ABSTRACTS

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Adult Mental Health

Keynote Addresses

Compulsive checking, from start to never-finished

Professor Adam S. Radomsky, Concordia University

Compulsive checking is one of the most common forms of OCD and, yet until recently, research focusing on this serious and often debilitating manifestation of the disorder has been lacking. The result of this is that, although compulsive checking brings with it a number of complex behavioural, cognitive and metacognitive features, frequently recommended treatments for maladaptive checking behaviour are normally the same as those used for other forms of OCD, usually exposure and response prevention and/or psychopharmacological interventions. Unfortunately, these effective treatments still leave a substantial proportion of individuals unwell. This presentation will report on a number of experimental studies conducted on cognitive and behavioural aspects of compulsive checking designed to assess factors such as perceived responsibility, probability and severity of harm, memory and metamemory as both contributors to, and the result of compulsive checking behaviour. Results from these studies have elucidated a number of important mechanisms and features of compulsive checking that speak to both the psychopathology of this form of OCD and to its treatment. It is hoped that findings from these and other investigations will lead to improvements in the specificity of effective psychological treatments for compulsive checking behaviour in obsessive-compulsive disorder.

Developments in CBT for personality disorders: translating the learning from research trials

Professor Kate Davidson, University of Glasgow; NHS Greater Glasgow and Clyde

Since the 1990s, there has been a rapid growth in the research literature and clinical interest in personality disorders. Although we now have more evidence on the effect of psychological therapies through randomised controlled trials, few have been methodologically rigorous until relatively recently. Long-term naturalistic follow-up studies suggest that temporal change in personality disorder is common. However, there is still no consensus on what we should measure when assessing change in clinical trials of personality disorder. The changes seen in “symptoms” in naturalistic studies may be those that are most likely to be changed by psychological therapy. Choosing appropriate measures may therefore be crucial in determining the outcome of a trial though results of trials may need to be regarded with caution.
Cognitive models of personality disorder are in their infancy. Therapy emphasises core beliefs and behaviour and the important role of childhood environment and rearing practices. Therapy produces change in beliefs about self and others and in behaviour, at least in patients with borderline personality disorder. Personality disorders are heterogeneous both within and across disorders and cognitive therapy will have to reflect these differences. The interpersonal difficulties that this group of patients show so clearly highlights the importance of the therapist-patient relationship. The use of supervision is essential in helping maintain a good therapeutic alliance and the skill of the therapist is crucial in determining outcome.

Symposia

New Advances in OCD Research and Treatment

Convenor & Chair: Adam Radomsky, Concordia University, Canada

The Impact of Interpersonal Beliefs About Responsibility on Compulsive Checking

Adam S. Radomsky, Andrea R. Ashbaugh & Monique Lahoud, Concordia University, Canada

An inflated sense of responsibility has been associated with elevations in behaviour and cognitions related obsessive-compulsive disorder (OCD). However, there are many components of responsibility that could impact these behaviours and cognitions. The purpose of this study was to experimentally investigate if believing that other people are not responsible for a task increases an individual’s checking related thoughts and behaviours. Undergraduate students (n = 82) completed a data entry task in pairs, where one individual was asked to read individual questionnaire item responses to their partner, who in turn was asked to enter the items into a computer spreadsheet. During this task, one partner was asked

to take full responsibility for the outcome of the task, and the other to relinquish their responsibility to their partner. Both at the end of the task and after receiving negative feedback on the outcome of the task, partners were asked to rate their urge to check, their perceived seriousness and probability of a negative outcome, how much criticism they anticipated from their partner, and their discomfort and anxiety. Results indicate that the responsibility manipulation did result in a significant increase on some variables, including anticipated criticism, $F(1, 78) = 6.94$, $p < .01$, and the urge to check, particularly following the negative feedback, $F(1, 78) = 5.15$, $p < .05$. The type of role assigned to each participant influenced the impact of the responsibility manipulation on some variables. For example, there was no difference in anxiety between high and low responsibility typers; however, high responsibility readers reported more anxiety than low responsibility readers, $F(1, 78) = 7.52$, $p < .01$. These results suggest that researchers should examine in greater detail how responsibility operates in interpersonal situations. Results will be discussed in terms of cognitive-behavioural models of OCD.

"Stopping" criteria in compulsive checking: An investigation into the factors that mediate the termination of compulsive checking in the naturalistic setting

Alice Hooper, Sutton Hospital, South West London and St George's Mental Health Trust, UK; Victoria Oldfield, South London and Maudsley NHS Trust, UK & Institute of Psychiatry, King's College London, UK; Paul Salkovskis, South London and Maudsley NHS Trust, UK & Institute of Psychiatry, King's College London, UK

This study investigated the recent elevated evidence requirements (EER) model proposed by Salkovskis and colleagues (Salkovskis & Wahl, submitted; Wahl, Salkovskis & Cotter, submitted) to account for how people with OCD decide to "stop" compulsive rituals once they have started. EER suggests that in OCD, when deciding to "stop" repeating particular actions, individuals tend to evaluate a greater range of criteria and more subjective criteria (e.g. how something feels emotionally) than people without OCD. This tendency means that rituals are prolonged as it is difficult and effortful for individuals to decide to "stop" ritualising based on such extensive and ambiguous criteria.

This study was based on the inventory and interview studies by Salkovskis and colleagues and used an interview and naturalistic experimental design, with an anxious control group. The experiment attempted to manipulate the ways in which individuals decided to "stop" checking two different actions by using alternating instructions: one based on relying on "sensory" (objective) information and the other based on "feelings" (subjective) information. It was hypothesised that when individuals with OCD used more subjective criteria, they would take longer to complete tasks in the experiment.

It was found that participants in the OCD group reported relying more on their 'feelings' and found decision-making more effortful than the control group when deciding to "stop" actions. However, the experiment was not found to be successful in producing a realistic compulsive check for the OCD group and therefore the finding that the OCD group did not spend longer checking actions than the control group may be attributed to methodological problems. Limitations and implications of the study were considered and interesting recommendations suggested for future naturalistic experimental research.

A qualitative investigation into the acceptability of intensive cognitive behaviour therapy (CBT) for obsessive-compulsive disorder (OCD)

Anna Bevan, Institute of Psychiatry, London, UK; Victoria Oldfield, South London and Maudsley NHS Trust, London, UK; Paul Salkovskis, Institute of Psychiatry, London, UK & South London and Maudsley NHS Trust, London, UK

Involving service users in research and service development has become an NHS priority, and it is clear that incorporating service user perspectives can enrich traditional methods of treatment evaluation. Qualitative methods are particularly appropriate for investigating subjective experience, and may offer unique insights into factors affecting change, such as service users' experience of the therapeutic alliance, engagement with treatment, or motivation to undertake difficult homework tasks. An intensive format for the delivery of CBT for OCD has been developed, and the results of a detailed comparative qualitative analysis of client perspectives on this format as well as a standard weekly format will be described. Participants who had completed treatment in each format were interviewed, and the transcripts were analysed in detail using Interpretative Phenomenological Analysis. Individual differences were apparent in preference for treatment format, and some service users felt the need for the slower pace provided by weekly sessions. However, treatment completers who chose their intensive therapy format viewed it as highly acceptable, valuing the high pressure and pace and believing that it improved motivation, engagement and eventual outcome. An intensive treatment format for the delivery of CBT for OCD can be highly motivating and acceptable to service users.

A 10 year review of a UK specialist service for young people with obsessive compulsive disorder (OCD)

Isobel Heyman, Institute of Psychiatry, UK & South London and Maudsley NHS Trust, UK; David Mataix-Cols, Institute of Psychiatry, UK & South London and Maudsley NHS Trust, UK; Nadia Micali, Institute of Psychiatry; Eriko Nakatani, Institute of Psychiatry, UK & South London and Maudsley NHS Trust, UK; Lola Perez, Institute of Psychiatry, UK &

South London and Maudsley NHS Trust, UK; Roz Shafran, Reading University, UK; Cynthia Turner, Institute of Psychiatry, UK & South London and Maudsley NHS Trust, UK

A specialist children's OCD clinic was established at the Maudsley Hospital just over 10 years ago, the first such dedicated clinic in the UK. 469 referrals from all over the UK were seen between July 1996 and June 2006. The majority of children had been previously assessed/treated by their local Child and Adolescent Mental Health Service (CAMHS). Referral to the national specialist OCD clinic was usually for assistance with diagnostic uncertainty, failure to respond to treatment or, in a few cases, at parental request. 318 of these referrals met diagnostic criteria for OCD.

We have recently been reviewing and studying this group of individuals in several ways, and will present data from some of our 4 main current studies on this sample of young people with OCD:

Symptom structure in paediatric OCD
Outcome of children receiving cognitive behaviour therapy in the clinic: a naturalistic study
Preliminary findings of a follow-up survey of these patients
Instrument validation studies
Short obsessive compulsive screener (SOCS)
Children's obsessive compulsive Inventory (ChOCI)

Personality disorder: trials, experiments and doing CBT

Convenor & Chair: Kate Davidson, University of Glasgow

Influence of therapist competence and quantity of CBT on suicidal behaviour and inpatient hospitalisation in a randomised controlled trial of cognitive behaviour therapy in borderline personality disorder. Further analyses of treatment effects in the BOSCOT study

John Norrie, Centre for Healthcare Randomised Trials (CHaRT) University of Aberdeen; Kate Davidson, University of Glasgow & BOSCOT Study Group

In this talk we further explore the estimated treatment effects found in the BOSCOT randomised controlled trial of cognitive behavioural therapy (CBT) in addition to treatment as usual (CBT plus TAU) compared with TAU alone in 106 people with borderline personality disorder reported in the *Journal of Personality Disorder* (Davidson *et al.*, 2006). Those results were based on the principle of intention-to-treat (ITT), recognised as the appropriate methodology for the principle reporting of a randomised controlled trial. The additional analyses presented here go beyond these results and report information on the quantity and quality of therapy received, relating this information to two of our primary outcomes, suicidal behaviour and inpatient hospitalisation, using causal modelling (in particular, the Complier-Adjusted Causal Effects, or CACE estimate, as discussed in Dunn *et al.*, 2003 & 2005). In addition, we investigate a possible delay in the treatment effect manifesting itself (sometimes a feature of complex interventions (MRC Guidelines, 2001) such as CBT), and discuss a predictive model for estimating the anticipated frequency of suicidal attempts over a 2 year period using information collected at the time of randomisation. We will also give brief details of the BOSCOT long term follow up study, now underway.

Certainty and uncertainty of identity in Borderline Personality Disorder

Marc Obonsawin, University of Strathclyde; K. M. Davidson, University of Glasgow; J. Carlisle, University of Glasgow

Developmental identity disturbance is a diagnostic criteria for Borderline Personality Disorder (BPD) (Lieb *et al.*, 2004; Sanislow *et al.*, 2000), and is a consistent feature in many conceptualisations of BPD (Livesley, 1998). Despite agreement about the importance of identity disturbance in BPD, there is little understanding of the nature of the disturbance. The aim of this study was to investigate self-clarity of identity in individuals with BPD. Individuals with a diagnosis of BPD, Major Depressive Disorder (MDD) and individuals without a psychiatric diagnosis rated the extent to which words reflect who they are (a score of 5) and who they are not (score of 1). Participants also completed a speeded computerised task during which they made a forced choice as to whether words reflect who they are (Like me) or who they are not (Not like me). The data provides scores that indicate the degree of certainty and uncertainty about different aspects of identity. These scores provide some information about the nature and range of identity disturbance in individuals with BPD.

The MASCOT Trial: a randomised controlled trial of cognitive behaviour therapy for violent men with antisocial personality disorder

Kate Davidson (on behalf of the MASCOT group), University of Glasgow & NHS Greater Glasgow and Clyde

We are currently completing a randomised controlled trial of CBT for violent men with Antisocial Personality Disorder. MASCOT is a two-centre randomised controlled trial of CBT for men who are violent and who meet diagnostic criteria of ASPD. Over 50 participants were randomised to either treatment as usual or to CBT for ASPD. Experienced mental health professionals trained in CBT undertook to provide either 6 and 12 months of therapy with the above patients. All patients receive three monthly in trial

assessments by research assistants who are blind to treatment group allocation. Trial methodology, measures and milestones will be described. Trial participants with ASPD are a severely disadvantaged group. The learning from this pilot RCT will help to shape a more definitive randomised controlled trial in ASPD.

CBT for antisocial personality disorder, The Therapist Experience

Judith Halford, NHS Greater Glasgow and Clyde; Kate Davidson, University of Glasgow

MASCOT is a randomised controlled trial evaluating the use of CBT delivered in NHS settings to men with antisocial personality disorder. This paper draws upon the experiences of the therapists delivering the treatment. They were all experienced CBT practitioners who had additional training and supervision in using CBT for personality disorder. The structure and content of the therapy will be outlined, and illustrated with anonymised clinical examples. The process of therapy will be discussed including the challenging issues raised by working with this patient group. The experience gained from delivering therapy should help to take future research trials forward and help the transfer of research into the reality of clinical practice.

Theoretical advances in bipolar disorder

Convenor: Matthias Schwannauer, University of Edinburgh

Chair: Mick Power, University of Edinburgh

Regulating Positive Emotion to Normative and Idiographic Stimuli in Bipolar Disorder

June Gruber, Allison G. Harvey & Sheri L. Johnson, University of California, Berkeley

Few studies have used basic emotion paradigms to experimentally examine precisely how positive emotion is dysregulated and whether people with bipolar disorder can use cognitive restructuring techniques (e.g., Gross, 1998; Kross et al., 2005) to regulate their emotions. In this talk, we will present data from two different studies which each include a comparison between euthymic bipolar participants (n = 30) and non-psychiatric controls (n = 30). We examined the generalisability of positive emotion regulation by presenting stimuli in both external/normative (films, Study 1) and internal/idiographic (imagery, Study 2) modes. We included euthymic bipolar participants in order to assess whether positive emotion dysregulation represents a trait-like pattern. Finally, to examine whether positive emotion abnormalities are observed across distinct domains of emotional response, we employed a multi-method approach by assessing emotional experience, behaviour, and autonomic physiology for both studies. The first study provides data on positive affect regulation in response to standardised film stimuli. Participants watched brief emotional film clips while their subjective (positive and negative emotion experience), expressive (positive and negative emotional behaviour coded using EMFACS [Ekman & Friesen, 1979]), and autonomic (heart rate, skin conductance, RSA) responses were collected. In the first condition, participants were instructed to watch a positive film carefully and respond naturally. In the second condition, participants were instructed to cognitively reappraise the positive film by "adopting a detached and unemotional attitude" during the film (Gross, 1998). Our second study examines positive emotion regulation in response to idiographic emotional imagery. Specifically, participants were instructed to recall a past experience in which they felt overwhelming positive emotion (procedure adapted from Ayduk, Mischel & Downey, 2002). In the first condition, participants were instructed to mentally image the positive memory by focusing on the deepest thoughts and feelings they experienced as the situation unfolded. In the second condition, participants were instructed to adopt a distanced-why perspective by "taking a few steps back and move away from your experience… as if it were happening all over again to the distant you . . ." (Kross *et al.*, 2005). Preliminary data from Study 1 and 2 suggest that (1) in the first condition, individuals with bipolar disorder exhibit increased positive emotional responding compared to controls while watching the positive film or imaging the positive autobiographical memory. (2) In the second condition, following the instructed reappraisal in Study 1 or distanced-why strategy in Study 2, participants with bipolar disorder were able to use these cognitive restructuring techniques to down-regulate their emotional responses and were indistinguishable from non-patient controls across subjective, behavioural, and physiological channels of emotional responding. The findings will be integrated with models of reward sensitivity and positive emotion in bipolar disorder. We believe that refining models of positive emotion dysregulation in bipolar disorder will ultimately enhance the prevention and treatment.

The Ups and Downs of Hypomanic Personality: Inspiration, Positive Self Appraisal and Substance Use

Steven Jones, University of Manchester

INTRODUCTION: Although hypomanic personality is associated with increase risk of bipolar disorder experiences associated with hypomania are often highly valued. This talk will consider three studies with individuals at behavioural risk of bipolar disorder to enumerate inspiration experiences, specificity of positive self appraisals and patterns of substance use.

METHOD: Study 1 surveyed 115 participants with respect to Hypomanic personality and frequency and intensity of Hypomanic experiences. Study 2 surveyed 244 participants with respect to HPS, positive and negative self appraisal. Study 3 compared 25 high and low HPS participants with respect to positive self appraisal and substance use.
RESULTS: Study 1 Behavioural risk of hypomania was significantly associated with intensity of inspiration experiences. Study 2 Behavioural risk of hypomania was uniquely as associated with positive but not negative self appraisal. Study 3 Individuals at high risk of hypomania reported greater average and peak alcohol use and greater social and personal impacts for alcohol and cannabis than controls.
DISCUSSION: Taken together the studies indicate that behavioural risk of hypomania is associated with both positive self appraisal and inspiration but also with elevated risk of substance use even in individuals without a clinical diagnosis.

Affect Regulation and Mixed States in Adolescent Onset Bipolar Disorder

Matthias Schwannauer, University of Edinburgh

The paper will present up to date clinical and conceptual considerations regarding the early development and psychological intervention in bipolar disorders. We want to focus on mixed emotional states which often provide the most challenging manifestations of bipolar mood for sufferers and clinicians alike. Phenomenology and plausible theoretical models of mixed affective states in bipolar disorder will be explored. Considerations are given to emotional, cognitive and psychosocial factors associated with processes of affect regulation. Affect regulation will be linked to onset and recovery in bipolar disorder. A particular emphasis of our investigation is the role and influence of key developmental factors such as attachment and reflective function in the development and course of bipolar disorder. In particularly targeting a first episode population of young adults in comparison with a group that experienced the first onset later in life we are able to investigate the associations of these factors with the developmental course of the illness. The basis for the paper will be a clinical intervention trial involving 180 individuals with bipolar disorder recruited from adolescent and adult psychiatry settings. The results of this study illustrate systematic differences in cognitive and psychosocial vulnerabilities in the comparison between adolescent onset first episode subjects and subjects with later onset and several illness episodes. Particular emphasis is placed on persistent states of low mood and mixed affective episodes. Drawing particularly on key developmental indicators such as attachment and reflective function a path model illustrates the relative predictive values of key cognitive and psychosocial factors in respect to outcome indicators and individual coping styles. In this model recovery and affect states are mediated by service engagement, support utilisation and coping with persistent and mixed affective states. Implications of the model for psychological interventions and conceptualisation of affect and affect regulation in bipolar disorders are discussed before the background of these results.

An Integrative Cognitive Model of Mood Swings and Bipolar Disorders

Warren Mansell, University of Manchester

A cognitive approach to understanding mood swings and bipolar disorders is provided, with the interpretation of changes in internal state as a central explanatory factor (Mansell, 2007; Mansell, Morrison, Reid, Lowens & Tai, in press). The model explains how attempts at affect regulation are disturbed through the multiple and conflicting extreme personal meanings that are given to internal states. They prompt exaggerated efforts to enhance or exert control over internal states, which paradoxically provoke further internal state changes, thereby feeding into a vicious cycle that can maintain or exacerbate symptoms. Counterproductive attempts at control are classified as either ascent behaviours (increasing activation), or descent behaviours (decreasing activation). It is suggested that appraisals of extreme personal meaning are influenced by specific sets of beliefs about affect and its regulation, and about the self and relations with others, leading to an interaction that raises vulnerability to relapse. Several recent studies of beliefs, autobiographical memories and information processing biases in bipolar disorder designed to test the hypotheses generated from the model will be summarised. The therapeutic implications of the model will be briefly explained.

Severe, Chronic, Refractory Obsessive-Compulsive Disorder (OCD); The Development of a new National Treatment Network

Convenor: Lynne Drummond, St George's, University of London

Chair: Peter Kolb, SW London and St George's Mental Health NHS Trust

Introduction to the concept of the NCG Service – this will set out the criteria which are necessary for acceptance into an NCG OCD/BDD service

Peter Kolb, South-West London and St George's Mental Health NHS Trust

Will discuss eligibility for an NCG Service for a patient with OCD/BDD and the criteria for entry to an NCG out-patient, community or residential unit service: To ensure these services are not overburdened or inequitably accessed by patients across the country strict protocols are applied.

The View from The National Commissioning Group of the Department of Health

Edmund Jessop, Department of Health, UK

Services are unable to treat a small but significant number of the most severely ill patients successfully, and the guidelines recommend that such patients should have access to highly specialised care. From 1st April 2007, the Department of Health decided to centrally fund treatment services for severe, chronic, refractory OCD and BDD. Dr Jessop will outline the role and process of National Commissioning Group.

Refractory OCD and BDD in Children and Adolescents

Isobel Heyman, Institute of Psychiatry, London

This presentation will start with a review of treatments for children and adolescents with OCD and will present her data from patients in this young age group using results from her work at the Maudsley Hospital. The services are provided for children and adolescents with severe, treatment resistant OCD, by the young people's out-patient OCD service at the Maudsley Hospital. There are also specialist inpatient beds for the most severe adolescents available within the adolescent service at the Priory Hospital North London. The functioning of this service will be discussed.

The role of Psychopharmacology in combination with CBT for refractory patients

Naomi Fineberg, QEii Hospital Welwyn Garden City & Annette Hughes, Institute of Psychiatry

This presentation will start with a review of psychopharmacological treatments for this severely disabled and resistant group of adult patients. She will present models of specialist care that are offered at Queen Elizabeth II Hospital in Welwyn Garden City. This unit specialises in a psychopharmacological approach combined with psychological treatments, including optimised drug therapy with group CBT (developed by Annette Hughes). There will be discussion about the current research in neuropharmacological therapies and the outcome of treatment in this unit.

Alternative ways of working with refractory patients

Paul Salkovskis, Institute of Psychiatry, London; David Veale, South London and Maudsley NHS Trust & Institute of Psychiatry

This presentation will review data from the Centre for Anxiety Disorders and Trauma based at South London and Maudsley Trust (SLaM). Community and outpatient treatment based more on psychological therapies but also with medication review is available at South London and Maudsley Trust and at the South West London and St George's Trust. A residential unit at the Bethlem Royal Hospital in South London treats patients who do not need 24 hour nursing care but who are unsuitable for Community treatment. This presentation will also examine alternative ways of working with patients.

Inpatient treatment for refractory OCD/BDD patients who require 24 hour nursing care at BCPU SW London and St George's Mental Health NHS Trust

Lynne Drummond, St George's, University of London

This review will present data from the inpatient unit based in SW London and St George's NHS Mental Health Trust, which will include details of previous treatment; treatment offered in the unit and outcome measures.

INTRODUCTION: To be eligible for in-patient admission patients must have specific reasons why less intensive treatment is unsuitable viz:

- Danger to self either due to chronic suicidality (acute suicidal episodes should be managed by local services) or due to extreme self-neglect (e.g. failure to drink sufficiently with incipient renal failure without nursing input)
- Danger to others due to OCD (e.g. impulsive acts)
- Compulsions so severe that cannot manage without 24 hour care (e.g. regular incontinence due to OCD; Compulsions taking >3 hours to get up in morning)
- Severe delayed sleep phase shift resulting in patient not being awake during the day
- Complicating additional diagnosis making close observation throughout treatment essential (e.g. anorexia nervosa; schizophrenia – both diagnoses may be exacerbated by the stress of exposure therapy)
- Diagnostic doubt meaning that 24 hour observation is useful initially.

RESULTS: Twenty-three patients have been admitted to the inpatient beds at the BCPU since 1st July 2005 who met NCG criteria. The mean age of patients was 37 years (sd 13; range 18 - 63 years) with a mean duration of OCD of 17 years (sd 13; range 4 - 50 years). On admission they scored an average of 36/40 on the Yale-Brown Obsessive Compulsive Scale (YBOCS) which represents profound OCD. They also scored an average of 29 on the Beck Depression Inventory which is indicative of significant depression. Patients stayed for an average 20 weeks (range 25 - 208 days; sd 51 days) in hospital. At the end of this time these patients improved by an average 42% reductions in OCD/BDD symptoms as measured by the YBOCS with a 35% reduction in depressive symptoms measured by Beck Depression Inventory.

Can we integrate cognitive and pharmacological approaches to understanding depression

Convenor & Chair: Catherine Harmer, University of Oxford

Repeated Recreational Use of MDMA ('XTC') and Cognitive Vulnerability to Depression

Willem Van der Does, Janet Van den Berg, Seline Muchall, Leiden University

BACKGROUND: 3,4-methylenedioxymethamphetamine (MDMA) or 'ecstasy' (XTC) has been shown to cause long term damage to serotonergic cerebral neurons in animals. The neurotoxic effects in humans are less clear and there is mixed evidence concerning the functional consequences. Some studies suggest that MDMA use poses a risk for developing brain serotonin injury. Since depression is associated with decreased brain serotonin function, we investigated the possibility that MDMA-users are putting themselves at risk of developing depressive disorders, by investigating the relationship between repeated recreational use of MDMA and cognitive vulnerability to depression.

METHODS: Twenty-five ecstasy users and a control group (n = 17) were compared. Both groups were from the same subculture and no participant was depressed at the time of the study. Vulnerability to depression was assessed by means of questionnaires that measure dysfunctional attitudes, cognitive reactivity, rumination and thought suppression. Several information processing tests, including stroop interference, visual memory and executive function tests were also administered.

RESULTS: Ecstasy users who did not meet criteria for dependency of other substances than MDMA appear to be no more vulnerable to depression than controls. However, polydrug users scored higher than the other groups on some measures of cognitive reactivity and on negative affectivity.

CONCLUSIONS: The present study found little evidence for a direct relationship between repeated use of MDMA and cognitive vulnerability to depression. However, repeated use of multiple substances was associated with a number of cognitive deficits. These results do not rule out the possibility of longer-term deleterious effects of ecstacy use, or of subtle deficits not picked up by our selection of instruments.

Effects of a new method of acute tryptophan depletion on memory, emotions and EEG

Anke Sambeth and Wim J. Riede, Maastricht University

Acute tryptophan depletion (ATD) can be used to decrease serotonin levels in the brain. Traditionally, ATD has been established by administering amino acid mixtures (AA). These studies have shown that ATD lowers mood in participants vulnerable to develop depression, but it also impairs memory in both healthy and vulnerable participants. In this talk, I will present results of the use of a recently developed gelatin-based protein-drink, which may be equally well in depleting serotonin as compared to the traditional AA method. In the first experiment, 16 healthy subjects participated in a double-blind, placebo-controlled study. Memory was assessed using a visual verbal learning test (declarative memory) and an object relocation task (spatial memory). The facial emotions task was used to examine subjects' ability to perceive subtle changes in emotional face expressions. In the second study, we assessed memory after ATD in another group of 16 participants while simultaneously recording their EEG. Furthermore, resting state EEG was recorded. The results of the two studies will be discussed in the presentation and related to symptoms found in depression.

Psychological mechanisms of antidepressant drug action

Catherine Harmer, University of Oxford

Pharmacological and psychological models of depression often emphasise rather different processes in the aetiology and/or treatment of major depression. However, recent evidence suggests that antidepressant drugs may also target processes believed to be important in cognitive models of this disorder. In this talk, I will consider experimental evidence to support the argument that antidepressant drugs work, in part, by reversing negative biases in depression, rather than targeting mood processes directly. Across a number of studies, antidepressant administration increased positive *vs* negative emotional processing in healthy volunteers very quickly after drug administration and independently from mood changes. Such effects have been seen across different cognitive domains of attention, perception and memory for emotional material and are apparent after just one dose of an antidepressant. Functional neuroimaging studies also support a direct action of antidepressant drugs on the neural circuitry underlying emotional processing and highlight a particular role for amygdala-dependent circuitry. These drug effects were generally opposite to negative biases observed in both behavioural and neuroimaging paradigms in depression and vulnerability to depression. These results suggest that neurotransmitters affected by antidepressants can directly modulate the processing of emotional information. Such actions may help to reverse processing biases seen in depression and anxiety and therefore suggest that pharmacological treatment for these disorders could be more similar conceptually to cognitive theories than previously envisaged.

Antidepressants and the early processing of threat

Susie Murphy, University of Oxford

There is a considerable body of empirical data demonstrating heightened attentional vigilance towards threatening stimuli in individuals with high levels of trait anxiety and individuals with a range of clinical

anxiety disorders. It has been suggested that these cognitive biases may play an important role in the maintenance, and possibly even the underlying aetiology, of anxiety. Such biases are a major focus of cognitive behavioural therapy for anxiety disorders and there is evidence that threat-related cognitive biases are reduced following successful psychological intervention. In this talk I will present recent behavioural and neuroimaging evidence that suggests that the drugs used to treat anxiety disorders may similarly act to reduce negative attentional biases to threatening stimuli. At a behavioural level, both serotonergic antidepressants and diazepam have been shown to reduce attentional vigilance towards fearful faces on a dot probe paradigm. Consistent with this, neuroimaging data suggests that these drugs act upon the neural mechanisms that are known to be involved in the automatic vigilance to threat, such as the amygdala. These effects are seen in healthy volunteers in the absence of any significant changes in mood or anxiety, which suggests that reduced attentional vigilance to threatening environmental stimuli may represent a direct effect of pharmacological treatment for anxiety disorders. These findings support a growing literature suggesting that an important mechanism through which pharmacological agents may exert their effects on mood is by reversing the cognitive biases that characterise the disorders that they treat.

A serotonergic antidepressant enhances cooperative communication

Wai S. Tse and Alyson J. Bond, City University of Hong Kong

BACKGROUND: Clinically depressed patients were found to be less cooperative which hinders them to building up meaning interpersonal relationship; received more interpersonal rejection and results in more depression. Serotonergic antidepressants are the most reliable drug treatment yet, the treatment mechanism remains unclear. However, it is known that the observable therapeutic effects of antidepressant were identified after 2-4 weeks of active treatment. This suggests that the treatment effect is not simply changes of neurotransmitters *per se* rather it is a product of cognitive and/or behavioural changes induced by the antidepressant. Improvement of cooperation might be one of the mechanisms involved in the therapeutic effects of antidepressants.

METHODS: 10 healthy volunteers took part in a double-blinded crossover study of 2 weeks treatment with citalopram (20mg/day) and placebo with a 2 week washout period. On the last day of each treatment period, the subjects socially interacted with a confederate behaving as a responsive person in a stranger-dyadic social interaction paradigm. After the interaction, subjects played the Mixed-motive game, which measures cooperative behaviour and communication, with the confederate.

RESULTS: On citalopram, healthy volunteers were found to be more cooperative during the game by giving more scores to their game partners and express more cooperative communication.

CONCLUSION: These results indicated that administration of citalopram can enhance cooperative behaviour. Further investigation on the relationship between cooperative behaviour enhancement and depression improvement after antidepressant treatment is necessary.

Open Papers

Depression: Exploring the Role of Cognition and Behaviour

Chair: David Gillanders, University of Edinburgh

Why do bad things keep happening to me? Rumination, Goal Linking, Daily Hassles and Life Events in Major Depression

Emily McIntosh, NHS Lanarkshire; David Gillanders, University of Edinburgh; Sheelagh Rodgers, NHS Highland

Rumination in response to stressful events and depressed mood is associated with a range of harmful outcomes, particularly a prolonged and more severe depression (Nolen-Hoeksema, 1991). Theories vary in the extent to which rumination is viewed as controlled versus automatic. In addition to intra-psychic processes, depression is also associated with daily hassles and major life events. Goal linking is the tendency to link achievement or failure of low level goals (e.g. weight loss) with achievement or failure of higher level goals (e.g. happiness). Self-regulatory beliefs such as goal linking could mediate the link between life events, daily hassles, rumination and major depression. This study explored whether people with major depression respond to daily hassles with rumination, as a function of their tendency to goal link, as previously observed by McIntosh and Martin (1992; 1995) in students with lower mood.

This proposal was investigated in a between groups design: 22 participants with major depression were compared with a group of 25 people experiencing other psychological difficulties and a group of 23 people with no depression history. Participants completed, in interview, self-report measures of goal linking, rumination, daily hassles and life events.

Participants with major depression reported significantly greater rumination, goal linking and daily hassles than both comparison groups, and greater impact of more major life events than never depressed controls. Rumination was found to be more strongly related to group differences in major depression than

goal linking. Daily hassles were more strongly associated with lowered mood than major life events. Daily hassles were strongly associated with rumination and this was not a function of goal linking.
Primary findings support some role for goal linking in depressive rumination. However, while participants with major depression responded to daily hassles with rumination, it was not as a function of their tendency to goal link. Goal linking appears to be a consequence, rather than a cause of rumination, which is most strongly associated with the presence of depressed mood. Theoretical and clinical implications are discussed.

A Test of The Interacting Cognitive Subsystems Model using a Laboratory Analogue of Depressive Interlock

David Gillanders, University of Edinburgh; Paul Fleming, NHS Glasgow

The Interacting Cognitive Subsystems (ICS) model has been described as a useful framework within which to understand a wide variety of psychological phenomena. There is now a small literature of studies that have found support for many of the model's basic features. One feature that has not been studied is depressive interlock, described as uncontrollable, repetitious processing of negative themes. This concept shares many overlapping features with rumination, which has been demonstrated to have several harmful effects when used as a response to depressed mood. Different approaches to repetitive information processing have differentially emphasised the degree to which it is a controlled versus automatic process. This paper describes an experimental study which tested predictions about repetitive information processing derived from the Interacting Cognitive Subsystems Framework.
We compared a group of clinically depressed participants to a non-depressed control group, using a specially designed cognitive task to examine the effects of emotional tone of stimuli on information processing.
Results indicated that depression (but not euthymia) is characterised by perseverative responding for both positively and negatively emotionally-toned self-related material, but not for similar neutral material. This result is suggested as further empirical support for the ICS framework, in contrast to predictions from clinical cognitive theory. It is also further support for the proposal that automatic processes operate in rumination, in contrast to rumination being viewed as a conscious choice. Clinical and theoretical implications will be briefly discussed.

Exploring Cognitive, Behavioural and Other Elements in Dysthymia

Sara Finn Kriger, Behavior Medicine Associates, Inc. USA

Studies on chronic depression in general, and dysthymia in particular, are few. They mostly focus on demographics, early adversities, course and personality traits associated with the disorder. Studies examining cognitive variables in dysthymia are meagre. This study attempted to isolate an array of cognitive, behavioural, biological and other variables operating in dysthymia.
Files of terminated, clinically-diagnosed, dysthymia patients were examined to identify expressions of attitudes, etc. This, together with eight items from the Dysfunctional Attitudes Scale, Form A, and eleven items from the Young Schema Questionnaire, L-3, yielded 34 statements of attitudes, beliefs, schemas and symptoms, appearing to be prototypical for patients with the disorder.
Experimental participants included adults seen in an outpatient practice in a major US city, during 2004 and early 2005. Selection criteria included: a) A clinical diagnosis of dysthymia; b) Elevation on the Dysthymia scale of the MCMI-III, and/or, a 27/72 Code-Type elevation on the MMPI-2; c) No indication of severe personality pathology.
The Control group was comprised of adults not meeting clinical criteria for dysthymia, whose test profiles were devoid of findings congruent with the selection criteria, and, who had no evidence of major depression nor personality disorder.
All participants responded to the questionnaire, indicating their agreement/disagreement with each statement on a 6-point rating scale.
It was hypothesised that a set of seemingly prototypical statements would differentiate between a group of participants with dysthymia (n=101), and those in the Control group (n=82).
Scores for both groups were subjected to a factor analysis, a reliability analysis, and a validity analysis. The factor analysis and reliability analysis suggested that all statements are related, and may constitute only one construct.
A set of 20 questionnaire items, yielding concurent validity of 0.687, and reliability of 0.945, was found to differentiate between the Experimental and the Control groups.
The findings suggest that individuals with dysthymia become easily overwhelmed by their tasks and responsibilities, and by their own expectations for themselves. They seem to hold extremely rigid and perfectionistic attitudes and standards for themselves. They set high, somewhat unrealistic goals, becoming self-punitive when they perceive themselves to fall short of their own expectations and/or standards. When they do meet their goals, they discount their achievements, and do not feel a sense of accomplishment. Behaviourally, they appear highly prone to procrastination. They also tend to ruminate a great deal, though they view this as a feature of their intellective and analytical thinking pattern. They associate the onset of their symptoms with the early teenage years.
The methodology of this study is limited by a modest sample size, and modest statistical analyses. In addition, the complexity of dysthymia eludes a thorough understanding of it as a conceptually distinct

psychopathological entity. Nevertheless, the results enable the preliminary identification of a set of cognitive statements that appear to be characteristic in dysthymia. This has implications for early identification of indivduals with the disorder, as well as for clinical work with such individuals, using CBT. Also, it is hoped that this study will provide an impetus for further research into the cognitive aspects of dysthymia.

Systematic review and meta analysis/regression of Individual Behavioural Therapy for depression

David Ekers, Tees Esk & Wear Valleys NHS Trust; David Richards, York University; Simon Gilbody, York University

Depression effects between 5-10% of the population and is the third most common reason for primary care consultation. It is set to become the second largest cause of disease burden by 2020. Psychological therapies particularly Cognitive Behavioural Therapy (CBT) is the recommended treatment approach consisting of both behavioural and cognitive interventions; a lack of clarity exists regarding the optimum mix of these. We conducted a systematic review and meta analysis of individual behavioural treatments of depression to ascertain clinical efficacy of such approaches.

We searched a broad range of psychological, nursing and medical databases from inception to January 2006 (EDLINE, EMBASE, PSYCHINFO, COCHRANE LIBRARY DARE, CINAHL. AMED and the British Nursing Index) including all randomised trials of individual behavioural psychotherapy for depression in any language. Comparators were grouped as waiting list/treatment as usual/inert treatments, CBT/CT treatments, alternative psychotherapies and supportive counselling. Data was extracted to assess symptom level, recovery rates and dropout via standardised mean difference and odds ration respectively at post treatment and follow up. The possibility of publication bias was assessed through a Begg funnel plot graph and tested for asymmetry via Egger weighted regression test. Regression analysis was conducted to explore mediators of treatment effect sizes.

Searches identified 20 randomised controlled trials of individual behavioural treatments of depression for inclusion in the review. Three trials were excluded from meta analysis due to insufficient data. No evidence of publication bias was observed in major comparator groupings. Behavioural interventions were an effective treatment of depression with superior outcomes to brief psychotherapies, supportive counselling and equally as effective as CBT. No difference was identified in dropout rates across groupings, recovery rates reflecting findings in symptom level analysis. Study level mediators were explored via meta-regression, baseline severity was associated with larger effect size of BT when in comparison with CBT.

We found that behavioural therapy for depression is an effective intervention that has equal if not better outcomes than alternative and currently recommended therapies. Our review adds to the literature in the area as it provides a broad overview of the evidence so far and reports data on recovery, dropout, mediators and publication bias in addition to depression symptom level change. Implications and limitations of the findings will be discussed.

A naturalistic study of Behavioural Activation System 'recovery' in Bipolar Disorder

Kim Wright, University of Exeter (presenting work carried out when at Institute of Psychiatry); Dominic Lam, University of Hull; Richard Brown, Institute of Psychiatry

The current study tests a prediction of the Behavioral Activation System (BAS) dysregulation theory of Bipolar Disorder (Depue & Monroe, 1986; Depue, Krauss & Spoont, 1987), namely that following high levels of reward or frustration individuals with Bipolar Disorder (BPD) will take longer than will healthy controls to return to baseline levels of BAS activity.

Eighty individuals (40 with BPD, currently euthymic, and 40 with no history of affective disorder) completed a daily diary over a 28-day period in which they recorded current symptoms of BPD, current BAS activity level, and details of significant events occurring during the day.

Following days containing high levels of perceived reward, all individuals showed an overall increase in BAS activity. However individuals with BPD showed a delay relative to non-affectively disordered individuals in time taken for BAS activity to return to baseline levels. The two groups were found to show an overall decrease in BAS activity following highly frustrating days, but did not differ in time taken for BAS activity to return to baseline levels.

The findings are supportive of the BAS dysregulation hypothesis of BPD with regard to BAS activation but not with regard to BAS deactivation.

Posters

Psychological Processes in Bipolar Disorder

Emma Van der Gucht, University of Leeds; Richard Morriss, University of Nottingham; Richard Bentall, University of Manchester; Peter Kinderman, University of Liverpool; Gill Lancaster, University of Liverpool

INTRODUCTION: Psychological treatment approaches for Bipolar Affective Disorder aim to reduce manic and depressive relapses, but have been developed without a complete understanding of the psychological processes underpinning the disorder. There is little understanding of either the processes involved in the transition to a manic state, the unique feature of bipolar disorder, or the psychological processes underlying the full range of symptoms seen in mania and depression. This study sought to examine some of the underlying hypotheses in the psychological model and identify cognitive vulnerabilities and information processing characteristics in remitted bipolar disorder patients, as well as identify psychological vulnerabilities seen in mania and depression.
METHOD: An observational cross-sectional study involving bipolar disorder patients in the three phases of the disorder and a healthy subject control group; 43 participants with a bipolar diagnosis but currently euthymic; 34 in a manic or mixed affective episode, 30 in a major depressive episode and 41 controls with no mental health difficulties. Participants completed a battery of assessments looking at cognitive vulnerability to recurrence and symptom formation; information processing; sleep; interpersonal styles and coping responses.
RESULTS: Significant differences were found between all three bipolar groups and the controls. indicating that a profile of cognitive, interpersonal and coping style vulnerabilities is seen amongst people with a bipolar diagnosis, even when well. Interesting similarities as well as differences were noted between the manic and depressed groups.
CONCLUSION: In order for psychological interventions for bipolar disorder to develop and improve outcomes for individuals, the psychological models that underpin them need to be built upon, refined, and developed. This paper goes some way to increasing our understanding of what some of the cognitive vulnerabilities in bipolar disorder might be, and to highlight a strong interpersonal factor that has in previous work been overlooked. It also provides further weight to the psychological model of mania that recognises depressagenic cognitions as a common feature, and highlights areas of interest that could be further investigated in future studies.

Cross-cultural study of conviction subtype Taijin Kyofu: proposal and reliability of Nagoya-Osaka diagnostic criteria for social anxiety disorder

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INTRODUCTION: Conviction subtype Taijin Kyofu (TK) is a subgroup of mental disorder characterised by conviction and strong fear of offending others in social situations, and it has often been considered culture-bound. Although the concept of conviction subtype TK overlaps most with that of social anxiety disorder (SAD), patients with conviction subtype TK often may not be so diagnosed with the current DSM-IV criteria. We propose the Nagoya-Osaka Criteria, an expanded version of diagnostic criteria for SAD developed to also diagnose conviction subtype TK. This study aims to examine the cross-cultural inter-rater reliability of the proposed criteria.
METHOD: 18 case vignettes of patients with SAD and related disorders were collected from 6 different countries, and 13 independent raters from 7 different nationalities diagnosed them according to the original DSM-IV and the expanded criteria.
RESULTS: The average agreement ratio for the most frequent diagnostic category in each case was 61.5% (SD=19.0) with DSM-IV and 87.6% (SD=13.0) with the modified DSM-IV with Nagoya-Osaka Criteria for SAD (Wilcoxon signed rank test, $p<0.001$). In terms of diagnoses for subtypes of SAD with the proposed criteria, the average agreement ratio for the most frequent diagnoses in each case was 61.5% (SD=17.1).
CONCLUSION: The Nagoya-Osaka Criteria for SAD can improve inter-rater reliability of SAD. The inter-rater reliability for subtypes within SAD according to the proposed criteria was satisfactory but warranted further refinement.

The relationships between self and informant- rated anxious and avoidant attachment styles and self and informant-rated therapeutic alliance

Katherine Berry, Alison Wearden, Lydia Morris, University of Manchester

INTRODUCTION: According to attachment theory, early experiences in relationships inform an individual's model of themselves and others; whether they believe themselves worthy of care and attention and whether they believe others will be available if they are distressed (Bartholomew & Horowitz, 1991). Previous findings in a mental healthcare setting have demonstrated that avoidant attachment style is associated with a poor therapeutic alliance (Daniel, 2006). The primary aim of this study was to investigate how the attachment dimensions of anxiety and avoidance are related to the quality of alliance between patients and healthcare professionals in a physical healthcare setting, a specialist diabetes

clinic. This study also examined the validity and reliability of self and informant versions of the Berry Attachment Measure (BAM) and Working Alliance Inventory (WAI) when used in a physical healthcare setting.
METHOD: We investigated associations between attachment anxiety and avoidance and therapeutic alliance in 25 adult out-patients with diabetes and 8 healthcare professionals. Patients completed a self-report version of the BAM and WAI, and healthcare professionals an informant version. Correlational analyses were used to assess the degree of agreement between self and informant- ratings of attachment dimensions and self and informant- ratings of alliance. The associations between attachment style and patient- healthcare professional alliance were explored using correlational analyses.
RESULTS: We found predicted negative associations between avoidant attachment and therapeutic alliance. Both self and informant- rated avoidance were significantly negatively correlated with informant-rated therapeutic alliance. Contrary to predictions significant correlations between self- ratings and informant- ratings of attachment dimensions and of alliance were not found.
CONCLUSION: Findings demonstrate that patient avoidant attachment style is associated with a weaker therapeutic alliance. Further research could confirm that avoidant attachment style is a useful predictor of difficulties in therapeutic alliance. Exploratory research has found that service provision can be adapted to accommodate avoidant individuals and consequently encourage collaboration and improve outcomes. Findings suggest that CBT based management approaches, which emphasises collaboration, patient control and problem solving, would be useful when assisting diabetes patients with an avoidant attachment style (Ciechenowski *et al.*, 2006).

Facilitating a Bipolar Disorder Psycho-education group in a Community setting

Clare Brizzolara, Northumberland, Tyne and Wear Trust; Dipty Reavley, Northumberland, Tyne and Wear Trust; Julia Hedley, Northumberland, Tyne and Wear Trust; Katherine Jenkins, Northumberland, Tyne and Wear Trust; Niraj Ahuja, Northumberland, Tyne and Wear Trust; Stuart Watson, Northumberland, Tyne and Wear Trust

INTRODUCTION: Knowing about one's illness would help to understand the treatment process better and empower one to cope. This knowledge traditionally comes from professionals, and the efficacy of psycho-education in relapse prevention of bipolar disorder has been supported by a Cochrane review 1 as well as NICE guidelines. Whilst community mental health teams are central to patients' health care journeys, their value in providing psycho-education is not always recognised, and expert patients have a great role to play in supporting this.
METHOD: A manualised psycho-education group was devised using NICE recommended principles of recognition of early warning symptoms, relapse prevention, medication adherence and lifestyle regularity. The group consists of 14 weekly sessions with 3 facilitators who are a combination of specifically trained expert patients and mental health professionals. Twelve participants with a diagnosis of Bipolar Disorder, currently well for at least 3 months, were drawn from secondary care to take part. A start date and time were identified, and the venue was provided free of charge by the local User Centre Advice Network, the service user group for North Tyneside. The objectives were: 1. Increasing awareness of their illness, how it affects them and those around them. 2. Identifying triggers to relapse, the early warning signs and symptoms. 3. Developing a relapse plan that can be shared with the care team. 4. Gaining mutual support.
RESULTS: Group One: Thirteen participants referred, out of which 5 dropped out. Two participants went on to complete a computer course. Two others commenced voluntary work. Group Two: Ten participants referred, out of which 3 dropped out. Unexpected results from empowered participants were: Establishment of the North Tyneside branch of Manic Depressive Fellowship Developing an electronic mood diary. Pursuing academic study towards a professional qualification. Group Three: There were 12 participants out of which 3 dropped out. The longer-term success of this group of participants is yet to be established. Group discussion was an aspect of the programme that received predominantly positive feed back.
CONCLUSION: The experience of having facilitated two psycho-education groups places one in a privileged position being able to deliver structured psycho-education on an individual basis. The lack of a group element makes individual work a little harder in a one-to-one session, due to the lack of group interaction and discussion. In a way, both these approaches seem to be complementary rather than exclusive to each other. It is still early days before the full potential is seen of delivering structured psycho-education, with regards to patients' self-management and likely reduction of future relapse. It is considered that there is a long-term need for such groups. The substance of the group programme reduces a significant portion of workload from CMHT workers. Relapse planning would be the mainstay of therapy, normalising Bipolar Disorder as any other illness, creating a path of hope and hence accelerating recovery.

Psychological therapies for generalised anxiety disorder: Cochrane systematic review

Vivien Hunot, Institute of Psychiatry; Rachel Churchill, Institute of Psychiatry; Vanessa Teixeira, Universidade Federal de Pelotas & Universidade Católica de Pelotas; Mauricio Silva da Lima, Universidade Federal de Pelotas & Universidade Católica de Pelotas

INTRODUCTION: Generalised anxiety disorder (GAD) is a highly prevalent condition, characterised by excessive worry or anxiety about everyday events and problems, and with a low rate of remission and recovery. Whilst clinical guidelines in the UK recommend cognitive behavioural therapy (CBT) as a first-line treatment for GAD (NICE 2004), psychological therapies used in UK NHS settings are predominantly person-centred, psychodynamic and integrative in theoretical framework (Stiles 2006). The Department of Health has announced plans to expand the delivery of evidence-based psychological services for people with depression and anxiety, through the Access to Psychological Therapies programme (DH 2007). To inform future health care policy on the use of psychological therapies for GAD, we aimed to examine the efficacy and acceptability of psychological therapies, categorised as cognitive behavioural therapy (CBT), psychodynamic therapy and supportive therapy (ST), compared with treatment as usual/waiting list (TAU/WL) and compared with one another, for patients with GAD.
METHOD: We searched the Cochrane Depression, Anxiety & Neurosis Group (CCDAN) Controlled Trials Register and conducted supplementary searches of MEDLINE, PsycInfo, EMBASE and LILACS in February 2006. We searched reference lists of retrieved articles, and contacted trial authors and experts in the field for information on ongoing/completed trials. We selected randomised and quasi-randomised controlled trials conducted in non-inpatient settings, involving adults aged 18-75 years with a primary diagnosis of GAD, assigned to a psychological therapy condition compared with TAU/WL or another psychological therapy. Data on patients, interventions and outcomes were extracted by two review authors independently, and the methodological quality of each study was assessed. The primary outcome was anxiety reduction, based on a dichotomous measure of clinical response, using relative risk (RR), and on a continuous measure of symptom reduction, using the standardised mean difference (SMD), with 95% confidence intervals.
RESULTS: Twenty-five studies (1305 participants) were included in the review, of which 22 studies (1060 participants) contributed data to meta-analyses. Based on 13 studies, psychological therapies, all using a CBT approach, were more effective than TAU/WL in achieving clinical response at post-treatment (RR 0.64, 95%CI 0.55 to 0.74), with 46% of patients assigned to CBT showing clinical response at post-treatment, in contrast with 14% in TAU/WL. Anxiety, worry and depression symptoms were also significantly reduced. Patients attending group therapy were more likely to drop out of treatment, and in contrast, those attending individual therapy were more likely to persist with treatment. Six studies compared CBT against ST (non-directive therapy and attention-placebo conditions). No significant difference in clinical response was indicated between CBT and ST at post-treatment (RR 0.86, 95%CI 0.70 to 1.06), however, statistical heterogeneity was indicated, which was partly explained by the number of therapy sessions.
CONCLUSION: Psychological therapy based on CBT principles is effective in reducing anxiety symptoms for short-term treatment of GAD. The body of evidence comparing CBT with other psychological therapies is small and heterogeneous, which precludes drawing conclusions about which psychological therapy is more effective. Further studies are required to inform UK health care policy on the most appropriate forms of psychological therapy in treating GAD.

How should we treat patients with severe resistant obsessive-compulsive disorder (OCD)?

Anusha Pillay, South West London & St George's Mental Health NHS; Lynne Drummond, South West London & St George's Mental Health NHS Trust; Shashi Rani, South West London & St George's Mental Health NHS Trust; Peter Kolb, South West London & St George's Mental Health NHS Trust

INTRODUCTION: We present a naturalistic study examining outcome in patients suffering from severe, chronic resistant obsessive-compulsive disorder. We compared those patients who were admitted to a specialised inpatient unit with patients who received intensive community treatment. The Inpatient Unit and the outcome with the most severely ill patients has been studied over many years (Drummond, 1993; Drummond *et al.*, 2007). The Enhanced Community Service for OCD has only recently been reported (http://www.nice.org.uk/page.aspx?o=391017)
METHOD: All patients were aged 18 years or older. Qualified psychiatrist interviewed all patients and ICD 10 diagnoses made. They were screened for evidence of severe refractory OCD. This was defined as: "Yale-Brown Obsessive Compulsive Schedule Score (YBOCS) >30 " Previous trials of at least 2 serotonin reuptake inhibiting (SRI) drugs at dosages recommended in the British National Formulary for at least 3 months " Two Previous trials of cognitive behaviour therapy (CBT) which included graded exposure and response prevention (ERP). Community Patients. Patients who met the above criteria and who did not display any contraindication for home-based or community treatment were included. Inpatients Patients admitted to the inpatient unit not only met severity criteria but had complications rendering community treatment unsuitable viz: " Patient danger to self or others " Extreme lack of self-care needing intensive nursing care e.g. incontinence of urine or faeces. " Poor self-care that getting up in the morning took >4 hours " Complicating diagnosis of schizophrenia or severe psychosis in addition to OCD " Profound OCD with reversal of patterns of night and day Demographic data were recorded including age; sex; duration of OCD and previous treatments Measure of severity of OCD and depression were recorded at commencement of therapy. Measures used were YBOCS; Padua; Beck Depression Inventory (BDI) Data were analysed using SPSS version 14.0.

RESULTS: Community Patients since May 2006, 18 patients examined with average age 37 years (sd 11.06; range 19 57 years) ; mean duration of OCD 21 years (sd 12.07; range 3 40 years); mean YBOCS 32.4/40(sd 1.6; 30-35) at start of treatment. Mean BDI score 29.2/63 (sd 11; 4-45). Patients so far showed 33% reduction of OCD symptoms and 45% reduction in depressive symptoms. Inpatients over past 2.5 years, 27 patients meet the severity criteria. Average age was 35.5 years (sd 13.4; 18 - 63 years); mean duration of OCD of 16.0 years (sd 11.0; range 4-50 years). Mean YBOCS Score 34.6/40 (sd 3.4; 30-40) at admission; mean BDI 29.2/63 (sd 12). At discharge, average 28% reduction in obsessive-compulsive symptoms and 48% reduction in depressive symptoms
CONCLUSION: With current emphasis on local services, there is a tendency to assume that they can provide optimal treatment for patients with all conditions and a range of severity. All the patients presented in this study were profoundly disabled by OCD. They had all received appropriate treatment in their local areas and had failed to improve significantly. Despite this they responded to treatment from a Unit with special interest and expertise in OCD. We suggest that each Healthcare Region could benefit from developing similar specialist community treatment centres for OCD. The provision of inpatient facilities for OCD is likely to be relevant to a much smaller group of the most profoundly ill individuals and can be provided at a national level.

Hypomania and Its Psychological Correlates in a Saudi Sample

Ahmad Al-Shayee, The University of Manchester, School of Psychological Sciences; Steven Jones, The University of Manchester, School of Psychological Sciences

INTRODUCTION: Hypomania is a severe mental illness described as a recurrent and persistent condition. Research into this condition was, until recently, concerned with its neurobiological aspects only, while the psychological features were relatively neglected. Nevertheless, psychological research has recently addressed this clinical phenomenon, and encouraging psychological conceptualisations have been suggested. However, as abnormal behaviour is seen to be affected by culture and culture-related variables, there is a need to incorporate culture into the psychological study of psychological disorders. That is, it might be relevant to re-examine the psychological views based on data collected from particular culture, using samples derived from other cultural backgrounds. Therefore, in order to develop more accurate and comprehensive insights into these behaviours, it seems important to increase role of culture in the psychological theories given to explain them. Hypomania, as a psychological disorder, is not an exclusion to this role. This attempt aims to extend this line of research by exploring the extent to which several psychological factors could account for hypomania as defined psychometrically. These factors have been found to be associated with hypomania in the literature; however, this correlational pattern has not been explored using Arab samples yet. The targeted psychological variables are: 1) Behavioural Activation and Behavioural Inhibition, 2) Appraisal of hypomanic experiences, 3) Positive and Negative Affectivity, 4) Goal-directed behaviour, 5) Regularity of daily routine, 6) Quality of sleep, 7) Self-esteem, 8) Response to positive affect and 9) Depressive, anxiety and manic experiences.
METHOD: Sample: A sample of university students (male and female) will be derived from the student population of King Saud University, Riyadh, Saudi Arabia, and Al-Jouf University, Al-Jouf, Saudi Arabia. Tools: For purposes of this project, a number of self-report scales were translated from English into Arabic using the back-translation procedure. They are: 1. Behavioural Activation/Behavioural Inhibition system (BIS/BAS) 2. Hypomanic Interpretation Questionnaire (HIQ) 3. Hypomanic Personality Scale (HPS) 4. Positive and Negative Affect Schedule (PANAS) 5. Social Rhythm Metric-Trait scale (SRM-T) 6. Internal States Scale (ISS) 7. Pittsburgh Sleep Quality Index (PSQI) 8. Achievement Goal Questionnaire (AGQ) 9. Responses to Positive Affect Questionnaire (RPAQ). In addition, the Arabic versions of Rosenberg Self-esteem Scale (RSES), Extraversion and Anxiety (Trait) were also used. The Ethical Consideration: This project has been approved by the Ethical Committee of The School of Psychological Sciences, The University of Manchester.
RESULTS: Data is being collected, and will be submitted soon.
CONCLUSION: Findings will be discussed on the light of the existing literature and the assumed role of cultural differences, and a number of recommendations will be suggested accordingly.

Sleep Disorders and Obsessive-Compulsive Disorder

Lynne Drummond, St George's, University of London; Shashi Rani, South West London and St George's Mental Health NHS Trust; Katharina Wulff, Imperial College, University of London; Josephine Sibanda, South West London and St George's Mental Health NHS Trust; Sarah White, St George's, University of London; Naomi Fineberg, Herts Partnership Trust; Hamid Ghodse, St George's, University of London

INTRODUCTION: It has long been recognised by clinicians that some patients with severe Obsessive-Compulsive Disorder (OCD) have difficulties in getting up in the morning and spend most of the night engaged in compulsive rituals. It appears that a significant number of OCD sufferers have a condition known as Delayed Sleep Phase Shift (DSPS) but this has only recently been described. Our group found that in a retrospective analysis of patients admitted to a specialist unit, 17 % met criteria for DSPS. Those most likely to be affected were younger and had an earlier age of onset of their OCD symptoms (Mukhopadhyay *et al.*, 2004). A subsequent prospective study found that almost half of the patients

admitted had evidence of DSPS. Younger patients, those who were male and those with the most profound OCD symptoms were most frequently affected (Turner *et al.*, 2004). It was decided to repeat a prospective analysis but include actigraphy and measures of urinary melatonin and cortisol to obtain a more reliable marker of sleep phase disturbance to examine whether this was a biological phenomenon or a learned behaviour.
METHOD: Successive admissions to the OCD Specialist Unit with OCD (DSM 1V) were invited to participate. This Unit has been described elsewhere (Drummond, 1993; Drummond ET AL., 2006). Standard measures of severity of OCD and depression were administered. Patients were asked to wear an actigraph and keep a sleep diary for 2 weeks. Sleep records were kept by nursing staff. Urine samples were analysed for melatonin and cortisol.
RESULTS: Nine patients have completed actigraphic recordings so far, of which seven exhibited severely disturbed rest and activity patterns. Specifically, patients showed abnormally high nocturnal activity throughout the night, a low interdaily stability (IS = 0.407 ± 0.111, n = 7) as well as a low rest-activity amplitude (RA) across day and night (RA = 0.702 ± 0.04, n = 5). These parameters indicate that the rest-activity regularity is severely disrupted in these patients. Extremely delayed and polyphasic sleep and activity phases were found in two patients suggesting changes in the circadian timing of rest-activity rhythms. Examples of these will be presented as well as the psychometric and urinalysis data.
CONCLUSION: DSP and other abnormal sleep patterns are common in the most profoundly ill OCD patients. They are associated with sleep-related neuro-endocrinological changes. The neurobiological clinical implications of these findings merit further exploration.

Client evaluation of a new anger treatment programme for mentally disordered offenders

Hayley Cooper, Nottinghamshire Healthcare NHS Trust; Les McClelland, Nottinghamshire Healthcare NHS Trust; Jo Darby, Nottinghamshire Healthcare NHS Trust

INTRODUCTION: A vital but often neglected element in evaluating any intervention is the opinions of clients who actually receive it. For psychological therapies to be effective clients must be willing to actively participate in the therapy. Engagement can be encouraged by adjusting therapy to make it more acceptable to the client. However, this is more difficult in protocol-driven group interventions which allow less scope for tailoring therapy to individual needs. Consequently there may be greater drop-out rates and lower levels of engagement by clients in group interventions.
Anger is strongly predictive of future patient aggression and violence in mentally disordered offenders (MDOs) and the importance of evidence-based therapeutic interventions for anger problems in MDOs cannot be underestimated. However, anger frequently has substantial adaptive value for those people considered to have 'anger problems' and the prospect of 'anger management' can often be met disparagingly (Novaco and Jarvis, 2002).
This study aimed to seek clients' opinions regarding a variety of aspects of the Novaco, Ramm and Walker group CBT anger treatment programme in order to consider overall acceptability of the programme to clients. Clients were all MDOs accommodated in a low secure environment at the time of participating in the anger intervention.
METHOD: Focus groups were conducted with clients who had participated in the 18-week protocol-driven anger treatment programme; this included those who had dropped out or were part way through the programme, as well as those who had completed it. The focus groups used semi-structured interviews with prepared questions to guide and stimulate discussion. Opinions were sought on a variety of areas, including pace and length of the programme, modes of delivery, content of the sessions and overall satisfaction with the programme. Content analysis was used to identify themes regarding clients' attitudes towards the intervention.
RESULTS: Preliminary analysis has identified that clients felt welcome and accepted in the group. Clients reported receiving positive feedback regarding their behaviour from their medical teams during the intervention and following completion of it, which encouraged their attendance. Themes also related to 'changing opinions about whether the intervention was relevant for me', 'varied nature of the delivery as a positive aspect' and '18 weeks is too long'.
CONCLUSION: Preliminary reports suggest that this intervention is highly acceptable to clients, which in turn encouraged engagement and better outcomes. Observational data also show high attendance levels and decreases in the levels of aggression of those clients who completed the programme, supported by psychometric data. For an anger treatment programme to be successful clients must be receptive to its content. This study indicates that the Novaco, Ramm and Walker protocol-guided therapy is conducive to engagement through being accessible and acceptable to this client group.

Eating and Impulse Control

Keynote Address

CBT for the eating disorders: To infinity and beyond, or a short walk in the dark?

Professor Glen Waller, Vincent Square Clinic (CNWL Mental Health Trust) Institute of Psychiatry

Cognitive-behavioural therapy (CBT) is currently the treatment of choice for some eating disorders (whether based on disorder-based protocols or individual-centred principles), though not for anorexic cases. If CBT is to retain and extend its superiority, we cannot afford to wallow in past successes – we have much further to go. This keynote will address key limitations of CBT and potential solutions. While there is a lot of effort going into improving CBT and expanding delivery technologies, there are gaping holes in our capacity to get the best treatment to the appropriate patients. For example, many clinicians claim to be offering CBT for the eating disorders, when they offer no such thing. Others offer CBT, but fail to deliver the key therapeutic elements (particularly those involving behavioural change). However, even when evidence-based CBT is available, problems in pathways of care make it unlikely that an individual with an eating disorder will be noticed or referred on to the appropriate service. Therefore, we need to work at a number of levels – improving CBT, disseminating and monitoring good practice, and ensuring access for patients. Otherwise, we will be wandering in the dark for a lot longer.

Symposia

Understanding compensatory behaviours in the eating disorders: New findings and their clinical implications

Convenor & Chair: Glenn Waller, Vincent Square Clinic (CNWL Mental Health Trust) Institute of Psychiatry

Why think about compensatory behaviours in CBT for the eating disorders?

Glenn Waller, Vincent Square Clinic (CNWL Mental Health Trust) Institute of Psychiatry

Formulations of the eating disorders commonly treat the compensatory behaviours as consequences of binge eating or perceived overeating. This overview will briefly consider the evidence that purging and exercise behaviours are more central to the maintenance of the eating disorders, with evidence that they are directly related to the cognitions and emotions that drive the eating disorders.

The impact of the binge-vomit cycle on internal states

Emma Corstorphine, St Georges' Eating Disorders Service

INTRODUCTION: While there is considerable evidence that bulimic behaviours serve the function of modifying internal states (e.g., satiety, mood), there is less clarity over the roles of the different behaviours across the binge-purge cycle. The present study examines the impact of bingeing and vomiting upon these internal states at different time points, and evaluates the potential reinforcement of those behaviours by the changes in internal states.
METHOD: Twenty-three women with diagnoses of bulimia nervosa completed a diary of all binge-vomit episodes over the course of seven days, rating their internal states (satiety, negative mood, positive mood) at four time points during each episode.
RESULTS: There were substantial changes across the cycle in levels of hunger, fullness, guilt/shame, anxiety/worry and happiness/relief, but not in other states.
DISCUSSION: The changes indicate that the binge-vomit cycle is maintained by the effects of both behaviours, but that the vomiting behaviour evokes the strongest pattern of reinforcement. Further research is needed to determine the levels of internal states during the binge itself.

Associations between body checking and compensatory behaviours in the eating disorders

Victoria Mountford, St Georges' Eating Disorders Service

INTRODUCTION: Body checking involves repeatedly checking aspects of one's body, in a range of ways. It is a manifestation of the over-evaluation of eating, shape and weight that is central to the eating

disorders. Checking behaviours and cognitions are related to the presence and severity of eating-disordered attitudes. However, it is not known whether checking is associated with other eating behaviours (e.g., bingeing, purging). The aim of this study was to determine whether body checking is more consistently associated with diagnoses or behaviours in a clinical group of eating-disordered patients.
METHOD: Eighty-four eating-disordered women completed measures of body checking behaviours and cognitions, and a measure of eating pathology. Objective weight, height and DSM-IV diagnosis were recorded. Data were analysed using MANCOVAs, controlling for age and body mass index.
RESULTS: Analysis by diagnostic category revealed some differences in level of cognitions and behaviours, with patients with anorexia nervosa engaging in less overall appearance body checking behaviour. There were no associations between the presence of objective binge eating and body checking. However, there were strong associations between body checking and compensatory behaviours.
DISCUSSION: Body checking is more closely related to compensatory behaviours than diagnosis. Differences across diagnoses seem to be a result of their behavioural differences. Further research is required into the role of compensatory behaviours (such as exercise and purging), in order to further our understanding of the eating disorders.

Exercise and the eating disorders: To compensate or not to compensate, that is the question

Caroline Meyer and Lorin Tanis, University of Loughborough

INTRODUCTION: In many cases, excessive exercise pre-dates the onset of an eating disorder, is the last symptom to subside, and is associated with poor therapeutic outcome and relapse. Exercise is often conceptualised primarily as a weight control behaviour, used to counteract calorific intake. However, the exercise motivation literature shows that this model is too simplistic, since exercise serves a clear emotion regulation function. The aim of the current research was to determine the mood-regulatory characteristics of exercise in relation to eating psychopathology among young non-clinical women.
METHOD: In two separate studies, 109 and 60 women completed the newly developed Eating Disorder Exercise Test and measures of mood intolerance.
RESULTS: Controlling for overall levels of eating psychopathology, there was a significant, positive association between compulsive exercise and poor tolerance of emotion. In addition, lack of exercise enjoyment was associated with lack of emotional acceptance, reduced emotion regulation strategies, reduced emotional impulse control, and lack of emotional clarity. Similarly, compulsive exercise and lack of exercise enjoyment were positively associated with avoidance of affect.
CONCLUSIONS: These preliminary findings suggest that exercise in the eating disorders is likely to serve a function of mood regulation. These data require replication with clinical groups. However, they suggest that therapies aimed at reducing an individual's reliance on exercise should focus on providing them with emotional tolerance and regulation strategies.

Open Papers

Clinical Perfectionism, Body Image and Eating Disorders

Chair: Freda McManus, Oxford Centre for Cognitive Therapy

The Clinical Impairment Assessment (CIA) Questionnaire – a new self-report measure of psychosocial impairment due to eating disorder psychopathology

Kristin Bohn, Oxford University Department of Psychiatry; Helen Doll, Oxford University Department of Psychiatry; Zafra Cooper, Oxford University Department of Psychiatry; Marianne O'Connor, Oxford University Department of Psychiatry; Robert Palmer, University Department of Health Sciences, Leicester General Hospital; Christopher Fairburn, Oxford University Department of Psychiatry

Eating disorders have profound and highly specific effects on psychosocial functioning. For example, these patients' over-evaluation of shape and weight, their so-called 'core psychopathology', can have a marked effect on their ability to socialise and form intimate personal relationships, and their concerns about eating may prevent them from being able to eat in the presence of others including family members. Secondary effects of this type are extremely disabling yet are likely to be missed by generic measures of health-related quality of life. The aim of the present study was to develop a clinically useful measure of the psychosocial impairment that results from eating disorder features and test its reliability, validity, and sensitivity to change.
Development of the instrument:
Four areas of life commonly affected by eating disorder features were identified: mood and self-perception, cognitive functioning, interpersonal relationships and performance at work. Examples of impairment within each domain were specified on the basis of interviews with eating disorder patients and the

authors' clinical experience. A 22-item instrument was created. The mean score on all completed items was used as the index of severity of current secondary psychosocial impairment.

Participants:

Data were collected from 170 eating disorder patients who were participating in a transdiagnostic cognitive behaviour therapy trial based in two eating disorder clinics in the UK (Oxford and Leicester). Participants were assessed before and at several intervals after treatment, and therefore exhibited the full range of eating disorder psychopathology, with regard to both, type and severity.

Tests of psychometric properties:

The following psychometric properties of the instrument were evaluated: internal consistency and factorial structure; construct validity; discriminant validity; test-retest reliability and sensitivity to change.

The instrument was found to have excellent internal consistency (Cronbachs alpha 0.96). The principal component analysis revealed one major component with 18 of the 22 CIA items loading highly on it, which suggests that the CIA is a uni-dimensional instrument. It was shown that the performance of the CIA was highly correlated with the independent clinical judgment of two expert eating disorder clinicians. The instrument discriminated successfully between participants with and those without eating disorders and was shown to possess satisfactory test-retest reliability. Finally, the CIA was sensitive to change in eating disorder psychopathology.

This is the first study describing the development and performance of a measure of the psychosocial impairment that results from eating disorder psychopathology. The findings support the validity and utility of the instrument. It is important that these findings are replicated.

The CIA should be of value to clinicians when assessing patients and their response to treatment. It should also help inform epidemiological research by providing a measure of the psychosocial impact of normative levels of eating disorder psychopathology.

Body checking, size estimation and eating disorder psychopathology

Michelle Lee, School of Psychology and Clinical Language Sciences, University of Reading; Roz Shafran, School of Psychology and Clinical Language Sciences, University of Reading; Christopher G. Fairburn, Department of Psychiatry, University of Oxford

The repeated, critical scrutiny of one's body size, shape and weight is a characteristic feature of patients with eating disorders and such body checking is addressed in the leading evidence-based treatment for bulimia nervosa. The overestimation of body size has also been suggested as an important clinical feature for some patients. The aim of the current study was to measure body checking and body size estimation in a sample of women with a clinical eating disorder before and after treatment to investigate whether these aspects (a) predict response to treatment, (b) change as a function of treatment, and (c) predict relapse.

Forty-one women with a clinical eating disorder were assessed using the Eating Disorder Examination and a structured diagnostic interview. Levels of body checking and body size estimation were assessed before receiving 10 sessions of CBT to address their eating disorder, and were reassessed immediately after treatment and at 20, 40 and 60 week follow up assessments.

High levels of body checking and body size estimation did not predict response to treatment although there was a trend for women with lower initial shape preoccupation to do better with treatment. Body checking was reduced across the sample after treatment, and there was a trend for women to make more accurate body size estimations after treatment. There was also a trend for the size of discrepancy between the women's actual and desired size to reduce after treatment. Body size estimation was not however associated with clinical status at 20, 40 and 60 week follow-up. Women whose levels of body checking remained high at the end of treatment were more likely to have poor treatment outcome at 8 week follow-up. They were also more likely to meet diagnostic criteria for an eating disorder at 20 and 40 week follow-up than women whose body checking was successfully addressed during treatment.

The results suggest that whilst high initial levels of body checking do not in themselves predict poor treatment outcome, failure to successfully address checking in treatment has important implications for both short and longer term outcome in patients with eating disorders.

Clinical perfectionism and eating disorder psychopathology

Michelle Lee, School of Psychology and Clinical Language Sciences, University of Reading; Roz Shafran, School of Psychology and Clinical Language Sciences, University of Reading; Caroline Riley, Institute of Psychiatry, Kings College, London; Christopher G. Fairburn, Department of Psychiatry, University of Oxford

It has long been recognised that some forms of perfectionism are dysfunctional and there is some indication that such perfectionism can impede the treatment of Axis I disorders. "Clinical perfectionism" is a new, highly specified construct designed to capture the type of self-focused perfectionism in which self-evaluation is overly dependent on striving and achievement. The construct of clinical perfectionism arose from our work with patients with eating disorders and the two problems are hypothesised to have a special relationship. The goal of the two studies presented was to examine the nature and relationship of clinical perfectionism and eating disorder psychopathology.

In the first study, 25 women with clinical eating disorders, 25 patients with obsessive compulsive

disorder and 25 healthy controls completed both interview and self-report measures of clinical perfectionism. In the second study, 41 women with clinical eating disorders completed a self-report measure of clinical perfectionism before and after brief cognitive behaviour therapy.
In the first study, results indicated that women with an eating disorder scored more highly than the other two groups on an interview-based measure of clinical perfectionism, and there was a trend for this group to score more highly than the OCD and control group on a self-report measure of perfectionism also. Both self-reported and interview measures of perfectionism were significantly correlated with eating disorder psychopathology. In the second study, results indicated that clinical perfectionism was significantly lower after treatment compared with baseline levels.
The two studies together suggest that clinical perfectionism may be an important factor in the aetiology and maintenance of eating disorder psychopathology. Study two also suggests that treatment can reduce levels of clinical perfectionism. The implications of this finding for eating disorders and other clinical problems are discussed.

An Extension of the Cognitive Errors Questionnaire for use in Perfectionism

Anna Coughtrey, University of Oxford; Roz Shafran, University of Reading; Jenny Yiend, University of Oxford

A number of self-report questionnaires assess cognitive errors in psychopathology including the Cognitive Errors Questionnaire (CEQ; Lefebvre, 1980). However, although the CEQ assesses four cognitive errors (personalisation, overgeneralisation, selective abstraction and catastrophising), it does not assess discounting of success and dichotomous thinking. This is a particular problem for the assessment of cognitive errors in dysfunctional perfectionism for which such errors are considered fundamental. The aim of the current study was to develop, adapt and extend the CEQ for use in dysfunctional perfectionism. It was predicted that this revised version of the CEQ would be internally consistent and highly correlated with levels of perfectionism.
The number of CEQ items was reduced by half by removing items with an American focus or with overlapping content. Maintaining the original structure, new items were added, three reflecting dichotomous thinking and three discounting of success. 39 student participants completed this revised version of the CEQ, along with the Clinical Perfectionism Questionnaire (CPQ; Fairburn, unpublished); the Dichotomous Thinking Questionnaire (DTQ; unpublished); the Multidimensional Perfectionism Scale (MPS; Frost, Marten, Lahart & Rosenblate, 1990); the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996); the Spielberger State Anxiety Inventory-Short Version (Marteau & Bekker, 1992), and a number of visual analogue scales to assess anxious, depressed and perfectionist state mood.
Results suggested that as levels of perfectionism increased so did levels of cognitive errors associated with perfectionistic thinking. Total scores on the revised version of the CEQ were negatively correlated with total scores on MPS and CEQ ($r(39) = -0.45$, $p = 0.004$; $r(39) = -0.45$, $p = 0.004$, respectively). Furthermore, these correlations remained significant when controlling for levels of anxiety and depression ($r(35) = -0.47$, $p = 0.002$); $r(35) = 0.374$, respectively). Total CEQ scores were also significantly correlated with 4/6 VAS measures of perfectionism, but were not significantly correlated with scores on the DTQ. The new dichotomous thinking subscale was significantly correlated with both the MPS and CPQ ($r(39) = -0.33$, $p = 0.040$; $r(39) = -0.55$, $p < 0.001$) and both these remained significant when controlling for levels of anxiety and depression ($r(35) = -0.37$, $p = 0.042$; $r(35) = -0.52$, $p = 0.001$). The discounting of success subscale was significantly correlated with the VAS urge to check and fear of failing to meet standards measures ($r(39) = -0.34$, $p = 0.033$; $r(39) = -0.49$, $p = 0.001$), but these did not remain significant when levels of depression and anxiety were controlled for. The internal consistency of the revised CEQ was high (cronbach s alpha = 0.85).
These results suggest that the CEQ can be adapted and expanded to measure cognitive errors relevant to dysfunctional perfectionism. Although the revised CEQ requires further evaluation and validation, as it is brief and easy to administer it may be useful in assessing levels of perfectionism and other forms of psychopathology in which dichotomous thinking and discounting of success are particularly problematic, particularly as it correlates with general measures of perfectionism (MPS and CPQ) rather than a measure of one specific cognitive error seen in perfectionism (DTQ).

Posters

Narcissistic personality features, self-reported anger and eating attitudes among non-clinical college population: An explorative study of underlying constructs

Jacqui Farrants, Director, Counselling Psychology Programmes/City University
Konstantina Kolonia, City University

INTRODUCTION: The contribution of personality disorders to disordered eating has recently been of particular interest as an attempt to further understand the phenomenon and address therapeutic difficulties. Narcissism has been found to be more characteristic of individuals with anorexia nervosa or

bulimia nervosa than those with other psychiatric disturbances. Literature suggests that both eating and narcissistic personality disordered individuals appear to have difficulty with recognising and tolerating negative emotions. Empirical corroboration of the mediating mechanisms between narcissistic personality disorder and bulimia nervosa is lacking. Additionally, research concerning gender differences, narcissism and anger has yielded equivocal results.
AIM: The aim of this study was to investigate the relationship between maladaptive aspects of narcissism, anger traits and different elements of eating disordered attitudes. The study also attempted to evaluate gender differences on the above mentioned variables and to investigate possible mediating mechanisms (i.e. anger) between narcissistic personality disorder and bulimic tendencies.
METHOD: One hundred and sixty non-clinical female and male participants have been recruited from universities classrooms of six London and Surrey based universities. The Brien Multiphasic Narcissism Inventory (OMNI), the State-Trait Anger Expression Inventory-2 (STAXI-2), the Eating Disorders Inventory-2 (EDI-2) and the Bulimic Investigatory Test Edinburgh (BITE) were used as the four measuring instruments for this study. Analysis has been carried out using Spearman's Rho correlations, Mann Whitney U tests, Mediation and Multiple regression analysis.
RESULTS: An association between narcissistic personality disorder traits, its defensive style and eating disordered thoughts and behaviours was partially supported. There was also evidence to suggest some relationship between aspects of anger and disordered eating patterns as well as aspects of anger and narcissistic disturbance. Significant gender differences on eating attitudes and concerns were observed. Female and male college students did not differentiate on narcissistic personality traits, nor on ways of experiencing, expressing and controlling anger. Narcissistic personality disorder traits were found to be mediated by state anger on individuals with bulimic tendencies.
CONCLUSION: Pursuing more complex conceptualisation and measurements of narcissism, anger and eating attitudes for both sexes is necessary for the better understanding of co-morbid disorders. Affect-driven therapeutic models need to be considered for the treatment of patients with narcissistic personality and/or eating disorder presentation as these individuals appear to have difficulties in anger experience, expression and control. Future research needs to evaluate therapeutic efficacy of those models in a clinical population and explore further the role of shame and emotional schemas in narcissistic pathology.

Adult Psychosis

Keynote Address

Violence and psychosis: myth or reality and the implications for psychological treatment

Professor Gillian Haddock, University of Manchester

There has been much attention paid in the media and in research studies to a possible relationship between severe mental illness and aggression and violence. However, despite much publicity following violent incidents committed by members of the public experiencing severe mental illnesses such as schizophrenia, the amount of violence committed by persons with schizophrenia is relatively low. This paper will review the evidence in relation to any links between schizophrenia and violence and examine other factors that have been implicated such as substance use, anger and psychotic symptoms. The paper will be supported by data from a number of recent studies and will describe a treatment programme that has been developed to address key issues that have been identified as being important in reducing the occurrence of violence and aggression.

Symposia

Should we rename schizophrenia, or can we abolish the concept altogether?

Convenor & Chair: Paul Hammersley, University of Manchester

Speakers: Paul Hammersley, University of Manchester

Jacqueline Dillon, Independent trainer, former national head of The Hearing Voices Network; David Kingdon, University of Southampton, Royal South Hants Hospital

Schizophrenia has been a controversial diagnosis since its inception. There are many problems associated with the diagnosis of schizophrenia; broadly speaking these problems fall into three areas: dubious scientific basis, high levels of associated stigma and overemphasis of the biological basis of this so called 'disease'.

1. Dubious scientific basis. The diagnosis of schizophrenia is neither valid nor reliable, it tells us little if anything about the source of an individual's psychological distress, the likely course of the difficulties or even effective treatment options. It is at best a catch all diagnosis covering a wide variety of clinical presentations. At worst it has been argued that a diagnosis of schizophrenia is actually a hindrance to recovery.
2. High levels of associated stigma. The diagnosis of schizophrenia is associated with almost unendurable levels of stigma for those unfortunate enough to receive it. It is often associated (unfairly) with violence, unpredictability and hopelessness amongst both the general public and professionals. The diagnosis has ceased to carry any genuine medical meaning and has instead become a term of abuse, particularly for young people.
3. Overemphasis of the biological basis of schizophrenia. Over one hundred years of research has revealed little with regard to the biological or genetic base of schizophrenia. It has become increasingly apparent over the last decade that the role of environmental factors in psychosis has been hugely underestimated. Factors such as trauma in childhood and adulthood, bullying, racism and discrimination are not merely triggers that serve to activate a psychosis, but are central features in their own right.

Meeting the NICE guidelines on schizophrenia: Training in CBT for Psychosis

Convenor: Suzanne Jolly, Institute of Psychiatry

Chair: Juliana Onwumere, Institute of Psychiatry

Implementing the NICE schizophrenia guideline: Training in CBT for Psychosis

Alison Brabban, University of Sunderland

NICE schizophrenia guidelines recommend that all service users who do not respond to medication should have access to CBT. Unfortunately there is a significant shortfall of appropriate skills amongst mental health practitioners to fully implement national guidelines. If evidence-based practice is to be delivered effectively it is clear that a substantial investment in appropriate CBT training is required. What is not so clear is what represents the most effective and efficient form of training.

This presentation reviews the literature on the impact of CBT for psychosis training, looking at the impact on attitudes, values, skills and post-training practice of trainees. Results show that this type of training appears to promote a recovery focused perspective and does increase the knowledge and skills of trainees. What is less clear is the level of skill that can be acquired from different forms of training and the competency of trainees post-training. Implications for commissioning training and for the successful implementation of CBT for psychosis will be discussed.

Results from three initiatives associated with the programme will be presented:

i) an audit of delivery of cognitive behavioural therapy (CBT) in 16 CMHTs

ii) an investigation of CMHT workers' understanding of referral criteria for CBT

iiii) the development and evaluation of a Trust based training programme in CBT for Psychosis.

Implications of the findings for services will be discussed.

Implementing the NICE Guideline for Schizophrenia: An Evaluation of the training and supervision of Mental Health Workers in Cognitive Behaviour Therapy for Psychosis

Pauline Callcott & Caroline Bryant, Newcastle Cognitive and Behavioural Therapies Centre

The NICE guideline for Schizophrenia states that Cognitive Behaviour Therapy should be available to all as there is a considerable evidence base suggesting that it is helpful in prevention of relapse, reducing symptoms, increasing insight and improving adherence to medication (NICE 2002). In addition the NICE guideline states that interventions of six months' duration and 10 plus sessions have shown greatest efficacy.

The pilot project described began with an audit of existing training and supervisory arrangements for CBT psychosis, describes a ten day tailored course for mental health workers from across a range of differing service settings and details results of supervision, training provision and patient outcomes.

The research data in the presentation includes an analysis of courses provided and supervision attended, skills acquisition from repeated training needs analysis during the course of supervision and describes some of the difficulties encountered in service implementation.

Patients were offered at least twelve sessions of CBT as well as optional/additional carer sessions.

The data presented will also include details of outcome measures including PSYRATS, BDI, BAI, CORE and MECCA for patients seen, as well as the monitoring of the use of bed days, crisis teams and medication usage.

Recommendations are made for future implementation plans.

CBT Psychosis training: PG Diploma Programme at University of Southampton

Nick McGuire, University of Southampton

The Postgraduate Diploma Programme in Cognitive Therapy for Severe and Enduring Mental Health Problems at the University of Southampton enables students to opt for supervision in either psychosis or personality disorders to complete the course.

A basic qualitative audit of Southampton alumni clinicians (intakes 2001 – 2005) was conducted to obtain information about the effect of the course on levels of activity and confidence in use of CBT for psychosis, and any constraints on the implementation of CBT in their roles as mental health professionals.

Fifty-four students opted to be supervised within psychosis (from a total intake of 97), out of which 47 completed the course, and 43 were contactable by email. Sixteen students replied.

Comments made indicated a high degree of variation in terms of ability to practise and constraints on CBT for psychosis. Some were able to devote all of their time whereas others had found it difficult to set time aside, citing lack of management support. Other important constraining issues were lack of supervision, isolation, inappropriate referrals and environmental issues. Factors implicated in the variation may be job roles and work setting. Community team working seems to be a particularly difficult area in which to operate as a CBT therapist, whereas specialist teams (e.g. early intervention) are much easier.

Meeting the NICE schizophrenia guideline in the South London & Maudsley NHS Foundation Trust (SLaM)

Sharon Wellington, Zoe Wiseman & Anna Moriarty, South London & Maudsley NHS Foundation Trust

The Increasing Capacity to Meet Demand (ICMD) programme has been established in SLaM to work with Community Mental Health Teams (CMHTs) with the aim of increasing access to psychological interventions for people with psychosis, in accordance with the NICE schizophrenia guideline.

Results from three initiatives associated with the programme will be presented:

i) an audit of delivery of cognitive behavioural therapy (CBT) in 16 CMHTs

ii) an investigation of CMHT workers' understanding of referral criteria for CBT

iiii) the development and evaluation of a Trust based training programme in CBT for Psychosis.

Implications of the findings for services will be discussed.

Factors affecting engagement in CBT for clients with psychosis

Convenor & Chair: Gillian Haddock, University of Manchester

The contribution of psychosis, anger and substance use to aggression and violence in schizophrenia: implications for engagement in CBT

Gillian Haddock, University of Manchester

BACKGROUND: Some studies have demonstrated that rates of violence in people with schizophrenia are higher than in other diagnostic groups and community controls. Other studies have found no such links between schizophrenia and violence when factors such as substance use, psychotic symptoms and anger have been controlled for. These conflicting findings can, in part, be explained by the methodological differences employed by researchers that have limited the conclusions which can be made.

METHOD: A sample of 77 people with a diagnosis of schizophrenia, with persistent, treatment resistant symptoms and a history of violence were recruited from inpatient and outpatient settings in the North West of England. Cross sectional assessment of type and content of psychotic symptoms, substance use and anger was carried out. Assessment of violence was carried out retrospectively and prospectively over 12 months from case notes. Staff ratings of anger and aggression were also collected.

RESULTS: There were no associations between severity of psychotic symptoms or substance use and aggression/violence. However, there were significant associations between the presence of threat control over-ride symptoms, anger and retrospective and prospective, aggression and violence.

CONCLUSIONS: There are multiple factors that are likely to contribute to the occurrence of aggression and violence in schizophrenia. Particular psychotic symptoms and anger are especially relevant and these factors are likely to respond to psychological intervention such as CBT, however, they are also ones that may limit to the degree to which an individual may wish to engage in a therapeutic intervention. The implications for psychological treatment will be discussed.

Command hallucinations, factors affecting compliance and the implications for treatment

Alastair Barrowcliff, Five Boroughs Partnership NHS Trust

INTRODUCTION: Developing our understanding of factors associated with compliance to auditory command hallucinations has important clinical implications in regard to issues such as risk assessment and therapeutic intervention with clients. Whilst past research has predominantly focused on issues of command content and severity of symptoms, recent research has indicated that certain beliefs associated with hallucinatory voices may be important determinants of compliance or resistance where commanding aspects are reported. It is further suggested that the differentiation of categories of

command is essential in the assessment process, such that 'command hallucinations' as a generic definition is insufficiently discriminatory. Such issues are considered here in the context of recent research findings examining psychological features of compliance to command hallucinations. Subsequent implications for therapeutic engagement and clinical intervention are considered.
METHODOLOGY: Recent research regarding compliance with command hallucinations is summarised, with particular focus on a recent study examining psychological features of compliance in a mixed sample of 49 command hallucinators. Implications for therapeutic engagement and intervention are briefly considered utilising case examples from clinical practice.
RESULTS: Aspects of both command content and beliefs associated with the hallucinatory voice are considered important in understanding determinants of compliance with commands of differing severity (e.g. benign, harm self or harm others). Key implications of this are that clinical assessment should differentiate types of command and inform clinical intervention in respect to core cognitive features associated with the client's own rationalisations for compliance.
CONCLUSIONS: Our understanding of factors associated with compliance to command hallucinations has greatly expanded over the past decade with subsequent implications for psychological assessment and CBT based interventions. Further research is still required in this area, such as prospective studies of the relationship between compliance and psychological variables.

Engaging clients in CBT within high secure services

Celia Vishnick & Kerry Manson, Ashworth Hospital, Merseycare NHS Trust

INTRODUCTION: Little work evaluating the effectiveness of CBT for people with psychosis has taken place within high secure mental health facilities. However, a randomized controlled trial evaluating the effectiveness of CBT for people with psychosis who have a history of violence has recently been completed for which a sub-sample of participants were recruited within Ashworth Hospital high secure services (Haddock *et al.*, 2007).
METHOD/TECHNIQUES: People with a diagnosis of schizophrenia, persistent psychotic symptoms and a history of violence were recruited from a high secure hospital as part of a larger, randomised controlled trial. Consenting participants were randomly allocated to receive either 1) an integrated CBT intervention of 25 sessions or, 2) a control intervention, Social Activity Therapy. Outcomes were assessed at 6 and 12 months.
RESULTS/OUTCOME: Changes in symptom, anger and aggression outcomes were mixed across the high secure sample. However, qualitative observations on the therapy process provided important observations on the therapy process in this type of setting. For example, the challenges of delivering CBT within a high secure environment such as, balancing therapeutic needs against risk management issues, integrating the intervention with usual mental health treatment and ensuring sufficient time to allow participants who are offered CBT to engage in the therapeutic process.
CONCLUSION/DISCUSSION: Most of the participants found the CBT style helpful and remained engaged in the treatment approach. The high secure environment is a unique one in which to deliver therapy and attention must be paid to the environmental challenges posed by this type of setting.

People with learning disabilities and psychosis: factors affecting engagement in therapy and outcome

Steve Oathamshaw, Cheshire and Wirral Partnership NHS Trust

Introduction: The last 15 years have seen a growth of interest in the application of CBT to the treatment of psychological problems in people with learning disabilities. People with psychosis and learning disabilities present particular difficulties for clinicians and while some of these difficulties are common to other clients with psychosis, others appear unique to this population. This presentation will consider factors affecting engagement in therapy and outcome and provide recommendations for other clinicians to consider.
METHODOLOGY: The literature base concerning cognitive behavioural treatment for people with learning disabilities was reviewed, with particular reference to literature assessing engagement and that evaluating treatment for people with psychosis. Factors identified will be illustrated with material from clinical cases.
RESULTS: A very small, but growing literature does exist and has paid particular reference to factors to be considered affecting engagement in treatment. Factors identified in the literature and from case material include adaptations to therapy, cognitive skills, motivation, support available, environmental factors and 'self efficacy' (belief in one's own ability to effect change). In common with the general population it is considered important to engage family members or carers in treatment for people with learning disabilities and psychosis where possible.
CONCLUSIONS: There is some evidence CBT treatment for people with learning disabilities and psychosis can be clinically effective, in particular with regard to positive symptoms. Psychological treatment may be undermined if factors affecting engagement and outcome are not considered. Further research is needed to investigate these factors, but recommendations can be offered for clinicians to consider, based on present knowledge.

Cognitive Behaviour Therapy in the Acute Psychiatric Inpatient Unit

Convenor & Chair: Isabel Clarke, AMH Woodhaven, Hampshire Partnership NHS Trust

Designing a CBT Service for an Acute In-patient Setting: A pilot evaluation study

Caroline Durrant, Isabel Clarke, Abigail Tolland and Dr Hannah Wilson, AMH Woodhaven, Totton, Hants

A frequent complaint by service-users of psychiatric in-patient units is the unavailability of talking therapy at precisely the time when they need to make sense of their situation. However, conventional models of CBT therapy delivery, with set numbers of sessions and diagnostic specificity are not well suited to the conditions of the acute ward, with variable and unpredictable lengths of stay and multiple and indistinct presentations. This pilot study describes a modification of CBT designed to deliver an effective, brief therapy in these conditions. The approach is grounded in the cognitive science based model, Interacting Cognitive Subsystems, and draws on Dialectical Behaviour Therapy and other recent, mindfulness based CBT approaches, to provide a combination of simple formulation and skills based treatment. Evaluation in the in-patient setting also presents challenges, and these have been met by choosing measures that tap into self efficacy and confidence in the management of emotions rather than symptomatic change. The evaluation data on a small number of cases suggests the effectiveness of the approach and the need for wider testing of the model.

Creating a Therapeutic Milieu in an Acute Psychiatric Hospital

Laura Dannahy; Vivia Cowdrill, Royal South Hants Hospital, Southampton, Hampshire, UK

According to the World Health Organisation (as cited by Reiss & Roth, 1993) “the creation of the atmosphere of a therapeutic (milieu) is in itself, one of the most important types of treatment which the psychiatric hospital can provide.” The therapeutic milieu is defined as the creation of a supportive and nurturing interpersonal environment that teaches, models and reinforces constructive interaction. It supports peer/staff feedback to service users on strategies for symptom reduction, increasing adaptive behaviours and reducing subjective distress. It encourages service users’ participation in decision-making and collective responsibility for ward events (Gutheil, 1985). Creating a therapeutic milieu within acute psychiatric settings requires a multi-disciplinary effort and the clinical psychologist or cognitive behaviour therapist has much to offer. The presentation will focus on two aspects of the work undertaken by the consultant and clinical psychologists in an inner city psychiatric hospital. Firstly, we will describe our experiences of establishing an “Acceptance culture” based on DBT-informed principles in the inpatient service, with specific reference to the development and evaluation of both a staff training programme, and a 6-session DBT-informed Emotional Coping Skills group. Secondly, we will focus our presentation on our experiences of influencing the therapeutic climate, with reference to the facilitation of reflective practice sessions for staff, and multi-discliplinary clinical discussion meetings on each ward.

CBT Formulation in the Inpatient Setting

Fiona Kennedy, Isle of Wight Healthcare NHS Trust

INTRODUCTION: Formulating the development and maintenance of clients’ problems is widely advocated as a useful activity in the practice of CBT. Little has been written about the specific application of formulation in the inpatient setting.

This paper addresses specific issues relevant to the relatively closed inpatient environment and advocates formulating CBT contingencies at several levels, from the individual, through the care-delivery staff to the management and organisational ethos level.

The effectiveness of formulation-only sessions is evaluated in a pilot study.

METHODS AND MATERIALS: Examples of such formulations are given, drawn from the author’s extensive experience of work on inpatient wards. Outcomes from 20 interventions consisting of one or two formulation-focused stand-alone sessions, using MCMI-II, BSI and CORE results, are used for evaluation.

RESULTS: Positive changes are reflected in outcome measures before and after sessions using the BSI and CORE, but little change was found on the MCMI-II.

REFLECTIONS AND CONCLUSION: The study lacks a control group and may suffer from strong demand characteristics predisposing the clients to answer positively. However, many of the clients were under similar pressure during ward rounds and visits and did not express positive changes.

The recent debate on the validity and reliability of formulation is mentioned. A case is made for a main therapeutic effect of formulation being the transformation of self-evaluations and staff-patient evaluations from blame attribution towards compassion, opening the way for collaborative work towards permanent change.

Suggestions for future research in this area include studies to examine shifts in self-self and staff-client relating following a formulation-based intervention in an inpatient setting.

Working with the staff in an acute adult inpatient unit: Using CBT principles to deliver effective staff training

Hannah Wilson, Hampshire Partnership NHS Trust

One way in which Clinical Psychologists and CBT Therapists can have a positive impact on inpatient units is to offer "cognitive therapy informed" training on difficult areas of patient care such as challenging behaviour. The current paper reports the experiences of delivering a 2 day training package looking at psychological approaches to managing challenging behaviours for mental health professionals working in a psychiatric inpatient hospital. Training of staff teams on inpatient psychiatric wards has a number of specific challenges. The paper explores these challenges: namely, being able to train whole teams together away from the ward environment, introducing new approaches with a psychological or behavioural emphasis within a predominately medical model, getting teams to adopt new ideas or suggestions for care plans from outside agencies or the "visiting expert", and working with existing staff attitudes and attributions about challenging behaviours. With these challenges in mind, a 2 day workshop for 50 mental health practitioners working at a purpose built inpatient unit for adults with mental health difficulties was planned and executed. The overall aim of the training was to strengthen staff team-work using evidence-based psychological principles in a way that treats clients with dignity and empowers them, while minimising risk. The paper will report on the content and the trainers' experiences of delivering the training package. Outcome evaluation data of the project suggested that the training was valued by the staff teams and had a positive impact on clinical practice.

CBT in Acute Care: An Opportunity for Research?

John McGowan & Rosalind Hall, Sussex Partnership Trust

Acute psychiatric care has historically had limited involvement from psychological practitioners and there is limited published assessment of the efficacy of psychological treatments in this context. Recently a number of authors have argued strongly that CBT should be more available to psychiatric inpatients. However, the acute environment provides a number of challenges in gathering evidence for psychological approaches. In particular, the complexity of this setting often does not lend itself to single model approaches and many psychological interventions may be preparatory. It may often be difficult to define good outcomes and psychological interventions frequently occur in conjunction with other treatments. Several attempts to measure outcomes and studies based on user experiences are reviewed. Particular attention is paid to difficulties in translating existing research into an acute psychiatric setting and measuring outcomes. A number of suggestions are made for developing research in this area including consideration of a range of outcome indicies and the ways in which psychological ideas may be employed in care planning.

Cognitive Behavioural Therapy for Preventing Psychosis: Treatment Approaches with Young People at Ultra High Risk

Convenor & Chair: Amanda Skeate, ED:IT, Birmingham & Solihull MH Trust & University of Birmingham

Discussant: Chris Jackson, University of Birmingham; Early Intervention Service, Birmingham & Solihull Mental Health Trust

Preventing Transition to Psychosis in a Community Mental Health Setting: The experience of ED:IT, Birmingham, UK

Amanda Skeate, Paul Patterson, Max Birchwood, Kelly Panter, Sherri Meese, ED:IT, Birmingham & Solihull MH Trust & University of Birmingham

Since 2002, the Birmingham Early Detection & Intervention Team (ED:IT) have utilised the criteria developed by the PACE clinic, Melbourne, Australia (Yung *et al.*, 1996) to detect individuals at ultra high risk (UHR) of developing a psychotic disorder. The experience of ED:IT confirms that young people at imminent risk of psychosis describe high levels of emotional distress, with 35.7% of clients reporting at least one previous suicide attempt and 65% complaining of suicidal ideation at baseline assessment. Furthermore, in spite of traditional mental health services often perceiving these clients as 'not ill enough' to require treatment, clients rate as having (on average) a moderate to substantial level of disability on the Global Assessment of Functioning scale, and 68% of clients assessed had one or more co-morbid diagnosis. The type of treatment offered needs to be carefully considered, balancing uncertainties around diagnosis with a need for intervention to prevent worsening of symptoms and reduction of distress in this client group. Birmingham ED:IT provides an individually tailored cognitive behavioural approach based on the protocol developed and evaluated by Morrison *et al.* (2002) in a randomised controlled trial. Operating within a moderated Assertive Outreach model, this intervention appears to be acceptable to many young people referred to ED:IT. In this presentation the service will be described with particular reference to intervention and preliminary outcome data will be reported.

Treatment and Outcome within the OASIS Service

Louise Johns, Lucia Valmaggia, Paul Tabraham, Matthew Broome, James Woolley and Philip McGuire, OASIS Team, Institute of Psychiatry, London

Outreach And Support In South London (OASIS) is a clinical service for young people who are at high risk of developing psychosis. 465 clients have been referred over the past four years and 117 (38%) of those assessed met criteria for an at risk mental state. The service is conducting a naturalistic study of intervention and outcome, and all patients are offered low-dose antipsychotic medication and/or cognitive behaviour therapy (CBT), in addition to monitoring and case management. Antidepressant medication is also prescribed according to client need. The CBT uses different therapy modules (e.g. anomalous experiences, depression and negative symptoms, anxiety disorders) according to the client's presenting problems and formulation, plus a core module on self-regulation and lapse prevention. 106 clients were taken on for treatment, and 76 (72%) accepted CBT, either alone (39) or in combination with antipsychotic (27) or antidepressant medication (10). Adherence to CBT (assessed by client attendance and engagement with treatment) was divided roughly equally between poor, moderate and good. Twenty-four OASIS clients (23%) made a transition to psychosis. There was no association between transition and having received CBT or antipsychotic medication. However, none of the clients who had taken antidepressants made a transition to psychosis, which was significant at trend level ($p = 0.067$). The results indicate that CBT is an acceptable treatment for this group, but that more needs to be done to improve adherence. Antidepressant medication may be an effective alternative to antipsychotics for this group.

An exploration of European treatment approaches to individuals at high-risk of psychosis from the EPOS project: is prevention of psychosis becoming viable?

Paul Patterson, Max Birchwood, Amanda Skeate and the EPOS collaboration, ED:IT, Birmingham & Solihull MH Trust & University of Birmingham

Prevention of psychosis remains a challenging yet inspirational ambition of many mental health research and clinical programmes and until recently effectively targeted approaches have seemed elusive. Recent early detection programmes have employed PACE criteria to identify individuals at high-risk of developing psychosis thus allowing a range of treatment strategies to be compared. The EU funded EPOS project has allowed comparison of both naturalistic and focused treatment approaches in n=242 'at-risk' individuals from four European countries over an 18 month follow-up period. Psychological and medication treatment practices are compared and contrasted with symptom profiles and transition rates and demographics of client samples are discussed. A focus on the model employed by the Birmingham ED:IT service raises questions of whether such methods could usefully be integrated into national strategies to encourage prevention of psychosis at the earliest opportunity.

Treating Paranoia in Young People at Ultra High Risk of developing Psychosis

Samantha Bowe, Paul French and Anthony Morrison, EDIT, Salford, BSTMHT & University of Manchester

The identification of risk factors suggests the possibility of employing psychological interventions to decrease the incidence of psychotic disorders (Morrison & French, 2002). Preliminary evidence from a randomised control trial suggests that cognitive therapy is an effective psychological intervention in reducing the transitions rate in individuals with an At Risk Mental State (ARMS). The therapeutic approach of the Salford Early Detection & Intervention Team will be described; focusing on treatment strategies for paranoia in the 'at-risk' group. In addition, the differences and similarities of paranoid symptoms in ARMS clients in comparison with clients with acute psychosis will be discussed. Finally, the overlap between paranoia and social anxiety will be examined.

Open Papers

Issues in Psychosis

Chair: Olga Luzon, Royal Holloway, University of London

Cognitive processes during the acute psychotic state: the role of heightened responsibility

Olga Luzon, Royal Holloway University of London; Chris Harrop, Royal Holloway University of London; Fiona Nolan, CORE, University College London

Some key concepts from the anxiety disorders literature, such as safety-seeking behaviours and intrusive thoughts have been shown to be important in psychosis (e.g. Morrison, Haddock, & Tarrier, 1995). A number of cognitive models have been developed to explore typical psychotic symptoms such as auditory hallucinations or delusions (e.g. Bentall, 1990; Garety *et al.*, 2001). However, much less is

known about cognitive processes during the acute psychotic state. In this study, it was hypothesised that further anxiety mechanisms could be significantly useful in understanding patient's experiences during an acute psychotic state or crisis. In particular, we were interested in the role of catastrophic interpretations, thought control strategies, and sense of responsibility.
60 patients aged 18-65 who met DMS-IV criteria for non-affective psychosis were recruited from a number of mental health services across London. Two groups of patients were recruited: a) 30 patients were experiencing acute psychotic symptoms severe enough to require immediate hospitalisation or the involvement of the local Crisis Resolution Team (CRT) with high scores on the Psychiatric Rating Scales (PSYRATS; Haddock *et al.*, 1999), and able to provide informed consent; and b) 30 patients were under the care of their local community mental health team (CMHT) and considered by the team as stable. Recruitment took place simultaneously at all sites over six months, with the cooperation of clinical staff, who identified suitable participants. From 72 patients approached, 60 consented and were recruited (response rate 83%). The assessment was completed in one meeting at their usual NHS clinical setting and lasted approximately 30 minutes. Additionally, a non-clinical comparison group of 30 people was recruited from the general population. Catastrophic misinterpretations were measured with the Anxiety Sensitivity Index-3 (ASI-3; Taylor *et al.*, 2007). Thought Control and Sense of Responsibility were assessed with the Obsessive Belief Questionnaire-44 (OBQ-44; Obsessive Compulsive Cognitions Working Group, 2004). Both measures have shown excellent psychometric characteristics with clinical and non-clinical samples, and were successfully piloted prior to data collection, in order to establish their validity for the population of this study.
Results indicate that people in acute psychotic crisis show significantly stronger beliefs about the probability and cost of aversive events and have a heightened sense of responsibility, than those with a similar diagnosis but who were currently stable. Patients in psychotic crisis also misinterpret cognitive processes in a catastrophic manner significantly more than control patients. Both groups scored significantly higher than the non-clinical sample on all measures.
The findings suggest that these anxiety concepts may be important to consider when working with acute-state clients. For example, a person who has been mildly symptomatic perhaps for years and managing to cope with their symptoms may, in an acute crisis, be presenting with an unusually heightened sense of responsibility and uncharacteristic need to take action, in a manner that has some similarities to a patient with anxiety who also has overpowering OCD. This wouldn't indicate that anxiety mechanisms have caused the crisis, but would identify that these are important mechanisms to target in the phase of acute distress.

The role of prolactin-induced somatic sensation in delusions of pregnacy formation

Niraj Ahuja, Steve Moorhead, Adrian Lloyd & Andrew Cole, Northumberland, Tyne and Wear NHS Trust & University of Newcastle upon Tyne, UK

Increase in serum prolactin is a recognised effect of antipsychotic medication. Elevated prolactin levels associated with antipsychotic treatment and other causes have been associated with delusions of pregnancy. Reduction of prolactin levels has been recognised to resolve these delusions.
We report a case series of 12 women with hyperprolactinaemia induced by antipsychotic medication which sheds some light on the mechanisms involved.
This report supports a role for emotional salience of pregnancy. This provides a psychological cue to interpreting symptoms of pregnancy, emerging with hyperprolactinaemia, as evidence of being pregnant in the context of active psychosis.
Clinicians should ask about symptoms of pregnancy associated with antipsychotic treatment to facilitate making delusions of pregnancy understandable. Findings will be discussed in relation to current psychological models of delusion formation. These may be open to a CBT intervention.

Adult attachment theory and psychosis: A framework for understanding symptom profiles, interpersonal problems and difficulties in therapeutic relationships

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

According to cognitive models of psychosis, difficulties in earlier relationships with significant others and interpersonal traumas lead individuals to form negative beliefs about the self and others, which then facilitate the development and maintenance of psychotic symptoms. Interpersonal difficulties are also one of the hallmarks of the diagnosis of psychosis and individuals often find it difficult to engage in therapeutic relationships (Penn *et al.*, 2004). Although initially based on studies of infants and caregivers, attachment theory is a lifespan developmental theory that provides a framework for conceptualising the role of earlier interpersonal experiences and social cognition on the development of psychological distress in adulthood and has had a significant impact on the study of human relationships. Insights from attachment theory may therefore inform current conceptualisations of psychosis and in particular develop understanding of interpersonal problems associated with the diagnosis (Berry *et al.*, 2007).
We investigated associations between attachment, symptoms, interpersonal functioning and therapeutic relationships in 96 patients with psychosis and psychiatric staff. We also assessed changes in attachment styles in a prospective design in both psychiatrically unstable and stable groups. We measured attachment using the Psychosis Attachment Measure (PAM). The PAM is a questionnaire measure of

attachment, with subscales assessing the constructs of attachment avoidance and anxiety. The PAM has been shown to have good psychometric properties which have been replicated in independent samples. Attachment style, interpersonal problems and therapeutic relationships were assessed from both staff and patient perspectives.
We found predicted associations between avoidant attachment and both negative symptoms and paranoia. Attachment ratings were relatively stable over time, suggesting the PAM was not confounded by the presence of symptoms. Predicted associations between high levels of attachment anxiety and avoidance and interpersonal problems were partially supported, with specific associations between attachment avoidance and interpersonal hostility and attachment anxiety and overly demanding behaviour. As predicted, high levels of attachment avoidance were associated with difficulties in therapeutic relationships. The majority of effects were maintained when controlling for severity of symptoms.
Findings suggest that adult attachment style is a meaningful individual difference variable in people with psychosis and may be an important predictor of symptom profiles, interpersonal problems and difficulties in therapeutic relationships over and above the severity of symptoms. Attachment theory has clinical implications and may be particularly informative in helping to develop more therapeutic relationships between psychiatric staff and patients.

ACT Early: using acceptance and commitment therapy to assist recovery from a first episode of psychosis

Eric Morris, Lambeth Early Onset Service, South London & Maudsley NHS Foundation Trust

A focus of research efforts within the acceptance and commitment therapy (ACT) community has been upon helping people with persisting symptoms of psychosis who are at risk of relapse/rehospitalisation (Bach & Hayes, 2002; Gaudiano & Herbert, 2006). Studies using brief packages of acceptance, mindfulness and behavioural activation methods have demonstrated promising results in terms of reducing relapse rates and the impact of symptoms over the medium term (Bach *et al.*, 2006). In this paper it will be argued that another potential area for clinical innovation and research is in assisting the recovery of people who are experiencing psychosis for the first time. First episode clients have a high risk of relapse of psychosis, comorbid conditions, suicidality, social exclusion, and self-stigmatising appraisals about the experience of psychosis and treatment. It has been argued that intervening early may reduce these risks as well as promote recovery (McGorry, 2000). This paper will outline how using a mindfulness-based therapy like ACT could make a contribution to early intervention with psychosis.
It will be argued that the therapeutic stance and methods of ACT may augment current treatment approaches in the first episode.
More specifically, the use of ACT may:

[1] foster the development of a psychologically flexible stance toward anomalous experiences,

[2] enable a values-based recovery,

[3] reduce the impact of fear of recurrence of psychosis through development of mindfulness and self as context,

[4] enable individuals to notice the process of self-stigmatisation, contexts where this operates as a barrier, and commit to valued directions in the face of these appraisals, and

[5] improve relapse prevention plans through the use of mindfulness and committed action.

A brief case example will be used to illustrate these points.
A case study is presented of a 16-session ACT treatment with a young woman recovering from a first episode of psychosis. The treatment approach involved case formulation based on ACT principles, and the use of mindfulness, values clarification and committed action strategies.
The stance of acceptance and committed action may allow for flexibility in response to persisting psychotic experiences, as has been suggested in ACT studies with the seriously mentally ill. There may be exciting potential for researching the impact of ACT early – helping first episode clients to recover from psychosis through the development of mindfulness toward unusual experiences and critical appraisals, and committing to values-based actions.

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Posters

MIDAS Trial – An Evaluation of Combined Motivational Interviewing and CBT for Schizophrenia and Substance use

Thomas Craig, Institute of Psychiatry; Linda Davies, University of Manchester; Gillian Haddock, University of Manchester; Shon Lewis, University of Manchester; Jan Moring, University of Manchester; Nick Tarrier, University of Manchester; Til Wykes, Institute of Psychiatry

INTRODUCTION: There is a high rate of substance use in Schizophrenia, with estimates in community samples at 20-40%. These dual diagnosis patients are at higher risk for a range of adverse outcomes, and their associated problems use a large proportion of staff resources and time. Despite this and their inclusion in the Department of Health Priorities and needs policy, research on treatment development and effectiveness is limited and there is little evidence based practice. The majority of published approaches to the problem have been carried out in the US where elements of mental health and substance use services have been integrated. The Cochrane systematic review identified that while integrative programmes could maintain patients, there was no evidence that any treatment plan was more effective than treatment as usual. An RCT by the grantholders found superior outcomes for treatment that combined three components – motivational interviewing (MI), cognitive behaviour therapy (CBT) and family intervention – when compared with standard psychiatric care. The MIDAS study is a development of this work. The hypotheses are (1) MI plus CBT for patients with schizophrenia and substance misuse in addition to standard psychiatric care will result in significant reduction in hospital admissions and death (2) reduction in substance use will mediate a reduction in patient symptomatology and relapse. The study will also evaluate the relative costs and outcomes of the intervention.

METHOD: The study is a pragmatic, rater blind randomised controlled trial comparing MI plus CBT with treatment as usual. 327 patients who met DSM IV criteria for both a diagnosis of schizophrenia, Schizophreniform or schizoaffective disorder and a diagnosis of drug and/or alcohol abuse or dependence as assessed by SCID, were recruited from 6 mental health trusts across London and Manchester. Participants in the experimental group are offered 26 sessions of MI plus CBT over 12 months. Patients in both groups are followed up for assessments every 6 months for 2 years. The primary outcome measure will be readmission to hospital for reason related to psychosis or death from any cause/not admitted to hospital in the 12 month post treatment period. Secondary outcome measures are substance use, patient psychotic symptomatology, and relapse. Twelve and 24 month primary and secondary outcome measures will be analysed separately on an intention-to-treat basis, using a logistic regression or analysis of covariance (depending on whether the outcome is binary or quantitative).

RESULTS: Recruitment to the study began in October 2004 and was completed in April 2007. Follow ups completed to date: 6 months 93% 12 months 90% 18 months 82% 24 months 84% Baseline Data Analysis (n=305) Demographics Mean age 39 Male 88% 83% White, 9% Black, 2% Indian/Pakistani, 6% Other Primary Diagnosis % Secondary Diagnosis % Schizophrenia 80 Alcohol abuse 9 Schizphreniform 1 Alcohol dependency 42 Schizoaffective Disorder 8 Drug abuse 3 Drug Induced Psychosis 3 Drug dependency 31 Delusional Disorder 1 Drug and Alcohol abuse or dependence 15 Psychosis NOS 4 Missing 2 Most Problematic Substance % Alcohol 42 Cannabis 35 Cocaine 9 Heroin 1 Ecstasy 4 Amphetamine 7 Benzodiazepine 1 Other 1.

CONCLUSION: A detailed analysis of all baseline data (n=327) will be completed in July 2007. Data collection for the study will finish in April 2009.

An Investigation of the Impact of Illness Perceptions on Treatment Adherence with Forensic Patients Diagnosed with Psychosis

Prveen Shah, University of Birmingham; Tim Hull, South Staffordshire Healthcare NHS Trust

INTRODUCTION: There is a large amount of research in health psychology literature regarding the importance of perceptions of illness in relation to treatment outcome. However, there is limited research into the influence of illness perceptions on treatment outcome adherence for individuals with a diagnosis of schizophrenia. This investigation aims to assess the importance of illness perceptions for this client group, whilst accounting for a variety of moderating factors (specifically, their attitudes to treatment, their general mood, and their level of negative symptoms).

METHOD: Participants are asked to complete the Illness Perception Questionnaire for Schizophrenia (IPQS); the Drugs Attitude Inventory (DAI); the Hospital Anxiety and Depression Scale (HADS); the Self report Quality of Life measure for people with Schizophrenia (SQLS); and the University of Rhode Island Change Assessment Scale (URICA). In addition staff are asked to complete the Service Engagement Measure Observer Version, and the Brief Psychiatric Rating Scale (BPRS), in order to gain more objective data. The research follows a cross-sectional design using both self-report and other-report (staff-report) measures. It is hypothesised that: Ÿ Those who perceive the illness to be more threatening (in terms of consequences and/or timeline) will show better treatment adherence Ÿ Those who perceive the illness to be controllable will also show better treatment adherence Ÿ The impact of these illness percep-

tions on treatment adherence will be moderated by attitudes to treatment (the impact will be stronger for those who view treatment in a positive way); the severity of negative symptoms (the impact will be stronger for those with fewer negative symptoms); and by depression (the impact will be stronger for those with less depression). Results are analysed using multiple regression, including moderator analysis.
RESULTS: At the moment all data has been collected and is undergoing analysis. This will be completed and the research written up by July 2007, and the results and conclusions will be available by the time the poster is designed. Preliminary indications are that the second hypothesis is to be supported by results, but that the first hypothesis may not be supported. The results relating to the third hypothesis are not yet available.
CONCLUSION: Discussion will include implications for theories of illness perception in mental health. The results will also be discussed in relation to their implications for the treatment of this client group, their relationship with staff, and how an assessment of illness perception can be used to inform management. Further discussion will involved consideration of ethical factors within mental health, such as service user involvement in treatment, and the shaping of staff attitudes.

The Impact of Traumatic Stress on Suicide in Schizophrenia

Alicia Picken, University of Manchester; Nicholas Tarrier, University of Manchester

INTRODUCTION: Suicide in schizophrenia is high. It is the primary cause of premature death in this population. A number of risk factors for suicide have been consistently found but few have predictive ability. This study considers the impact of traumatic experiences and post-traumatic stress disorder (PTSD), a common co-morbid disorder, on levels of depression and hopelessness and associated suicide risk.
METHOD: 110 individuals with a diagnosis on the schizophrenia spectrum were assessed for levels of depression, hopelessness and suicide. They were asked about past traumatic experiences, both independent and dependent on their psychosis, and the current impact of these experiences.
RESULTS: 31 individuals met full criteria for PTSD. 16 reported an independent event, such as physical or sexual assault, as their most traumatic event. 15 reported a dependent event, such as hospitalisation, as their most traumatic. Comparison of the PTSD and non-PTSD groups show significant differences in both hopelessness and suicide scores with those with a trauma history reporting higher levels of hopelessness, a greater number of past suicide attempts and more current ideation and plans. This difference is more significant when the trauma identified is dependent on psychosis.
CONCLUSION: The results indicate a need for information about trauma history to be routinely collected when care plans and risk assessments are being produced.

Behavioural Medicine

Keynote Address

Facing Death and Finding Life

Dr Stirling Moorey, South London and Maudsley Foundation Trust

Freud said that 'our own death is indeed unimaginable' and we prefer to spend much of our time acting as if we are immortal. Receiving a diagnosis of a life threatening illness like cancer shatters our assumptions forcing us to re-evaluate our lives: am I the person I thought I was, or must I radically review my life? Some individuals quickly regain their old coping patterns, while others see the diagnosis as a wake-up call and reconsider their lifestyle. I will show how CBT can help people to assimilate information about possible death into pre-existing schemas, and also *accommodate* their schemas to devastating news. It is possible to regain hope, strength, control and problem solving abilities in the face of illness. Therapy may also facilitate significant schema change: a compassionate cognitive conceptualisation can help the person recognise how certain coping styles and strategies may have restricted their life options, giving opportunities for creating new more flexible and expansive ways of relating to the world. I will discuss how even in terminal illness it is still possible to improve quality of life through the informed application of relatively simple behavioural and cognitive techniques. We now have evidence that palliative care nurses can learn to use these methods effectively with dying patients in their own homes. I will also consider how themes of acceptance, life review and meaning-making may be incorporated into standard CBT in palliative care.

Symposia

Women's health: cognitive behavioural interventions in gynaecology

Convenor: Myra Hunter, Institute of Psychiatry, King's College London

Chair: Pauline Slade, University of Sheffield

Discussant: Myra Hunter, Institute of Psychiatry, King's College London

Cognitive Therapy for Menstrual Cycle Symptoms

Pauline Slade, University of Sheffield

This paper will provide a brief historical overview of the development of psychological interventions for premenstrual symptoms. It will cover background information on the nature of symptoms and consider how is premenstrual distress defined. Developments will be traced through early behavioural approaches to the articulation of psychological models based upon sensitivity to bodily changes and attributions in the early 90s to more recent and complex understandings of cognitive patterns.

The limited literature on open intervention and randomised controlled trials incorporating comparisons with medical interventions will be discussed. Recent developments in the literature around personality factors such as perfectionism, assertiveness and perceived availability of social support and how these relate to menstrual cycle symptoms will be described. Potential implications for further development of cognitive ideas deriving from these findings will be considered.

Current ideas for best practice will be reviewed. Gaps in knowledge to facilitate the development of more sophisticated cognitive understandings will be identified.

Beliefs about menopausal hot flushes: development of the hot flush beliefs scale (HFBS)

Melanie Rendall, Canterbury Christ Church University College

INTRODUCTION: Though menopause is construed as a positive, or neutral, event for many women, approximately 15-20 per cent of women experience their hot flushes and night sweats as problematic. There is some evidence that women's cognitive appraisals may help explain individual variation, and that cognitive behaviour therapy can successfully alleviate distress associated with the experience of hot flushes. Further progress in this area has been hindered by the lack of validated measures. This study describes the development of the Hot Flushes Beliefs Scale (HFBS), a questionnaire measure to assess women's cognitive appraisals of their hot flushes and night sweats, and reports on the reliability, validity, and factor structure of the scale.

METHODS: An initial pool of 63 items was generated from several sources: empirical literature, clinician's views, and in-depth interviews, with the aim of reflecting common thoughts and beliefs about hot flushes and night sweats. A total of 103 women, aged 41-64 years, who were currently experiencing hot flushes and/or night sweats, completed the initial measure. Principal components analysis and principal axis factoring were applied to the data, with both orthogonal and oblique rotation to determine the most coherent and interpretable solution.

RESULTS: Item and exploratory factor analyses led to a reduction of total items, culminating in a 27-item measure comprising three dimensions: beliefs about social and interpersonal consequences of hot flushes; emotional and cognitive reactions to hot flushes; and emotional and cognitive reactions to night sweats. The HFBS was internally consistent, with subscale alphas ranging from 0.78 – 0.93, and test-retest reliability 0.74 – 0.78. Validity was supported through correlations with other measures of mood, anxiety, and menopause beliefs.

CONCLUSIONS: Preliminary analysis of the HFBS reveals it to be a psychometrically sound instrument for assessing subjective hot flush related thoughts and beliefs. The HFBS has the benefit of being firmly grounded in women's experiences, and shows initial promise as a tool to aid further clinical and theoretical understanding of the impact of hot flushes and night sweats.

Cognitive behavioural therapy for menopausal symptoms: a viable alternative to HRT?

Myra Hunter, Institute of Psychiatry, King's College London

INTRODUCTION: There is a pressing need for effective alternatives to hormone replacement therapy (HRT) for the treatment of menopausal symptoms – hot flushes and night sweats. The urgency is related to the publication of recent prospective studies on HRT and the ensuing guidance from the Department of Health. Women are encouraged to discontinue HRT if they have taken it for over five years. In addition, women who have had breast cancer treatment experience more severe and troublesome menopausal symptoms and HRT is contraindicated. Complementary therapies and herbal remedies are popular, but their efficacy is uncertain and while SSRIs are moderately effective adverse effects limit their use.

There is evidence that anxiety and stress can lower the threshold for hot flush reporting, that relaxation and paced breathing can reduce hot flushes, and that certain beliefs are associated with more problematic symptoms. A cognitive behavioural treatment (CBT) has been developed (Hunter & Liao 1996), which will be described.

METHODS: CBT (4 sessions) were compared to HRT and a wait list control condition using a patient preference design. 61 women were recruited form general practices. Hot flush frequency and problem ratings were the main outcome measures post treatment and at 3 month follow up. We carried out a survey of treatment preferences in a sample of women who had had breast cancer. A group form of the treatment (Group CBT) has been developed and evaluated in an exploratory trial with 24 breast cancer patients using a pre post design and 3 month follow up.
RESULTS: Four sessions of individual CBT were found to be as beneficial as HRT in study of well mid-aged women, in terms of hot flush frequency and problem rating. Women who had had breast cancer expressed preferences for CBT and complementary therapies to treat menopausal symptoms. Group CBT was acceptable and preliminary results suggest significant reductions in problem ratings and frequency of menopausal symptoms in women who have had breast cancer treatment.
CONCLUSIONS: The results of two studies suggest that CBT may be an acceptable and effective alternative to HRT in the treatment of menopausal symptoms.

Pelvic Pain: a review of conceptualisations of pain, treatment efficacy and service models

Emma Harrold, Guy's & St Thomas Foundation Trust

The challenge of how to conceptualise pelvic pain is illustrated by the different diagnostic categories found in the clinical literature. Clinical practice and service delivery reflect this. For example, patients might attend uni-disciplinary clinics, with some individuals referred to a clinical psychologist or a pain management programme at a later stage.
This presentation reviews conceptualisations consistent with a chronic pain model and gives clinical examples of a cognitive behavioural approach for pelvic pain. The context is presented in a brief outline of the following: an evidence-based cognitive behavioural approach to pain management; inter-disciplinary work; developments in integrating medical treatments and self-management of chronic pain and an emphasis on early intervention. The conclusion provides an example of a way forward for clinical work and suggestions for research.

Chronic Fatigue Syndrome: Cognitive behavioural model and treatment

Convenor: Trudie Chalder, Institute of Psychiatry

Chair: Kate Rimes, Institute of Psychiatry

Psychological vulnerability factors for chronic fatigue syndrome

Kate Rimes & Trudie Chalder, Institute of Psychiatry

Various beliefs have been proposed as vulnerability factors for developing chronic fatigue syndrome (CFS), including unhelpful beliefs concerning perfectionism, showing one's emotions to others, and the importance of putting others' needs before one's own ('self-sacrifice'). Previous research has investigated perfectionism, but comparisons between CFS sufferers and healthy controls have shown inconsistent results, perhaps because once CFS has developed, people are forced to modify their high standards. This study investigates beliefs in people with CFS and healthy controls, with the former rating both current beliefs and beliefs they held in the six months before CFS onset. People with CFS endorsed more unhelpful beliefs about self-sacrifice and about experiencing and revealing negative emotions than healthy controls, and these beliefs were held even more strongly before CFS onset. They also reported greater perfectionism and perceived stress in the six months prior to onset than healthy controls, although their current perfectionism was not significantly different than that of controls. Before CFS onset, people with CFS reported a greater impact of their work and main hobby on their self-worth than healthy controls but there were no group differences in the time or energy invested in either area, or in work stress. Implications for cognitive-behavioural models and treatment will be discussed.

A prospective study investigating the role of perfectionist beliefs and behaviours in the development of fatigue

Antonia Dittner, Katharine Rimes, Susan Thorpe, South London and Maudsley NHS Trust

Cognitive-behavioural models of CFS suggests that people who believe that failure to meet high standards indicates unacceptability to others (a form of 'negative perfectionism'), may be at risk of developing fatigue after a period of illness or stress. The present study investigates this using a prospective design. Possible mediating factors in the relationship between beliefs about high standards and fatigue are also investigated. Undergraduate students completed questionnaires at the beginning of the academic year (n=436) and again following a time of academic pressure, 16 weeks later (n=318). Participants were significantly more fatigued following a time of academic pressure (time 2) than at the beginning of the academic year (time 1). Negative perfectionism was positively associated with all measures of fatigue and predicted subsequent levels of physical fatigue when controlling for time 1 fatigue. Time 1 negative perfectionism was not associated with particular time 2 perfectionist studying behaviours, greater distress about academic work or particular health behaviours, but was associated with time 2 depression. Results also indicated that depressed mood at the time of academic pressure

may account for the relationship between baseline negative perfectionism and subsequent fatigue. The results are consistent with cognitive-behavioural models of CFS that suggest that negative perfectionism is a risk factor for the development of fatigue at times of stress. This relationship may be mediated by depressed mood. This is the first prospective study to demonstrate a significant relationship between perfectionism and subsequent fatigue.

Cognitive, behavioural and emotional predictors of outcome after CBT for chronic fatigue syndrome in a specialist setting

Trudie Chalder, Sally Cregeen, Kate Rimes, Institute of Psychiatry

Previous trials have shown that both cognitive behaviour therapy (CBT) and graded exercise therapy are effective treatments for chronic fatigue syndrome (CFS) in terms of reducing fatigue and improving physical functioning. Factors which have been associated with a poor outcome include being a member of a self-help goup, being in receipt of sickness benefit at the start of treatment and dysphoria. Good outcome has been associated with change in avoidance behaviour and related beliefs. We have now developed a scale to examine specific cognitive and behavioural responses and examined predictors of outcome after CBT in our specialist clinic in secondary care. Patients in this study were recruited from consecutive GP and Consultant referrals to the CFS specialist Unit. CBT was offered to those who fulfilled criteria for CFS. Patients received an average of 8 sessions of CBT on a fortnightly basis and their progress was reviewed at 3 and 6 months post treatment. Outcomes included fatigue, social adjustment and global clinical ratings. In addition we measured specific cognitive and behavioural responses such as fear avoidance, catastrophising, symptom focusing or all or nothing behaviour. In addition to improvements in fatigue, social adjustment and global ratings patients also reported improvements on all of the cognitive behavioural responses such as fear, avoidance and symptom focusing. More extreme cognitive and behavioural responses at baseline were associated with a worse outcome. These results are discussed within the context of the cognitive behavioural model of CFS.

Treatment considerations for working with severely affected adolescents with chronic fatigue syndrome

Mary Burgess & Trudie Chalder, South London and Maudsley NHS Trust

Chronic fatigue syndrome (CFS) like any other chronic illness poses a real challenge to healthcare professionals. Although there is some evidence that cognitive behaviour therapy (CBT) is an effective treatment for CFS in adolescents (Stulemeijer *et al.*, 2005, Chalder *et al.*, 2002), these studies involved ambulatory patients that were able to attend a hospital setting for appointments. Little research has focused on the severely affected i.e., those who are bed-bound, wheelchair bound or who can only leave home on a very infrequent basis. Over the past 3 years, I have been working with severely affected patients. In this presentation I will outline specific considerations for working with this group of patients and their families. I will describe three cases with whom I have been working and present outcome data for each of them.

Families' experience of Cognitive Behavioural Therapy and Psycho-education for Childhood Chronic Fatigue Syndrome: A Qualitative study

Laura Dennison, Rachel Stanbrook, Rona Moss-Morris, Lucy Yardley, Trudie Chalder, University of Southampton

BACKGROUND: Recent trials have produced optimistic results for family-focused cognitive behavioural therapy (CBT) for childhood Chronic Fatigue Syndrome (CFS). However, little is known about the experiences of patients and families who participate in such interventions.

METHODS: 16 children and 16 parents who had participated in a trial of family-focused CBT versus Psycho-education (PE) for CFS were interviewed about their expectations and experiences of therapy and views on therapy effectiveness. Key themes were discerned using inductive thematic analysis.

FINDINGS: Most families had few preconceptions of therapy, low expectations of a cure, but hope for improvement. Help with goal-setting and establishing activity routines was perceived as helpful, as was the opportunity to talk and gain support, recognition and validation. Many participants did not find the 'psychological' elements of therapy beneficial and some felt wrongly pigeonholed. Family involvement was perceived as facilitating although sometimes awkward. Most participants felt therapy was a stepping-stone back to normal life, although many also felt it was incomplete. Many young people continued to experience CFS-related symptoms and limitations. In general, few differences were found between CBT and PE participants' themes. Notable exceptions were that every young person who experienced CBT described therapy as helpful, whereas the participants strongly opposed to the therapy approach had experienced PE.

DISCUSSION: This study provides new, detailed insights which may inform service delivery and help clinicians adopt a more patient-centred approach. Findings may also prompt further study of aspects of CBT and PE for CFS or inspire future qualitative research on therapy experiences.

Cognitive Therapy in Chronic Physical Illness

Convenor & Chair: Stirling Moorey, Institute of Psychiatry

Suffering: Its Assessment and Associations

Tom Sensky, Imperial College

Although alleviation of suffering is a crucial outcome of health care, there is relatively little published work on this topic, mainly because there has to date been no method of quantifying suffering. The seminal definition of suffering suggests that suffering is the consequence of a threat to the individual's Personhood. On the basis of this definition, it will be argued that suffering is essentially a cognitive construct. A brief description will be given of a novel instrument to measure suffering, and some validation data will be presented. Some constructs will be summarised that are likely to be associated with the alleviation of suffering, and preliminary data will be presented supporting some of these mechanisms.

A Randomised Controlled Trial Of Cognitive Behaviour Therapy For Common Mental Disorders In Patients With Advanced Cancer

Stirling Moorey, Matthew Hotopf, Elizabeth Cort, Barbara Monroe, Penny Hansford, Marcia Kapari, Institute of Psychiatry

This pragmatic trial aimed to discover if basic cognitive behavioural techniques used by palliative care workers in the homes of severely ill patients could reduce symptoms of anxiety and depression. Fifteen clinical nurse specialists at St Christopher's Hospice were randomised to receive training in CBT or to continue their usual practice. New patients on their caseload who scored high on anxiety or depression as measured by the HAD received their usual treatment from the home care team – if they were under the care of a CBT trained nurse this included some CBT as part of the home consultation. Patients were assessed at 6 weeks, 10 weeks and 16 weeks after entering the trial. 80 patients eventually entered the trial: most of those who were not entered into the trial were too ill to participate. Both groups showed an improvement in anxiety and depression as measured by the HADS over the course of the study. For anxiety, there was an interaction between group and time, with individuals assigned to the CBT nurses having a significantly lower anxiety score over time (coefficient -0.20, 95% CI: -0.35, -0.05; p=0.01). For depression, no interaction or group effects were detected. The St Christopher's home care package improves quality of life as measured by symptoms of anxiety and depression in terminally ill cancer patients. Nurses trained to use basic CBT skills in their home visits have a greater impact on anxiety symptoms than nurses not trained in these methods.

The use of Cognitive Behaviour Therapy in the treatment of MS: A Clinical Perspective

Sally Jones, Eli Silber; Trudie Chalder; Richard Gray; Anthony David; Kevin Gournay; Pauline Shaw, Institute of Psychiatry

Multiple Sclerosis is a chronic debilitating neurological condition. It commonly occurs in people aged between 20-40 years old and results in a wide variety of symptoms, such as optic neuritis, speech and language difficulties, cognitive impairment, problems with mobility and emotional distress. Approximately 70% of people with MS experience chronic physical and mental fatigue that impacts on their ability to function and their quality of life. Prevalence rates of depression are also elevated in comparison to the general population with a 50% lifetime risk of developing depression. The current evidence base for the treatment of depression, fatigue and other emotional problems suggests that CBT is useful as an adjunct to other medical treatments, although sample sizes are small. Given the prominence of fatigue and emotional distress in this population group, a service has been developed that aims to treat fatigue and other mental health problems in the MS population. The service comprises one mental health nurse specialist who provides assessment and treatment to the MS population. This presentation will highlight the research evidence for the use of CBT in the treatment of MS and will discuss its clinical relevance. Clinical Outcomes that focus on depression, fatigue and anxiety will also be considered.

A multi-centre randomised controlled trial comparing the effectiveness of two psychological treatments with usual diabetes care in improving glycemic control in adults with type 1 diabetes

K. Ismail, S. Thomas, E. Maissi, T. Chalder, U. Schmidt, J. Bartlett, A. Patel, C. Dickens, F. Creed, J. Treasure, Institute of Psychiatry

The health care needs of patients with type 1 diabetes are vast. There is some preliminary evidence that a variety of psychological interventions, including cognitive behaviour therapy (CBT), impact positively on health outcomes. Most of the interventions, however, have focused on co-morbid anxiety and depression while diabetes specific beliefs and behaviours have not necessarily been the focus. We developed a diabetes specific intervention which took into consideration the special needs of patients with diabetes and tested its efficacy within a randomised controlled trial. We compared motivational enhancement therapy (MET) + CBT, MET alone and treatment as usual for patients with type 1 diabetes whose blood glucose levels were putting them at risk of developing complications. The CBT was delivered by diabetes specialist nurses (DSNs), who were trained specifically for the trial. 344 participants were randomised to MET + CBT (12 sessions) over 6 months or MET alone (4 sessions) over 2 months or to usual care. The

main outcome was the 12 month glycated haemoglobin adjusted for baseline glycated haemoglobin and the secondary outcome was change in depression scores (Patient Health Questionnaire-9) from baseline to 12 months. The adjusted mean 12 month glycated haemoglobin was 0.45% lower in the MET + CBT group compared to usual care and 0.16% lower in MET alone compared to usual care. In individuals with persistent sub-optimally controlled diabetes, nurse-delivered MET + CBT was associated with an improvement in glycemic control compared with usual care. MET alone was not.

Child and Adolescent Mental Health

Keynote Address

Sleeplessness in Children and Adolescents

Dr Luci Wiggs, Oxford Brookes University

Disturbances of sleep (especially sleeplessness) are one of the most frequent child behaviour problems to be reported by parents, affecting about 30% of typically developing children and adolescents with much higher rates reported for children with a range of developmental disorders (DDs). Sleeplessness in young people with DDs deserves attention, not least because this problem is common and often persistent but also because of the additional stress that it places upon carers and the potential contribution that sleep disturbance might be making to daytime behaviour and cognition problems.
This talk aims to provide an overview of the topic of sleeplessness and its management in children and adolescents (including children with DDs). The talk will also explore the family context of child sleeplessness in an attempt to better understand the mechanisms underlying the development and maintenance of childhood sleeplessness and the implications that this has for management approaches. Available data indicate that children, and their families, benefit from improved sleep patterns and that at least some associated improvements in child functioning may be mediated by parental changes rather than arising as a direct result of reversing the effects of sleep loss in the child.
It is proposed that sleeplessness might be better theoretically conceptualised as comprising two distinct states with different causes and effects. Firstly, a 'biologically-defined sleeplessness` characterised by a child having objectively impaired sleep quantity or quality, relative to their biological sleep needs. Secondly, a 'socially-defined sleeplessness' characterised by the child's sleep pattern deviating from a desired sleep pattern. Judgements about what constitutes a 'desired' sleep pattern will be influenced by multiple factors including expectations and culture. Both of these states may exist independently, or coexist and may be explained by different theoretical models with implications for preventive and management possibilities.

Symposia

Child Anxiety: Causes, Effects and Cures

Convenor & Chair: Andy Field, University of Sussex

Verbal threat information and physiological responses to novel animals in children: the mediating effect of temperament

Khanya Price-Evans & Andy P. Field, University of Sussex

INTRODUCTION: An increasing body of experimental work has shown that verbal threat information is a viable pathway through which children acquire fear beliefs, behavioural avoidance, attentional biases and physiological responses to novel animals (e.g. Field & Lawson, 2003; Field, 2006). The behavioural inhibition system (BIS) is the neural substrate of trait anxiety and appears to mediate the effect that verbal threat information has on avoidance and attentional biases to novel stimuli associated with threat information (Field, 2006). However, its effect on physiological responses is, as yet, untested.
METHOD: An experiment is reported in which children (N = 54) aged between 6-10 were given verbal threat information about novel animals before completing a behavioural approach task during which their heart rate was measured. BIS sensitivity was also measured using self-report.
RESULTS: Consistent with past work, verbal threat information increased heart rates during the approach task, but also BIS sensitivity mediated this effect.

CONCLUSION: This suggests that the BIS is a mediating influence on the verbal information pathway through which children acquire fears.

The effects of child temperament and parental rearing styles on the verbal information pathway to children's fear

Helen Barker, Shirley Reynolds, Charlotte Wilson, Vicky Hurst, Andy Field, University of East Anglia, University of Sussex

INTRODUCTION: Fears in childhood are common and part of normal development. However for a significant number of children these fears can become severely disabling. There is substantial evidence that specific fears are acquired through direct and indirect conditioning pathways. Researchers have begun to investigate factors that influence this process. Individual differences in child temperament and particular parental rearing styles are consistently shown to be associated with anxiety development in children. We hypothesised that the same factors would mediate the effect of threat information on children's fear acquisition. We also hypothesised that child temperament would predict variations in children's reduction of fear following counter-conditioning methods.

METHOD: A sample (n=90) of non-clinical children (age 6-8) and their parents were recruited from schools. An observational design with an experimental component was used. Parents completed the Children's Behaviour Questionnaire (CBQ, Very Short Form, Rothbart, 1996) to measure child temperament, and the self and partner report sections of the Rearing Behaviour Questionnaire (RBQ, Bögels & van Melick, 2004). Children completed the mother and father report sections of the RBQ and the Spence Children's Anxiety Scale (SCAS, Spence, 1997). An experimental manipulation was used to induce fear by giving children threat information about novel animals. Children's fear beliefs, implicit fear and behavioural avoidance were measured. A fear correction procedure was then used and children's fear levels were reassessed.

RESULTS: Little evidence was found to support the hypotheses that child temperament (negative affect and effortful control) and parental rearing style (overprotective and rejecting parenting) mediate the effect of threat information on children's fear acquisition. However, tentative support was found for the hypothesis that child negative affect predicted variations in the reduction in children's fear following counter-conditioning. The results will be discussed in relation to theory and their implications for clinical practice.

The Interaction of Pathways To Fear in Childhood Anxiety: A Preliminary Study

Andy Field, University of Sussex

INTRODUCTION: Recent research has shown that the verbal information pathway to fear creates long term fear cognitions and can create cognitive biases and avoidance in children. However, the interaction between the verbal information pathway to fear and other pathways is untested.

METHOD: This experiment exposed children (aged 6-8) to threat information about a novel animal to see the impact on a measure of avoidance after a subsequent simulated direct negative encounter with that animal.

RESULTS: Results showed that verbal information in combination with a direct negative experience had the greatest effect, a bad experience or threat information alone produced a similar effect.

CONCLUSIONS: These results support theories of fear acquisition that suppose that verbal information impacts on the strength of associations formed in subsequent conditioning episodes, and suggest that pathways to fear have interactive effects.

The peer reputation of children and adolescents with social fears

Robin Banerjee, University of Sussex

ABSTRACT: INTRODUCTION: Numerous researchers have observed that children's fears and anxieties about social interaction are intimately linked to their peer relations, but not enough is understood about the mechanisms involved. This paper reports on the behavioural reputation of children and adolescents with social anxiety within their peer group, assessing the way in which this peer reputation mediates the links between social fears and peer acceptance.

METHOD: Two samples of pupils participated in this study, one from various primary schools (age 8-11 years, n = 258) and one from various secondary schools (age 11-16 years, n = 196). The pupils completed the age-appropriate version of La Greca's Social Anxiety Scale and a sociometric survey requesting three peer nominations each for: most-liked, least-liked, cooperative, disruptive, shy, fight and leader (the last five reputation items were accompanied by short descriptions). Each pupil received a mean score (range 1-5) for general social avoidance and distress (GEN), social avoidance and distress in new situations (NEW), fear of negative evaluation (FNE), and total social anxiety (TOT). The numbers of peer nominations received by each pupil for each item in the survey were tallied and standardised within class.

RESULTS: Regression analyses were used to evaluate the value of the social anxiety scores, including interactions with sex, for predicting the sociometric variables. In both samples, social anxiety was negatively associated with peer acceptance (most-liked nominations), but both were linked with the peer reputation measures. A reputation for lower leadership served to mediate the link between social anxiety and peer acceptance, for both the primary and secondary school samples. In the primary school sample, a reputation for lower cooperativeness was an additional significant mediator. In the secondary school sample, a reputation for higher shyness was an additional significant mediator. The mediation

effects were most apparent for the GEN subscale. It should be noted that although NEW scores in secondary school were associated with a reputation for lower levels of disruptive and aggressive behaviour, these features did not mediate the link between social anxiety and peer acceptance.
DISCUSSION: The behavioural reputation of children and adolescents with social fears is likely to play a key role in shaping their peer relations. General social avoidance and distress fears are especially likely to generate a more negative peer reputation, with poorer perceived qualities as a leader appearing to be at least partly responsible for lower peer acceptance. In primary school, social fears may inhibit cooperative behaviour which could also lead to lower peer acceptance. However, in line with suggestions that social withdrawal becomes seen as more salient – and deviant – with increasing age, a specific reputation for shyness served as a significant mediator only in the secondary school sample.
CONCLUSION: Evidence regarding the ways in which behavioural reputation mediates the link between social fears and peer acceptance during childhood and adolescence provides a valuable foundation for forming hypotheses about causal mechanisms. In turn, our understanding of why social anxiety is linked to lower peer acceptance can inform the development of intervention strategies.

Can Rachman's indirect pathways be used to counter-condition fear? The effect of positive verbal information and modelling a non-anxious response on fear beliefs and behavioural avoidance in children

Vicky Hurst, Charlotte Wilson, Shirley Reynolds, Helen Barker, Andy Field, University of East Anglia, University of Sussex

INTRODUCTION There is an increasing body of evidence that suggests fear is acquired along specific conditioning pathways (Rachman, 1977), but little experimental evidence investigating how fear might be counter-conditioned. Understanding counter-conditioning, i.e. the process of un-learning fears, may help prevent anxiety disorders and improve existing treatments. We hypothesised that positive information and modelling a non-anxious response are effective methods of counter-conditioning fears that have been acquired through verbal information, and that positive verbal information is more effective than modelling.
METHOD: Using an experimental paradigm involving two novel animals (Field & Lawson, 2003), 107 children aged 6-8 years were randomly assigned to negative information about one animal and no information about another or vice-versa. Fear was measured via questionnaire, an affective priming task and behavioural avoidance. Children were then randomly assigned to one of three counter-conditioning groups: positive verbal information, modelling a non-anxious response and a no counter-conditioning control group and fear beliefs and behavioural avoidance were measured again.
RESULTS: Children who received positive information or modelling a non-anxious response had lower fear beliefs and behavioural avoidance than children who received no counter-conditioning. Positive information was significantly more effective than modelling in reducing children's fear beliefs but there was no difference in behavioural avoidance, both methods significantly reduced behavioural avoidance in fearful children.
CONCLUSION: This study supports Rachman's (1977) information and modelling pathways as viable fear counterconditioning pathways and provides support for associative learning theories. Clinically, it highlights the importance of providing positive learning experiences when trying to countercondition fear.

Child and Adolescent Psychopathology: Current Issues and their Implication for Treatment

Convenor & Chair: Cecilia Essau, Roehampton University

Cognitive Style and Symptoms of Insomnia in Children

Alice M. Gregory, Allison G. Harvey & Thalia C. Eley, Goldsmiths, University of London

Cognitive Behavioural Therapy (CBT) constitutes a successful treatment for insomnia in adults. Children experience high rates of sleep problems and disorders (e.g. Wiggs & Stores, 2001) although little is known about the cognitive style of children with such difficulties. This study was designed to examine whether links that have been identified between cognitions and insomnia in adults – and which form the basis of CBT, are also found in children. Preliminary results from an ongoing study of 100 children aged 8-9 years will be presented. Six specific areas of cognition linked to insomnia in adults will be examined. First, biased attention to sleep stimuli will be examined using the Flicker Paradigm (Jones *et al.*, 2005). Second, negative interpretation of ambiguous sleep-related stimuli will be examined using the Ambiguous Sentences Task (Ree *et al.*, 2006). Third, catastrophising about sleeplessness will be examined using the Catastrophising Experiment (Harvey *et al.*, 2003). Fourth, dysfunctional beliefs about sleep will be examined using the Dysfunctional Beliefs about Sleep Questionnaire (Morin *et al.*, 1993). Fifth, pre-sleep cognitive arousal will be examined using the Pre-Sleep Arousal Scale (Nicassio *et al.*, 1985). Sixth, the content of pre-sleep arousal will be explored by using a series of open-ended questions. It is hoped that this information will be useful in developing effective CBT for children with sleep problems.

An experimental manipulation of responsibility in children: A test of the inflated responsibility model of obsessive-compulsive disorder

Jennifer Reeves, Shirley Reynolds & Charlotte Wilson, , University of East Anglia

OBJECTIVES: There is a small body of literature suggesting that cognitive models of obsessive compulsive disorder (OCD) may apply to children, but little experimental evidence has investigated the causal relationship between cognitive processes and obsessive-compulsive symptoms. This study aimed to investigate whether the inflated responsibility model of OCD (Salkovskis, 1985) applied to children, by experimentally manipulating perceived responsibility in a sorting task and examining the effects on checking behaviour and anxiety.

DESIGN: Participants were randomly allocated to conditions in a between-subjects experimental design adapted from the experimental manipulation methods reported in the adult literature (Ladouceur *et al.*, 1995).

METHODS: Eighty-one children aged 9 to 12 years completed baseline measures of anxiety, depression, obsessive compulsive symptoms, and inflated responsibility beliefs. They were randomly assigned to one of three experimental groups: high responsibility, no manipulation of responsibility and reduced responsibility. Children had to sort sweets based on whether they contained nuts or not. Dependent variables were checking behaviours, hesitations and anxiety.

RESULTS: Children in the high responsibility group checked and hesitated more than children in the reduced responsibility group. There were no other significant differences between the groups in terms of number of checks, hesitations or anxiety. The results replicated some of the findings reported in the adult literature.

CONCLUSIONS: The results offer preliminary support for the link between inflated responsibility and increased checking behaviours in children, and adds to the small but growing literature suggesting that cognitive models of OCD may apply to children. Some methodological issues were identified, however the findings have implications for cognitive models of OCD in children and for clinical practice. Some research priorities were also identified.

How stable is major depression in non-referred adolescents?

Cecilia Essau, Roehampton University

The aims of this study were to examine the course of MDD in non-referred adolescents, and to examine factors related to its stability. Five hundred and twenty-three adolescents were interviewed twice at an interval of about 15 months using the computerised Munich version of the Composite International Diagnostic Interview. Of the 90 adolescents who met the diagnosis of MDD at T1, 22 (24.4%) still met the same diagnosis at T2. Sixty-eight (75.6%) of them no longer met the diagnosis of MDD at T2, and in some of these cases, their depression was replaced by several other disorders; 44 adolescents received no diagnostic criteria for any DSM-IV disorders. The factors that were significantly associated with the stability of MDD included the presence of substance use disorders and parental alcohol problems, negative life events and negative coping, past suicidal attempt, suicidal thought, and concrete suicidal plan at the T1-interview. Adolescents with "chronic" (T1 and T2) compared to "transient" (only T1) MDD and those without any disorders were significantly more impaired in various life domains. The course of MDD in majority of the adolescents seemed to have a favourable course, whereas in some adolescents, it tended to have a heterogeneous pattern.

Autistic Spectrum Disorders and Obsessive Compulsive Disorder: Perspectives from practice

Tim Williams, University of Reading

Autistic spectrum disorders are characterised by repetitive behaviours, as is Obsessive Compulsive Disorder. However the nature of the repetitive disorders is not the same. This presentation will explore the overlap between the autistic spectrum disorders and obsessive compulsive disorder using both behavioural and cognitive methods and case examples. Suggestions will be made about both diagnostic methods and intervention techniques.

Metacognition in adolescents and their families. The relationship with anxiety

Sam Cartwright-Hatton, University of Manchester

This paper will review the role of metacognition in adolescents and their families in their experience of anxiety.The first study describes the development of a measure of metacognition for adolescents. The results of the study show that adolescents as young as 13 do report positive and negative metacognitive beliefs about their thinking, and that these are positively associated with anxiety symptoms in the same way as they are in adults. The second study examines the relationship between metacognition in adolescents and the parenting styles that they received as children. The results demonstrate that some features of reported parenting are associated with positive and negative metacognitive beliefs in the adolescents. Moreover, the metacognitive style of the adolescents partially mediates the relationship between their received parenting and their current anxiety symptoms. This suggests that sub-optimal parenting may have some of its effect by means of engendering a negative metacognitive style. Finally, the development of a measure to assess parents' beliefs about their children's thinking and worrying – i.e. parents' metacognitive beliefs about their children, will be reported.

Open Papers

Considerations in the Delivery of Therapy and Parenting Issues

Chair: James Bennett-Levy, Oxford Cognitive Therapy Centre

A cognitive explanation of PTSD in women following childbirth

Elizabeth Ford and Susan Ayers, University of Sussex

Ehlers and Clark (2000) propose a cognitive model of PTSD in which the individual processes the event in a way which maintains a sense of current threat. Women can suffer from PTSD following a traumatic experience of giving birth (Ayers & Pickering, 2001; Czarnocka & Slade, 2000; Soet, Brack, & Dilorio, 2003). It is not currently clear whether childbirth is qualitatively comparable to other traumas, as it is generally entered into voluntarily and with preparation, may be very positive for some women, and may have positive aspects even if regarded as traumatic. It is not clear, therefore, whether PTSD following this particular stressor is characterised by the same vulnerabilities or cognitions as PTSD after other stressors. However this particular paradigm does lend itself to prospective studies, which other traumas do not. This prospective study aimed to examine aspects of Ehlers and Clark's model of PTSD in women following childbirth. It measured pre-trauma risk factors, and post trauma appraisal, as well as post-traumatic stress symptoms, but did not attempt to characterise the nature of the trauma memory.

214 women consented and 116 women completed postal questionnaires at 2 time-points, 36 weeks pregnancy and 3 weeks after birth. 104 women also completed questionnaires at 3 months postpartum. Time 1 measures were trauma history (Foa, Cashman, Jaycox, & Perry, 1997), prior beliefs and prior coping (dysfunctional attitudes (Weissman, 1979)), self-efficacy (Scherer *et al.*, 1982)); Time 2 measures were characteristics of trauma (birth intervention score (Clement, Wilson, & Sikorski, 1999; Slade, MacPherson, Hume, & Maresh, 1993)), trauma sequalae (perception of social support (Sherbourne & Stewart, 1991)), post-traumatic cognitions (Foa, Ehlers, Clark, Tolio, & Orsillo, 1999), and PTS symptoms (Foa *et al.*, 1997). A further measure of PTS symptoms was made at Time 3.

All proposed risk factors (trauma history, dysfunctional attitudes, self-efficacy, social support, birth intervention score, and post-traumatic cognitions), correlated significantly with the outcome of PTS symptoms at both 3 weeks and 3 months postpartum (rho range = .195 - .454). Structural equation modelling was used to test the relationship between these variables. Trauma characteristics were found to be a direct predictor of PTS symptoms at 3 weeks and 3 months, while the other predictors were found to covary and to be fully mediated by post-traumatic cognitions as predicted by Ehlers and Clark's model (2000). The model fitted the data well (chi-square = 10.84, D.F. = 10, p = .37, CFI = 1.0, RMSEA = .03 (90% CI .00-.11), Standardised RMR = .07)

These preliminary results suggest a cognitive model fits well on to the phenomenon of PTSD following childbirth, at least as far as appraisal processes are concerned. Limitations of the study are that the full model was not tested, and the high dropout rate may have masked higher symptomatology in the non-respondents. A test of the full model on a larger sample is warranted. If these data are representative, cognitive therapy may be appropriate for women presenting with PTSD as a result of childbirth.

Promoting the Transition to Parenthood: The Effects of Cognitive Models of Anticipatory Guidance on the Transition to First-Time Parenthood

Michael Killoran Ross, Greater Glasgow and Clyde NHS (Scotland)

There is increasing interest in Primary Care Mental Health Services in the promotion of psychological well-being and the prevention of common mental health problems. A life transitions model informs this activity, and among, adult life transitions, the transition to parenthood is one of the most developmentally intense. The transition to parenthood (defined as the period of time between conception and the first months of having a child) is associated with predictable relationship difficulties for first-time parents. Evidence based on research conducted over the past 50 years has indicated that new parents experience a decline in relationship satisfaction/quality, that this decline is more marked for new mothers than for new fathers, and that maximal relationship dissatisfaction appears to ocur within the first three post-natal months. Further, in a significant minority of new parents, there is evidence to indicate the presence of psychological morbidity. In an attempt to promote the psychological well-being of new parents during the transition to parenthood, the current study, the largest study of its kind in Scotland, was established. Cognitive models of Anticipatory Guidance were examined in a comparative outcome study based within the context of existing NHS ante-natal education service delivery.

All participating couples (n=123 couples) attended five ante-natal classes delivered by Community Midwives/Physiotherapists. The study intervention was delivered by a Clinical Psychologist. There were four Treatment Conditions.

There were no significant statistical differences among Conditions. However, significant differences were observed among the entire sample over time, which supported earlier findings in the transition to parenthood literature.

Although the research hypothesis was not supported, this study raised substantive issues in the use of cognitive models in mental health promotion. Further, substantive issues were also raised for future transition to parenthood research.

Posters

Cognitive style and symptoms of insomnia in children and adolescents

Thomas Willis, Goldsmiths College, University of London; Amanda Bye, Goldsmiths College, University of London; Megan Crawford, Goldsmiths College, University of London; Jessica Holland, University of Bath; Allison Harvey, University of California, Berkeley; Alice Gregory, Goldsmiths College, University of London

INTRODUCTION: Studies of cognitive style in individuals with and without insomnia have led to the development of effective cognitive behavioural therapies for this common disorder (for a review see Morin *et al.*, in press). These studies have to date focused almost exclusively upon adults. Research has shown that a sizeable proportion of children and adolescents suffer from sleep disturbances and these difficulties are associated with negative outcomes (including poor daytime functioning as well as emotional and behavioural difficulties (Gregory, 2005)) and cause major concern for parents (Kahn *et al.*, 1989). We therefore conducted two studies attempting to investigate cognitive style and sleep problems in children and adolescents.

METHOD: Two samples were recruited. The first focuses on 100 children aged 8 to 10 years; and the second comprises 46 adolescents aged between 11 and 17 years. All Study members completed the Dysfunctional Beliefs About Sleep scale (DBAS) and the Pre-Sleep Arousal Scale (PSAS). In addition, the children completed the Sleep Self Report (SSR) and their parents completed the Children's Sleep Habits Questionnaire (CSHQ). The adolescents completed the Pittsburgh Sleep Quality Index (PSQI) and the Pittsburgh Sleep Symptoms Questionnaire (PSSQ). Measures were modified for use with children/adolescents. A within-participants design was used to analyse relationships between dysfunctional beliefs about sleep and symptoms of insomnia.

RESULTS: Data collection is ongoing, and due to be completed in late-June. Preliminary analyses suggest that dysfunctional beliefs about sleep and cognitive arousal prior to sleep are associated with sleep problems in children and adolescents.

CONCLUSION: Cognitive behavioural therapies designed to reduce insomnia have thus far been developed from the study of adult samples. Research focusing upon children suggests that it may be possible to adapt certain adult therapies for use with children and adolescents.

Examining implicit associations towards sleep in children using the sleep "IAT"

Megan R. Crawford, Institute of Psychiatry/Goldsmiths; Thalia C. Eley, Institute of Psychiatry; Jessica E. H. Holland, Institute of Psychiatry/University of Bath; Alice M. Gregory, Goldsmiths University/Institute of Psychiatry

INTRODUCTION: Cognitive models of insomnia have highlighted links between cognitive styles and sleep problems in adults. Based on these models, cognitive behavioural therapy has been used successfully to treat insomnia. Previous research has tended to emphasise explicit as opposed to implicit attitudes and biases towards sleep stimuli; and focuses almost exclusively upon adults. In order to further understand links between cognitions and sleep, and encourage further understanding of sleep difficulties in children, this study focuses upon implicit attitudes towards sleep in children.

METHOD: We examined sleep difficulties using the child-report sleep-self report (Owens, Maxim *et al.*, 2000) and the parent-report child sleep habits questionnaire (Owens, Spirito & McGuinn, 2000). A new task was developed to investigate implicit attitudes towards sleep (adapted from the race implicit test for children, Child-IAT, Baron & Banaji, 2006). In this measure, participants were asked to assign stimuli to the right or the left side of the screen. In critical trials, sleep stimuli (for example a picture of a pillow) and bad stimuli (words such as mean, yucky etc.) are either allocated to the same, or to opposite sides. Mean error rates (dependant variable) and response latencies (dependant variable) in the critical trials were measured and compared using a within-participant design.

RESULTS: Data collection from 100 children aged 8-10 years is currently underway and will be discussed upon completion.

CONCLUSION: As data collection will not be complete until the end of June, definite conclusions cannot be made. Yet based on previous research, we hypothesised that children with sleep problems will be quicker and more successful in the trial in which sleep and bad stimuli are paired to the same side than to different sides, suggesting they have negative implicit attitudes towards sleep. This finding could then possibly fill the current deficit in the literature on implicit attitudes towards sleep in children. I would like to be considered for an Excellence Award, as I am currently in my undergraduate education.

Investigating Interpretive Bias in Insomnia in Children

Jessica E. H. Holland, The Institute of Psychiatry/The University of Bath; Thalia C. Eley, The Institute of Psychiatry; Allison G. Harvey, University of California Berkeley; Megan R. Crawford, The Institute of Psychiatry/The University of Surrey; Alice M. Gregory, The Institute of Psychiatry/Goldsmiths

INTRODUCTION: The tendency to interpret ambiguous stimuli as threatening has been hypothesised by cognitive theories to be highly associated with psychological disorders. Research into interpretive bias in

insomnia is sparse; however, groundwork investigation in adults has shown interpretive bias is present in poor sleepers (Ree *et al.*, 2006). Such research is important for the development of successful cognitive behavioural therapy for insomnia. Sleep problems in children are highly prevalent and can have negative implications on daytime cognitive performance. However, little is known about the cognitive processes associated with childhood sleep problems. With this in mind, we investigated interpretive bias in insomnia in children.
METHOD: Child sleep difficulties were measured by child self-report using the Sleep Self Report (Owens, Maxim *et al.*, 2000) and also using the parent report Child Sleep Habits Questionnaire (Owens, Spirito & McGuinn, 2000). A task to assess interpretive bias was developed by a team of psychologists (based on the measure developed by Ree *et al.*, 2006). This was adapted so that it was suitable for children aged 8-10. It comprised 20 ambiguous sentences each with 2 possible interpretations. Ten of the questions were insomnia related and 10 were anxiety related. Participants were presented first with an open-ended interpretation of the question, then a forced-choice response of either threatening or non-threatening interpretations.
RESULTS: Data collection is currently in progress from 100 children aged 8-10. We hypothesise that children identified as poor sleepers will display disproportionate propensity to interpret ambiguous situations as threatening, displaying an interpretive bias.
CONCLUSION: This is one of the first investigations to explore associations between interpretive bias and sleep problems in children. Adults who are poor sleepers display a tendency to make threatening interpretations of all ambiguous sentences (both insomnia and anxiety related). It is hypothesised this will also be the case in children, but empirical evidence is needed. Should this study show that children with sleep problems also show interpretive bias, this may be useful for the development of age-appropriate treatments for sleep problems. Data collection is still in progress so no conclusions are currently available. However, data collection is due to be complete by June 22nd and preliminary analyses shall be presented. As an undergraduate student, I would like to note that I would be eligible for an excellence award for new and young presenters.

Systenatic review of psychological interventions for postnatal mental health

Heather Counsell, Brighton and Sussex Medical School; Susan Ayers, University of Sussex; Daniel Wright, University of Sussex

INTRODUCTION: Childbirth is a life changing experience. The physical, social and psychological changes that take place can have an impact on women's mental health in the postpartum period. Postnatal depression is a widely recognised condition and has been studied extensively, yet the range of additional postnatal mental health sequelae is less widely understood. No systematic review has yet evaluated interventions for all postnatal mental health sequelae. The aim of this review is to assess the literature on interventions for postnatal mental health including cognitive behavioural therapy, counselling, education, debriefing and support.
METHOD: Medline, Cinahl, PsychINFO and the Cochrane Library were searched for randomised controlled trials of any form of psychological intervention to prevent or improve postnatal mental health. Studies were categorised according to the type of intervention delivered and the timing of the intervention, either prenatal or postnatal. The 44 studies included were published between 1982 and 2006 with 19,107 participants in total. The majority of women were from normal community samples. Women in high risk groups for postnatal mental health problems were also included.
RESULTS: Interventions delivered in the antenatal period have short term effects on postnatal mood particularly in high risk groups. Larger effects on postnatal depression are more likely if the intervention continues into the postnatal period. Psychotherapy improved postnatal mental health in the short-term; however there is less evidence for their efficacy in the long-term, measured at nine months postpartum, and no evidence psychotherapy prevents subsequent episodes of postnatal depression. However, when interventions were individual-based they were more successful than group-based interventions in reducing symptoms of depression. Supportive interventions when used in isolation had no effect on postnatal depression; however one-to-one support interventions over three months had an effect on symptoms of depression. It is difficult to comment conclusively, as the active component of interventions is unclear. There was no evidence that written educational information had any effect on postnatal mental health. Similarly, debriefing interventions were not effective for depression or posttraumatic stress disorder either in the short or long term.
CONCLUSION: Interventions for postnatal mental health have mixed results. In general it appeared that interventions modified specifically for individuals were more effective. In the short term, there is evidence that individual orientated interventions, such as CBT and counselling or one-to-one support interventions improved postnatal mental health. However, it is difficult to determine whether effects are due to the type of intervention, or the extent and duration of the intervention. There is no evidence suggesting that there are long term benefits for any postnatal mental health intervention when followed up four to six years postpartum. Additionally, there is also no evidence to support debriefing interventions to prevent posttraumatic stress disorder, anxiety or acute stress.

Post-traumatic stress and psychosocial adjustment in siblings of leukaemia survivors

Shoshanah Lyons, Royal Holloway, University of London; Gary Brown, Royal Holloway, University of London; Sophie Gosling, Royal Holloway, University of London; Diane Melvin, Great Ormond Street Children's Hospital, London; Alison Leiper, Great Ormond Street Children's Hospital, London

INTRODUCTION: Recent research has indicated that a model of post-traumatic stress is applicable to paediatric patients who have a diagnosis of cancer, and their mothers and fathers. However, research on the long-term sequelae of siblings of cancer survivors is limited and inconsistent, and it is not clear whether a model of post-traumatic stress also applies to siblings. This study investigated whether siblings of childhood leukaemia survivors experience long-term post-traumatic stress symptoms (PTSS) and poor psychosocial adjustment. It also aimed to identify risk factors influencing PTSS, and parental perceptions of child post-traumatic stress.

METHOD: 66 child and adolescent siblings of leukaemia survivors were compared with 70 control participants on measures of PTSS, anxiety, depression and self-esteem. Parents completed a measure of behavioural problems and child PTSS.

RESULTS: 35% of siblings reported mild PTSS, and a further 35% reported moderate-to-severe PTSS, which was significantly higher than the control group. No overall differences were found between groups on measures of general adjustment, however, siblings who did not have PTSS fared better than controls on measures of depression, anxiety and low self-esteem. No demographic, individual or illness variables predicted PTSS. Parents of siblings significantly under-estimated their child's PTSS, and this was associated with the severity of sibling distress.

CONCLUSION: Levels of PTSS, but not depression, anxiety, low self-esteem or behavioural problems were elevated in siblings of childhood leukaemia survivors. Furthermore, siblings who did not report PTSS appeared to show post-traumatic growth following their experience. Thus, PTSS may be a useful model for understanding siblings' long-term adjustment to childhood cancer. This notion has theoretical implications regardng the development of PTS in young people, and significant clinical implications for all health care professionals working in paediatric contexts. Future areas of research are also highlighted.

Intellectual and Developmental Disabilities

Keynote Address

Psychotherapeutic Interventions for People with Intellectual and Developmental Disabilities: Developments in Research and Practice

Professor Nigel Beail, Sheffield University; Barnsley Primary Care Trust

Following a long history of therapeutic disdain towards people who have intellectual and developmental disabilities the tide has started to turn. Over the last 25 years cognitive behaviour and psychodynamic psychotherapies have been increasingly made available and research concerning their application outcomes has gradually emerged. In this presentation the current state of the art will be critically evaluated. In particular I will focus on outcomes and the means to evaluate those outcomes. The current research could be seen as riddled with bias in terms of topic, research modality and research setting. It is also evident that the tools at the researcher's disposal are not what they could be. The culture of outcomes is also not a shared culture across the therapeutic workforce. However, developments in practice are interrelated with outcomes of research. Thus we need to continue our research endeavours; and as a small community, work together to achieve a bigger and better research and knowledge base.

Symposia

Developing appropriate interventions with people with Asperger's syndrome

Convenor: Dougal Julian Hare, University of Manchester

Chair: Chris Cullen, University of Keele & North Staffordshire NHS Trust

Dougal Julian Hare, England

Symptomatology, alexithymia, and illness perception in individuals with Asperger's Syndrome (AS) presenting to a specialised AS Service: A comparative study with illness perceptions, appraisals and psychological distress in the carers of AS participants

Frank Chapman, Paul Skirrow and Dougal Julian Hare, University of Manchester; Merseycare NHS Trust; University of Manchester

Significant numbers of people with Asperger's syndrome [18] receive their diagnosis post-18 years and delay in attaining appropriate diagnosis can result in mental health problems for them, and distress for their supporters (Tantam, 2000). The Self Regulation Model (Leventhal *et al.*, 1984) and the transactional model (Lazarus and Folkman, 1984) have been applied to people with schizophrenia diagnoses, and negatively-held beliefs regarding the condition have been found to be related to poorer outcomes in patients and their supporters (Lobban *et al.*, 2004; Fortune *et al.*, 2005). Because aspects of AS can resemble schizophrenia, it was hypothesised that appraisals held by these persons and their supporters might resemble those found in schizophrenia populations, and predict supporters' distress, particularly where relatives struggled to adequately express their affective states (alexithymia). 25 dyads (person with AS and their supporter) completed adapted measures of health belief; measures of appraisal/coping & distress (supporters group), and symptomatology and alexithymia (people with AS) were also completed. Dimensions of the health belief model were significantly associated with supporters' distress, as were supporters' appraisals of their relative's 'challenging' behaviours. Although the AS group experienced elevated levels of psychiatric symptomatology, contrary to expectation it was the supporters of those with lower alexithymia scores who experienced greater levels of distress. The results are discussed with reference to the applicability of health belief, appraisal/coping, and alexithymia models to the AS.

I wish people were nicer to me; I am doing my best - paranoia and adults who self-identify as having Asperger's Syndrome

Pippa Hembry (Royal Holloway), Chris French (Royal Holloway) & Dougal Julian Hare (University of Manchester)

Clinicians and researchers have reported that people with Asperger's syndrome (AS) experience frequent paranoid thoughts and associated distress. Models of paranoid thinking developed for non-AS populations have been investigated for their ability to account for the development of paranoia for people with AS. So far none has adequately met this task. The current study was the first to test the ability of the multifactorial model of paranoia to account for the development of paranoid thinking for people with AS. This was considered a good candidate for investigation because of the shared features between the multifactorial model and the presentation of Asperger's syndrome (namely, emotional disturbance, anomalous sensory experiences and reasoning biases). Respondents were recruited anonymously to either an internet or postal survey. People who self-identified as having AS were asked to complete formal measures of paranoia, anxiety, depression, evaluative beliefs, sensory anomalies and a need for closure. The analysis sample had a size of n=200, with an age range from 18 to 73 years old. The theoretical model was tested using multiple regression analysis. The results suggest that negative evaluative beliefs about others, the belief that others have negative evaluative beliefs about oneself, meta-worry and anomalous sensory experiences are strong predictors of paranoia in people with AS. These results offer support for the multifactorial model as useful in understanding the generation of paranoid thinking for people with Asperger's syndrome. These findings have implications for clinical work in that theories of anxiety that emphasise meta-cognitions and negative evaluative beliefs are suggested as most relevant in formulating around the psychological distress of people with AS.

The Cognitive Behavioural Development Programme and autistic spectrum disorders: A systemic approach to support and structure in a secure hospital

Jonathan Jones & Victor Levinson (Care Principles UK)

The CBDP has its theoretical roots in Social Learning Theory and Cognitive Behavioural treatment approaches. The approach emphasises that given the necessary learning conditions, including the opportunity to observe and practise adaptive skills, people can learn new skills, new ways of thinking and new ways of behaving. The CBDP also draws upon principles which emphasise a positive, non-aversive approach to support and treatment. The purpose of the CBDP is to help people experience success and achievement within a framework that also provides opportunities for developing coping and problem solving strategies. The presentation will outline the structure and use of the CPDP at Ashley House, an independent secure hospital for people with developmental disorders, and discuss its application with two case studies.

Outpatient Psychological Services and Treatment in High Functioning Autism Spectrum Disorders – A preliminary evaluation

Russell, A.J., Anson, M.A. & Rose, E. (Institute of Psychiatry)

Studies of both children and adults with high functioning Autism Spectrum Disorders (ASD; including Asperger's syndrome), have consistently found higher than average rates of co-morbid mental health problems (Tantam, 1991; Ghazuiddin *et al.*, 1998), with depressive and anxiety disorders the most

commonly described. First-line treatments for anxiety and depressive disorders include psychological treatments such as Cognitive Behaviour Therapy (CBT). Service configuration nationally can result in people with ASD falling between the gap in adulthood, i.e. fitting neither within adult mental health or intellectual disability provision. Referral to specialist services is often the outcome. Outpatient CBT for co-morbid psychological problems in ASD can be difficult to access, and it is not clear if this is a useful service provision for this group. Evaluation of specialist outpatient psychological services provided to this group by the South London and Maudsley NHS Trust commenced in 2002. More than 50 adults have been treated for a range of problems, including anxiety and depression. The group are described in terms of presenting problems, type of service delivered, and outcome measurement in the case of those attending for outpatient psychological treatment within a cognitive behavioural framework. The results will be discussed in terms cognitive models of anxiety and depressive disorders, and their potential application for people with ASD.

Where's the 'C' in CBT for People with Intellectual Disabilites?

Convenor & Chair: John L Taylor, Northumbria University

The Relevance of Cognitive Variables in CBT for Offenders who have Intellectual and Developmental Disabilities

Nigel Beail, Jo Sessions and Tracey Proctor, Sheffield University and Barnsley Primary Care Trust

BACKGROUND: The evidence base for cognitive behavioural therapy validates the targeting of anger as a dependent variable. However, in the treatment of offenders, a range of cognitive variables have been suggested as relevant targets for change alongside the most significant behavioural variable – recidivism. This paper examines the relevance of attending to cognitive variables in CBT with offenders who have intellectual and developmental disabilities.

METHOD: Two studies using matched cross-sectional designs compared groups of offenders who have intellectual disabilities with those with no offending history. The cognitive variables compared were empathy (interpersonal reactivity and emotional perception), social reasoning, social-moral reflection and social problem solving.

RESULTS & DISCUSSION: The findings challenge the current view regarding the relevance of cognitive variables in the treatment of offenders who have intellectual disabilities. Further these findings are consistent with other recent findings on cognitive factors. The implications for offender treatment are discussed.

How to Make CBT Less Mindlessness-Based

Bruce T. Gillmer, Northumberland, Tyne and Wear NHS Trust

Stepping aside from the arid debate between cognitive mentalism and behavioural radicalism, even the most ardent proponent of cognitions as internal behaviours would concede the central relevance of the thoughts, emotions and aspirations of people with intellectual and developmental disabilities (IDD). Nonetheless, once beyond the basics of what works and for whom -- and that is beginning to emerge, even for people with IDD -- it is incumbent on reflective scientist practitioners to consider what the effective agents and components are. A range of programmatically delivered interventions, offered within a large in-patient forensic service for people with IDD, is described and illustrated with brief case vignettes. Whilst cognitive re-structuring is possibly over-shadowed by cognitive skills training and meta-cognition, it will be argued that this work goes beyond what is ordinarily considered behaviour modification or even behavioural therapy and, as such, is not 'mindlessness-based'. A treatment fidelity framework is proposed, comprising design, training, delivery, receipt, and enactment criteria of therapy, as an example of establishing standards of practice that make the questions raised by theoretical controversy more methodologically accessible.

Formulation Based Working in a Learning Disability Mental Health In-Patient Unit: Reflections on the Contribution of the 'C' in CBT

Lesley Clarke, Northumberland, Tyne and Wear NHS Trust

This presentation reflects on formulation-based working with people with learning disabilities (LD) and complex mental health problems in an acute in-patient setting. A cognitively framed ('Five P') approach is used to conceptualise patients' difficulties. This approach incorporates the individual's difficulties and the context in which these have developed and are maintained. It has been proposed that the way we perceive ourselves, the world and the future is cognitively underpinned and shapes our emotions and our behaviours. This understanding can be developed to apply not only to our experiences as individuals, but also to our emotions and our behaviours towards others, mediated by our attributions. There is a long-standing literature concerning the importance of staff attributions in understanding and working with people with LD and challenging behaviour. Staff attributions are equally important in understanding the often highly complex issues presented by people with LD and mental health problems. Using the 'Five P' formulation approach to develop a shared understanding, we can address the attributions of others

towards the client's difficulties. Attribution theory underpins this parallel aim of the formulation-based approach – to help the wider staff group recognise the significance of situational influences on the patient's emotions and behaviour and move away from an implicit model of individual pathology. This approach to formulation is illustrated with case examples.

Cognitive Ability, Skills and Remediation in CBT for People with Intellectual Disabilities

John Taylor, Northumbria University

BACKGROUND: Historically, people with intellectual disabilities (ID) have been denied access to psychological therapies, including CBT, that have been shown to be effective for a range of mental health and emotional problems. There has been an assumption that people with lower levels of intellectual functioning would not be able to engage in and benefit from the cognitive elements of CBT interventions.
METHOD: Process data collected as part of several studies designed to evaluate the effectiveness of CBT interventions for people with mild-borderline ID was used to examine participants' abilities to engage in, use and benefit from the cognitive components of a modified CBT intervention.
RESULTS AND CONCLUSIONS: The results of these investigations indicate that people with mild-borderline ID can work effectively with cognitive content as well as the cognitive skills component of CBT interventions and that participants' level of intellectual functioning does not appear to impede this process. These findings challenge previous research and their implications for practice and further research are outlined.

Basic Processes

Keynote Addresses

Style before Content: lessons for the treatment of depression from experimental research into rumination

Professor Edward Watkins, University of Exeter

CBT for depression has traditionally focused on thought content, for example, thought challenging. However, a key process implicated in the onset and maintenance of depression is rumination (repetitive thought about the self, about mood, and about problems), which has been conceptualised as a response style (Nolen-Hoeksema, 1991; 2000). Importantly, there is evidence that rumination about the same negative content can sometimes be maladaptive, but at other times be adaptive, for example, in effective cognitive processing, planning and problem solving. My programme of research has focused on considering the mechanisms that may determine whether rumination is constructive or unconstructive, in order to use this knowledge to systematically refine our psychological interventions. Experimental research funded by the Wellcome Trust has now demonstrated that there are distinct processing styles during rumination that have distinct functional effects for the consequences of rumination on a range of clinically-relevant cognitive and emotional processes: overgeneral autobiographical memory (Watkins & Teasdale, 2001; 2004), social problem solving (Watkins & Baracaia, 2002; Watkins & Moulds, 2005), emotional processing (Watkins, 2004), global self-judgments (Rimes & Watkins, 2005), and emotional vulnerability (Moberly & Watkins, 2006). Based on this research, it is proposed that a processing mode characterised by abstract-evaluative construals during thinking about negative content will produce more negative consequences than a processing mode characterised by concrete lower-level construals. Such research has important applied clinical implications by indicating how treatment may rapidly shift patients from a harmful to a beneficial form of thinking about negative material. Derived from this experimental work, two new treatments for depression are being developed and evaluated, both of which focus on shifting style rather than content: (a) Rumination-focused Cognitive Therapy, an individual-based face-to-face therapy (funded by NARSAD), which has positive results in the treatment of treatment-refractory residual depression in an extended case series (Watkins *et al.*, in press) and a pilot randomised controlled trial; (b) Concreteness training, a facilitated self-help intervention intended to increase the availability of psychological interventions for patients (funded by MRC).

Converting life stress into specific psychopathologies: Why become a worrier when you could develop a compulsion, a phobia, an eating disorder and more?

Professor Graham Davey, University of Sussex

Many psychopathologies are preceded by stressful life events, but the range of psychopathologies that such events give rise to are staggeringly diverse and include obsessions, compulsions, pathological worrying, anorexia, bulimia, panic attacks, specific fears, substance abuse and dependency, and so on. The challenge for clinical psychology research over the next 20 years will be to elaborate models describing how an apparently limited range of precipitating life events can generate such diversity of symptoms, and how specific symptoms can be predicted in specific cases. This presentation will attempt to outline the kinds of theoretical approaches needed to create such predictive models of aetiology.

Symposia

From the Laboratory to the Clinic: Translating Experimental Findings into Innovative Treatments for Clinical Disorders

Convenor & Chair: Michelle Moulds, The University of New South Wales, Australia

Reducing intrusive image memories after watching trauma: considering "flashbacks" in trauma and "flashforwards" in depression

Emily A. Holmes, Shuqi Zhang, Anna Chilvers & Corin Bourne, University of Oxford

Intrusions occur across a variety of psychological disorders, including "flashbacks" in posttraumatic stress disorder (PTSD) and depression. In comparison to studying memory that is deliberately recalled we know relatively little about involuntary memory, yet involuntary intrusions across disorders are a key target for cognitive therapy. Work will be presented on analogue, experimental studies of intrusive memory, motivated by clinical research with patients with PTSD. A clinical background to the experimental investigation of intrusive memories will be discussed. Examples are given of intrusive images in PTSD, and the 'hotspots' (worst moments) in memory associated with them (Holmes, Grey & Young, 2005). Recent Cognitive Behaviour Therapy (CBT) models of PTSD are briefly summarised which lay the foundations for the predictions of our experimental work (Holmes & Bourne, 2008). In the laboratory, films with traumatic content can be used as an analogue for real trauma which allows us to prospectively study intrusive memory development. Our previous work has explored the effects of different concurrent tasks while watching a traumatic film (peri-traumatically) on intrusive memory development (Holmes, Brewin & Hennessy, 2004). More recently, we have begun to focus on experimental analogues of not only peri-traumatic but "post-traumatic" processing, that is, manipulating cognitive processing in the immediate aftermath of a traumatic film. Intrusive images of the film were recorded in a diary for one week. Interestingly, a somewhat different pattern of findings is emerging for post-traumatic compared to peri-traumatic tasks. Post-traumatically, it appears that a variety of cognitive tasks, particularly visuospatial pattern-tapping, may help protect against intrusion development. We speculate on the mechanisms linked to memory consolidation post-trauma. We discuss how this experimental work may drive future treatment applications to reduce intrusions as an adjunctive technique in cognitive therapy in not only PTSD but also depression. While we have focused on flashbacks to trauma, we also propose that there can be "flashforwards" e.g. to suicide and this may be a future target area.

Intrusive memories in depression

Michelle L. Moulds, Alishia D. Williams & Susannah Starr, The University of New South Wales, Australia

Recurrent and distressing intrusive memories of negative past events are the cardinal diagnostic feature of posttraumatic stress disorder (PTSD). As such, intrusive memories have been predominantly investigated in traumatised individuals. Recent findings demonstrate that intrusive memories are also frequently a feature of depression. Although not studied extensively in depressed samples, there is growing evidence of parallels in the nature and cognitive strategies employed to manage intrusive memories in depression and PTSD (Starr & Moulds, 2006; Williams & Moulds, in press). This talk will describe studies that have borrowed paradigms and methodologies from the PTSD literature to examine intrusive memories in depression. Findings to date demonstrate the importance of intrusive memories in the maintenance of depression, highlight overlap in the characteristics and cognitive avoidance strategies (e.g., rumination, thought suppression) adopted in response to intrusive memories in PTSD and depression, and indicate that unsatisfactory emotional processing of negative events is a key feature of depressive disorders. The findings underscore the need for cognitive interventions that specifically aim to reduce avoidance and successfully process intrusive memories in order to effectively treat depression and prevent recurrence.

Verbal comparisons during positive interpretation bias training

Tamara J. Lang & Emily A. Holmes, University of Oxford, UK

Positive information does not always make one happy. Recent evidence has shown that positive cognitive bias modification methods targeted on interpretative biases (CBM-I; techniques aimed to induce

positive interpretation bias) using verbal processing instructions produced unexpected negative emotions. That is, decreases in positive affect and positive interpretation bias alongside increases in anxiety (Holmes, Mathews, Dalgleish & Mackintosh, 2006). This has since been replicated (Holmes, Lang & Shah, submitted). Given the importance of understanding what aspect of verbal processing caused the mood deterioration, we will discuss an experiment testing a potential mechanism. We proposed that verbal processing instructions encouraged comparative processing. We suggest that participants may have unfavourably compared the outcome of the overtly positive scenarios with their own not as (extremely) positive experiences thus resulting in deterioration of their mood. Using the CBM-I paradigm as in Holmes *et al.* (2006) we presented participants with auditory scenarios, which consistently resolved positively. Along with the original imagery instructions (with participants asked to imagine), we changed the verbal instructions (participants asked to focus on the words and meaning) and created two new conditions aimed to either increase or decrease the amount of comparisons being made whilst verbally processing the scenarios. We found that the increased comparisons condition produced greater increases in anxiety over training than both the verbal reduced comparisons and imagery conditions. Overall this suggests that the paradoxical mood effect of verbal positive CBM-I can be partially accounted for by verbal comparisons. The clinical implications for verbal comparative processing will be discussed.

The Influence of Emotional Valence on Perceived Duration of Autobiographical Memory Narratives

Leah A. Campbell & Richard Bryant, University of Oxford

This study investigated the role of emotional valence on prospective time estimation in four groups of non-clinical and clinical samples (N=60), which varied in terms of trauma-exposure and post-traumatic symptomatology. Participants narrated three memories of differing emotional valence (positive, negative, and neutral), each for 60s, while at the same time engaging in a time-keeping task (pressing the space-bar once for every 10s that had elapsed). Consistent with avoidance theories of time perception, we predicted that people with a current diagnosis of post-traumatic stress disorder (PTSD) would overestimate the duration of their trauma narrative compared to positive and neutral narratives. The results supported the hypothesis. In addition, participants previously meeting a diagnosis of PTSD who had been treated did not overestimate how long they narrated their trauma memory for, and functioned comparably to the control group. Implications for novel clinical interventions and the use of this experimental design as a measure of treatment outcome will be discussed.

The Impact of Rumination on Self-Referent Encoding in Depression

Eva Kandris, Michelle L. Moulds & Alishia D. Williams, The University of New South Wales, Australia

Previous findings have linked rumination to enhanced retrieval of negative memories (Lyubormirsky *et al.*, 1998) and overgeneral autobiographical memory (Watkins & Teasdale, 2004) in depression. However, little is known of the impact of rumination on the encoding of information; specifically, self-referent information, in depression. This study examined the impact of rumination on self-referent encoding in high (BDI-II > 12) and low (BDI-II < 5) dysphoric participants. Participants were randomly allocated to a rumination or distraction condition, then completed the self-referent encoding task in which they rated the self-descriptiveness of a series of adjectives (positive, negative), and later received a memory test for the adjectives. Consistent with prediction, high dysphoric participants endorsed more negative and less positive adjectives as self-descriptive, and participants in the rumination condition endorsed more negative words as self-descriptive. For the recall task, a significant interaction reflected greater recall of negative self-referent words for high dysphorics in the rumination condition, after controlling for the proportion of words endorsed as self-descriptive. The findings demonstrate that rumination results in enhanced encoding of negative, self-related material, and may contribute to the maintenance of negative evaluations of the self observed clinically in depression. Implications for cognitive therapy will be discussed.

Cognitive Bias Modification: influencing cognitions in anxiety, depressions and intrusions

Convenor & Chair: Bundy Mackintosh, UEA and MRC Cognition and Brain Sciences Unit, Cambridge

The specificity and timing of induced attentional bias

Michael Browning, Catherine Harmer, Emily Holmes, Oxford University

A wide body of experimental work indicates that patients with anxiety disorders show biases in the deployment of attention towards threatening stimuli. However, the situation is complicated by the dynamic nature of attention which can flit between stimuli on a millisecond scale and by findings which suggest that attentional function varies between different stimuli type (e.g. words *vs*. faces). Never-the-less, the proposal that a tendency to attend to threatening stimuli is causally related to anxiety has been given direct support by MacLeod *et al.* (JAP 2002) who demonstrated that a bias in attentional deployment can

be experimentally induced in healthy volunteers and that a negative bias produced a susceptibility to anxious symptoms. This finding raises the intriguing possibility that this “training” procedure could be modified to ameliorate the biases demonstrated in anxiety disorders, offering a novel approach to the treatment of these conditions. This paper reports on two studies which partially replicate and extend Macleod’s findings with the specific aim of categorising the extent to which induced attentional bias generalises across stimuli type and timings. The results of experiment one indicate that training using words induces a bias relatively late in the deployment of attention and that this bias seems to generalise to pictures of faces. Experiment two demonstrates that training using faces can induces a bias, again relatively late in the deployment of attention, but fails to demonstrate any generalisation of this bias to words or effect on mood. By demonstrating the extent of the induced biases it should be possible to predict how this intervention could be modified to improve its effectiveness and, ultimately, how it could most usefully be appended to existing treatments for anxiety disorders.

The distress from intrusions following an analogue trauma event can be altered using Cognitive Bias Modification methods

Peggy Postma, Bundy Mackintosh, Emily Holmes, Helen Buxton and Tim Dalgleish, University of East Anglia

Distressing intrusions are a hallmark of PTSD. Studies have shown relationships between trauma-related thoughts and beliefs (such as those measured by the Post Traumatic Cognitions Inventory (PTCI)) and level of post traumatic psychopathology. This study directly manipulated these potentially maladaptive cognitions, using Cognitive Bias Manipulation (CBM) techniques, with the intention of altering the quality/quantity of intrusions following an analogue trauma experience (watching distressing films). Participants completed negative or positive training designed to alter trauma related beliefs, before experiencing the distressing films. In the week following the laboratory session, participants completed diaries recording quantity and quality of their film related intrusions. Intrusion number was not influenced by CBM training condition but the distress experienced during the intrusion was, with positively trained individuals experiencing less distress. CBM training succeeded in influencing both degree of distress from intrusions and the post-film scores on the PTCI, which were themselves correlated with participants’ distress.

Cognitive bias training: Thinking about positive events doesn’t always make you happy

Emily A. Holmes, Dhruvi Shah, Anna Coughtrey & Abigail Connor, Oxford University

Our work has shown that mental imagery may have a particularly strong impact on emotion compared to verbal processing of the same material. Using an interpretation training paradigm (also known as "CBM-I: cognitive bias modification – interpretation") in which non-clinical participants were given repeated negative scenarios, we found that imagery had a greater impact on increasing anxiety than verbal instructions (Holmes & Mathews, 2005, Emotion). Conversely, for positive training material the use of imagery has a greater impact on promoting positive mood than verbal processing (Holmes, Mathews, Dalgleish & Mackintosh, 2006, Behavior Therapy). We therefore concluded that in CBM-I, the use of mental imagery instructions (rather than simple verbal processing) may be a vital ingredient in successful modification of bias and mood. However, it remains to be shown if a similar pattern of results extend to depressed as well as anxious mood, and what aspects of imagery versus verbal processing might be responsible for these effects. A series of bias modification experiments in relation to depressed mood will be discussed. Findings suggest (1) negative imagery training increased depressed mood and bias relative to benign training. More importantly for therapy we also need to consider training for positive events. Findings show that, (2) training in imagining positive events led to increased happiness, whereas conversely, (3) verbal training about the same positive material led to a reduction in positive affect, i.e. made people "sadder". (4) Positive imagery training protected against a later negative mood induction whereas positive verbal training did not. (5) The impact of imagery is contingent on the imagery perspective adopted. Reasons for the paradoxical impact of imagery versus verbal instructions on positive material will be explored, including implications for cognitive therapy. To our knowledge, these are the first experimental attempts to apply imagery positive training to depression, and suggest that an imagery component may be crucial in enhancing positive mood. Our findings suggest that imagining taking part in a positive event can make you “happy”, but verbally thinking about the same event can make you “sad” (Holmes, Lang & Shah, submitted).

Cognitive Bias Modification: the role of imagery and active generation

Laura Hoppitt, Andrew Mathews, Jenny Yiend, Bundy Mackintosh, University of East Anglia

Training participants to select threat or non-threat interpretations of emotionally ambiguous stimuli or passively exposing participants to valenced scenarios can modify later interpretation of ambiguity. However, only when participants are encouraged to actively select meanings do congruent changes in emotional response occur (Mathews & Mackintosh, 2000). The present series of studies assessed whether active training was critical in modifying emotionality of ambiguous scenarios post-training. Results suggested that this was the case, and that these results could be explained by transfer appropriate processing.

However, consistent with Holmes and Mathews (2005) without the requirement for participants to imagine the scenarios, active training had no effect. This emphasises the dual role of active generation of meaning and imagery in successful cognitive bias modification.

The specificity of experimentally induced biases in interpretation and their influence on vulnerability to anxiety

Bundy Mackintosh, Andrew Mathews, Laura Hoppitt & Doris Eckstein, UEA and MRC Cognition and Brain Sciences Unit, Cambridge

Recent research has on many occasions shown that biases in interpretation can be induced experimentally using a variety of methods. Measures of the successfulness of bias modification often make use of material that is similar in nature to that used in training. In a series of experiments using script based training, we aimed to explore the specificity of this 'training' to determine how closely training material needs to be matched to tests of induced bias and vulnerability to anxiety. In one experiment, material centred on social anxiety was used during training. Tests to determine the extent of an induced bias included both social anxiety, matching the training theme, and physical anxiety themes. This was followed by a laboratory stress task designed to induce test anxiety: a "cognitive ability test" in which participants attempted to solve difficult or impossible puzzles under time pressure. Transfer of training only occurred to social anxiety items in the interpretation bias test. No training group effect occurred for the interpretation of physical anxiety items in this test, nor during the laboratory stressor. Subsequently, we used Cognitive Bias Modification methods with test anxiety training material and again provided a test anxiety stress situation. Under these circumstances training significantly influenced anxiety in response to the stressful test anxiety situation. It also registered a marked effect on the interpretation of ambiguous test descriptions when they were concerned with test but less so with social anxiety. We conclude that to effectively induce a bias in interpretation, training materials must broadly match the content of ambiguous descriptions used to test any interpretation bias and, more importantly, interpretation training will only influence vulnerability to anxiety when the training theme matches the subsequent stressor.

Basic mechanisms of perseveration in psychopathology

Convenor & Chair: Graham Davey, University of Sussex

Catastrophic worry and persecutory beliefs

Helen Startup, Daniel Freeman, Philippa Garety, Institute of Psychiatry, UK

In a recent multi-factorial model of the formation and maintenance of persecutory delusions it is suggested that persecutory beliefs arise from an interaction between internal experiences, external events, reasoning and emotion (Freeman *et al.*, 2002). A novel feature of the model is that anxiety is given a central role in delusion development. The aim of the current research is to elucidate further this association between anxiety and persecutory delusions.

We applied the methodology of catastrophic worry research to persecutory delusions.

Previous research with individuals with chronic worries has shown that they generate significantly more catastrophising steps than those without chronic worry and that this is achieved by them posing automatic question of the "what if…?" kind (Startup & Davey, 2001).

Thirty individuals with current persecutory delusions completed assessments of delusion conviction, preoccupation and distress. They also completed a measure of trait worry and took part in the catastrophising interview. Furthermore, they were followed up after three-months in order to assess whether the presence of a worry style was predictive of persistence of the delusions.

Dieting stop rules as predictors of pathological eating patterns

Hussien Niyazi & Graham C. L. Davey, University of Sussex

This paper describes studies investigating how mood-as-input predictions might be applied to perseverative dieting and eating disorder symptomatology. Study 1 describes the development of an instrument for measuring dieting stop rule use, and Study 2 used structural equation modeling to determine how dieting stop rule use related to variables associated with eating disorder symptomatology. In particular, use of 'as many as can' stop rules was associated with 'drive for thinness', and both 'as many as can' and 'feel like continuing' stop rules were associated with bulimia. Negative mood was also a significant variable interacting with both types of stop rule to predict both 'drive for thinness' and bulimia.. The paper will discuss some of the theoretical benefits of viewing dieting behaviour as an open-ended task that is influenced by the deployment of different types of stop rules.

Specific negative moods as information for perseverative worrying and checking

Frances Meeton, University of Sussex

This presentation will discuss the results of three experiments designed to examine the role of specific negative moods in perseverative worrying and checking. Experiment 1 examines the effect of sadness, anger and anxiety on checking behaviour. Experiment 2 examines positive and negative affect in relation to perseverative worrying, and experiment 3, effects of anxiety and anger on perseverative worrying.

Experiment 1 found a main effect of stop rule on all checking measures, no effect of mood and no mood stop rule interaction. Experiment 2 demonstrated that when the task was personally relevant, there was a significant interaction between mood and stop rule. Those in a negative mood using an “as many as can” stop rule exhibited a greater number of catastrophising steps than either those in a negative mood using a “feel like continuing” stop rule, or those in a positive mood using an “as many as can” stop rule. Experiment 3 found that when participants were anxious or angry, those using an “as many as can” stop rule perseverated for significantly longer at a worry task than those using a “feel like continuing” stop rule. These results suggest that specific negative moods affect perseveration in a similar manner. It is possible that when the task is personally relevant, a generic ‘negativity’, rather than specific negative affect, combines with “as many as can” stop rule use to result in task perseveration.

What ends a worry bout? An analysis of changes in mood and stop rule use across the catastrophising interview

G. C. L. Davey, University of Sussex, UK; Fiona Eldridge, University of Sussex, UK; Jolijn Drost, University of Maastricht, The Netherlands; Benie A. MacDonald, University of Sussex

This paper reports the results of two experiments designed to test predictions from the mood-as-input hypothesis about the factors that contribute to the ending of a worry bout. Experiment 1 looked at changes in self-reported mood across a catastrophising interview task. Experiment 2 investigated whether there were any changes in stop rule deployment between the beginning and end of a catastrophising interview task. Experiment 1 demonstrated that worriers tended to show increases in negative mood and decreases in positive mood over the course of catastrophising. In Experiment 2, participants exhibited a significant shift away from endorsing the use of ‘as many as can’ stop rules and a significant increasing tendency to endorse the use of ‘feel like continuing’ stop rules over the course of catastrophising. These results suggest that worriers exhibit increases in negative mood across the worry bout, but shift from the use of ‘as many as can’ to ‘feel like continuing’ stop rules. Mood-as-input hypothesis predicts that if high worriers ask the question “do I feel like continuing?” in the context of increasing negative mood, this will imply that the activity is no longer enjoyable or profitable and should be terminated. The results are discussed in the context of mood-as-input accounts of pathological worrying and the therapeutic implications of these findings are reviewed.

The Transdiagnostic Approach: Advances in Research, Treatment and Theory

Convenor & Chair: Warren Mansell, University of Manchester

Transdiagnostic Cognitive Processes in Bipolar I Disorder, Unipolar Depression and Somatisation Disorder: A Prospective Study

Sari Saatsi, Warren Mansell, Richard Brown, Gemma Paszek, University of Manchester

It is widely acknowledged that there are marked similarities in the cognitive-behavioural processes, which have been identified as important across different psychological disorders (Harvey *et al.*, 2004; Hayes *et al.*, 1996; Wells, 2000). These transdiagnostic processes (i.e. processes occurring across diagnostic groups) have been suggested to play a role in the aetiology and maintenance of a number of disorders, although much past research has been based on analogue non-patient samples. The aim of this study was to investigate the presence of such processes (i.e. worry, rumination, thought suppression, experiential avoidance and metacognitive beliefs) across four groups: patients with bipolar I disorder (n=26) in remission, individuals in remission from unipolar depression (n=26), those meeting the criteria for current somatisation disorder (n=7), and healthy controls (n=34) at Time 1. The present study also aimed to explore the association between these processes and clinical symptom severity one month later (Time 2), by utilising a number of well-validated self-report measures in a prospective between-groups design. The results indicated that the bipolar I and remitted unipolar groups demonstrated higher levels of worry, rumination, thought suppression, experiential avoidance, and negative metacognitive beliefs regarding the uncontrollability and dangerousness of thoughts compared to the healthy controls. The somatisation disorder group appeared to score similarly to the other clinical groups, although it had to be excluded from statistical analyses due to insufficient sample size. The bipolar I group and the remitted unipolar depression group demonstrated similar levels of worry, rumination, and metacognitive beliefs regarding cognitive confidence, cognitive self-consciousness and need to control thoughts, whilst the former scored significantly higher on thought suppression and metacognitive beliefs about the uncontrollability and dangerousness of thoughts. However, it seems possible that this finding was influenced by the larger relative number of individuals with co-morbid anxiety disorders in the bipolar group. An exploratory multiple regression analysis suggested that worry predicts levels of general psychopathology over time. This cognitive process appears to play an important role in maintaining symptoms. It was concluded that while this research had some limitations, it was successful in adding to our current understanding of transdiagnostic processes, and thus has a number of theoretical and clinical implications.

Rumination as a transdiagnostic process

Edward Watkins, University of Exeter

Rumination has been demonstrated to be a core process in the onset and maintenance of depression. However, recent evidence has suggested that rumination may also be involved in the onset and maintenance of other psychological disorders, particularly anxiety disorders, leading to the suggestion that negative repetitive thought is a transdiagnostic process (Harvey, Watkins, Mansell, & Shafran, 2004). This presentation will review recent studies indicating a role for rumination in other disorders (e.g., Nolen-Hoeksema *et al.*, 2007) and then consider evidence from several recent studies investigating the role of rumination in other disorders. First, data will be presented from a clinically depressed sample indicating the relationship between rumination and co-morbid Axis I and II disorders. Second, data from a randomised controlled trial will be presented to examine the effect of treating rumination with a focused CBT intervention on disorders co-morbid to depression – both sets of data indicate that rumination contributes to anxiety as well as depression and, in particular, is associated with generalised anxiety disorder.

Investigating and Extending the Transdiagnostic Approach Using Prospective Designs and Intervention Studies

Warren Mansell, Liz Hay, Kim Drummond, Maaria Faruq, Timothy Bird, Elizabeth Reilly, University of Manchester

The transdiagnostic approach proposes that there are core processes shared across a wide range of psychological disorders that maintain and exacerbate symptoms. Examples of (overlapping) processes already identified are worry, thought suppression, rumination and experiential avoidance. While reviews of the literature are consistent with the transdiagnostic approach (e.g. Harvey, Watkins, Mansell, & Shafran, 2004), few studies have tested it directly. One appropriate methodology is to examine the ability of the core processes to predict multiple symptoms in a prospective design, when controlling for baseline symptoms. A second method is to study whether interventions targeting the core processes reduce symptoms. Three studies will be described that apply these methodologies to large analogue student samples. The studies provide evidence that transdiagnostic processes predict symptoms of depression and anxiety over time, and that these processes are amenable to a self-help intervention. However there are limitations in assessing a wide range of sub-clinical symptoms in an analogue population. Future studies would need to refine measures, extend the sample size and study duration, and broaden the range of symptoms and their severity for a more effective test of the transdiagnostic hypothesis. In addition, the question of how valid diagnoses can be obtained despite the validity of a transdiagnostic approach needs to be addressed. For example, a label of a specific disorder may be related to the presence of a certain constellation of personal concerns and cognitive behavioural processes. There is also a clear need for a theoretical framework to underpin a truly transdiagnostic CBT approach.

The Measure of Mundane Meaning: A Study to Establish Reliability and Validity

Gary Brown, Anna Roach & Kate Joseph, Sharif El Leithy, Royal Holloway, University of London

The recent emphasis in PTSD research on posttraumatic growth has over-shadowed the more modest task for victims of trauma and those experiencing major life events merely to make sense of their experience. Further, there is a distinction to be made (e.g., King, 2004) between finding the "meaning of life"' and finding "meaning in life". It is the more mundane, second sense of meaning that is the focus of the current study. We describe the development and preliminary validation of a measure of "mundane meaning" intended to measure disruptions in personal meaning across the range of disorders and adjustment problems that arise following a major life event. A survey of archival qualitative data from four previous studies of assault victims, women experiencing recurrent miscarriage, and psychiatric outpatients with PTSD, along with the content of previously developed scales, and a further series of interviews with PTSD patients provided the basis for items. The preliminary Measure of Mundane Meaning was administered to a small sample of undergraduates to explore its initial reliability and validity. The pattern of associations was consistent with prediction, and mundane meaning appeared to be related but distinct from linked constructs.

Examining the Effectiveness of the Method of Levels

T. A.Carey, M. Carey, R. J. Mullan, C. G. Spratt & M. B. Spratt, University of Canberra, Australia

Despite advances in methodology, fundamental questions regarding the mechanisms and treatment structure of psychotherapy remain unanswered. Using Perceptual Control Theory (PCT) as an integrative framework to understand psychological problems regardless of specific diagnosis, it is suggested that a patient-perspective paradigm might provide answers to these questions. In this study, analyses of statistical and clinical significance were conducted. Qualitative data were also analysed to understand psychotherapy from patients' perspectives. A 12-month study was conducted with 120 patient participants and 4 clinicians. The clinicians used a programme of psychotherapy based on the principles of PCT called the Method of Levels (MOL). This is a technique that raises clients' awareness of their current perception of their presenting problems and key conflicts between their goals that may be main-

taining it and blocking recovery. Data were collected on the attendance patterns of patients, their ages, referral problem, and socio-economic background. A standardised questionnaire of depression, anxiety and stress measured pre and post treatment effects. The null hypothesis of no difference between pre and post treatment scores was examined by the derivation of p values and the construction of 95% confidence intervals. In all cases the null hypothesis was rejected, suggesting the the intervention led to lasting improvement. However, the provision of a waiting list control group in a future study would provide a more robust test of the intervention. Qualitative analyses as well as the examination of individual cases demonstrate the uniqueness of the psychotherapy experience for individuals and the relevance of a patient-perspective approach to research.

Ruminative processing in depression: Developing new paradigms

Convenor & Chair: Edward Watkins, University of Exeter

Getting stuck in a mental rut: Some process and experiential attributes

Philip Barnard, Cognition and Brain Sciences Unit, Cambridge
Ed Watkins, Bundy Mackintosh & Ian Nimmo-Smith, University of Exeter

A number of clinical conditions share the characteristic that the same or similar thoughts keep coming to mind over and over again – as if the mind enters an "interlocked state" or, more simply, just gets stuck in rut. Rumination about negative self-related themes in depressed moods and excessive concerns with social and physical threats in anxiety states are perhaps the two most thoroughly researched areas. In this paper we focus on attributes of interlocked mental states in general rather than on specific moods or dysfunctional themes. How might we characterise "stuckness" in terms of duration, repetition, control, context and its patterning over different affective states? If there are identifiable patterns in being stuck in a mental rut, are those patterns associated with mental processes with particular properties or experiential attributes? In this paper we report the preliminary findings from two questionnaire studies. Using factor analysis we identify four characteristic patterns in which the mind dwells on similar themes. We then relate these patterns to other patterns, also established via factor analysis, in attributes of processes (e.g. Analytic/dendritic) and of experiential qualities (e.g. awareness of mental/situated imagery). The implications of these generic patterns for theory and research will be discussed.

Impaired inhibition and maintained attention for negative information in depression

Rudi De Raedt, Lemke Leman, Ellen Goeleven, Ernst Koster & Saskia Baert, Ghent University, The Netherlands

A growing consensus is emerging on the important role of cognitive processes in the development and maintenance of depression. There are numerous indications from both a clinical and a neurobiological perspective that impaired inhibition and a difficulty to disengage from negative affective material might be a crucial aspect of depression vulnerability. Therefore, we investigated inhibition of positive and negative affective stimuli in depressed patients, formerly depressed individuals, and never depressed controls. We used an affective modification of the negative priming task (NAP) with pictures of sad and happy faces. Compared to never depressed controls, depressed patients showed a specific failure to inhibit the negative stimuli, whereas inhibition of positive material was unaffected. Surprisingly, formerly depressed individuals demonstrated impaired inhibition of both negative and positive information. We also examined attentional biases for angry facial expressions in depressed patients versus never depressed control participants using an emotional modification of the Exogenous Cueing task. The depressed patients showed maintained attention for angry faces compared to neutral faces. Moreover, compared to the non depressed participants, they showed a stronger attentional engagement for angry faces. The never depressed control group showed a positive bias, directing attention away from angry faces more rapidly compared to the neutral faces. Based on the present findings we argue that impaired inhibition and maintained attention for negative affect could indeed be an important process linking cognitive biases to neuropsychological impairments and clinical observations such as prolonged activation of negative schemas in depression.

Ruminative self-focus and negative affect in real-time and real-world settings: an experience sampling approach

Nicholas J. Moberly & Edward R. Watkins, University of Exeter

Cross-sectional and prospective studies have linked ruminative self-focus with a number of adverse psychological outcomes. However, surprisingly little is known about the inter-relationship between ruminative self-focus and negative affect over short time periods in natural settings. Using experience sampling methodology, we asked a non-clinical sample of 93 adults to record ratings on each of these variables eight times daily over one week. Cross-sectional analyses revealed that ruminative self-focus was associated with negative mood and that the strength of this association was related to individuals' levels of depressive symptomatology. Cross-lagged analyses showed that ruminative self-focus predicted negative affect at a later occasion, but also that negative affect predicted ruminative self-focus at a later occasion. These results suggest that ruminative self-focus and negative affect have reciprocal

causal influences on one another, at least over relatively short intervals, when measured in everyday settings.

Reduced concreteness training as a treatment for dysphoria

Edward Watkins & Nicholas J. Moberly, University of Exeter

Recent research has suggested that an important element that contributes to the maladaptive effects of depressive rumination is the adoption of an abstract, evaluative mode of processing during focus on self, mood and problems (Watkins & Baracaia, 2002; Watkins & Moulds, 2005; Watkins & Teasdale, 2001; 2004). It was therefore hypothesised that training participants into a concrete mode of processing, antithetical to that found in depressive rumination, would have beneficial consequences. Consistent with this hypothesis, a series of experimental studies found that a single session of training into a concrete mode of processing reduced emotional vulnerability to an immediately subsequent negative stressful event, compared to training into an abstract-evaluative mode of processing (Moberly & Watkins, 2006). The training involved non-clinical participants focusing on a series of emotional scenarios, in either a concrete ("imagine in concrete detail a movie of how this event unfolded") or an abstract style ("think about why this event happened and analyse the causes, meanings and implications of this event"). We hypothesised that repeated concreteness training, by reducing emotional vulnerability, would reduce symptoms of depression in a vulnerable group. To test this hypothesis, participants with stable levels of dysphoria (BDI-II = 14 for two consecutive weeks) were randomly allocated to concreteness training versus an active treatment control (relaxation training) matched for non-specific treatment effects. In both conditions, participants received a training session and then practised with audio-recorded materials each day for a week. Preliminary results suggest additional benefit from reduced concreteness training.

Mechanisms of change in Mindfulness-Based Cognitive Therapy (MBCT)

Emily Holden, Willem Kuyken, Kat White & Ed Watkins on behalf of the Exeter MRC MBCT Trial Group & University of Exeter

Two randomised controlled trials suggest that MBCT halves the rates of depression relapse compared with treatment as usual (Ma & Teasdale, 2004; Teasdale *et al.*, 2000). While there are theoretical proposals that MBCT might help to prevent relapse partly through reducing rumination (Segal, Williams, & Teasdale, 2002), to date there are almost no compelling data demonstrating that this mechanism mediates the prophylactic effects of MBCT .In the Exeter MRC trial we compared MBCT with maintenance anti-depressants in a group of people with recurrent depression. This paper will present analyses from the trial that examine rumination as a mediator of change.

The role of the body in mood disorder and brain injury: From basic science to clinical application

Convenor & Chair: Barney Dunn, MRC Cognition and Brain Sciences Unit

Discussant: Phil Barnard, MRC Cognition and Brain Sciences Unit

Follow your heart? Experimental investigations of the influence of bodily feedback in psychopathology

Barnaby Dunn, MRC Cognition and Brain Sciences Unit, Cambridge; Tim Dalgleish, MRC Cognition and Brain Sciences Unit, Cambridge; Ruth Morgan, University College London; Hannah Galton, University of Cambridge; Clare Oliver, University of Cambridge; Nakul Vyas, University of Cambridge; Marcel Meyer, MRC Cognition and Brain Sciences Unit, Cambridge

There is a long tradition arguing that feedback from the body can influence emotional and cognitive function. The James Lange theory (James, 1884) famously and controversially proposed that perception of changes in the body "as they occur is the emotion". More recently, the somatic marker hypothesis (Damasio, 1994) suggested that emotional biasing signals arising from the body regulate decision-making in situations of uncertainty and complexity. Given the prevalence of somatic symptoms in psychopathology it is plausible that disturbances of these bodily feedback systems might be involved in the onset and maintenance of conditions such as depression and anxiety. Moreover, a range of therapeutic interventions could in part act by changing the relationship to the body (e.g. mindfulness based approaches). Surprisingly, this possibility has received relatively little attention in the CBT literature to date. This talk will present the results of recent experiments run in our laboratory investigating whether alterations in activity in the body and how accurately this is perceived (interoception) influence emotional processing and decision-making in healthy and depressed individuals. Further, data from preliminary investigations of whether mindfulness in parts works by increasing interoceptive accuracy will be shared and the clinical implications of these findings discussed.

Recovery of the embodied self: A novel process account of Anorexia Nervosa with treatment implications

Rebecca Park, University of Oxford; Philip Barnard, MRC Cognition and Brain Sciences Unit, Cambridge

There is “a pressing need to develop new treatments for Anorexia Nervosa (AN), because the outcome is so poor” (Fairburn 2005). For treatment development, a better understanding of processes underpinning AN is urgently required. This paper introduces the conceptual background, preliminary evidence and clinical applications of a novel process account of AN (Park & Barnard 2006; Rawal, Park & Williams 2007). This account is developed from a cognitive science based framework ‘interacting cognitive subsystems’ (Teasdale and Barnard 1995), which applied to depression has underpinned development of novel interventions such as mindfulness (Teasdale 1999; Segal, Williams & Teasdale 2002). This novel process account of AN schematic models and modes of mind focuses on how bodily states interact with two qualitatively distinct levels of meaning: intellectual, conceptual meanings and the abstract, emotionally charged meanings (reflecting schematic models of experience). This account augments existing understandings by providing a detailed account of processes by which therapeutic strategies exert effects, and testable concise predictions for research and clinical practice. The framework suggests guiding principles indicating what will help and what will hinder recovery, and novel treatment strategies. Clinical applications of this process account of AN are discussed, incorporating the notion of schematic models and modes as tools to further understanding maintaining processes and guide treatment development. Implications for implementation of current treatments and the development of novel treatment strategies will be suggested.

Changes in emotion based decision making following brain injury and clinical implications

Fergus Gracey, Becky Rous, Giles Yeates, Oliver Turnbull, Caroline Bowman, The Princess of Wales Hospital, The Oliver Zangwill Centre for Neuropsychological Rehabilitation, Cambridgeshire PCT

Changes in the control of emotion and behaviour are very well documented following brain injury. Over the past ten years interest in social and emotional aspects of processing and their contribution to problems following brain injury has developed. A body of work suggests that certain types of damage to the frontal lobes of the brain, common following traumatic brain injuries, results in a specific difficulty using internal emotional states (in part based on feedback from the body) to guide behaviour and decision making in complex situations, such as social interactions. We report preliminary findings addressing the question of whether brain injury affects this ability, in comparison with healthy controls, as measured by the Bangor Gambling Task. Our results suggest the brain injured group perform at a lower level than healthy controls, consistent with our prediction. We describe the clinical implications of such potential ‘disembodied cognition’ or disruption of the links between felt experience and conscious thought, on the understanding of emotional disorders following brain injury and provision of CBT to this client group.

Working with psychosomatic disorders – Tapping into the resources of the body

Margaret Landale, Chiron Centre for Body Psychotherapy, London

Poorly regulated emotional arousal levels have a detrimental influence on the main systems of the body such as the immune, hormonal and respiratory systems and can lead to psychosomatic conditions or medically unexplained symptoms. This presentation will explore how the body can provide vital resources for the treatment of psychosomatic disorders. I will be looking in particular at how to help the patient observe sensory and felt experience mindfully, how to monitor and manage emotional arousal levels and how to work therapeutically with the breath.

Therapeutic and Applied

Keynote Address

Approaching problems of identity from a cognitive-behavioural perspective

Dr Gillian Butler, Oxford Cognitive Therapy Centre

Many of those who come to therapy as adults, after having suffered multiple traumatic experiences during childhood, speak as if they have no sense of self. As cognitive behaviour therapists we have been slow to understand the implications of the things that they say, for example about not existing, and also slow to develop ways of helping them that fit with our general approach to treatment. The ideas present-

ed here have been developed during clinical work with about 40 such people. A set of strategies that appears to be effective in helping people to develop a more functional sense of self – or identity will be described. The ideas presented are intended to raise questions as well as to answer them, and to contribute to the process of developing more effective treatments by helping to pinpoint some potentially productive research issues.

Symposia

Self-help: how does the theory work out in practice?

Convenor & Chair: Christopher Williams, University of Glasgow

Can people read self-help manuals for depression? – A challenge for the stepped care model and book prescription schemes

Rebeca Martinez, University of Glasgow

Self help approaches are increasingly being used in healthcare settings through over 100 book prescription schemes in the UK. The use of Cognitive Behavioural Therapy (CBT) self-help materials for depression is advocated as part of stepped care service models. We assess how the reading ages of the most recommended self-help books for depression compare to British literacy levels. The most recommended self-help books for depression were identified; seven CBT based self-help books were included in the analysis as well as a widely used booklet for depression. Readability scores and reading ages were calculated using the Readability Studio® software to generate a wide range of key readability and comprehension scores. The reading ages of the selected books were between 12.6 and 15.4. Reading ease varied amongst the texts, and their complexity (percentage of unfamiliar words, range: 14.8% - 22.6%). This would leave a significant proportion of the UK population to struggle to use some of the current CBT-based self-help books recommended. For some patient groups, non text based self help materials as well as shorter and more easily read written materials may be more appropriate. Publication of the reading ages of the recommended books within the book prescription schemes may allow for a more accurate match between the book and the reader.

Internet-based CBT for Bulimia – the ACCESs Project: identifying and treating the 'iceberg' of unmet need

Calum Munro & Varinia Sanchez-Ortiz, Institute of Psychiatry

Large numbers of young women have Bulimia Nervosa. Many of these never access any treatment. CBT is known to be an effective treatment for BN, yet there is insufficient provision to meet even the demand of those that present for treatment. We have recently completed a randomised controlled trial of 76 students with BN or EDNOS. The students were recruited from 6 varied higher education institutions across London, primarily via e-mail. The treatment group had access to 8 sessions of Overcoming Bulimia, an internet-based CBT self-help treatment. They were supported by e-mail contact with a therapist. The presentation will describe preliminary quantitative and qualitative results from the project including: the severity and co-morbidity of the participants; efficacy on our primary outcome measure the Eating Disorders Examination and secondary outcome measures of depression, anxiety and quality of life; the participants' experience of using the package; and the experience of delivering e-mail support.

Guided self-help provided by mental health workers with limited training and experience: An uncontrolled evaluation

Paul Farrand, University of Plymouth

There has been considerable development of guided self-help within primary care. This study examines acceptability, efficiency and effectiveness of guided self-help provided by mental health workers with limited mental health training and experience. Over a 15 month period 1162 referrals were made to clinics supported by 7 Graduate Mental Health Workers. Following an initial drop out prior to assessment (18%), 658 patients went on to adopt guided self-help. Patients using guided self-help received an average input per patient, excluding assessment, of 4 sessions of 40 minutes. Clinic acceptability during the regular support sessions was good (76% attendance), however only 39% of patients attended the 3-month follow-up session. Between 55 and 63% of patients experienced clinically significant and reliable change with effectiveness improving at 3-month follow-up, with up to 7% of patients deteriorating. Acceptability and effectiveness of guided self-help provided by mental health professionals with limited experience compares to that of an experienced CBT mental health nurse (Lovell, Richards & Bower, 2003). However it was considerably less efficient, with concerns arising with respect to the operation of the clinics within stepped care.

How to deliver guided self help within stepped care: the Newham IAPT model

Ben Wright, Newham Psychological Treatment Centre; Paul Farrand, University of Plymouth, Newham IAPT Team

The full integration of guided self help (GSH) within the stepped care framework presents clinical, organisational and managerial challenges. Ensuring that the right people receive GSH in a timely manner provided by appropriate and competent staff are the principle challenges. Newham IAPT has made the transition from a service largely focusing on the delivery of individual CBT to a service that continues to deliver high quality individual CBT integrated with a team delivering low intensity CBT (including GSH) as an initial element of care within a semi-stratified stepped care framework. The presentation will outline (1) the integrated care pathway, (2) the clinical issues associated with stratification, particularly the use of semi-structured clinical interviews within telephone triage (3) skills development, professional support and supervision structures for the low intensity team, (4) key supportive structures for delivering an integrated service, (5) early efficiency and outcome data, (6) making the transition to an integrated service.

Improving Access to Psychological Therapies: Progress to date from the pilot sites

Convenor & Chair: Rob Dudley, University of Newcastle Upon Tyne

An independent evaluation of the IAPT experiment

Glennys Parry, University of Sheffield; Michael Barkham, University of Sheffield; John Brazier, University of Sheffield; Gillian Hardy, University of Sheffield; Tony Kendrick, University of Southampton; Karina Lovell, University of Manchester; Pete Bower, University of Manchester; Jo Rick, University of Sheffield; Kim Dent-Brown, University of Sheffield

The NHS Service Delivery & Organisation R&D Programme has commissioned an independent research evaluation of two IAPT demonstration sites, in Doncaster and Newham, due to report in 2009. The study tests one central hypothesis, namely that access to primary care CBT psychological therapies via newly configured service delivery models will be cost-effective when compared with existing organisation of services drawn from comparator sites. This mixed-method study integrates quantitative and qualitative methods and comprises three strands: (1) an evaluation of the comparative costs and outcomes of the demonstration sites compared with routine psychological therapy services in demographically similar areas, with outcomes benchmarked against archived datasets; (2) an organisational case study evaluating system impacts and lessons to be learned in implementation; (3) a qualitative study of patients' experience within the demonstration sites. The challenges of addressing this type of policy research question are reviewed. Emergent findings are presented and placed in a policy context.

High-Volume Psychological Therapies: Data from the First Year of The Doncaster Increasing Access to Psychological Therapies Demonstration Site

Dave Richards, University of York

The Doncaster Increasing Access to Psychological Therapies Demonstration Site went 'live' in mid-August 2006 with the explicit aim of providing psychological therapies to high-volumes of people with common mental health problems in Doncaster. It is organised according to two critical stepped care principles: a) treatments delivered are always the 'least restrictive', with the burden on patients as low as possible whilst achieving a positive clinical outcome; b) treatments are self-correcting via scheduled review of outcomes using validated symptom schedules to assist in clinical decision making. In Doncaster the majority of people receive a low-intensity, CBT based psychological intervention delivered by para-professional 'case managers' with supervision and scheduled monitoring of clinical outcomes from experienced CBT-trained mental health professionals. A small minority of patients are stepped up to cognitive-behaviour therapy after scheduled reviews. Each month 300-350 referrals are received. Three quarters of patients have mixed anxiety and depression; 20% depression alone and 5% anxiety alone. Patients receive a mode of four sessions with case managers or CBT therapists (range, 1 to 18). Mean total treatment duration in minutes is two hours and 20 minutes per patient. The uncontrolled pre/post effect size for depression and anxiety is large (1.3). Between 75-80% of people are treated using a low-intensity CBT based Depression Guided Self-help 'Recovery Programme' (Lovell and Richards, 2006) with 40-50% also using materials from the Overcoming Anxiety programme (Williams, 2003). 96% of patients receive at least one face to face contact whilst 75% of contacts' post-assessment are telephone mediated.

One year on: an update of the Newham IAPT Demonstration Site

Ben Wright, Newham Psychological Treatment Centre, East London and the City University Mental Health NHS Trust

The presentation will provide a summary of the background, key care elements, achievements to date and outcome data for the Newham IAPT demonstration site. The service provides an integrated stepped

care framework that ranges from active engagement, low intensity work through to formal high quality individual CBT. A range of challenges have presented themselves through the implementation of the programme and the presenter will outline the ways in which these have been addressed.

Empowering people to help themselves

Convenor, Chair and Discussant: Fiona Lobban, University of Manchester

The Experience of self management in individuals with bipolar disorder

Emma Van der Gucht, University of Leeds & MDF Bipolar Organisation

The MDF Bipolar Organisation is a UK wide charity for people affected by bipolar disorder. Their aims are to help enable people affected by the disorder gain support, education and increased controls of their lives and difficulties. One of the ways in which they do this is through offering a free self management training programme designed and run by people with Bipolar Disorder, which is independent of psychiatric or psychological services. In the autumn of 2006 members of the Airedale MDF group travelled to London to take part in the self management programme. This presentation will highlight the key themes of their experiences and what they felt were the strengths and weaknesses of the training. It is hoped that this will further encourage us as clinicians and researchers to learn from people with Bipolar Disorder who are often experts in their conditions and experiences.

Living Life to the Full – Can it reach people currently not engaged in the Clinical Services?

Michelle McAuley, Chris Williams, University of Glasgow

INTRODUCTION: Living Life to the Full (LLTTF) www.livinglifetofull.com is a free online life skills resource which aims to empower users by providing information to help cope with problems such as low mood and anxiety. The course is based on the Five Areas Approach, a style of Cognitive Behavioural Therapy (CBT), which has been shown to be effective in treating depression.

The obstacles that limit the treatment of common mental health disorders are well recognised. The most significant barrier is the "treatment gap" – between people who would benefit from help – compared to those receiving treatment. In Europe there is a 45.4% treatment gap for depression, accounting for 14 million persons going untreated annually. Possible reasons that people do not seek help may be the limited access to evidence-based care, unwillingness to access care, stigma attached to mental health disorders, or a lack of knowledge regarding their symptoms and/or the resources available to help.

A treatment gap exists for psychological services. CBT practitioners are in short supply and there is need for novel and innovative methods of delivery. A recent CSIP-funded review recommended free computerised Cognitive Behaviour Therapy sites, such as LLTTF, be routinely offered to people in England.

METHODS: There are currently (March 2007) 24000 registered users of the website. Registration is mandatory and records the mental health status using the Hospital Anxiety and Depression Scale (Zigmund & Snaith, 1983). The sample included all persons who had registered with LLTTF between 16 January 2006 and 15 January 2007.

People were excluded if they failed to log on to the website once registered. Duplicates were eliminated in order of date registered – only the first date being included. Only persons accessing the website for personal use were included (86.1% - 10689 of 12413 registrants).

RESULTS: Overall 65.4 % of users are female and 69.6 % between 17-44 years of age. Only 1.6% were > 65 years of age. Of persons using the website for personal use, 79.6% (8504) experienced either clinically significant anxiety or depression using a cut-off of 10 for each on the HADS. Of these cases, 55.3% were not seeing anyone for mental health treatment, and similarly 52.8% were not currently taking any medication for psychiatric purposes. Overall, 25% were using self-help books and 54.3% described using other resources (not including video, tape, internet and self-help groups), with only 8.7% not using any other resources.

DISCUSSION: Importantly we present data that as well as providing an opportunity to offer computerised CBT to people already within the NHS, there is also an opportunity to provide access to people not currently engaged in clinical services. We are exploring ways of offering support for users via the voluntary sector – and two pilots with support from National Phobics Society and Depression Alliance Scotland will be briefly mentioned.

Empowerment through education: a service development for patients with bipolar disorder

Dipty Reavely; Julia Marshall; Stuart Watson, Newcastle General Hospital

In Newcastle, we are developing a novel bipolar service. The aim is to enhance the quality of care provided by our Trust by facilitating the development of specialist skills, empowering patients and creating a structure to allow the delivery of self management training.

We are creating a hub and spoke structure, such that within each of our mental health care teams we aim to develop, via training and the formation of supportive networks, specialist bipolar health care professionals and experienced patients. These individuals will be trained together to allow them to act as

a resource for the team and to co-facilitate self management training groups.
We have developed a 14 session self management training package, which has run now on 3 occasions. The experience of professionals and service users training and working together to co-facilitate self management training groups is fairly unique. We will describe our experiences and discuss our successes and the challenges that we have faced.

Developing a Guided Self-Help Intervention for Mild to Moderate Depression

Judith Gellatly, University of Manchester

Depression has been recognised by the World Health Organisation as one of the largest causes of "disease burden" in the world. It is a significant cause of distress and disability resulting in serious economic consequences for patients, families and the wider society.
However, whilst the NICE guidelines highlight CBT as an effective treatment, there exists a huge disparity between need and provision within current services. In an attempt to improve access to psychological therapies Government policy has recommended a stepped care model of service delivery (NICE, 2004) where the first line treatment is least intensive but still likely to produce health gain. Throughout this model, interventions are recommended which to varying degrees promote patient empowerment.
For mild to moderate depression Guided Self-Help (GSH) interventions are recommended at step 2 of the model. GSH is used to refer to self-help interventions that require minimal professional (or paraprofessional) input which may provide the optimal balance between efficiency and effectiveness (Gellatly *et al.*, 2007) and has been defined by NICE (2004) as "a self-administered intervention which makes use of a range of books or a self-help manual that is based on an evidence-based intervention and is designed specifically for the purpose".
Although there is preliminary evidence that GSH is more effective than no treatment or usual care, there is insufficient high quality evidence from UK primary care settings. In addition, there is little known about the critical components of GSH, e.g. which professional group should deliver GSH, what level of guidance is required, and what is the appropriate health technology, i.e. books, leaflets, computers etc.
This study aimed to use the MRC Complex Interventions Framework to identify and understand the critical components of this complex intervention, in order to design an effective and feasible protocol for testing in a large scale definitive trial. There are two stages of the study:
Phase 1 (modelling) – to develop a protocol for the delivery of feasible and effective guided self-help for mild/moderate depression in a primary care stepped care system. Phase 2 (exploratory trial) – to test the application of the GSH protocol and to provide estimates to assist in planning a definitive trial.
The development of the GSH intervention will be presented.

Service delivery innovations in primary care: beyond the tip of the iceberg: Part A

Convenor: Stephen Kellett, Barnsley PCT NHS Trust

Chair: Linda Matthews, Barnsley PCT NHS Trust

"Doing Well": delivering stepped care for depression to a defined population

Helen Sandbach & Michael Smith, New Sneddon Street Clinic

There is a need to improve the access to and quality of psychological and pharmacological treatments for people with depression. "Doing Well" is an innovative programme that seeks to deliver such care by providing prompt access to a "stepped care" model in 14 General Practices in a mixed urban-rural area in Scotland, UK. An observational study of the implementation of the programme is described.
The "Doing Well" model of stepped care is a "complex intervention" characterised by: universal electronic referrals; no "referral threshold" for new cases of depression; specialist care delivered in primary care settings; integration of electronic information systems between primary and secondary care; continuous measurement of depression outcome measures; and enhanced training and supervision for "Doing Well" clinicians.
This model enabled a relatively small team of five to six clinicians to provide effective depression care (including guided self-help, psychological interventions such as a Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT), and appropriate pharmacological care) for about 1,000 new cases of depression each year. Significant cost savings were made in the antidepressant budget. Service user satisfaction ratings were high.

Effectiveness of CBT self-help delivered in Primary Care – evidence from a large RCT

Chris Williams; Jillian Morrison; Philip Wilson; Alex McMahon; Andrew Walker; Lesley Allan; Yvonne McNeil; Louise Tansey; Jim White, Greater Glasgow and Clyde NHS University of Glasgow

INTRODUCTION: NICE (2004) guidelines advised that healthcare professionals should consider recommending a guided self-help programme based on cognitive behavioural therapy (CBT) for patients with mild to moderate depression. A recent review has concluded that CBT self-help can be best delivered

with supportive monitoring – and that a practitioner with a non-clinical qualification is able to obtain the same results as a qualified mental health worker. We report the use of protocol-delivered written CBT self-help treatment delivered over 3-4 short sessions by a psychology assistant.
METHOD/TECHNIQUES: A randomised-controlled trial compared the structured CBT self-help treatment package 'Overcoming Depression: A Five Areas Approach' (Williams, 2001) with GP treatment as usual. Patients were recruited from seven GP practices in Glasgow. For inclusion they had to present to their primary care worker with symptoms of depression, a BDI score of 14 or more, be aged eighteen or above and be willing and able to use the materials. Patients with suicidal intent and impaired concentration and motivation were excluded. Patients were randomly allocated by a central telephone randomisation service to treatment as usual or to the self-help arm. Use of the self-help workbooks was supported by a psychology assistant via three 40 minute appointments at week 1, 2 and at one month – with the option of a fourth session if needed (the 2+1 model). Patients in both arms of the study completed the same assessments at set time points, week 1, week 2, 1 month, 4 months and 12 months.
RESULTS/OUTCOME: 281 patients entered the study – 140 patients were allocated to the self-help arm and 141 to TAU. 24 patients withdrew, 52 were lost to follow-up and 1 died of an unrelated physical illness. Follow-up data was collected at the 4 month time point for 204 patients. The primary outcome was the BDI-II. There was a 5.36 point mean difference (95% CI) on the BDI-II in favour of the self-help arm over and above the drop in the TAU arm ($p<0.0001$ on the ANCOVA analysis). The effect size for the CBT self-help arm based on the mean difference is 1.27. The effect size for the TAU arm is 0.68. The same changes are also seen on the CORE-OM questionnaire – and in each of the CORE sub-domains (Well-being, Problems, Functioning and Risk) – each statistically significant. There were also positive and significant outcomes for satisfaction and knowledge. We are at present completing the one year follow-up and economic analysis.
CONCLUSION/DISCUSSION: Patients move from the high moderate/severe border to mild for the self-help arm but stay moderately depressed for the treatment as usual arm. This study provides evidence of strong effectiveness and our data support the use of guided self-help materials for mild to moderate depression.

Going beyond the tip of the iceberg: a multi-level/multi-purpose service for common mental health problems

Jim White, Greater Glasgow and Clyde NHS; Chris Williams, University of Glasgow

While CBT approaches are strongly recommended for the treatment of common mental health problems (NICE guidelines, December 2004), the reality is that these services are scarce on the ground, typically low volume, involve high drop-out and significantly poorer outcomes at the routine clinic level than at the research centre level. Long waiting lists are the rule in NHS services. In addition, these approaches often fail to take into account the social realities experienced by service users. Other factors to be taken into account are the large number of people with these conditions who do not seek help (for a range of reasons), those missed at the primary care level, therapists intervening far too late down the line, lack of relapse prevention approaches and the lack of user choice in most services. Most CBT approaches are based on a 'cure' model when, for many, keeping their heads above water may be a more realistic aim. STEPS aims to develop a high volume multi-level/multi-purpose service that attempts to tackle the above problems. At the clinic level, we can offer individual therapy and a range of 'Rapid Access Services' (RAS) that offer a real alternative to prescribing and allow user choice. Individuals, not referrers, are responsible for choosing the RAS. Currently, these self-referral RAS include 'Stress Control' large group (100+) evening classes, Advice Clinics and Advice Lines, Mental health sections in public libraries, 'book prescribing' schemes, support groups run by an 'expert patient' ex-service user, self-help book series, website (www.glasgowsteps.com) and exercise options. At the community level, we are developing awareness raising approaches (Good Mood Week, schools, DVD, podcasts, 'StressMaster' days, etc). We are working with members of the Pakistani community to develop culturally appropriate approaches, including training faith leaders. Some of the services will be delivered by members of that community. We offer training in awareness and intervention to other statutory and non-statutory groups. This 'cascading' of skills is a crucial aspect of the service. By offering the RAS service, we are able to provide help to over 200 people each month and have no waiting lists for individual therapy. We are a Scottish Executive Exemplar site. This talk will look at the theoretical and practical rationales behind this approach along with results from the first year evaluation showing what is working and what is not.

Identifying the relationship between 'session impact' and outcome in large-group psychoeducative CBT

Suzanne Clarke, Central and North West London Mental Health NHS Trust

Large-group psychoeducative CBT is an integral aspect of the stepped care model and has recently been shown to be equally as effective with regards to outcome as matched individual therapies. However, 'how' psychoeducative CBT actually works for clients is still somewhat of a mystery. The focus of this project was to explore relationships between how attendees experience psychoeducative sessions and their clinical outcomes. A poly-diagnostic sample of 265 attendees from five groups provided longitudinal session by session data (CORE, Work and Social Adjustment Scale, and the Session Impact Scale) over the course of the 5 session group intervention. Repeated measure ANOVAs tested for statistical

and clinical changes across the group duration, whilst correlations were used to identify relationships between the rated impacts of sessions and associated outcomes. Results are discussed in terms of the clinical and organisational effectiveness and efficiency of psychoeducational CBT and the implications on the design of stepped care models.

Service delivery innovations in primary care: beyond the tip of the iceberg: Part B

Convenor & Chair: Jim White, Greater Glasgow & Clyde NHS Trust

The role and effectiveness of Graduate Mental Health Workers in a stepped care model

David Ekers, Newcastle NHS Trust

In terms of 'New Ways of Working' the recruitment and deployment of Graduate Mental Health Workers (GMHWs), and the redesign of the remit and role of existing workers, is a key strategic and workforce issue in a stepped care model of service delivery. The focus of this project was to examine the clinical outcomes from pilot clinics run by GMHWs, in terms of their effectiveness in intervening with 'simple' anxiety and depression clients referred from Primary Care. Outcomes from the pilot clinics are compared to those achieved in more 'traditional' service designs. The challenges of successfully developing the roles and career paths of GMHWs in stepped care models are identified and then placed in the context of future potential commissioning arrangements.

An evaluation of the uptake, attendance and effectiveness of large-group psychoeducational CBT: A session by session picture of clinical change

Kat Baker, Sheffield University

StressPac is a large-group psychoeducative CBT approach used within stepped care model to treat those clients that can use such low-level input effectively and quickly and identify those clients that need more intensive one-to-one therapy in Barnsley PCT. The service recently changed evaluation methods from simple pre and post group data collection, to subsequently collecting data at each of the six psychoeducative sessions, in order to allow the shape and rate of change over the duration of the intervention to be examined. A quantitative repeated measures design was used, to collect within and between group data using the CORE-OM and the Work and Social Adjustment Scale. A total of 177 clients contributed to the data set with 103 clients completing measures after at least 4 sessions. Results indicated statistically significant reductions in clinical distress and high rates of clinically significant improvement. The shape of change identified is that of an 'inverted hockey stick,' indexing client making smooth progress in the early stages of the intervention, with some deterioration at the end of the group. The results are discussed in terms of how to handle 'termination issues' in a large-group setting.

An evaluation of the impact of a large group psycho-education programme (Stress Control) on patient outcomes: does empathy make a difference?

Anne Joice, Greater Glasgow and Clyde

Large psycho-education groups have been found to be effective in improving mental health. There is also a well established link between empathy, therapeutic relationship and outcome in individual therapy but little is understood about the impact of empathy and the therapeutic relationship within psycho-educational settings. This study used a before – after quasi-experimental design to investigate the impact of delivering large psycho-education groups on patient outcomes and empathy within the therapeutic relationship. A large group six week psycho-educational course (Stress Control) was evaluated by administering a questionnaire, which consisted of measures of outcome, empathy and relationship, at the first and last sessions of two courses of Stress Control.

The results show that Stress Control had a positive impact on patient outcomes over the duration of the course; the CORE score reduced significantly by 0.63 (95%CI 0.82 – 1.14) ($t = 9.18$, $df = 55$, $p = <0.001$), patents felt highly enabled, and reported changes to their main complaint and well being sufficient to enhance their quality of everyday life. Attendees perceived the course leader as empathetic. However, the relationship between perceived empathy and attendee outcomes was less clear. No significant relationship was found between the main outcome measure (CORE) and the empathy or relationship measures. However evidence of significant associations between most of the other outcome measures and the empathy and relationship measures was apparent, similar to that reported in studies of individual therapy. The main factors that were found to be important to the main clinical outcome (change in the CORE) were age, the severity of the symptoms at baseline, the presence of a long-term illness or disability, and whether attendees tried the techniques out at home (homework). Attendance rate and homework were also important in most of the other outcomes measured.

The findings are useful for Primary Care Teams that offer large psycho-education groups and the implications for service provision within a stepped care service model are discussed.

Getting the message out: use of media in stepped-care services

Sandra Johnston, Greater Glasgow and Clyde

As part of the STEPS six level stepped-care model (individual therapy, groups, single contacts, non face-to-face work, working with others, population level), we have developed a range of approaches aimed at getting to the very large number of people who suffer or are in some way affected by common mental health problems and, who, due to capacity issues, would be unable to access help from a therapy team. This talk will look at the development of the STEPS website (www.glasgowsteps.com); radio programmes, pod casts and booklets. Issues relating to complexity of language will be discussed. In order to address literacy issues, two DVDs aimed at mental health awareness and self-help have been compiled. One of the DVDs includes comedy put together in collaboration with some well-known local stand-up comedians. Clips from this DVD will be shown. The talk will look at how these services fit into the main STEPS programme.

Panel Debates

NICE and Beyond

Convenor & Chair: Rob Dudley, University of Newcastle Upon Tyne

Speakers: Tony Roth, University College London; Graham Turpin, University of Sheffield; Glennys Parry, University of Sheffield; Dave Richards, University of York

Cognitive Behavioural Therapy is established as the psychological treatment of choice for a host of presenting problems. The strong emphasis on evaluation has led to a large evidence base that is now endorsed by a number of regulatory agencies including the National Institute for Clinical Excellence (NICE). This is a fantastic endorsement of the value of CBT. Increasingly there are demands from individuals, and their families to have access to CBT. Services are being placed under greater pressure to increase access to and provide effective psychological therapy. This presents both opportunities and challenges. In this panel discussion brief presentations will be followed by the opportunity for extended discussion and debate as to how these demands are met. Consideration will be given to how we develop a variety of levels of training in CBT, as well as how we develop competencies in CBT that help increase access to psychological therapies. Moreover, consideration will be given to how best we design and deliver services. CBT has long taken pride in the emphasis on empirical evaluation of its effectiveness; however, the challenge is now effective dissemination and delivery. These are challenges crucial to the future of CBT and will affect us in our current and future roles as practitioners. The panel debate will allow close consideration of these issues with contributions from key figures involved in helping develop and deliver CBT beyond NICE.

Implications for CBT therapists of 5 studies of CCBT and other research: A Panel Debate

Convenor: Isaac Marks, King's College London and Institute of Psychiatry

Chair: Dave Richards, University of York

Speakers: Dave Peck, University of Edinburgh; Kate Cavanagh, University of Newcastle; Chris Williams, University of Glasgow; Isaac Marks, King's College London; Dave Richards, University of York

The 90-minute Panel will start with the Chairperson saying for 2 minutes why the Panel was convened. After this 5 Panel members will each present a 5-minute paper followed by 3 minutes of questions from the floor and Panel to that speaker about that presentation only. The presenters will speak about Implications for CBT therapists of 5 CCBT studies and other research based on:
Kate Cavanagh (Univ of Newcastle): Chelmsford CBT-specialist CDROM-CCBT study with depression
Chris Williams (Univ of Glasgow): Experiences with CD-ROM-CCBT for diverse conditions
Isaac Marks (King's College London): Field implementation of internet-CCBT for panic/phobia in Primary Care Trusts around England
Dave Richards (Univ of York): Training of case-managers for brief CBT for the training of brief supporters of CCBT users.
Each speaker will present NOT the results of any CCBT study *per se* but rather its lessons for CBT therapists. Each of the presentations will be for 5 minutes followed by 3 minutes of discussion of that paper alone, followed by 38 minutes of general discussion and questions from the floor and Panel to all the Panel members. The Panel will end with a 2-minute summary from each of the panel members.

Open Papers

Improving Service Delivery in Minority Groups

Chair: Nick Maguire, University of Southampton

Deprivation and its impact on attendance at individual therapy appointments

Arlene Watts, STEPS, Primary Care Mental Health Team, Greater Glasgow & Clyde NHS; Jim White, STEPS, Primary Care Mental Health Team, Greater Glasgow & Clyde NHS

Low socioeconomic status is generally associated with greater prevalence of mental health problems and poor access to health care (Lorant *et al.* 2003). Therefore, there is a need to monitor the equity of mental health services as well as their effectiveness. The aim of this study was to establish whether social deprivation affected the attendance behaviour of people referred to STEPS, a Primary Care Mental Health Team in the South-East of Glasgow. Current UK government policy places a strong emphasis on increasing access to effective talking therapies, particularly for those in receipt of incapacity benefits (Layard 2005). However, attrition is a major problem for psychotherapy services with the only consistent findings relating to socioeconomic variables (Self *et al.*, 2005). Therefore, services must develop more responsive methods of delivery if individuals are to receive equitable, high-quality care.

A retrospective sample covering September 2005 to August 2006 was collected to investigate the association between deprivation, as measured by Scottish Index of Multiple Deprivation score (SIMD, Scottish Executive 2006), and attendance at individual therapy appointments. Participants were all patients discharged from STEPS over the 12 month period sampled. On the basis of their post code, each individual was allocated an SIMD category score. Patients were also categorised into 4 groups: those attending individual therapy, those that failed to opt-in, those that failed to attend their first appointment and those that dropped out within therapy. STEPS offer both CBT and Person Centred Counselling. Data were collected from individual case files, and from two existing departmental databases maintained for audit and admin purposes. Within the 12 month period analysed, a total of 1272 people were referred for individual therapy. Data were missing for 8% of this sample leaving a total of 1181 for analysis. Information on patients, referring GP, age, gender and the type of therapy offered was collected along with their SIMD score compared to the rest of Scotland and SIMD score compared to the rest of Glasgow. A significant association was found between deprivation and attendance at individual therapy. This paper will discuss the results in light of their implications for service delivery.

There is evidence that individual therapy is not being accessed by the majority of people referred. There is a need for services to develop more responsive methods of delivery.

Primary Care and Ethnic Minority Mental Health: Dilemmas and Solutions

Ruth Jamieson, STEPs Primary Care Mental Health Team

In the South East of Glasgow, 11% of the population is Pakistani Muslim. This presents a challenge to the NHS, currently underused by this population, to become more accessible to this community by overcoming linguistic and cultural barriers. An additional barrier for the mental health services in the NHS is the varied and diverse cultural understanding of mental health and well-being within these communities. STEPs Primary Care Mental Health Service, based in South East Glasgow, has endeavoured to overcome these challenges. This is a particular priority for STEPs because the South East is the area of Glasgow most densely populated by the Pakistani Muslim community. The aim of this paper is to describe specific efforts made by STEPs to make this service more accessible to the BME community by means of a number of different events/engagements. It has been a challenge to develop a culturally appropriate service, taking into consideration linguistic barriers, religious diversity and the variety of meanings attached to mental health in different cultures. With limited resources to develop a culturally appropriate service, STEPs have begun to widen the doors of its Primary Care Mental Health Service to the Pakistani Muslim community. A particular effort has been made to make the service more accessible to the Pakistani Muslim community. Efforts have been made to overcome linguistic and cultural barriers through the adaption and translation of the 'STEPs Out of Stress' series of self-help booklets in to Urdu. These booklets have been adapted to be culturally relevant, and will be made accessible to the Muslim community (e.g. available at Mosques). In addition, there will be an Urdu section in the new STEPs website, and podcasts available to download in Urdu. STEPs' mental health awareness DVDs also have Urdu voiceover available. STEPs has set up 'Healthy Reading' sections in libraries across Glasgow. In these sections, there are books and videos about mental health available in Urdu. STEPs therapists have made a number of appearances on Radio Ramadhan and Awaz FM to discuss mental health issues, and do mental health phone-ins. They have also interviewed religious leaders – Sikh, Muslim, Buddhist, Catholic and Protestant on the subject of religion and mental health. These interviews will be available to download from the STEPs website. STEPs sponser the Muslim prayer timetable, which features 3 pages of culturally appropriate mental health advice, and information about accessing STEPs services. STEPs therapists have carried out Mental Health Awareness Training with Imams. In addition, Stress Control is a didactic course that teaches stress management techniques. The format of this course is less threatening to more traditional members of the Muslim community. STEPs have

engaged in a number of creative and imaginative ways to engage Pakistani Muslim community, and continue to look for opportunities to make the service more and more accessible to this population. A formal audit of these activities is planned. Our initial perceptions of these efforts are that these small inroads are resulting in increased uptake of services offered by STEPs by the Pakistani Muslim community.

CBT training and intervention in an Indian context

Fiona Kennedy, Isle of Wight NHS Trust; David Pearson, Dreamadream.org

This paper describes the experience of two clinical psychologists volunteering with an Indian NGO 'Dream a Dream'. This NGO works with partner NGOs which provide accommodation and education in various forms for ex-street and impoverished children. The partner NGOs have found that around 70% of the children go back to the streets when they reach 18 and leave the shelters. Bangalore is known as the 'silicon city' of Asia. Giant multinational software and telecommunications companies such as IBM, Dell, GE, Oracle receive incentives such as tax holidays to base themselves there. These companies have strong 'social responsibility' programmes and encourage their young privileged employees to volunteer to work with NGOS. Dream a Dream organises enrichment activities for the children, such as sports, reading and computer education programmes, using these volunteers. Dream a Dream approached the psychologists to request help in addressing the problem of the young people's transitions to adulthood, by setting up a 'mentoring' programme, pairing privileged voluneteers with disadvantaged children for two years, with the aim of preventing their return to the streets when they leave school. The psychologists volunteered to go to Bangalore for 14 weeks to train the volunteers. The paper also discusses cultural differences and the transferability of theory, skills and research methods from Britain to India.

A mentoring programme was designed for 20 experienced volunteers to partner a given young person for at least two years and form an attachment with them, helping them to find jobs, get housing, make relationships.

The psychologists designed and delivered a CBT training programme for the volunteers, to address the psychological issues stemming from abuse, neglect and failure to thrive which the young people have experienced. This included elements from CBT and DBT approaches for personality disorder, CBT formulation skills, teaching about development and attachment patterns, how these are affected by trauma and neglect and how these manifest in behavioural and cognitive patterns in young people. Role play and actual histories were used extensively.

The psychologists also created a reflective practice forum for the volunteers' peer supervision.

Outcome measures include the WHO quality of life questionnaire standardised for Indian populations (WHOQOL_BREF Hindi). This measures psychological and physical wellbeing, social functioning and mental health. Some specifically designed quantitative and qualitative measures of achievement of independence are also being used, such as the relative success of the young people in gaining jobs, accommodation, making adult relationships. The young people receiving mentoring are compared with 20 young people matched on age, background and gender who are not receiving mentoring before, during (every three months) and after the two year intervention.

The intervention began in January 2007 so that no outcomes are available as yet.

Despite the study being in its early stages the authors would greatly appreciate the opportunity to present the work and discuss the generalisability of CBT techniques and training interventions in a different cultural setting. They would also welcome inputs from others who have been involved in such enterprises before and networking with other therapists who might also be interested in volunteering in India.

Cognitive Behavioural Therapy and the reduction of repeat homelessness

Nick Maguire, University of Southampton

The homeless population is a heterogenous group. For some the problems are primarily practical, and the solutions are in the provision of tenancies, whereas for others the provision of a tenancy does not solve the problem. For this group drug and alcohol problems and associated antisocial behaviours lead to repeated tenancy breakdown. Traditional interventions have until now focused in the main on housing solutions and practical skills. A number of third sector therapeutic communities using analytic techniques and drug rehab services using counselling techniques have been set up to engage this challenging population, but CBT is not widespread, and dedicated psychological services are rare. This project set out to investigate whether the use of CBT with previously homeless men housed in a small homelessness hostel could reduce tenancy loss, as well as reduce the behaviours which led to loss of tenancy.

In collaboration with a local homelessness charity, a four bed project was set up with dedicated psychology time purchased from the local NHS trust. Initial funding was provided by a government department and administered through the local authority and charity. The psychologist visited the project three mornings and one afternoon per week, and saw the residents on an individual basis. In addition, a supervision session was run along CBT lines involving the charity support workers. In this way the formulations and methods were shared, and the support workers were able to contribute to the goals set by the residents.

A case study was run over the first year and a half of the project, involving the first four men referred. A number of measures were taken before the men came to the project, at the start of the project and one

year after the start. The Clincal Outcomes in Routine Evaluation (CORE; CORE Systems Subgroup, 1998) was used as the primary mental health and functioning measure. In addition a number of incidence and behavioural self-report measures were used, specifically incidence of violence, theft and rough sleeping. Self-efficacy and alcohol dependence measures were also used.
The results were mixed. There were no consistent changes in self-efficacy or alcohol dependence. With respect to the CORE, the 'Wellbeing' and 'Problems and Symptoms' subscales also showed no consistent change over the four cases. However, the 'Functioning' subscale reduced for three of the residents and the 'Risk' subcale reduced for all four. The incidence of violence, theft and rough sleeping also reduced for all four men. Tenancy sustainment was good, ranging from four months to over a year. There is no comparison data against which to evaluate this. Anecdotal evidence suggested that these figures were an increase on the norm for this population
Snapshot data from eight residents using the CORE. Three out of the four subscales and total score exceeded the published norms for a psychiatric population.
This data was published as a brief clinical report in the BABCP journal (Maguire, 2006).
This group of homeless men evidenced a high degree of psychological distress, apparently using drugs and alcohol as coping mechansms. The use of CBT did seem to impact on functioning and risk behaviours, and on incidence of antisocial behaviours. This is no surprise, given that this was the goal of the therapeutic intervention.
This represents preliminary evidence that CBT may be useful in reducing antisocial behaviour and thereby increasing tenancy sustainment. However a controlled trial would be needed to formally demonstrate this.

Considerations in the Delivery of Therapy and Parenting Issues

Chair: James Bennett-Levy, Oxford Cognitive Therapy Centre

Woolly no more: A conceptual framework for understanding empathy in cognitive behaviour therapy

James Bennett-Levy, Oxford Cognitive Therapy Centre; Richard Thwaites, Cumbria Partnerships NHS Trust

Since Beck's first writings about cognitive therapy, empathy has been seen as a necessary but not sufficient condition for change to occur in CBT. All significant CBT textbooks mention the importance of empathy in CBT. However, it is hard to find a useful conceptualisation of empathy within CBT. There is much lip service, and a large dose of woolliness. A similar picture exists with regard to research on empathy in CBT. There is very little. Nor are there any sophisticated measures of empathy derived from a CBT framework. Interestingly, the scant research that exists suggests that empathy may account for around 25% of the variance in CBT outcomes, which is a greater percentage of outcome variance than for other therapies. With regard to training and supervision, CBT trainers and supervisors might reasonably argue that it is hard to train empathy when you don't have a clear idea of exactly what it is you are meant to be training. This may partially explain why CBT courses have tended to focus on conceptual and technical skills and regard empathy as a given – an increasingly dangerous assumption with the current initiative to train large numbers of therapists from diverse backgrounds. Given this background, our aim has been to develop a conceptualisation of empathy within a CBT framework. We shall be proposing a model of therapeutic empathy (Bennett-Levy & Thwaites, 2007; Thwaites & Bennett-Levy, in press), consisting of four key elements: Empathic Attunement, Empathic Attitude/Stance, Empathic Communication and Empathy Knowledge. The model points to the importance of the 'person of the therapist' and self-reflection in the development of therapeutic empathy; and describes how the specific contribution of CBT knowledge and skills can help therapists understand clients' moment-to-moment experiences, and, if used sensitively, can enhance the empathic process. This model has considerable implications for therapists, trainers, supervisors and researchers including: more accurate identification and targeted strategies to address therapeutic empathy problems; recognition of the value of personal experiential work and self-reflection in empathy training; increased understanding of the functions of empathy; and development of finer-grained clinical and research measures.

Acceptance and Commitment Therapy and Stress Inoculation Training at Work

Paul Flaxman, City University, London; Frank Bond, Goldsmiths College, University of London

CBT-based stress management training (SMT) is one of the most widely implemented interventions for improving employees' well-being. Reviews of the stress management literature suggest that such interventions are at least moderately effective in improving mental health (e.g., Kelley, 1995; Murphy, 1996; van der Klink *et al.*, 2001). However, few studies have investigated why these interventions are effective (cf. Bunce, 1997). Also, while SMT programmes have traditionally been based on Meichenbaum's (1985) stress inoculation training, researchers have recently begun to incorporate 'third wave' (mindfulness-based) CBT approaches (e.g., Bond & Bunce, 2000; Flaxman & Bond, 2006). Hence, the present study compared a worksite SMT programme based on Acceptance and Commitment Therapy (ACT; Hayes *et*

al., 1999), with the more traditional stress inoculation training (SIT) approach. The aims were twofold: 1) to examine whether both ACT and SIT would be effective in improving employees' psychological health; and 2) to investigate whether ACT and SIT operate via distinct mechanisms of change.
One hundred and fifty-eight (158) UK local government employees were randomly assigned to one of three groups: 1) stress inoculation training (SIT); 2) acceptance and commitment therapy (ACT); or 3) a wait-list control group.
SIT and ACT were delivered using a 2 + 1 method, whereby participants attended three group sessions: two on consecutive weeks and a third three months later. Each session lasted for approximately three hours. Participants in the ACT and SIT groups completed questionnaires at the beginning of session 1 (T1) and session 3 (T2 [T1 + 3 months]), and again three months after the third session (T3 [T1 + 6 months]). Control group participants completed the same questionnaires at the same time intervals. The questionnaires included measures of general mental health (GHQ-12), psychological flexibility (AAQ), dysfunctional cognitions (DAS), and thought reappraisal (TCQ).
ACT and SIT resulted in equivalent (and statistically large) reductions in psychological distress across the six month assessment period, with no change observed in the control group. Mediation tests revealed that the benefits of ACT were principally mediated by an increase in psychological flexibility. In the SIT condition, no significant pattern of mediation was found between Times 1 and 2; however, between Times 1 and 3, the improvements in this group were partially mediated by a reduction in dysfunctional cognitions. Additionally, the use of thought reappraisal coping decreased in the ACT group and increased in the SIT group.
Both ACT and SIT appear to be effective when delivered as worksite SMT programmes. Moreover, the pattern of change in each condition was broadly consistent with the underlying theoretical models; ACT reduced distress by increasing psychological flexibility, while SIT reduced distress (at least in part) by modifying core dysfunctional beliefs. The post-intervention differences on the thought reappraisal scale suggest that ACT and SIT impart quite distinct coping skills. More generally, this study highlights the utility of using worksite SMT programmes to test cognitive-behavioural theories of therapeutic change.

Coaching Psychology and CBT: Old Wine in New Bottles? A guide for the perplexed

Waseem Alladin, Centre for Cognitive Neuropsychology Therapy/Autism Care UK

By now, most of us have heard about coaching and life coaching, coaching psychology, positive psychology and even empowerment psychology. Then there is emotional intelligence and mentoring. Are these just fancy ways of dressing up what cognitive behavioural therapists have been doing for years and stealing some of the thunder from cognitive behavioural therapies? Consider for example the claim that "CBT is for the worried well and the mentally or medically ill whereas coaching psychology is for everybody." Or are there some empirically identifiable distinctions and refinements of cognitive behavioural concepts which justifies a new movement which is gathering pace in UK and Australia in particular.
The author, who has a background in positive psychology, cognitive behavioural therapy and coaching psychology, shares some of the views of the leading proponents in these fields and hopes to clear some of the confusion in the field and highlight areas which appear to be fuzzy and fudging the roles of cognitive behavioural therapists.
It is recognised that there are areas of controversy between coaching psychologists and cognitive behavioural therapists and these are discussed.
It is concluded that whilst there are some areas of commonalities between coaching psychology and cognitive behavioural therapies for example, there are also a few distinctions which appear to justify the new movement and there are opportunities for cognitive behavioural therapists to develop new roles or extend their current ones.

Therapy & Poetry: A practising poet looks at his day job

Peter Armstrong, Newcastle Cognitive & Behavioural Therapies Centre

Although certain elements of poetic practice have been recognised as relevant to the theory and practice of CBT (see Teasdale's seminal paper 'Two kinds of meaning' re theoretical parallels, the work of Holmes and others concerning imagery, and the explicit use of poetic material by mindfulness practitioners), no systematic presentation of pertinent poetic concepts has been offered from the perspective of poetic expertise.
The presenter will draw on:
1) nearly 30 years' personal experience as a published poet, occasional critic and editor, and
2) collated consensus opinion of other experts in the field of poetry
to abstract several key concepts central to the acts of perception and construction in poetry that he will argue are pertinent to the work of cognitive therapy.
The intended outcome is the framing of more formal hypotheses that will be amenable to both qualitative and quantitative research.
Implications for the application of poetic concepts to therapeutic, self-reflective and training contexts will be discussed.

Evaluating Psychological Interventions across Disorders

Chair: Despina Learmonth, North Essex Trust/City University

The impact of implementing a computer-aided Cognitive Behavioural Therapy intervention for anxiety and depression within a NHS Specialist CBT service

Despina Learmonth, North Essex Trust and City University; Jo Trosh, North Essex Trust; Sid Rai, Independent Researcher; Kate Cavanagh, University of Newcastle; Janet Sewell, North Essex Trust

Almost 1 in 6 of the UK adult population suffers from depression or anxiety or both; yet a shortage of trained therapists means most waiting lists for therapy exceed 9 months and in some areas there are no therapists available at all. Accordingly, authorities and advisory bodies are focused on achieving a reduction in waiting times and improvements in waiting list management (Healthcare Commission, 2005). Computer-aided cognitive behavioural therapy (CCBT) may be able to assist in providing a solution to the problem. The Department of Health (2007) has recently offered guidance to Primary Care Trusts on implementing CCBT in routine care. However, waiting lists can be of an equally unacceptable length in secondary and tertiary mental healthcare services where service users often suffer from more severe and complex mental health problems. The aim of this study was to establish the effectiveness (in terms of clinical outcomes, and waiting list management and service capacity) of the NICE-endorsed CCBT program Beating the Blues in an NHS specialist CBT unit.

From May 2001 until April 2006 the secondary/tertiary mental healthcare service offered Beating the Blues as a treatment choice to service users referred with anxiety and/or depression and assessed as appropriate for CCBT. Five hundred and fifty-five service users on the waiting list for face-to-face CBT used Beating the Blues as part of routine care. The BDI-II and BAI outcome measures were administered before the program's first session and at follow-up assessment session with a therapist approximately 6 to 8 weeks after completing the program.

Eight hundred and twenty-nine service users were offered Beating the Blues, 266 (32%) declined this offer. Of those who started Beating the Blues, 399 (71%) completed all 8 sessions. The Beating the Blues program was effective in significantly reducing both BDI-II and BAI scores, with only 18% of completers requiring further individual face-to-face CBT sessions. Twenty-six percent of completers achieved both reliable and clinically significant change on the BDI-II, with a further 25% achieving reliable improvement. Similar outcomes were measured on the BAI.

These results suggest that CCBT, administered with minimal supervision in a CBT specialist unit, can be associated with good uptake and adherence rates, and positive clinical outcomes for service users suffering from anxiety and depression.

By using Beating the Blues as an integral part of the specialist service treatment pathway, the service has managed to control waiting list times whilst increasing its capacity. it has seen a 50% increase in referrals (753 in 2006) – to provide effective treatment for service users. Gournay, Denford, Parr and Newell (2000) estimated that each CBT nurse completes 70 treatments a year; this service has added to its capacity 80 completed service user treatments per year, which is roughly equivalent to 1.1 CBT nurses caseloads.

Despite these promising outcomes, the study is not without its limitations: a lack of control group, and further information regarding chronicity, co-morbid mental and physical health difficulties, medication, and previous treatments to strengthen the generalisability of the results.

Blues Begone: A stand-alone computer-based cognitive behavioural treatment package for the treatment of depression and anxiety

David Purves, London Metopolitan University; Mary Bennett, Berkshire Mental Health Trust; Caroline Cole, Berkshire Mental Health Trust; Nigel Wellman, Thames Valley University

Computerised cognitive behavioural therapy (cCBT) treatment has started to become accepted as a viable option within the range of CBT treatments available. One problem that has potentially hindered greater uptake of cCBT has been the need for additional resources to facilitate patient use with the additional cost that entails. Blues Begone is a computer-based, responsive-mode stand-alone form of cCBT for the treatment of depression and anxiety. Each user receives a unique and individualised self-help treatment package based on comprehensive electronic assessment and formulation. In a radical departure from existing computer-based approaches, the program compiles itself to reflect the individual needs of the user and each interactive session works in a completely responsive manner, providing tailored and continual treatment. Furthermore, each user works through the structured, daily sessions using their own computer. Thus, the method provides a completely confidential treatment plan for the user in a private environment. The software package contains 30 CBT sessions, to be used 5 days per week for 6 weeks, which provides between 15 to 40 hours of interactive CBT treatment. Blues Begone was developed to minimise additional resources and also treatment costs by offering a completely stand alone treatment package. This pilot study evaluated the viability of the stand alone format and assessed the clinical outcomes for Blues Begone.

Blues Begone was tested in an open study in an NHS Primary care setting. Nine general practices

referred patients who were judged by their GP to be suffering from depression, anxiety or both into the trial. Patients waited, on average, less than 1 month before being assessed by a trained assistant and then commenced Blues Begone at home immediately thereafter. Data were collected at initial assessment using the BDI-II and BAI and again after program completion, normally within 8 weeks of commencement. Patient satisfaction data were also collected.
Data are available for the first 30 patients who completed the initial phase of the trial. Paired samples tests showed significant statistical change following use of Blues Begone with the level of change indicative of significant clinical improvement. User satisfaction was high with many users expressing a desire to continue using the program and disappointment that it had ended.
This preliminary study demonstrates the viability of stand alone cCBT when high levels of usability are designed into the program at the outset. Blues Begone proved to be both engaging and motivating with good levels of user satisfaction. Although the lack of a control group is a limitation of this study, nevertheless these data suggest that Blues Begone has the potential to be a highly useful clinical tool.

A preliminary evaluation of integrated treatment for co-existing substance use and severe mental health problems: Impact on teams and service users

Emma Griffith, Hermine Graham, Alex Copello, Max Birchwood, Jim Orford & Dermot McGovern at University of Birmingham/Birmingham and Solihull Mental Health Trust; Kim Mueser, New Hampshire-Dartmouth Psychiatric Research Centre, NH, USA; Ruth Clutterbuck, University of Birmingham

AIM: This study sought to develop a methodology to measure the integration of substance use treatment within five existing assertive outreach (AO) teams in Birmingham, UK. Changes in the way teams approach and discuss drug and alcohol problems amongst clients with severe mental health problems were anticipated. This was assessed at team meetings, through clinical sessions and case notes. The impact of change in team practice was also measured at the level of service users by assessing psychiatric symptoms, engagement, amount of substance used and conviction ratings of positive substance-related beliefs.
METHOD: Each team was provided with training and supervision to deliver cognitive behavioural integrated treatment (C-BIT). This aimed to increase awareness of the relationship between psychosis and problem substance use and provide skills to manage these difficulties. Data was collected at intervals over a 36 month period.
RESULTS: Staff within teams increased in self reported confidence and skills to deliver C-BIT and these gains were maintained over time. Findings suggest that following training, integration was achieved to a degree and changes in teams practice were observed. Improvements in client engagement and reduction in alcohol intake and positive alcohol-related beliefs were also noted but occurred regardless of team training.
CONCLUSIONS: Training and supporting AO staff to use an integrated treatment approach is well received and produces lasting changes in confidence and practice. Whether this can go on to impact upon client outcome is yet to be established.

The Feasibility, Reliability and Validity of Diaries for the Assessment of Childhood Separation Anxiety Disorder

Jennifer Allen, Universität Basel; Silvia Schnieder, Universität Basel; Judith Blatter, Universität Basel

Although the use of self-monitoring procedures is common practice amongst practitioners of cognitive-behavioural therapy (CBT), little research has been conducted with anxious children to evaluate the feasibility and psychometric properties of parent and child diaries. Importantly, diaries have not previously been examined as a measure of treatment outcome in a randomised clinical trial.
Children formally diagnosed with separation anxiety disorder (SAD) aged 8 to 13 years and their parents completed 7-day diaries at baseline and one-week following completion of an individual family CBT programme for SAD. Diaries assessed the number of separation situations in addition to parent and child thoughts, feelings and behaviours associated with these situations. Healthy control children and their parents also completed their respective diaries at timepoints corresponding to baseline and post-treatment data collection points.
To date, baseline data has been collected for 44 children with SAD and 21 healthy controls, while post-treatment data is available for 15 children in the SAD sample and 8 children in the control sample. Data collection will be completed well in advance of the conference.
Findings will be discussed in terms of the utility and validity of parent and child diaries and their ability to increase our understanding of the phenomenonology of separation anxiety disorder.

Group CBT: A new anger treatment programme for mentally disordered offenders in a low secure environment in England

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INTRODUCTION: Anger is one of the factors strongly predictive of future patient aggression and violence, within both psychiatric hospitals and the community. Therefore it is imperative that evidence-based

therapeutic interventions address ongoing anger and aggression problems in mentally disordered offenders (MDOs). Previous anger management programmes for MDOs have generally accommodated either clients with psychosis or clients with a personality disorder, but rarely both. In response to this, Ramm and Novaco (2003, unpublished manual) developed an evidence-based CBT anger treatment programme for MDOs at the State Hospital, Carstairs (high secure). This programme has few exclusion criteria so is suitable for clients with psychosis and/or personality disorder and it places strong emphasis on formulating each client's anger. Evaluation of the programme found it to be very effective compared to waiting list control and routine treatment. The programme was revised in 2006 (Novaco, Ramm & Walker) and this paper describes the first implementation of this programme in a low secure environment. The aims of the programme were to:
a) reduce anger arousal and violent/aggressive incidents (including self-harm)
b) encourage patients to effectively problem solve based on abilities to weigh up the costs/benefits of their actions in both the short and longer term.
METHOD/TECHNIQUES: Participants completed 11 validated measures of anger and mental health at pre-group, mid-group, post-group and follow-up. The 18 week protocol-guided intervention consisted of one group session (2.5 hrs) and one individual session (1hr) per week. The programme was designed to increase engagement, motivation, awareness of anger and skills for achieving greater self-control. The core areas were 'Understanding Anger', 'Managing Anger' and 'Relapse Prevention'. Delivery of the group utilised PowerPoint, video clips, discussion and role-play. Individual sessions encouraged clients' understanding of the aetiology of their anger and consolidation of group material. Sessions were delivered by a clinical forensic psychologist, a nurse therapist and an assistant psychologist.
RESULTS/OUTCOME: Psychometric data demonstrated a reduction in anger, aggression and hostility scores and an increase in self-esteem in all clients. By comparison there were no significant changes for clients receiving 'treatment as usual'. Since completion of the group there have been no reported incidents of aggression by group members and 75% of those who completed the programme have successfully moved from low secure to rehabilitation settings. Qualitative feedback and observational data shows clients are now more successful at avoiding conflict and can effectively use active communication and thought-challenging skills. They are more insightful, appropriately assertive and self-confident.
CONCLUSION/DISCUSSION: This programme is highly effective in improving anger control and self-esteem, which is maintained post-intervention at 3- and 6-month follow-up. The group is a cost-effective therapy option and clients have demonstrated positive movement along their care pathways towards discharge. The programme led to an increased understanding of all aspects of anger and its treatment for both clients and group facilitators.

Posters

A revision of the CBT concept of schemas: What are the consequences in terms of therapeutic targets and techniques

Alan Howarth, University of Newcastle-upon-Tyne; Ian Andrew James, Centre for the Health of the Elderly, Newcastle General Hospital; Mark Freeston, University of Newcastle-upon-Tyne

INTRODUCTION: The central construct within CBT of depression is the schema. The theory suggests that a schema, formed in childhood, can lie dormant until triggered by a salient event. The activation of this schema can then lead to the manifestation of depression (D.A. Clark & A.T. Beck, 1999). Within the CBT literature the content of schemas is core beliefs (J.S Beck, 1995). Over the last 15-20 years dissatisfaction with this perspective has grown, partly due to the lack of evidence for schema therapy for depression. James and his colleagues have suggested a revision of the concept of schema, within the original CBT framework (James, Reichelt, Freeston & Barton, 2007). They propose that the purely cognitive definition of schemas is too narrow and suggest a definition which attempts to reconnect schemas with its links in the memory literature. They argue that schemas are multimodal representations which include, for example, repeating cognitive themes, behavioural strategies and sensitivities relating to smells and noise. This study investigates clinicians views of the clinical validity of the revised definition, and whether it would alter their approach in schema therapy, relative to the traditional Beckian perspective.
METHOD: Fifty clinicians with varying degrees of training in CBT attended a workshop on schemas. During the workshop they received a presentation on the Beckian definition before being asked to complete two questionnaires (developed for the study), one assessing the clinical validity of the definition, and another assessing the targets (i.e. aspects of a client's presentation) they would address in therapy and techniques they would use to do so, using the Beckian definition. After this they received a presentation on the revised definition before completing the questionnaires again, this time in relation to the revised definition.
RESULTS: Clinical validity: The revised definition was rated as equally as valid as the Beckian definition. Targets: On measures assessing the targets participants would address in therapy, significantly more targets were indicated following the revised definition, relative to the Beckian definition. Importantly, there was a significant interaction between definition and target subscale, with significantly more revised and

generic items being selected following the revised definition, relative to the Beckian definition. Techniques: On measures assessing the techniques participants would utilise in therapy, significantly more techniques were indicated following the revised definition, relative to the Beckian definition. Importantly, there was a significant interaction between definition and technique subscale, with significantly more revised and target-free items being selected following the revised definition, relative to the Beckian definition. The results were independent of experience within mental health and practising CBT. CONCLUSION: The results suggest that the revised definition is viewed as clinically valid and that the use of it in therapy would lead to different targets being addressed and different techniques being used to do so. It is the contention of the authors that the use of the revised definition could potentially lead to better outcomes in schema therapy. Future research should focus on increasing the specificity of the definition and creating stronger links with other aspects of the CBT model.

Training practitioners in the use of Cognitive Behaviour Therapy based self-help workbooks for common mental health disorders : the SPIRIT project

Sheraz Ahmed, Sally McVicar, Rebeca Martinez, Susan Ross, Chris Williams, at the University of Glasgow

INTRODUCTION: Mental health problems are common and cause significant distress. A number of psychotherapies have an evidence base for effectiveness including Cognitive Behaviour Therapy (CBT). However access to specialist CBT practitioners is restricted in most clinical settings. One solution is to use structured CBT self-help materials delivered by non-specialist practitioners. There is an increasing evidence base that these are effective. To deliver and monitor self-help materials safely and effectively requires specific workforce development. The SPIRIT (Structured Psychosocial InteRventions In Teams) course trains practitioners to deliver self-help materials and is the first course training staff in using self-help. The SPIRIT course consists of 10 workshop sessions and 5 hours of clinical supervision.
OBJECTIVES: 1. To evaluate the effectiveness of training mental health community and inpatient staff in the use of cognitive behaviour self-help (CBSH). 2. To explore whether there is a difference in how trainees from various professional backgrounds experience the course in terms of their knowledge and skill gains.
METHOD: Design: 1. Before and after training design. Baseline knowledge and skills and use of a problem-focused clinical assessment evaluated using a self-report questionnaire (before, during and three months after training). Use of CBSH evaluated at 3 months post course. 2. A repeated measures design was used to evaluate SPIRIT trainees' knowledge and skill regarding key aspects of CBT and SH at baseline, course completion, and at follow-up. Both within and between groups tests were used to analyse the data.
RESULTS: To date 551 people from multi-disciplinary teams (MDT) within the Greater Glasgow area have completed the course. Baseline measures 4 weeks prior to the course are followed by before/after ratings at the 10 main sessions. Key measures are repeated three months after training. Key findings confirm statistically and clinically significant improvements in both subjective and objective knowledge and skills ($p<0.001$). Participants also complete formative training assessments as part of the course to achieve the competencies required. Satisfaction with the training has been high. Three months after the training 40% of staff reported use of Cognitive Behaviour Self Help (CBSH) in the last week. The within groups' results were consistent with previous findings in SPIRIT, indicating significant increases in knowledge and skill for the trainees. However, the between group results indicated there was very little difference between professional groups, in terms of knowledge and skill gains.
CONCLUSION: The SPIRIT training has gone some way to increasing access to CBSH for use in everyday clinical practice. The training is skills based, and focuses on the achievement of areas of competence for practice. The results indicate that the SPIRIT training is having a positive impact on workforce development within Multi-disciplinary teams (MDT), irrespective of professional background. This emphasises the suitability of SPIRIT, indicating that it is an accessible, and acceptable, method of training practitioners in the delivery of supported CBSH to different professional groups. Future developments within SPIRIT will focus on the introduction of competency based assessments, peer supervision and analysis of session tapes. This will allow for the exploration of how this approach is incorporated into each clinicians' practice; further facilitating future developments, with the emphasis on ensuring these materials are clinically effective in practice as well as in theory.

"All Train, No Gain?": What effect does experience of CBT Skills Training have on a Psychiatric Trainee's Actual Clinical Practice?

Susie Easton, GMC, Southern General Hospital

INTRODUCTION: The Royal College of Psychiatrists (2002) recognises knowledge and skills in a range of psychotherapeutic models as being a core trainee learning objective prior to gaining membership. Cognitive Behavioural therapy (CBT) is the psychological approach with the best evidence base for efficacy across a range of mental health problems including depression, anxiety and some eating disorders (Department of Health 2001; National Institute for Clinical Excellence 2004.) Consequently, a growing number of psychiatric trainees are undertaking basic training in CBT, seeing it as an effective and relevant skill to develop. A number of previous studies have explored skills utilisation by consultant with postgraduate CBT qualifications. They have found that, although consultants regard CBT as a valuable treatment option, in practice, many senior clinicians find themselves unable to devote significant amounts of

time to its formal application (Le Fevre and Goldbeck, 2001; Whifield *et al.,* 2006; Ashworth *et al.*, 1999). A literature review revealed a number of studies looking at the psychotherapy training on general of psychiatric trainees, but none looked specifically at CBT. Of a survey that looked at use of CBT skills amongst formally trained psychiatrists, it indicated that even after completing the certificate/diploma course, the majority of psychiatrists tended to see a small number of patients, and of those that were seeing patients, very few were receiving supervision (Whitfield *et al.*, 2006). This study looks at a group of junior psychiatrists who have undertaken basic CBT skills training and hopes to establish whether they have been able to make active use of the CBT skills they have learnt. If not, what are the reasons?
METHOD: This is a prospective descriptive study. Our study looks at graduates from an 8 session basic CBT skills course for psychiatric trainees, which has now completed 3 separate cycles at a Glasgow teaching hospital. The 16 who had participated in the course took part in a semi-structured interview, with the aim of determining whether or not the course had made any impact on their clinical practice. We enquired about new CBT cases taken on since completing the course; ease of finding suitable cases; ease of finding adequate supervision and qualifications of the supervisor. For those who had not taken on any new cases, we enquired about use of CBT skills out-with formal cases, in day to day clinical work and also about factors which may have prevented them from practising their new CBT skills. We also asked about perceived usefulness of attending the training, and future plans to undertake formal training.
RESULTS: So far, the data collection for this survey is not complete. However, our initial impression is similar to the previous findings from consultant psychiatrists with CBT skills: that only a few cases are being taken on post training, and that they do not always receive adequate supervision. However, it may be that trainees are able to use the CBT skills they learn out with formal CBT cases and our survey also looks to explore the nature of this.
CONCLUSION: We hypothesise that our survey results will show that despite increased exposure to CBT skills training, the trainees are not sustaining their learning by continuing to take on supervised cases after the end of the course. We hope to clarify some of the potential problems which may be blocking trainees from undertaking further cases, and look at ways to enable them. Learning CBT is a time consuming pursuit (and considerable financial commitment is necessary if trainees go on to pursue formal certification). In order for it to be a worthwhile and cost effective exercise, psychiatrists who undertake CBT training must be able to formally apply it in their clinical work, and this means adequate time and supervision to do so. This must be given consideration when formulating these medics job-plans and timetables.

Self-help Access in Routine Primary Care (SHARP) Project

Mike Lucock, University of Huddersfield and South West Yorkshire Mental Health Trust; Mike Lawson, South West Yorkshire Mental Health Trust; Kenneth Stuart Lloyd, Ash Grove Surgery, Knottingly, West Yorkshire

INTRODUCTION: NICE guidance has recommended the provision of CBT-based guided self-help interventions for patients with mild to moderate anxiety and depression. The guidance also recommends that self-help interventions are provided as part of a stepped care model. Various stepped care service models are being developed and this pilot focused on the provision of CBT based self help materials in routine primary care. A training programme for primary care practitioners was developed and piloted, linked to the development of 40 brief self-help leaflets accessed via the practitioners' PCs.
METHOD: The training programme consisted of three half day workshops and ongoing support/supervision groups. The emphasis was on knowledge and skills to identify appropriate patients, engage them in a self-help approach, identifying key problems and goals, selecting appropriate self-help leaflets and supporting patients to make use of the materials – all within routine ten minute consultations. The programme was validated at the University of Huddersfield and a dedicated website has been developed to support the programmme and its use in routine practice. The pilot was evaluated using pre and post questionnaires to determine the impact of the training and support on practice and feedback from a follow up workshop.
RESULTS: The pilot programme took place between March and July 2007 and 14 practitioners attended, GPs, health visitors and primary care practitioners. The results of the pilot will be analysed in August 2007 and the development is being linked to local commissioning arrangements.
CONCLUSION: The resuts of the evaluation will be reported with a discussion of the implications for providing self-help materials and guidance in routine primary care.

Cognitive vulnerability after an Internet based Cognitive Behavioural Therapy

Ian W. Ross, Psychology Dept., University of Chester; Andrew Guppy, Psychology Dept., University of Chester; Helen L. Page, Psychology Dept., University of Chester

INTRODUCTION: Mental health services for students in Higher Education institutions have been the subject of criticism. Insufficient resources and an increasing incidence of depression and anxiety amongst student numbers means that there is a need for more cost and resource effective deliveries of evidence based interventions such as cognitive behavioural therapy, particularly for students with a vulnerability to depression and anxiety. The aims of this study were to design, carry out and evaluate a pilot implementation of the internet based MoodGYM CBT programme as a first line intervention for University of Chester students, who self refer to student services with depression and anxiety.

METHOD: Five psychometric measures in the form of Pearlin Mastery Scale (PMS), Cybernetic Coping Scale (CCS), Hospital Anxiety and Depression Score (HADS), Automatic Thoughts Questionnaire (ATQ) and Dysfunctional Attitudes Scale (DAS), were used in assessment and were evaluated as predictors of the outcomes of the MoodGYM intervention and more specifically, DAS as possible indicator of levels of cognitive vulnerability to depression and anxiety.
RESULTS: MoodGYM was well received by the participants. The measures ATQ, HADS and DAS provided potential predictors of intervention outcomes and more specifically, DAS scores pre and post intervention potentially indicated cognitive vulnerability to depression in some participants. The number of participants who completed the study was small (N=22) and so the internal validity, as expected, is limited. This was confirmed by small effect sizes.
CONCLUSION: Further research is needed to evaluate the use of internet based interventions which could be used in the delivery of more focused therapeutic support and to also confirm the clinical implications of these preliminary results.

New Developments

Keynote Address

Improving Access to Psychological Therapies: Do mind the quality but also feel the width!

Professor Graham Turpin, University of Sheffield

Abstract to be confirmed.

Posters

Developments in Stepped-Care

Arlene Watts, STEPS, Primary Care Mental Health Team, Greater Glasgow & Clyde NHS; Ruth Jamieson, STEPS, Primary Care Mental Health Team, Greater Glasgow & Clyde NHS

INTRODUCTION: Stepped-care CBT models have the ability to greatly expand the options at the primary care level not only to improve individual therapy but to develop more population-based approaches. STEPS is a CBT primary care mental health team in a deprived area in Glasgow. We have developed a high volume multi-level/multi-purpose service that attempts to tackle the above problems. At the clinic level, we can offer individual therapy and a range of Rapid Access Services (RAS) that offer a real alternative to prescribing and allow user choice. Individuals, not referrers, are responsible for choosing the RAS. Currently, these RAS include Stress Control large group (100+) evening classes, exercises classes, social confidence groups, 'Mood Matters' groups; Advice Clinics and Advice Lines, Mental health sections in public libraries, book prescribing schemes, support groups run by an expert patient, self-help book series, website (www.glasgowsteps.com) At the community level, we are working with, and training, others, going into schools and developing awareness raising approaches (Good Mood Week, DVD, StressMaster days, etc). We are a Scottish Executive Exemplar site. This poster will highlight the full range of activities STEPS has developed.

Older Adults

Symposia

BABCP older adults special interest group – Innovative models and clinical practice developments responsive to the needs of older adults

Convenor: Gwyn Higginson, North Staffordshire Healthcare Trust

Chair: Grainne Sheridan, Nottingham NHS Trust

The cognitive correlates of co-occurring anxiety and depression in later life

Chris Rewston & Chris Clarke, Humberside NHS Trust

Evidence shows that anxiety and depression co-occur well above the level of chance in older people (Lenze *et al.*, 2000; Stanley & Beck, 2000). Co-occurring anxiety and depression in late-life is linked with a range of negative outcomes including greater feelings of worthlessness and guilt, more suicidal behaviour, poorer responses to pharmacological therapy and greater relapse rates (Lynch *et al.*, 1996; Meyers *et al.*, 1996; Shear & Mammen, 1997, Flint & Rifat, 1997). Based upon both previous research findings and our own data from ongoing research into the links between worry, rumination and late life anxiety-depression, we will propose a new cognitive model of co-occurrence. We will discuss the clinical implications for older people and how particular gerontological and psychological factors might influence the degree and presentation of co-occurrence.

Cognitive Behaviour Therapy, Older Adults and Generalised Anxiety Disorder

Grainne Sheridan & Chris Clarke, Humberside NHS Trust

Access to Psychological therapies is fairly limited for Older Adults (people 65+) this has partly been excused by assumptions that therapies that have been shown to be effective in adults of working age may not be easily transferable to older people without the need for modifications.

This presentation will investigate current thinking on the physiological and psychological impact of anxiety on older adults identifying factors that influence the interventions they receive and diagnoses. Finally, a comparison of outcome studies of CBT and GAD with both younger and older adults will be discussed identifying outcomes, differences in therapy delivery and modifications.

Compassionate Mind training for individuals experiencing shame and self attacking in response to memory lapses related to vascular dementia in the early stages

Gwyn Higginson, North Staffordshire Combined Healthcare Trust; Grainne Sheridan, Nottinghan NHS Trust

The work of Gilbert (2005) has raised awareness of the impact of shame. His development of Compassionate Mind Training for shame and self attacking has led to the delivery of this training responsively to individuals in the early stages of a dementia syndrome in particular vascular dementia. Anxiety and depression and crucially shame are often the main emotions the person complains of, and the memory lapses are concealed. The resulting fear and withdrawal can be now understood within the framework of internal and external shame and self attacking due to their not understanding the effects of the organic changes on their behaviour and thus not able to develop empathy for their distress and ultimately able to get on with their lives.