed conversations between Socrates and his pupils. That kind of a dialogue is pursued via open questions where the client is invited to provide any answer he/she thinks that applies better to the question addressed, and refers to his/her case.

In CBT terms, guided discovery is also called 'Socratic questioning', whilst the open questions it involves aims at eliciting thoughts/cognitive appraisals, physical sensations and emotions, escapist and/or untoward choices that introduce a faulty maintenance cycle which keeps perpetuating the problem of the client further.

Socratic questioning, in such an approach, will become the foundation of a qualitative development of CBT statements using the tenets of grounded theory and narrative analysis. The qualitative methodology statements to be employed will add to the discussion of the use of CBT for qualitative client work, out of which typical and/or atypical symptoms may arise assisting CBT practitioners in the furtherance of knowledge concerning individual conditions.

1. Theoretical: Socratic questioning is the basis of CBT methodology in qualitative research
2. Methodological: Narrative analysis could become the context Socratic questioning is based on, so better understanding on the dialogue and collaborative therapeutic alliance between client and practitioner to be introduced
3. Practical: In line with the above, symptomology of conditions could be offered further exploration; goals agreed could be relevant to clients’ understanding of their conditions; interventions discussed could be focused on accommodating constructive changes in the domains of cognition, emotion, and behaviour
4. Therapeutic: Clients achieve their goals through learning how to explore own narratives in line to personal progress in therapy

Narrative analysis will be discussed according to the following parts:
1. Codes of polyphonic importance - resonating others' responses in terms of anticipated meanings.
2. Codes of heteroglossic importance - others' interpretation of one's personal condition one tends to believe in.

Clients' narratives inform clinical practice in terms not only of symptomology based on typical symptoms, but on atypical ones as well.

The impact of shame in generalised anxiety disorders

Megan Edwards, University College Cork
Sean (pseudonym) initially presented with low mood and anxiety associated with relationships and life choices. Further assessment revealed generalised anxiety disorder (GAD). Over subsequent sessions, a strong sense of shame emerged, this was central to indecision and self-doubt.

Depression was formulated using a Behavioural activation approach (Martell et al 2010), incorporating values and goals (Kanter et al 2009), this exacerbated anxiety and indecision and the primary problem was reformulation as being GAD (Dugas et al 1998). Experiments in tolerating uncertainty including reducing procrastination and work on positive worry beliefs began. Soon after the client presented in crisis, reporting high levels of shame associated with heightened self-criticism and avoidance. He viewed himself as "not a real person". Risk was assessed. A review was undertaken highlighting the role of shame within the maintenance of both GAD and low mood. A compassion focused therapy approach (CFT) (Gilbert & Irons 2005) was incorporated.

Therapy is ongoing; the emphasis on shame has led to more active engagement. Beliefs about the self, as well as worry have been targeted leading to significant behavioural change. Scores on all measures were improved.

In this clinical case example, the addition of CFT to the GAD protocol to address high levels of shame and self-criticism with a limited capacity to manage emotions enabled engagement and enhanced the GAD protocol (Dugas et al 1998) for this individual. The role of shame and GAD warrant further analysis.

Psychological inflexibility and coping strategies: Influence on emotional symptoms and life satisfaction in a clinical sample

Beatriz Rueda, Faculty of Psychology. National University of Distance Education (Spain); Esperanza Valls, Actur Sur Mental Health Center (Spain)

Psychological inflexibility (PI) can be defined as a rigid process involving the unwillingness to be in contact with aversive internal experiences, and the tendency to try to alter or avoid them. PI has been associated with emotional symptoms and lower life satisfaction. Other mechanisms, such as coping strategies, are also strongly related to these negative outcomes. However, until now, little is known about the association of PI with coping strategies in clinical patients. Likewise, there is a lack of studies testing the potential mediating role that coping strategies could play in the relationship of PI with depressive and anxious symptoms and life satisfaction.

This research examined the association between PI and coping strategies in a clinical sample. It also explored whether the relationships of PI with depressive and anxiety symptoms and life satisfaction were mediated by coping strategies.

A total of 164 clinical patients (114 women and 50 men) participated in the study prior to beginning psychotherapy. They were included if they had an Axis 1 diagnosis according to
They completed the Acceptance and Action Questionnaire-II, the Brief Cope, the Beck Depression Inventory, the Hamilton Anxiety Rating Scale and the Satisfaction with Life Scale. The bootstrapping method was used to examine possible mediation by coping. The results showed that PI was positively correlated with denial, blame, behavioral disengagement and venting, and negatively correlated with acceptance, positive reinterpretation and life satisfaction. PI was also associated with higher levels of depression and anxiety symptoms, and lower life satisfaction. <br>Mediation analysis showed that negation partially mediated the effect of PI on depressive and anxiety symptoms, although PI also had a direct effect on both outcomes. Furthermore, the relationship between PI and depressive symptoms was partially mediated by acceptance coping. With respect to life satisfaction the effect of PI was direct, suggesting that there was not any meditational effect by coping strategies. These results revealed that PI was associated with maladaptive coping strategies. They also demonstrated that PI had a direct and deleterious effect on life satisfaction and emotional symptoms, although the relationship with these symptoms was also partially mediated by coping strategies. These findings underscore the negative impact that PI has on clinical patients, and the relevance of targeting and reducing this process through psychotherapeutic interventions. These findings support that psychological flexibility and adaptive coping strategies represent important psychological protective factors to be fostered in patients with psychological disorders. Cognitive-behavior therapy can contribute to increase psychological flexibility in an experiential manner, that is, by helping patients actively accept their negative inner experiences, such as emotions, sensations, thoughts or memories, and develop a welcoming stance towards them. Intervening on psychological flexibility also implies changing the function that negative inner experiences have rather than trying to reduce or eliminate them. This functional criterion can be particularly relevant when guiding patients to modify their maladaptive coping strategies.

**Group CBT for Hoarding**

**Augusta Chandler, SW London and St Georges Mental Health NHS Trust, Robert Fogg, SW London and St Georges Mental Health NHS Trust**

Hoarding Disorder is now understood to be a distinct diagnosis. Internationally there is a lack of CBT research in this area. As a tertiary service we have noted increasing referrals for this severe, enduring and often misunderstood mental health problem. Historically we had offered individual home based sessions, but decided to trial group therapy as a cost effective alternative. There is limited research showing evidence that group CBT for Hoarding disorder is effective (Muroff J. et al 2009, Muroff J. et al 2012, Gilliam C. et al 2011).

We invited referrals from primary and secondary care across the 5 boroughs (population 1 million). Home based assessments were conducted and measures taken. Up to 8 people were invited to participate in the treatment, which consisted of 11 x 2 hour group sessions over a 6 month period. The group was closed and facilitated by 2 CBT Therapists experienced in working with Hoarding Disorder. Measures were repeated midway and at discharge. The content of the group included goal review with photographic evidence, psychoeducation such as beliefs attached to hoarding, in vivo voiding, problem solving and goal setting. The local fire officer was invited to give a brief presentation and fire safety visits were encouraged. We also invited a previous group participant to meet with the 2nd group members to share his experience.

1. **Attendance**
   Of the 15 subjects 1 dropped out, 5 attended 100% and 9 attended an average of 79%. The attrition rate is therefore 6.6%.

2. **Measures**
   % Improvements for measures used at assessment and discharge <
   Frost Saving Inventory 31.2% (63 – 43.3)
   Beck’s Depression Inventory 37.1% (25.7 – 16.14)
   Sheehan Disability Scale 36.2% (22.35 – 14.25)
3. Qualitative feedback
Satisfaction questionnaires were given during and at the end of the groups and a range of comments were obtained, mostly positive. An example –
“The group therapy was new and experimental and very helpful. It has helped to meet with other people with the same problems. Sharing at each meeting including discarding items has made a great deal of difference to me.”

Discussion
This is a novel and under researched area of delivering CBT to this complex and challenging client group. Results to date demonstrate that this is an effective model of treatment with clear cost benefits compared with individual home based sessions. We have noted that the groups have required skilled management in order to optimise delivery of treatment. Our demographic data indicates that individuals wait many years before seeking help and they often experience deep shame and isolation. Given the commonality of the condition, this can then be addressed directly in the group – a benefit that is absent from individual therapy.

Points for the future
We are constantly reviewing the content and structure of the group based on client feedback, results and observation of group cohesion. Our delivery of the group is dynamic and evolving. Changes to date include extending the sessions out to 12 and introducing a 2nd home visit for reassessment before the last group session. There is a significant lack of psychological and support services available to people with Hoarding Disorder. We are making links with a range of statutory and non-statutory providers, and encourage collaboration. We are planning to further evaluate the efficacy of group CBT and add to the small body of published research.

How to motivate people to be more active

**Jackie Andrade, Plymouth University; Liz Lennox, Plymouth University, Jon Plymouth University, Plymouth University; David Kavanagh, Queensland University of Technology**
Physical activity can aid recovery from addiction and depression but requires motivation. Mental imagery has long been used to improve sporting outcomes but recent advances in psychological theory suggest it can be harnessed more effectively. Functional Imagery Training (FIT) builds motivation by helping people to create and use emotionally engaging images about goals, paths to attaining them, and proximal benefits. A pilot randomized controlled trial with 48 gym members who wanted to increase their frequency of exercise sessions. We compared the effects of a 45-minute FIT interview against an information booklet over 2 weeks. FIT resulted in more frequent exercise sessions, without reducing session duration or intensity. Changes in exercise frequency were associated with the frequency of motivational imagery, and the availability of motivational cognitions. FIT may have promise as an intervention to increase physical activity. Further research needs to establish duration of effect and superiority to an active treatment control. FIT is a brief intervention that can be incorporated into CBT programmes. It can be used to motivate diverse behavioural changes, including potentially engagement with a CBT treatment programme.

Cognitive Behavioural Therapy for adjustment difficulties following a traumatic brain injury

**Hannah Wiseman, University of Bath**
This case study describes patient X, who sustained a traumatic head injury in a road traffic accident. X was referred to Psychological Therapy Services two years afterwards, and presented with low mood and self-harm. Since his accident X has become unemployed, and his relationship has broken down. Therapeutic work took into account these contextual factors, and responded to fluctuating levels of risk.
X initially attended for neuropsychological assessment, in order to inform decision making about his ability to engage in psychological intervention. Information gathered during neuropsychological assessment was used to adapt standard CBT techniques, and a more didactic, direct and structured approach was adopted. X showed slowed speed of processing, so sessions were paced accordingly. X demonstrated that he benefited from repetition. Written summaries, visual resources and electronic devices were used to enhance retention of material.

A maintenance formulation of low mood was developed based on Beck's model of hopelessness. It was hypothesised that acquired impairments prevented X from achieving tasks he used to do, which threatened his self-worth and activated negative self-schema. This led to X having negative thoughts about being worthless and being a failure. X held negative views of the world and of his future, leading to a sense of hopelessness. In response to this X avoided situations in which he might 'fail' and spent a lot of time ruminating about how things used to be. X found it difficult to express his emotions, and sought short term relief in self-harm behaviours.

X found it helpful to formulate his depression, and noted a connection between activity and mood. Activity scheduling was used to decrease avoidance behaviours and rumination, and increase activities that might promote pleasure and mastery. Part of the intervention focused on encouraging X to identify a new sense of purpose, as he believed this to be lost since losing his employment.

X currently presents as being 'severely' depressed and has low self-esteem. However he continues to engage in CBT and his mood has shown a positive trend since beginning to increase activity. Ongoing work should continue to identify meaningful activities, with the aim of reducing depressive symptoms.

Theory suggests that identifying meaningful activities is central to therapeutic work with this population, and in this case study it seems to have been a catalyst for change. We would predict that future engagement in purposeful activities that provide opportunities for achievement will improve self-esteem and self-efficacy and reduce depressive symptoms. This case illustrates the intersection between neuropsychology and psychotherapy, and highlights the importance of tailoring assessment, intervention and therapist approach, in order to optimise engagement, learning, and change. The importance of creating opportunities for purpose and meaning following a traumatic brain injury is highlighted.

Regular Eating as a Mediator of Enhanced Cognitive Behaviour Therapy for Eating Disorders

Katy Sivyer, University of Oxford; Rebecca Murphy, University of Oxford, Elizabeth London School of Hygiene and Tropical Medicine, London School of Hygiene and Tropical Medicine; Zafra Cooper, University of Oxford, Christopher Fairburn, University of Oxford

Enhanced cognitive behaviour therapy (CBT-E) and interpersonal psychotherapy (IPT) are both evidence-based treatments for eating disorders. Little is known regarding their mechanisms of action, although they are hypothesised to work in different ways; CBT-E directly targeting eating disorder (ED) behaviours, and IPT targeting interpersonal problems thought to be maintaining the disorder. A specific mechanism of CBT-E is hypothesised to be regular eating; the implementation of a structured eating pattern, which is hypothesised to help reduce frequency of binge-eating.

A mediation sub-study assessing regular eating as a mediator of change in frequency of binge-eating in CBT-E was embedded within a randomised controlled trial comparing CBT-E and IPT for eating disorders. Adherence to a regular eating pattern ('regular eating') and frequency of objective binge eating (OBE) were assessed by two independent assessors based on patients’ monitoring records of their eating behaviours.

Results suggested different relationships between change in regular eating and change in OBE between CBT-E and IPT, with structural equation modelling supporting regular eating as a mediator of binge-eating in CBT-E.

Whilst results were consistent with the hypothesis that regular eating may be a specific mediator of binge-eating in CBT-E, as change in regular eating did not clearly occur before...
change in frequency of OBE (change in the mediator should occur before change in the outcome if the mediator is driving change in the outcome) conclusions remain tentative. Implementation of a regular eating pattern is a key procedure in CBT-E. The current research supports its role in helping patients with eating disorders reduce their binge-eating.

Treatment of health anxiety in parallel with investigations for potentially serious physical illness

Nick Stewart, University of Bath

Mr N visited an IAPT service complaining of Health Anxiety (HA) which he related to treatment for a tumour in his spine six years previously. He noticed that he spent time scanning his body for pains and always jumped to the worst case scenario. Mr N was keen to pursue psychological help to address the crux of the problem rather than treat his anxiety medically.

A formulation was developed collaboratively in which Mr N’s experience of having a spinal tumour was identified as the critical incident. His diagnosis had appeared to confirm pre-existing fears that innocuous bodily sensations could have a sinister cause, despite medical reassurance to the contrary. A ‘vicious flower’ maintenance formulation (Salkovskis et al., 2003) highlighted how Mr N’s responses to his fears tended to increase the strength of his catastrophic misinterpretations. Among these responses, reassurance-seeking was hypothesised to be the key factor maintaining Mr N’s concerns.

Treatment consisted of a variety of cognitive-behavioural techniques (incorporating mindfulness) over ten weekly sessions. An ‘alternating days’ behavioural experiment was implemented with the aim of eliminating reassurance seeking; on one day Mr N sought as much reassurance for health concerns as he wanted; on the other day he avoided seeking reassurance completely.

Partway through therapy Mr N received the results of a recent medical test implicating referral to a medical specialist to rule out possibilities, including cancer. Salkovskis et al. (2003) recommend that CBT for HA should not take place if the client is undergoing major medical tests, but also suggest that such tests may prove to be a valuable source of information for therapy (i.e., variations in anxiety levels before, during and after medical tests). In concordance with Mr N’s wishes therapy continued as planned.

Mr N’s scores on the Health Anxiety Inventory (HAI-18; Salkovskis et al., 2002) dropped during intervention from 41 (0.46 SD above the mean score seen in people with HA) to 25, a decline equivalent to 2.35 SD. The improvement coincided with the ‘alternating days’ behavioural experiment. Although HAI-18 scores indicated that Mr N was still health anxious at the end of therapy, his improvement was considerably above the reported statistically reliable change of ≥4 points. Mr N reported subjectively feeling more at ease with regard to HA by the end of therapy and found that he was having more ‘moments of clarity’ (i.e., times when he could rationalise his health fears as worries rather than real concerns).

This case provides evidence to support the suggestion that ongoing medical tests need not be a barrier to treatment for HA. These tests provided useful live data to explore collaboratively in session, ultimately enabling both cognitive change and improvement in HA symptoms. Symptom change coincided with experiments aimed at reducing and later eliminating reassurance seeking, underlining the importance of encouraging clients with HA to put thinking into practice during therapy (Salkovskis et al., 2003).

Research is currently lacking regarding the active ingredients and non-specific factors important in therapy for HA (Thomson & Page, 2007). This case highlights how CBT for HA can be adapted to meet the specific physical health-related circumstances of clients (i.e., receiving the results of what could be perceived as a major medical test). Therapists who encounter similar cases should take special care to be responsive to the needs of the client.
during the periods of considerable emotional fluctuation that accompany medical tests for
HA clients.

Mental contamination in obsessive-compulsive disorder: a case study

Sally McGuire, University of Bath

Background: Research suggests that mental and contact contamination are separate but related constructs, and patients with Obsessive Compulsive Disorder (OCD) may present with symptoms relating one or both types. Patients experiencing mental contamination may be more responsive to treatment with a more cognitive focus. Method: The case study describes CBT therapy for a patient with a 25-year history of OCD whose symptoms were predominantly related to mental contamination. Due to symptom persistence, the patient attended four phases of CBT treatment, with the first three phases being in an Improving Access to Psychological Therapies (IAPT) primary care service, followed by a fourth phase in secondary mental health services. Results: Following secondary care CBT therapy, OCD symptoms (measured using the Obsessive Compulsive Inventory (OCI)) fell by 44% to their lowest recorded level since treatment began (OCI highest score: 125, lowest score: 70). Conclusion: Intensive CBT for OCD using an individual formulation and cognitive therapy with behavioural experiments may be more effective for people who experience contamination from non-physical contaminants.

Three years on: The challenges and success of delivering a primary care CBT service for people with eating disorders

Charlotte Cooper, Avon and Wiltshire Partnership NHS Trust

Bristol was the first area of the UK to develop a primary care service for people with eating disorders. The aim was to deliver accessible evidence based treatment. This service evaluation reports on its effectiveness. Qualitative and quantitative client feedback is reviewed. GP satisfaction is reviewed. Clinical outcome measures are compared to Fairburn and Waller outcomes. Service referral rates are reviewed. Service attrition rates are reported. Service user and GP satisfaction is high. Referral rates continue to increase. Clinical outcomes are comparable with studies of CBT with a similar client group. Non-attendance of those referred close to the 35% as demonstrated in Waller et al.'s (2009) study. A primary care service proves to be popular, accessible and effective. Potential service development tasks regarding further increasing accessibility and the challenges of limited service resource are outlined. Everyday clinical implications include addressing motivation within CBT; treatment planning (including no. of sessions) in line with client goals at point of contact; waiting list management including regular written communication and promotion of self help materials. Service level implications include fostering positive relationships with GPs and the value of provision of regular clinical and caseload supervision.

A CBT approach to suicide assessment and intervention

Colin Hughes, Queens University Belfast; Paul Canning, Queens University Belfast, Colin Hughes, Queens University Belfast, Jean Queens University Belfast, Queens University Belfast; Fiona Martin, Queens University Belfast. Within Northern Ireland the Department of Health allocates over £7 million pounds to suicide prevention. This is invested in programmes to improve resilience and well-being, in spite of this according to the Office for National Statistics (ONS) (2016) Northern Ireland continues to have the highest rate of suicide in the UK per head of population. Unfortunately we have little ability to predict suicide, as there are many factors to be considered. The purpose therefore is to not predict suicide but better understand the sources of a service users distress and thereby develop an informed approach to intervention (Muzina, 2007).;As
such using a basic CBT approach a one day training was developed and implemented covering assessment and intervention, with trainees asked to assess how confident they felt the programme equipped them for working with an adult mental health population. Due to the apparent service provision difficulty the authors proposed an initial service improvement training project for third year Mental Health Nursing Students. An initial cohort of 40 trainees were offered the opportunity to participate on a voluntary basis all trainees who were offered this training engaged with the training, an indication perhaps of the need for this format of training.

Using the basic CBT model as proposed by Beck (1967) and the ABC technique as proposed by Ellis (1957), the authors developed a bespoke assessment tool/model and intervention process. Training involved the use of audio visual media, didactic teaching, small group tutorials and practical role play, to provide the trainees with the necessary information and practical application.

All participants agreed the training improved knowledge and their ability to utilise this knowledge in everyday practice. They reported reduced anxiety when thinking about the topic and the implications for practice Comments such as 'the workshop was beneficial...' 'the role plays within groups were a good experience as it helped build confidence in carrying out assessment within practice', 'carrying out role plays and having feedback and prompts when unsure what to say was useful'; Overall the results were positive, however participants did suggest some improvement to content and format which will be brought forward and included in subsequent training.

As suggested the programme will be modified to include a longer duration over two days, in addition to this the use of additional video work and the inclusion of this format of training during year one, two and three of training using a skills escalator approach will be considered.; As this was initially proposed as a service improvement project additional work and research will be conducted to evaluate the trainings quantitative value this will include service users and carers perspectives. Overall the training appears to have met the proposed objectives of providing a framework practitioners could use to improve skills of both assessment and intervention when working with service users with heightened levels of emotional distress.

Using basic conceptualisations already well researched and understood within and indeed without the CBT community but applied in a specific format it is expected that practitioners from tier two to tier five will be able to improve their skills with assessment and intervention. It is possible this can become a standardised approach within Northern Ireland in order to ensure service users have access to standardised and competent assessment and intervention with the overall aim of reducing the rates of suicide for those within mental health services. In addition it is hoped this approach will encourage a wider understanding of the problem making it a more acceptable topic for discussion.

Cognitive Behavioural Therapy for Anorexia Nervosa: Outcomes in Routine Clinical Practice

Jon Kelly, Beat, Glenn Waller, University of Sheffield,
While there is recent evidence that specific forms of cognitive-behavioural therapy (CBT) can be used to treat anorexia nervosa with more success than other therapies, its moderate level of efficacy needs to be backed up with evidence of effectiveness in everyday clinical settings.

The patients were a case series of 16 anorexia nervosa patients from routine NHS settings, all of whom completed 30 sessions of individual outpatient CBT (with a focus on weight gain). They were assessed on change in BMI, improvement in eating attitudes, and changes in other variables (e.g., anxiety, depression, working alliance).
The patients showed considerable improvements in all variables, with strong effect sizes. There were no factors that suggested that pre-treatment variables prevented some patients from doing well. These findings confirm that CBT for anorexia (with a focus on the primary outcome variable of weight gain) is effective in everyday clinical settings. While outcomes for anorexia nervosa remain moderate at best, CBT has established its role as the first option when treating adults. CBT for anorexia nervosa should focus on weight gain, and should be considered the first option when treating adults.

Brief Behavioural Activation treatment for depressed adolescents (Brief BA) delivered by non-specialist clinicians: A case illustration

Elizabeth Hodgson, Berkshire Healthcare NHS Foundation Trust; Laura Pass, Charlie Waller Institute, University of Reading, Hannah Whitney, Charlie Waller Institute, University of Reading, Shirley Charlie Waller Institute, University of Reading, Charlie Waller Institute, University of Reading

Depression in young people is a common, debilitating psychological disorder that is associated with numerous negative long term impacts, including poor academic attainment and lower employment prospects and wages, mental health difficulties in adulthood, and suicide. Access to evidence-based treatments such as Cognitive Behavioural Therapy (CBT) is variable and can often be limited by availability of qualified clinicians. Increasing the number of qualified clinicians is impeded by the relatively high costs of training and employment. To increase availability and access, there is a need to develop and evaluate alternative treatments that are brief, acceptable to clients, and that can be delivered by a wider range of professionals in a range of settings. Behavioural Activation (BA) can be as effective as Cognitive Behaviour Therapy (CBT) for the treatment of depression in adults, but to date, there is little research with adolescents. This is problematic given the recognised need to increase access to evidence based interventions for depression in young people.

An adaptation of Brief Behavioural Activation had been developed that is specifically for adolescents; Brief Behavioural Activation adolescent depression (Brief BA; Pass & Reynolds, 2014). The highly structured approach means that brief BA can potentially be delivered by CAMHS staff who do not have formal training in psychological therapies. We present a case example of Brief BA with session by session monitoring. The client ("Emma") was a 16 year old girl who presented with moderate Major Depressive Disorder (MDD). The clinician was a Psychology Assistant who had no experience of psychological interventions with depressed adolescents. Training and supervision were provided by a qualified Clinical Psychologist.

The intervention involved eight weekly one hour sessions and a 30 minute post-treatment review. Sessions were structured and focused on monitoring activities, identifying values across life areas, and planning value-based activity into daily life. Young Person and Parent session by session worksheets were provided and the parent was invited for part of sessions 1, 6, 8 and review.

The parent and young person RCADS depression subscale showed reliable and clinically significant improvement through Brief BA, moving from a clinical range at the initial assessment to a normal range by review. The young person ORS score also showed reliable and clinically significant improvement, moving from a clinical range at BA session 1 to a normal range by review. The parent ORS remained normal through the course of Brief BA. Emma was very positive about the therapy she had received. She reported that Brief BA "has helped me to work on things I had never thought to work on before" and "has lifted my mood so much". Emma’s mother noticed that Emma seemed happier and her overall sense of well-being had improved. Emma's mother reported that Brief BA "made everything seem more positive". It was agreed that Emma would be discharged from the service following completion of BA.
This case example illustrates how Brief BA for the treatment of adolescent depression can be successfully delivered by a non-specialist clinician, with a minimal amount of training. The clinician learnt that BA is a practical and straightforward approach, which allows for flexibility within fidelity. It was found that good quality, BA specific supervision is important to maintain adherence to the approach and problem-solve any difficulties with engagement. Further research is needed to evaluate this approach and determine effectiveness compared to other current psychological interventions such as CBT, including cost of clinicians.

A brief, structured intervention for adolescent depression may be appealing for some young people and their families. Additionally, adolescents with depression may have deficits in abstract cognitive reasoning and executive functioning that may interfere with their ability to engage fully in cognitive treatments such as CBT. Brief BA is simple to understand and deliver, and may be an effective and cost effective treatment for adolescent depression. If further research supports its effectiveness, BA could be offered as an alternative to current treatments such as CBT or IPT for some young people.

Body Dysmorphic Disorder: A Case Report

Kirsty Ryninks, University of Bath

CL was referred to the Complex Psychological Interventions team following contact with a private hospital in search of cosmetic surgery. She presented with a number of symptoms indicating the presence of Body Dysmorphic Disorder (BDD). CL was 80% sure that she was scarred on her face and believed that other people noticed and made negative judgements about her. CL’s beliefs about herself had a significant impact on her life and she had withdrawn from socialising altogether.

Treatment consisted of a variety of cognitive behavioural techniques delivered over ten sessions. Six sessions were spent collaboratively creating a timeline together, as CL had made no connection between her past and her current presentation. These sessions were crucial in developing the therapeutic relationship and the timeline was a helpful way for CL to make sense of her previous experiences, connecting traumatic events to the development of negative beliefs. It became clear that these early experiences laid the foundations for the development of CL’s BDD.

A cognitive-behavioural formulation of BDD (Wilhelm et al., 2013) was collaboratively developed in sessions seven and eight to understand how CL’s BDD had developed and what was maintaining it. The strong therapeutic alliance, developed over the course of generating the timeline, was crucial to CL feeling safe to explore her thoughts and feelings about her BDD. The formulation highlighted how CL’s attempts to block the negative thoughts about her appearance may have been altering people’s reactions to her, increasing the strength of her catastrophic misinterpretations.

Cognitive Restructuring was introduced in the remaining sessions, where CL generated information on the links between her thoughts and feelings, and answered negative thoughts with rational responses. Exposure and Response Prevention will be undertaken by another Clinical Psychologist, because the author was a trainee on placement.

CL’s scores on the Beck Depression Inventory (BDI-II; Beck, Steer & Brown, 1996) and Appearance Anxiety Inventory (AAI; Veale et al., 2014) dropped from 34 and 33 to 24 and 29 respectively. CL learnt to trust another and develop a therapeutic relationship. Her mood showed some improvement by session ten and CL reported feeling less depressed and more positive about the future.

This case provides evidence to support the idea that embedding timeline generation (in the presence of past trauma) in an extended CBT formulation can provide a more effective base from which to work on BDD. Previous studies emphasise focussing treatment from the outset on resolving BDD using CBT techniques (Wilhelm et al., 2013). However, others have suggested that a history of abuse may potentially complicate treatment for BDD and need to be considered in the first instance.

It was evident that in CL’s case, exploration of the past traumas was an important first step and helped her to feel understood prior to introducing CBT treatment strategies for BDD.
More research is needed, but this single case highlights the importance of including timeline generation as part of a comprehensive treatment approach for BDD.

Assessment and formulation in obsessional slowness

Cara Haines, University of Bath

CBT is well established as an effective treatment for OCD (NICE, 2005) and accordingly, there is a wealth of evidence-based cognitive-behavioural resources to draw on for assessing and formulating OCD. Obsessional slowness, in contrast, is a rarely encountered disorder with very limited literature to guide assessment and formulation. This case report details the use of broad CBT principles to guide assessment, formulation and treatment with a patient with diagnosis of obsessional slowness. The patient presented with very long morning and evening routines caused by extreme slowness in completing a range of self-care activities. CBT principles were used to guide assessment and to work up an initial formulation. As has been reported in previous case studies, the patient had great difficulty in explaining his slowness. Intervention took the form of hypothesis testing, and used prompting, shaping and pacing as recommended in existing literature. Behavioural experiments and hypothesis-testing resulted in the patient being able to provide more information, which resulted in a much richer, longitudinal formulation of his slowness.

This is the first known case study to provide such an in-depth CBT formulation for obsessional slowness.

It is hoped that this case study will contribute to understanding and conceptualisation of obsessional slowness, which in turn will inform treatment direction.

Exploring the efficacy of brief CBT intervention targeting anxiety in a person with a diagnosis of schizophrenia

Holly Panting, University of Bath

Exploring the efficacy of brief CBT intervention targeting anxiety in a person with a diagnosis of schizophrenia

Presenting problem:
People with a diagnosis of schizophrenia are more likely to have both anxiety symptoms and anxiety disorders than the general population. Recent initiatives and guidelines highlight the importance of assessing and treating anxiety in people with schizophrenia because the presence of anxiety is likely to have implications for symptoms, risk, psychosocial functioning and quality of life. Brief CBT interventions (4-8 sessions) have been evidenced to be effective for treating Axis I disorders, and have obvious advantages in terms of saving time, resource and cost. However, the use of brief CBT interventions has yet to be examined in people with a diagnosis of schizophrenia.

Case conceptualisation and intervention:
This poster presents a case study (n=1) which examines the efficacy of a brief CBT intervention targeting anxiety in a client with a diagnosis of schizophrenia.

Outcome:
Results suggest that the intervention was well-received and effective.

Review and evaluation:
Clinical implications and limitations are discussed, as well as indications for future research.