# BABCP Glasgow 2018 Abstract Book

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Keynote Addresses

Treating posttraumatic stress disorder effectively and efficiently: A cognitive approach

Anke Ehlers University of Oxford
Over the past decades, there has been significant progress in the development of psychological treatments for posttraumatic stress disorder (PTSD). Several trauma-focused cognitive behavioural treatments for PTSD have been shown to be efficacious, and the effect size for symptom improvement with treatment has increased over the years. The presentation will review some of the research that informed the development of more effective treatments, using the example of cognitive therapy for PTSD (CT-PTSD; Ehlers & Clark, 2000).

Despite these advances, there remains room for improvement and a significant minority of patients only show modest benefits. Recent research has sought to better understand the psychological mechanisms of treatment effects. For example, trauma-focused psychological treatments have in common that they focus on the patients’ memories of their traumatic events and the personal meanings (appraisals) of the trauma. Mediation analyses and latent growth curve analyses of changes over time showed that changes in appraisals and memory qualities drive symptom change. A further challenge is that despite large-scale dissemination efforts, many people with PTSD are currently not able to access psychological treatments. Self-study assisted treatments and therapist-assisted internet-based treatments show promise and may play a role in solving this problem. A recent trial showed that the number of therapy sessions required to treat PTSD effectively CT-PTSD could be nearly halved by self-study modules that patients completed between sessions. The modules will be made available at https://www.psy.ox.ac.uk/research/oxford-centre-for-anxiety-disorders-and-trauma. A pilot study found that internet-delivered CT-PTSD may offer further improvement in the efficiency of treatment without loss of efficacy.

Nodding Off: The importance of sleep for child and adolescent mental health

Alice Gregory, Goldsmiths University
We spend a third of our lives asleep, and it’s been argued that if it is not absolutely vital, it is a colossal evolutionary mistake. In this talk, Professor Gregory examines concurrent and longitudinal associations between sleep and child and adolescent psychopathology – pointing out that disturbed sleep can be an invisible risk, yet constitute a red flag for other difficulties. She discusses mechanisms underlying these associations, exploring how characteristics of specific psychiatric disorders can increase the likelihood of certain sleep problems developing; and how shared vulnerability can underlie multiple difficulties. She ends by pointing to research demonstrating that improving sleep appears to be one route by which to reduce symptoms of child and adolescent psychopathology and discusses new considerations when addressing difficulties sleeping. Throughout she emphasises the importance of always considering sleep when addressing child and adolescent psychopathology.

Use of therapeutic lies in therapy

Ian James NTW NHS Foundation Trust & University of Bradford
Good communication skills are the tools of every CBT therapist. We have previously shown, however that clinicians are poor at articulating such skills, despite using them in day to day practice. This presentation reviews 15 years of work into the communication skills of carers of people with dementia. It shows how we can enhance existing interaction skills to improve clients’ well-being and reduce incidences of challenging behaviour.

As part of the presentation I will examine the negotiation skills of the Police and the customer care skills of major high street retailers for clues in how to communicate well. I will then apply this literature, within a CBT framework, to show how to talk and physically interact with people who are sometimes confused and may be experiencing a different sense of reality.
My narrative will examine details from the LA Police Department, schema therapy, time-travelling and by the end I endeavour to have convinced you of the need to become better ‘therapeutic’ liars and deceivers.

Understanding the transition between suicidal thoughts and suicidal attempts

Rory O’Connor, University of Glasgow
Suicide and self-harm are major public health concerns with complex aetiologies which encompass a multifaceted array of risk and protective factors. Recent approaches to understanding suicide risk have conceptualised suicide as a (health) behaviour, such that an individual makes a decision to take their own life, therefore an appreciation of the psychology of the suicidal mind is central to suicide prevention. Another key challenge is that our understanding of the factors that determine behavioural enactment (i.e., which individuals with suicidal thoughts will act on these thoughts) is limited. Although a comprehensive understanding of these determinants of suicidality requires an appreciation of biological, psychological and social perspectives, the focus in this presentation is primarily on the psychological determinants of self-harm and suicide. To address these issues, I will describe the Integrated Motivational–Volitional (IMV) Model of Suicidal Behaviour (O’Connor, 2011) which derives from health, social and clinical psychological theory. This tripartite model maps the relationship between background factors and trigger events, and the development of suicidal ideation/intent through to suicidal behaviour. I will present a selection of clinical, experimental and intervention studies to illustrate how psychological factors increase suicide risk and what can be done to ameliorate such risk. The implications for the prevention of self-harm and suicide will also be discussed.

Single-case research in the 21st century: A scientific approach to understanding clinical cases

J.D Smith, Northwestern University Feinberg School of Medicine, USA
Single-subject experiments have a long tradition in clinical and behavioural psychology. Despite their feasibility and value to clinical researchers, they are not as widely used as they could be. This design is particularly relevant for clinician researchers who wish to understand the effectiveness of interventions along with the nature of clinical change—a characteristic that is obscured by group-based comparison designs. To conduct this type of research without unbearable burden on individual clinicians, systems are needed to support the fundamental research activities. Relatedly, the ubiquity of Internet-enabled devices in society today, such as cellular phones and tablets, and advancements in healthcare technology can facilitate these activities. In this talk, perspectives from systems and implementation science are offered to further the use of experimental single-subject experiments and technology-based solutions are proposed for some of the challenges that clinicians and healthcare systems face in conducting this type of research.

The psychology of physical sensation

Christopher Eccleston, Bath University
Psychology has neglected the study of the body, thinking of it only as a taxi for the mind. Even the psychology of sensation has traditionally been concerned with the big five senses, neglecting the more interesting ten physical senses. In this lecture I will argue for an invigorated return to the study of embodied perception, focussing on a physiological psychology built on a foundation of functionalism, phenomenology, and practical application (in equal measure). The ten neglected senses of balance, movement, pressure, itch, pain, fatigue, temperature, appetite, respiration, and expulsion, will all be introduced and a greater exploration will be made of four: itch, fatigue, expulsion, and pain. Novel effective and safe interventions for helping people to live and die with chronic physical (symptomatic) illness will come only from a thoroughgoing understanding of the psychology of being embodied.

Cognitive rehabilitation for people with dementia: a behavioural approach to supporting everyday functioning
**Linda Clare, University of Exeter**

Cognitive rehabilitation is a behavioural intervention that aims to enable people experiencing changes in cognition that affect everyday activities to function at the best possible level considering their intrinsic capacity and current health state. This presentation will describe the development of cognitive rehabilitation interventions for people with dementia, discuss what research to date has shown about the benefits of this approach, and consider the prospects for integrating a rehabilitation perspective into services that support people living with dementia and their families.

**Neuroscience informed approaches to psychological treatments for anxiety and depression**

**Michelle Craske University of California, Los Angeles**

The therapeutic strategy of repeated exposure is effective for fears and anxiety disorders, but a substantial number of individuals fail to respond. Translation from the basic science of inhibitory extinction learning and inhibitory regulation offers strategies for increasing response rates to exposure therapy. The underlying theories and evidence for these strategies will be presented, including prediction error correction (‘violation of expectancy’), variability across stimuli and contexts to enhance generalization, interference with hippocampal activation to enhance context generalization, bridging techniques to retrieve exposure memories in novel contexts, induction of positive valence, and linguistic processing (‘affect labeling’) of feared stimuli.

**The evidence for psychological therapies for adults with intellectual disabilities**

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

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

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

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

Conclusions: The NICE approach to identifying and rating research evidence is rigorous but rigid and can lead to what some might consider somewhat narrow recommendations. A broader approach to reviewing the evidence is needed.

**Treating personality disorders: Meeting the conceptual and practical challenge**

**Michaela Swales, Bangor University**

Personality disorder diagnoses are controversial and stigmatising. People who are given these diagnoses often do not benefit as much from standard evidence-based treatments. Whereas treatments developed specifically for people given the diagnosis are often intensive and complex further limiting access to evidence-based treatments. This talk will discuss recent changes in diagnostic approaches to personality disorders that move towards a continuous and trait-based descriptive system. Conceptualisations of personality styles as over- and under-controlled will be discussed as a framework for intervention.
Advancing CBT Research and Practice for Hoarding Disorder

Gail Steketee, Boston University, USA
This talk will focus on research and practice in the area of hoarding disorder (HD) as a potential model for coordinating teams across multiple disciplines to advance scientific efforts to understand and resolve mental health problems. Psychologists, social workers, psychiatrists, and members of several other service disciplines are needed to identify, assess and intervene with clients who have HD. This includes the fields of public health, housing, medicine, aging and protective services, fire, safety, and animal protection. Research findings and practice methods developed by many of Dr. Steketee’s colleagues will highlight the skills of these multiple disciplines and fields. Of particular interest are multi-method assessments and CBT interventions that span the range from individual to group treatments, delivered by mental health professionals, by non-mental health professionals, and by peers.

Developments in how we can assess our competence in delivering CBT

Freda McManus, Stirling University
Effective assessment of Cognitive Behaviour Therapy (CBT) competence is crucial to the successful widespread dissemination of evidence-based CBT protocols into routine practice. However, a lack of consensus about how CBT competence should be assessed has resulted in the use of numerous different methods, many of which have been widely criticised. This keynote will present the advantages and disadvantages of the various methods for assessing CBT competence within Miller's (1990) framework for assessing clinical skill, in the context of ‘evidence-based training’ (Ravoshik & McManus, 2010).

Observational ratings of therapists’ in session performance using standardised rating scales is the ‘gold standard’ for assessing therapists’ ability to effectively apply their knowledge and skills within clinical practice settings (Barber et al., 2007; Muse & McManus, 2013). Given the need to further refine the rating scales that are currently available (Fairburn & Cooper, 2011; Muse & McManus, 2013; Muse & McManus, 2015), a BABCP funded initiative was to develop a novel CBT competence rating scale: the Assessment of Core CBT Skills (ACCS – Muse, McManus, Rakovshik & Thwaites, 2017). The ACCS aims to build upon existing tools (particularly the Cognitive Therapy Scale [www.beckinstitute.org] and the Cognitive Therapy Scale-Revised [CTS-R: Blackburn et al., 2001]) by providing a behaviourally-specific rating scale with discrete items applicable across a range of CBT interventions and adult mental health problems, and serving as a developmental tool for providing formative feedback and engaging in self-reflection. Results from preliminary studies investigating the psychometric properties of the ACCS rating scale in ‘real world’ CBT training and routine practice contexts suggest that both the self-rated and assessor-rated versions of the ACCS demonstrate good internal consistency, inter-rater reliability, and discriminant validity. Thus the ACCS is suitable for use in clinical practice, training settings and research studies, and can be used as a self-rating tool as well as an assessor-rated tool. In addition, the ACCS was found to be correlated with, but distinct from the Revised Cognitive Therapy Scale (CTS-R), was comparable to the CTS-R in terms of internal consistency and discriminant validity, and may have advantages over the CTS-R in terms of inter-rater reliability. Thus the ACCS may provide an acceptable alternative to the CTS-R, with updated criteria and broader applicability.

Positive Cognitive Behaviour Therapy

Fredrike Bannink Amsterdam, the Netherlands
Positive CBT offers the best constructive vision to date of what CBT can look like when joined with positive psychology and solution-focused brief therapy. Positive CBT – “fourth wave CBT” – combines the analytic reductionist paradigm with the synthetic paradigm in which new concepts, solutions or realities are created. In this keynote speech I will discuss my model of Positive CBT and the research at Maastricht University, the Netherlands, comparing traditional CBT and Positive CBT.
Prof. Paul Gilbert: “Dr. Bannink captures the essential importance of building on positive feelings, motives, imagery, memories and behaviours. Positive CBT changes what we focus on and how we work in helping people change.”
Prof. Willem Kuyken: “What dr. Bannink is doing is radical, synthesizing CBT with the psychology of resilience in a grounded and pragmatic way.”
Christine Padesky PhD: “Positive CBT offers a wealth of practical suggestions for how CBT therapists can become more positive in every aspect of therapy.”

References:

Preventing recurrence of psychosis: Should Cognitive Behavioural Therapy give up or step up?

**Andrew Gumley, University of Glasgow**
The recurrence of psychosis is linked to significant personal, interpersonal and societal costs. For individuals, the recurrence of psychosis is frequently linked to significant emotional distress and disruptions in daily life, personal relationships and the experience of coercive interventions. However, despite the considerable advances made by Cognitive Behavioural Therapy for Psychosis (CBTp), the prevention of relapse remains an elusive target. It is argued that the failure of CBT to successfully alleviate the recurrence of psychosis is due to a lack of clarity regarding the definition and complexity of recurrence itself; an emphasis on risk; and a lack of clarity regarding cognitive, interpersonal and systemic causal mechanisms underpinning recurrence. There is therefore an urgent need to develop and refine components of treatment using causal-interventionist principles. A cognitive interpersonal model predicts that recurrence of psychosis arises from an interaction of individual cognitive (including fear of relapse, stigma, shame), interpersonal (attachment appraisals, interpersonal coping and help seeking) and systemic (responses of others including mental health staff) factors. Current approaches to defining recurrence fail to fully capture the complexity of interactions contributing to the experience of recurrence. Indeed, approaches to CBTp need to evolve to meaningfully target these proposed causal mechanisms and embrace not just individual based CBTp but also digital technology and systemically based interventions.

Is CBT Enduring or do Antidepressant Medication Prolong the Underlying Episode?

**Steve Hollon, Vanderbilt University, USA**
No abstract.

Which Cognitions are best to Target in CBT and their Empirical Support

**Ray di Guiseppe St John’s University, New York**
This presentation will focus on which cognitive variables might be most central to effective psychotherapy. For each of these topics, I will focus on the evidence from basic psychology, CBT theory, research in clinical practice, and topics for future investigations. The first topic will focus on targeting evaluative cognitions or appraisals rather than focusing on negative thoughts. BT focuses mostly on identifying and changing negative thoughts and schema associated with patients’ disturbance. Basic research in cognitions and emotion indicate that appraisals of events rather than thoughts about the occurrence of negative events are necessary for emotional disturbance. Therapy outcomes can be enhanced by identifying and changing appraisals of negative predictions. Second, people have imperative thoughts about the way reality should be. These imperative thoughts are related to cognitive inflexibility and represent a predisposition to rigidly adhere to ideas and resist adjusting one’s thoughts to match empirical reality. Therapy can focus on increasing cognitive flexibility and acknowledging the world as it is. Third, people experience evaluative thoughts about their internal thoughts and emotions. Such evaluations can result in a spiralling increase in disturbance. Many theorists have focused on these types of reactions. Acceptance of emotional discomfort represents an important intervention to prevent the escalation of emotions. Yet we do know how often such processes occur.
Fourth, our conceptualization of emotionsrests on an Aristotelian model of essences. New research casts doubt on this model and suggests that people’s ability to conceptualise alternative emotional experiences is associated with adjustment. I will suggest that effective psychotherapy involves a change in the qualitative nature of patients’ emotions rather than a quantitative reduction in emotional experiences.

Finally, I will focus on the state of research on cognitive constructions and their influence on disturbance. Evidence to support CBT requires that research demonstrates that changes in cognitions mediate therapeutic change. This requires psychometrical better goodness of scale to assess cognitive constructs. Present research in cognitive constructs is plagued by poor scale construction, poor content validity, inadequate comparisons of multiple constructs and their relationships with psychopathology.

**Symposia, Roundtables and Panel Discussions**

**Delivering novel formats of evidence-based treatments for PTSD: Early Issues & Solutions**

**Internet-delivered cognitive therapy for PTSD: a development pilot series**

Jennifer Wild, University of Oxford

Randomised controlled trials have established that face-to-face cognitive therapy for PTSD (CT-PTSD) based on Ehlers and Clark’s (2000) model of PTSD is highly effective and feasible with low rates of dropout. Access to evidence-based psychological treatments for posttraumatic stress disorder (PTSD) is insufficient. Several studies have shown that therapist-assisted treatment delivery over the internet is a promising way of improving access to CBT interventions. We aimed to develop an internet version of CT-PTSD that significantly reduces therapist contact time without compromising treatment integrity or retention rates.

We describe the development of an internet version of CT-PTSD. It implements all the key procedures of face-to-face CT-PTSD, including techniques that focus on the trauma memory, such as memory updating, stimulus discrimination and re-visiting the trauma site, as well as restructuring individually relevant appraisals relating to overgeneralisation of danger, guilt, shame or anger, behavioural experiments and planning activities to reclaim quality of life. A cohort of 10 patients meeting DSM-IV criteria for PTSD worked through the programme, with remote guidance from a therapist, and were assessed at pre- and post-treatment on PTSD outcome, mood, work and social adjustment, and process measures.

No patients dropped out. Therapists facilitated the treatment with 192 min of contact time per patient, plus 57 min for reviewing the patient's progress and messages. Internet-delivered CT-PTSD was associated with very large improvements on all outcome and process measures, with 80% of patients achieving clinically significant change and remission from PTSD. iCT-PTSD appears to be an acceptable and efficacious treatment. Therapist time was reduced to less than 25% of time in face-to-face CT-PTSD. Randomised controlled trials are required to systematically evaluate the acceptability and efficacy of iCT-PTSD.

**Intensive Cognitive Therapy for PTSD in routine clinical practice**

Hannah Murray, University of Oxford

Delivering Cognitive Therapy for PTSD in an intensive format (over 5-7 days), has been found to be as effective as weekly treatment in a randomised controlled trial (Ehlers et al., 2014). For some patients, intensive treatments may be preferable, more convenient and efficient, and lead to more rapid improvement than weekly treatment. However, as yet, intensive treatments are rarely offered in most clinical settings, and routine clinical practice may differ in important ways from research trial environments.

In this talk, data will be presented from a matched comparison audit comparing intensive and weekly treatments delivered as part of routine clinical care in an NHS service. Unexpectedly, the results showed that intensive treatments were more effective at reducing PTSD symptoms than weekly treatments. However, the data also revealed important differences in which patients are
offered and/or choose to receive intensive treatments, suggesting that they may suit some patients better than others.

The advantages and disadvantages of using intensive treatments will be discussed. Implementing intensive treatments requires practical considerations, for example in managing therapists’ caseloads, providing adequate supervision and guarding against potential burnout. The talk will therefore also provide some practical recommendations on how to implement intensive treatments in routine clinical practice.

**Panic attacks versus Panic Disorder in PTSD**

Alice Kerr, Kings College London

Panic disorder is a common comorbid disorder that frequently presents alongside PTSD. Panic disorder can be difficult to diagnose and treat in the context of PTSD. Patients often have panic symptoms in response to subtle trauma-related stimuli. These can feel like they are coming ‘out of the blue’ when the patient is unaware of their trauma triggers and panic disorder can be misdiagnosed as a result. Stimulus discrimination is usually a more appropriate intervention for panic triggered by trauma-related stimuli. Careful assessment is essential to ascertain whether the panic disorder is truly distinct from the PTSD. Notably however, patients can still catastrophically misinterpret their physical sensations regardless of whether the panic attacks are triggered by trauma-related triggers and therefore might benefit from specific intervention for panic. iCT-PTSD has therefore been modified to treat panic disorder in the form of a specifically designed panic module that is given to people with comorbid panic disorder. The content of the module will be presented and the key components discussed. Case examples will be presented in the context of the module.

**Sleep and Psychopathology in Young People**

Eilidh Smith, University of Edinburgh

The adolescent period is associated with high levels of sleep deprivation, circadian shift and high rates of onset of mental health disorders. This study aimed to examine symptoms of depression, anxiety and subjective wellbeing and their relationship with sleep and emotional regulation, within this period of increased risk. Adolescents (aged 13-18) completed the Core Consensus Sleep Diary (N=106) and a subset wore Philip's Respironics Actiwatch 2’s (N=73) for one school week. Depression symptoms (measured using the Mood and Feelings Questionnaire) were significantly correlated with subjective sleep measurements (sleep onset latency, and wake after sleep onset), whereas emotional reactivity (measured using the Emotional Reactivity Scale) was significantly correlated with objective measures of sleep (percentage of time awake and efficiency of sleep).

**The mindful sleeper: How mindfulness and symptoms of insomnia, depression and anxiety are related and the role genes and environment play**

Mel Schneider, Goldsmiths, University of London

This study investigated associations between mindfulness and symptoms of insomnia, depression and anxiety. Mindfulness was disaggregated into 5 subscales: ‘nonreactivity to inner experience’, ‘observing’, ‘acting with awareness’, ‘describing’ and ‘nonjudging of inner experience’. Twin models were used to examine genetic and environmental influences on mindfulness, symptoms of insomnia, depression and anxiety and on their associations. Data came from a longitudinal twin/sibling study (G1219) comprising 862 individuals (age range 22-32 years, 66% females). Less mindfulness was associated with greater symptoms of insomnia, depression and anxiety (r = .22-.46). Of the mindfulness subscales, ‘nonjudging of inner experience’ was most strongly associated with the other traits. Overall mindfulness was largely influenced by non-shared environmental factors (E = .72) although familial influences played a role for overall mindfulness, as well as for the ‘acting with awareness’ and ‘describing’ subscales. Only non-shared environmental factors significantly contributed to the associations between mindfulness and symptoms of insomnia, depression and anxiety (common E = .11-.39 for each phenotype).
Does early life adversity exacerbate neural vulnerabilities associated with evening chronotype in late adolescence?

Erika Forbes, University of Pittsburgh, USA

Early adversity and evening chronotype both increase the likelihood of experiencing reward-related psychopathology such as depression during adolescence. A possible mechanism for the effects of these characteristics is the brain's reward circuitry. In fact, altered function in neural reward circuitry is evident both in adolescents who experienced early socioeconomic disadvantage (Romens et al., 2015) and in those who report higher eveningness (Hasler et al., 2014). Furthermore, neural response to reward mediates the association between these factors and psychopathology: it explains relations between early disadvantage and depression and between eveningness and alcohol dependence. We explore the possibility that evening chronotype, a trait-like tendency to feel more energetic, alert, and productive later in the day, moderates the association between higher adversity during infancy and neural response to reward in adolescence. Using data from a longitudinal study of 311 late adolescent boys from high-risk backgrounds who have been studied prospectively since infancy, we test whether the combination of between early neighborhood risk, a broad composite of socioeconomic status, and self-reported evening chronotype predict neural response to reward. A group with putatively lowest risk—that is, lower adversity and morning chronotype—showed greater medial prefrontal cortex response to reward. This pattern could indicate healthy development of reward circuitry in those with a combination of less-challenging environments and more stable, trait-like biological rhythms. We will explore associations with severity of depression and anxiety.

Feasibility and acceptability of brief CBT-I for depressed adolescents

Faith Orchard, University of Reading

Sleep disturbances including difficulty initiating and maintaining sleep, early morning awakening and sleeping too much (DSM-5; APA, 2013), are reported by 92% of depressed adolescents (Goodyer et al., 2017) and 25% of the adolescent population (Lovato & Gradisar, 2014). The relationship between sleep and psychopathology is complex (Gregory & Sadeh, 2012). Recent reviews have concluded that sleep disturbances, especially wakefulness in bed, precede anxiety and depression more than the reverse (Lovato & Gradisar, 2014; McMakin & Alfano, 2015). Furthermore, emerging evidence suggests treatment of sleep disturbances alleviates anxiety and depression symptoms in adults (Boullin, Elwood & Ellis, 2016) and more recently, in adolescents (Blake, Sheeber, Youssef, Raniti & Allen, 2017), highlighting the critical importance of treating sleep disturbances in the adolescent population. Following this, the current project aimed to evaluate the feasibility and acceptability of an individually-delivered, brief CBT-I intervention in a routine child and adolescent mental health service. Depressed adolescents with a symptom of insomnia were offered a brief CBT-I intervention prior to treatment for depression. The intervention is an adaptation of the single-session CBT-I protocol developed by Ellis et al. (2015). Treatment consists of four-sessions with parental involvement, combining face-to-face and telephone appointments. A range of symptom measures, and acceptability questionnaires were administered to adolescents and their parents. These included measures of anxiety and depression, sleep diaries and sleep questionnaires, session by session ratings and feedback questionnaires. This presentation will discuss findings on the feasibility and acceptability of the intervention with depressed adolescents and their parents. Descriptive statistics and effect sizes will also be presented examining the change in reported insomnia and depression across the CBT-I programme, as well as indices of reliable and clinically significant change from pre- to post-treatment for each participant.

How to work with older people in IAPT and Stroke settings: adjustments and innovations

Improving Access for Older Adults: The Sheffield Experience

Shonagh Scott, University of Sheffield

Mental health problems are as common in older adults as they are in younger adults and are associated with considerable individual suffering, suicide, higher use of health and social care services and poorer outcomes for physical illness. However, mental health symptoms in older people are far less likely to be volunteered, detected or treated. Specifically, older people are less likely to complain about losses...
(of relationships or abilities) as these may be considered to be normal. The presentation of mental illness is much more likely to be with physical rather than emotional symptoms (Older People’s Mental Health & Dementia, NHS England 2017). One in five over-65’s living in the community is affected by depression but, despite Improving Access to Psychological Therapies (IAPT) services in England being open to all adults, older people are underrepresented amongst those accessing services. Psychological therapies are as effective for older people as for those of working age.

This symposium aims to provide an overview on research evidence and best practice guidance for delivering CBT with older adults. It will also present developments and experiences from services which have been aimed at improving the number of older adults accessing appropriate psychological therapies across the care pathway, including primary and secondary care and the role of training within IAPT course to ensure the provision of skilled and confident therapists to work with older people.

Katharina Reichelt will present CBT formulation models and discuss their use, and adaptations, with older adults.

Alison Hobbs will present work from the North Yorkshire IAPT service which has sought to increase older adult referrals by setting up a project group specifically focusing on this area.

Shonagh Scott will provide an overview of a number of initiatives and service developments from Sheffield.

**Behavioural activation therapy for depression after stroke (BEADS): a feasibility randomised controlled trial**

**Shirley Thomas, University of Nottingham**

Introduction: There is currently insufficient evidence for the clinical and cost-effectiveness of psychological therapies for treating post-stroke depression. The objective of the BEADS trial was to evaluate the feasibility of undertaking a full trial to evaluate the clinical and cost effectiveness of behavioural activation (BA) compared to usual stroke care for patients with post-stroke depression.

Method: This was a parallel group feasibility multicentre randomised controlled trial with nested qualitative research and economic evaluation. Participants were recruited from stroke services, and were eligible if they were at least three months post stroke and identified as depressed on the Patient Health Questionnaire-9. Blind outcome assessments (mood, activity level, carer strain, quality of life and resource use) were completed six months after randomisation. A sample of participants and carers were interviewed following outcome assessment.

Results: Forty-eight participants were recruited from three centres. In the BA and control groups respectively, there was a difference of -3.8 (95% CI: -6.9 to -0.6) after adjusting for baseline PHQ-9 score and centre, representing a reduction in depression in the BA arm. Participants randomised to receive BA attended a mean of 8.5 (SD 4.4) therapy sessions (range 0-14). Ten therapy sessions were video recorded across eight participants. Most components of the manual that were intended to be delivered were evident in all sessions. The video recordings highlighted some aspects not otherwise recorded.

Discussion: BEADS was feasible with regard to the majority of outcomes and strategies. It was also acceptable to participants, carers and therapists. The participants were generally positive about their experiences of taking part and gave some suggestions for improvements.

Conclusion: The main issue is whether a sufficient number of participants could be recruited within a reasonable timeframe for a definitive trial.

**Cognitive and behavioural interventions for people with stroke: a modified CBT framework that shows promise**

**Ian Kneebone, University of Technology Sydney, Australia**

Introduction: Mood disorders such as anxiety and depression are common after stroke as are sleep disorders and fatigue; all affect rehabilitation outcome. CBT has proved effective for these disorders in other populations. A modified CBT has been proposed that takes into account the cognitive and communication disabilities which are prevalent in stroke, to support benefit from CBT in this client group.
Method: The proposed framework for the modification of CBT will be presented and progress towards its application will be subject to narrative review.

Results: A number of studies have supported elements of the modified CBT framework. This includes behavioural interventions for both anxiety and depression and CBT for fatigue and insomnia. Unfortunately the quality of the studies is such that definitive statements about efficacy cannot yet be made.

Discussion: There is support, although limited, for the use of behavioural activation for depression after stroke, and for relaxation training for anxiety. More effective therapies are required. CBT for insomnia and fatigue has initial support in a preliminary trial and secondary data from this work supports the potential for treatment of both anxiety and depression. Appropriately powered studies are required so definitive statements about efficacy can be made.

Conclusion: Modified CBT shows promise for the amelioration of psychological disorders after stroke, but further research is required.

Panel Discussion: Research waste, rigor and transparency in research on psychological therapies

Ioana Cristea, Babes-Bolyai University, Romania; Panel: Gary Brown, Royal Holloway University of London, Michelle Craske, University of California at Los Angeles, USA; Ioana Cristea, Babes-Bolyai University, Romania; Stirling Moorey, King’s College London

While a burgeoning field in other disciplines, meta-research (“research on research”) and its applications have penetrated very little in cognitive behavioural therapy, clinical psychology and mental health research in general. Consequently, clinical psychology and psychotherapy is still a field lacking substantial critiques, despite its enormous public health implications and its declarative adherence to the standards of evidence-based medicine. In the absence of such critiques, it is difficult to determine with certainty how much of the research in clinical psychology, psychotherapy outcome research and mental health research in general is in fact sound, relevant and useful and how much of it is instead “research waste”, tarnished by biased, low quality studies, hunting for fleeting small effects, hiding negative findings in the file drawer, with problematic validity or touching on aspects with little relevance for patients and clinicians.

The panel discussion focuses on highlighting some of the major issues in this direction, analysing their extent and reverberations, as well as suggest potential solutions. Speakers represent multiple perspectives, comprising research, editorial, practice and training, and can hence provide a nuanced and complementary perspectives.

The benefits and limits of meta-research tools and studies, as well as potential untoward costs, will be critically analysed. Discussions will also touch on the field’s delay and reticence in adopting research integrity practices that are becoming norm in other scientific fields, such as looking for ways to improve reproducibility of findings, reducing publication bias, transparently declaring financial conflicts of interest, or directly aspects to minimize risk of bias in clinical trials, such as mandatory prospective registration and data sharing.

Clinical Roundtable: Clinical dilemmas in couple therapy

Marion Cuddy, South London and Maudsley NHS Foundation Trust; Speakers: Dan Kolubinski, Reconnect UK; Michael Worrell, Central and North West London Mental Health NHS Foundation Trust; Rozina Thaci, City and West Psychology

Couple therapy poses particular challenges for cognitive behavioural therapists that are not encountered in individual therapy. For example, the two partners may enter therapy with different perspectives on their problems, different goals for the therapy, and different levels of motivation to remain in the relationship. The therapist must develop an ‘expanded’ therapeutic alliance with the couple, which includes a relationship with each partner individually as well as an alliance with them as a couple (Sprenkle, Davis, & Lebow, 2009). This more complex therapeutic alliance can be difficult to maintain, particularly if the partners do not have a strong ‘collaborative set’ (Jacobson & Christensen, 1996), and thus struggle to work as a team to address their difficulties.
These issues can be problematic in themselves, and can also influence how specific challenges in couple therapy are dealt with, such as disclosure of ‘secrets’ by one partner to the therapist or the display of abusive behaviour from one partner to the other.

In this clinical round table, a panel of experts in couple therapy will discuss common dilemmas encountered in couple therapy and how they have dealt with them. These dilemmas will include:
1) Dealing with secrets disclosed by one partner, including disclosure of infidelity.
2) Problems in the therapeutic alliance, such as siding with one partner over another.
3) Addressing destructive patterns of interaction, such as ‘borderline’ partner abuse.
4) Sexual issues and sexuality, for example differences in sexual preferences.

Audience members will be encouraged to participate and to discuss challenging couples they have worked with in what we hope will be a lively and informative session.

References:

This roundtable will participants an opportunity to reflect on and discuss common dilemmas encountered in the practice of couple therapy, and to bring some of their own case material to the discussion.

Clinical Roundtable: Launching the Special issue of the Cognitive Behaviour Therapist on the Cultural Adaptation of CBT

Lydia Stone, Oxfordshire County Council; Speakers Michelle Brooks, Insight Healthcare East Midlands; Maja Jankowska, University of Bedfordshire; Saiqa Naz, Chair of BABCP Equality and Culture Special Interest Group & Sheffield IAPT; Raphael Kada, Greater Manchester Mental Health NHS Foundation Trust

The past 20 years has seen incredible growth in the application of CBT for a wide range of mental health problems in a wide variety of contexts and settings. Thought originally developed by and for white majority populations in European and North American settings CBT is now increasingly being used with ethnic and sexual minority communities in Western countries and in Low and Middle Income Countries (LMICs).

This special guest-edited issue of tCBT (BABCP Practitioner Journal) brings together for the first time a wide variety of clinicians and researchers who are working to make CBT effective and available to an unprecedented range of communities in settings that are often very different to those that the therapy was originally.

This round table discussion will bring together several authors from the special issue to discuss the current state of adapted western and LMIC contexts and will provide a comprehensive survey of the current state of the evidence base and future challenges in continuing to expand the available of evidence based interventions.

At the time of the deadline for conference submissions we are still taking submissions for journal however several authors have already indicated their availability for the conference and willingness to participate in the round table. We will be able to confirm the speakers by the end of February 2018.

We would argue that cultural competence is a necessity for CBT therapists, rather than an optional extra. The purpose of both the special issue of tCBT and the roundtable is to provide practitioners with a range of examples of where cultural adaptations have been made to increase engagement and the effectiveness of CBT. This would enhance the ability of therapists to be aware of cultural difference on a day-to-day basis and subsequently adapt therapy within an evidence-based framework.

Adaptations and new developments in CBT

An ACT-based Group Psychoeducation Intervention – Evaluation of Clinical Changes
Neil Frude, Cardiff University
A new psychoeducation course based on Acceptance and Commitment Therapy (ACT), “ACTivate Your Life” (AYL), is currently being delivered in a number of health boards across Wales. The course consists of four 2-hour sessions and is delivered as a transdiagnostic intervention by trained presenters (often psychology assistants, nurses and occupational therapists). Within the Abertawe Bro Morgannwg University (ABMU) Health Board the course is delivered to groups of participants as part of the “Living Life Well Programme” which provides a number of low intensity psychological interventions to adults with mild to moderate psychological health conditions. Participants in the AYL course are invited to complete a number of measures to assess their levels of depression, anxiety, self-esteem, mindfulness based self-efficacy, wellbeing and psychological flexibility immediately before the first course session and at the end of the final (fourth) session. A key identity system is used to enable the pairing of measures at time 1 and time 2 while maintaining the participant’s anonymity.

Matched comparisons of participants’ scores at the beginning and end of the course show highly significant positive changes on all measures, with large effect sizes, particularly for anxiety and depression. The idea that the course may be having substantial beneficial impact on participants’ wellbeing is reinforced by highly positive qualitative feedback. This being a service evaluation of a community-based ‘walk-in’ service, with participants’ anonymity assured, it has not been possible to compare the changes on measures with those of a control group or to conduct a follow-up evaluation of later changes in participants’ scores. However, the consistency and magnitude of the changes observed do suggest that the AYL course may be having a significant clinical impact on a proportion of those who participate in this brief intervention. Epidemiological evidence indicates that there are very high numbers of people who might benefit from psychological interventions but are unable to access such treatment. Developments including on-line interventions, bibliotherapy schemes and IAPT have done much to address the issue of ‘reach’ and have significantly increased the overall impact of CBT. Live psychoeducation courses delivered to groups also have a significant role to play in providing accessible interventions and there is considerable evidence that this approach can be effective and highly cost-effective. The implication of the present service evaluation is that low intensity interventions based on “third wave CBT”, including ACT, may merit serious consideration as additional resources to meet the overwhelming need for psychological help.

Development of an Islamic Trauma Healing program and Initial Pilot Data
Belinda Graham, University of Oxford

Several interventions are known to effectively address symptoms of posttraumatic stress disorder but despite substantial need there are considerable barriers to access and uptake by refugee groups. In the northwest of the USA, where the initial phases of this project are taking place, there is a relatively large population of Somali refugees who have frequently experienced substantial trauma but who rarely access help through existing care pathways. Culturally appropriate interventions are needed that are accessible and consistent with the Islamic faith and worldview. To address this need among Somali refugees in the Seattle area, a small pilot study examined feasibility and utility of a six-session group intervention for healing after trauma. The Islamic Trauma Healing program is led by members of the community within local mosques, and specifically targets the emotional wounds of trauma. The program incorporates elements of cognitive and exposure therapies, along with Islamic-informed principles, using Prophet stories and talking to Allah about traumatic experiences. Pre- to post-group pilot data is presented for men’s (n = 6) and women’s (n = 7) groups, assessing PTSD, depression, somatic symptoms, well-being, and satisfaction. In addition, qualitative analysis of feedback from group members and leaders was also conducted.

The results indicated large effects across all measures from pre- to post-group (g = 0.76 to 3.22). Qualitative analysis identified high perceived need for culturally appropriate interventions embedded in the community. In addition, it suggested that the Islamic Trauma Healing intervention operates on themes of community, faith integration, healing, and growth. The program was well received by participants and offers a community-based model for delivering a trauma-focused intervention to Somali refugee communities that could be adapted to other contexts, including the UK.
This study adds to the accumulating evidence that combining culturally appropriate components including faith-based principles with cognitive and behavioural therapies can be critical to ensuring that psychological intervention is relevant, accessible, and sustainable.

**A mixed-methods approach to understanding and treating intrusive mental imagery**  
**Sophie Homer, University of Plymouth**

Negative mental imagery is highly prevalent and highly debilitating. It features in a wide range of disorders and as such is a key treatment target for various therapeutic approaches. Recurrent and intrusive images are particularly problematic in social anxiety: they are almost ubiquitous in cognitive models and visualising negative self-images has been shown to lower self-esteem, maintain social fears, and impair social performance even in healthy samples. How best can these intrusions be understood and treated?

Through a series of qualitative and experimental studies, we demonstrate how theoretically driven qualitative and exploratory work has influenced applied research into imagery-focused interventions for social anxiety, specifically the working memory interference component of Eye Movement Desensitisation and Reprocessing (EMDR) therapy.

Results from these studies indicate that employing working memory interference interventions such as the eye movement component of EMDR may be beneficial in reducing or preventing increases in image vividness during visualisation, and that this could reduce anticipatory anxiety of a novel, feared future event. They also suggest that intrusive images are qualitatively different to voluntarily generated images, and may behave differently during intervention.

The distinction between intrusive and voluntarily generated mental images is a crucial consideration for both researchers and practitioners, and future research is necessary to determine their relative utility as treatment targets. Moreover, the studies discussed here represent a tentative first step towards developing an evidence base for EMDR/working memory interference techniques in social anxiety. Overall, the research demonstrates the need for a mixed-methods approach in understanding and treating clinical phenomena.

Intrusive mental imagery receives much research attention and is a key treatment target for a range of therapeutic approaches, including those used within and alongside CBT. The results presented here highlight its prevalence and importance in social anxiety, and highlight its phenomenological differences to voluntarily generated imagery. Overall, they demonstrate the need for harmony between research and clinical practice to best inform novel therapeutic techniques and facilitate evidence-based practice.

**The Role of Simulation in Imagery Rescripting for Posttraumatic Stress Disorder: A Single Case Series**  
**Kathy Looney, University College Dublin (UCD)**

Imagery Rescripting (ImRs) is a treatment approach that involves imagining alternative, hypothetical endings to traumatic events and is predominantly used to target intrusive images in posttraumatic stress disorder (PTSD). While a growing body of evidence suggests that ImRs is effective in reducing PTSD symptomology (e.g., Arntz, Tiesema & Kindt, 2007; Grunert, Weis, Smucker & Christianson, 2007), there is considerable variation in how therapists conduct rescripting sessions, with little consensus about the necessary factors for change. Thus, further systematic research is needed into the underlying change mechanisms of ImRs (Arntz, 2012) and the aspects of therapy that bear upon these mechanisms. The aim of this study was to explore the role of simulation as a mechanism for change in ImRs. Both ImRs and simulation involve the mental construction of a hypothetical event that has not actually happened. It was hypothesised that rescript simulation levels would link to reductions in (1) image intrusiveness and (2) counterfactual thinking associated with intrusive images.

Seven individual cases with a diagnosis of PTSD were followed for the duration of rescripting of one image using a single case experimental design (SCED). Participants completed continuous Symptom Severity measures and pre-/post- counterfactual thinking measures. All sessions were recorded and coded for goodness of simulation (GOS) as well as additional ImRs factors (e.g., rescript believability, vividness, therapist guidance).

Using Jacobson and Traux's (1991) Reliable Change Index, participants were divided into high- and low-responders and coding was compared across groups. High-responders’ rescripts were rated as
Memory-focused Cognitive Therapy for Cocaine Use Disorder: rationale, development, and preliminary efficacy

John Marsden, King’s College London

Cocaine is a powerfully addictive, illicit stimulant. There are no NICE approved medication therapies for Cocaine Use Disorder (CUD) and no specific psychosocial interventions. In this presentation, we summarise the rationale, development and preliminary evaluation of a novel psychosocial intervention called “memory-focused cognitive therapy” (MFCT). CUD is an associative learning process in which conditioned, specific and drug-neutral cues, trigger episodic, involuntary, intrusive thoughts, followed by a brief, or sustained, urge and intention to use cocaine which is experienced at different degrees of strength. This experience is commonly called ‘craving’. MFCT adapts cognitive therapy techniques for post-traumatic stress disorder to reconsolidate cocaine memories and diminish craving. It has five sequential components: (1) cognitive conceptualisation assessment of CUD maintaining processes to formulate treatment; (2) education about cocaine’s effects; (3) cocaine-related cue-induction (in vivo images and objects) to elicit mental images and appraisals; (4) reliving, restructuring and reconsolidating specific cocaine-related memories; and (5) standard CBT relapse prevention.

We did a two-arm, external pilot randomised controlled trial at a specialist community National Health Service addictions clinic in London, UK (ISRCTN164627831). 30 adults (?18 years), voluntarily seeking treatment for CUD (enrolled ?14 days; all with moderate-to-severe CUD), were individually randomised (1:1) to a control group (ongoing TAU; 3x90 min CUD cognitive conceptualisation assessments; 2x30 min cocaine-related cue-induction procedures; and 3x30 min research follow-ups); or to an intervention group (ongoing TAU; 3x90 min cognitive conceptualisation assessments; 2x30 min cocaine-related cue-induction procedures; 5x120 min, one-to-one, MFCT sessions [in 1 week]; and 3x60 min research follow-ups and MFCT-relapse prevention). The primary outcome was the total percentage score on the frequency version of the Craving Experiences Questionnaire (CEQ-F) at 1-month follow-up (clinical endpoint; recall period past 2 weeks; higher score indicating greater craving). Secondary outcomes at the 1-month follow-up were percentage days abstinent (PDA) from cocaine, and longest period (days) of continuous abstinence (LPA) in the prior 28 days.

Outcomes were analysed as an unadjusted group mean difference (with Hedge’s g effect size [ES] with associated 95% Confidence Interval [CI]) for the primary outcome and a 90% CI for the secondary outcomes. Exploratory, multivariable linear (primary outcome) and Poisson regression (secondary outcomes) with sex, age, baseline outcome score, and months of regular cocaine use estimated the effectiveness of the intervention.

Between July 15, 2015, and November 27, 2016, 58 patients were assessed for eligibility and 30 participants were randomised (14 to the control group and 16 to the intervention). With outcome data collected for all participants for the endpoint, the intervention group mean CEQ-F score (14.77; SD 21.47) was lower than the control group mean (51.75; SD 22.72); ES -1.62 (CI -2.45 to -0.80).
MFCT was associated with more cocaine abstinence in the intervention group (PDA 85.94; SD 18.96) than the control group (PDA 54.59; SD 30.29); ES 1.19 (CI 0.54 to 1.84). There was also greater maximum abstinence in the intervention group (LPA 15.69; SD 10.10) than the control group (6.00; SD 7.36); ES 1.06 (90% CI 0.41 to 1.70)). At the 3-month follow-up (80% confidence interval), there was evidence for lower craving experience (CEQ-F ES -0.59) and cocaine use (PDA ES 0.75; LPA ES 0.65) among the intervention group. Exploratory, confounder-adjusted regression models for this preliminary effect supported the treatment association for reduced craving, more abstinence, and greater maximum abstinence time.

We have gathered preliminary evidence for the effectiveness of a novel cognitive therapy for cocaine use disorder. Our study is a first required step towards securing effectiveness evidence for a new, adjunctive psychological intervention. With positive findings from the present study, we believe there is a strong case to progress to a fully powered, RCT to evaluate the effectiveness of MFCT.

There are practice implications for CBT: (1) How to undertake cognitive conceptualisation assessments with patients with CUD, to develop a functional formulation of CUD maintenance, focusing on recent drug use situations, recalled images, sensations, beliefs/appraisals, avoidance/coping strategies, cocaine use and post-drug use evaluations; (2) Evidence for effective change techniques to help patients with cocaine use disorder attain cognitive control over craving processes, using imaginal exposure, memory reconsolidation and approach-based behavioural experiments for relapse prevention.

New cognitive and behavioural interventions to prevent PTSD and depression in at risk groups

**An evaluation of an existing group-based resilience intervention for high risk occupational groups**

*Shama El-Salahi, Michelle Degli Esposti, Anke Ehlers, and Jennifer Wild, Department of Experimental Psychology, University of Oxford*

**Background:** Emergency workers experience higher rates of mental ill health compared to the general population. Effective interventions to improve their resilience and wellbeing are urgently needed.

**Methods:** 430 emergency workers were randomly allocated on a 3:1 basis to receive an existing six-session group-based resilience intervention offered by the mental health charity, Mind, or an online control intervention consisting of psychoeducation. Participants completed a number of measures assessing resilience, wellbeing, coping and social capital at three assessment points: pre-intervention, post-intervention and three-month follow-up.

**Results:** There were no specific effects that could be linked to Mind’s group-based intervention. That is, participants in both conditions showed similar, small rates of change over time. All effect sizes were small. The majority of participants enjoyed the interventions, indicating a discrepancy between their experiences and measurable improvements in resilience, wellbeing, coping and social capital.

**Conclusions:** The group-based intervention may not be cost-effective in its current form. The limited success of this intervention is consistent with the wider literature. Future refinements to the intervention may benefit from targeting predictors of resilience and mental ill health.

**Evaluating a new resilience intervention for emergency workers: A pilot randomised controlled trial**

*Gabriella Tyson, Anke Ehlers and Jennifer Wild, Department of Experimental Psychology, University of Oxford*

**Background:** First establishing predictors of mental ill health in emergency workers, we then developed a mixed format intervention, consisting of 4 online modules and 4 linked group sessions, to modify predictors. The online modules include psychoeducation in text and whiteboard video format, experiential exercises, video testimony, and questions to answer. Here we evaluate the new resilience intervention in a pilot randomised controlled trial.

**Methods:** Emergency workers (N=180) were randomly allocated on a 1:1:1 basis to receive the new resilience intervention, a placebo intervention or a wait period of four months. Participants
completed a number of measures assessing resilience, wellbeing, coping and social capital at three assessment points: pre-intervention, post-intervention and three-month follow-up. 

Results: Significant improvements over time in resilience, wellbeing, social capital, psychological distress, mental health awareness and confidence to manage mental health were specific to the resilience intervention and were not seen in the placebo or wait conditions. Participants receiving the intervention also demonstrated a trend to ruminate less often in response to unwanted memories by post-intervention compared to participants receiving the placebo and wait conditions, and this change was sustained at follow-up. All effects of the intervention were small to medium. The strongest effect of the intervention was linked to improvements in mental health awareness, which tapped use of tools to manage mental health. The modules which appeared to be the most effective focused on types of over-thinking, rumination and worry, with greater learning linked to these two modules being significantly associated with greater changes in outcome. 

Conclusions: The success of this intervention is promising and may be associated with changes in targeted predictors of mental ill health. Future research could evaluate the intervention with a much larger sample and investigate mediators of outcome.

Daily planning ahead to improve the mental health of student paramedics: A pilot randomised controlled trial

Hjördis Lorenz, Sophie Holland, Anke Ehlers and Jennifer Wild, University of Oxford

Introduction: Due to the nature of their job, student paramedics are more likely to suffer from stress induced mental health problems, such as posttraumatic stress disorder (PTSD) and depression, than the general population. Existing programmes have not been very effective in preventing the development of mental health problems in at risk groups. There is an urgent need for evidence-based prevention programmes. Research by Wild et al. (2016) established rumination as a major risk factor for PTSD in student paramedics. Since training to think concretely has been shown to reduce ruminative thinking in students, it is possible that strategies which promote concrete thinking may also improve mental health and resilience in this population. Planning ahead is a tool that encourages concrete thinking and has been shown to reduce psychological distress in students. We hypothesised that internet-based planning ahead would reduce psychological distress and increase wellbeing compared to control training and no training.

Methods: Student paramedics (N = 68) were randomly allocated to two-week online training in planning ahead, psychoeducation about mental health, or to a waitlist group. Planning ahead involved making a written plan for the next day and including one enjoyable activity in the plan. Participants completed measures of PTSD, depression, mindful attention, wellbeing (Warwick Edinburgh Mental Wellbeing scale (Tennant et al., 2007) and psychological distress (General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988) at baseline, one week later mid-way through the study, and two weeks later at post-intervention and again, at 3-week follow-up.

Results: Significant improvements over time in wellbeing and psychological distress were linked to planning ahead and not to the reading or wait control conditions.

Conclusion: Daily planning ahead may be a useful tool to increase psychological wellbeing in student paramedics. It is possible that planning ahead improves skills in concrete thinking and hence reduces opportunity for rumination. Planning ahead has been included as part of a larger resilience training programme for student paramedics, which aims to modify predictors of PTSD and depression, and is currently under evaluation in a large randomised controlled trial.

Adolescent resilience after child adversity

Anna-Laura Van Harmalen, University of Cambridge

Adolescence is a sensitive time characterized by marked cognitive, hormonal and neurodevelopmental changes as well as a rapid rise in the prevalence of mental health disorders. Mental health disorders that first occur in adolescence are more severe and more likely to recur in later life. Importantly, approximately 30% of all mental health problems are attributable to childhood adversity such as parental psychopathology, peer victimization, financial difficulties, or abuse and neglect. Up to 50% of children and adolescents growing up worldwide experiences such traumatic and stressful events in early life. Therefore, childhood trauma was recently suggested to be ‘Psychiatry’s greatest public health challenge’. Fortunately, not all adolescents who have experienced childhood adversity develop psychopathology. These ‘resilient’ adolescents may have
the resources and skills to cope with, or recover from the effects of early life adversity. In this talk I
will discuss the social, cognitive and behavioural mechanisms that may aid resilient functioning in
adolescents with a history of CA.

CBT and ACT for people with physical disease

An overview of the psychological problems associated with cancer
Stirling Moorey, South London and Maudsley Trust and Marc Serfaty, University College
London
Despite dramatically improved prognosis for many forms of the disease, a diagnosis of cancer
remains a life changing experience, and may feel daunting for both patient and the therapist who
helps them cope with their illness. We will present an overview of the current understanding of
psychological morbidity in cancer and the interplay of psychological and physical components of the
illness. A cognitive behavioural model of adjustment to cancer will be presented which integrates
processes of appraisal, coping behaviour and the challenges that life-threatening illness presents to
underlying schemas.

Empathy and validation in the therapeutic relationship in palliative care
Kathy Burns, St Christopher’s Hospice, London
CBT in physical illness requires the establishment of an empathic relationship in which the client
feels understood but is also able to explore how their thoughts about their illness and their ways of
coping may be contributing to their distress. Clinical examples from cancer and palliative care will be
presented by KB to illustrate how the therapeutic relationship can be established balancing empathy
and validation, with sensitive use of cognitive and behavioural techniques, and effective problem
solving.

CBT for depression in advanced cancer: the CanTalk trial
Marc Serfaty, University College London and Stirling Moorey, South London and Maudsley
Trust
The CanTalk trial is a large multicentre trial of CBT for treating depression in people with advanced
cancer using mixed methods. One hundred and twenty IAPT therapists from 24 IAPT services across
England were trained to deliver CBT to 230 people randomised to up to 12 sessions of CBT or
Treatment as usual and evaluated at 3 and 6 months for depression using the BDI-II. Findings
suggest that IAPT delivered CBT is not effective for treating people with depression in advanced
cancer. Outcome data will be presented as well as therapists experiences of delivering therapy to an
advanced cancer population.

A pragmatic approach to measuring adherence in treatment delivery in psychotherapy and
Acceptance and Commitment Therapy in advanced cancer: the CanAct trial
Marc Serfaty, University College London
We will describe the development of a tool to measure adherence to manualised treatment, using a
self-rated Therapy Component Checklist (TCC) and its application in research and clinical practice.
A group of experts agreed on the key components of therapy to be delivered using a treatment
manual. Therapists completed the TCC at the end of each therapy session. This provided
information about the processes of CBT used during the therapy session. A selection of recordings of
the therapy were then rated using the same checklist. The validity of the TCC was demonstrated and
it proved to be a quick and cost effective way of evaluating the main components of therapy.

Developing cognitive behavioural treatments for chronic pain: A tribute to Professor Stephen
Morley

Cognitive Biases in Chronic Pain: Summary and Synthesis
Tamar Pincus, Royal Holloway, University College London
Understanding the underlying mechanisms behind selective cognitive processing held a fascination
for Stephen Morley. In the early 1990s the first experimental designs were adapted from studies in
groups with depression and anxiety to groups with chronic pain. By 2002 we were able to analyse existing studies and develop a data-driven model that could account for the patterns of cognitive biases seen in these studies and relate the findings to patients’ level of distress. The Self-Enmeshment Model of Pain has since been one of the leading models to direct future research. We now know much more about attention biases, although there are still large knowledge gaps in the study of interpretation and recall biases in population with pain. In recent years Stephen, myself and our colleagues have started to explore how these biases behave in real-life situations, rather than laboratory-based experiments, with an aim to tie the research closer to treatment.

**Meta-Analysis of Psychological Treatments for Chronic Pain**

Matthew Price, Leeds University

Though we know that psychological interventions for adults with chronic pain are effective, many unanswered questions remain. In particular, we have a poor understanding of how some aspects of treatment, such as treatment ‘dose’, relate to outcome. In this meta-analysis and meta-regression of randomised controlled trials exploring psychological treatments for adults with chronic pain (excluding headache), we investigated whether the dose of therapy was related to outcome. The findings of 64 trials of cognitive and / or behavioural psychotherapies indicate limited evidence for the moderating role of ‘dose’ on outcome. That is, the number of hours of psychological treatment did not relate to magnitude of change. There was some evidence that the period of time over which treatment was delivered may be related to outcome, however; this was limited to only some patient outcomes. These findings will be discussed in the context of how we conduct research exploring the effectiveness of therapies how we might better understand the relationship between dose and outcome.

**Conceptualising Clinical Improvement: A Systematic Review**

Dean McMillan, York University

Quantifying improvement in psychological symptoms was one among the many intellectual strands of Stephen Morley’s contribution to psychological science. Of the methods of quantifying improvement, Stephen saw Jacobson and Truax’s reliable and clinically significant change (RCSC) criteria as a front-runner. The RCSC criteria can be easily interpreted, are meaningful and derive from what we know psychometrically about a measure. The original description of the RCSC method suggested that single estimates of psychometric values are used to make the calculations, but there are problems with this approach. If a measure is commonly used, there are likely to be many possible psychometric values available in the published literature. There is no assurance that a selected single estimate is representative of all the available ones. There is also the risk of gaming: a researcher or clinician might be tempted to select those psychometric values that will, when entered into the RCSC calculations, give the most flattering estimate of clinical improvement. Stephen proposed that adapting standard systematic review and meta-analytic methods may be a solution to this problem and a refinement of the RCSC technique. Systematic review methods could be used to identify all relevant psychometric values and, when appropriate, meta-analytic strategies could be used to provide pooled psychometric estimates, with these – rather than single-value estimates – used to make the RCSC calculations. The talk will present the results of an application of this approach to the Social Phobia Inventory (SPIN) and also give some personal reflections of working with Stephen.

**Applying Single Case Designs: Developing Treatments for Chronic Pain**

Ciara Masterson, Leeds University

Stephen Morley’s expertise in single-case design has been a key contribution to the DClinPsy training course at Leeds University for more than 30 years. Stephen believed that single-case design had a considerable contribution to make to the development and testing of new interventions, and the example of Interoceptive Exposure treatments for chronic pain will be presented here. This treatment is based on the fear-avoidance model of chronic pain, which states that patients who perceive their pain as threatening and react by avoiding activities they associate with pain are likely to become distressed and disabled. Some key elements of the treatment will be described, with reference to the single-case research that provides evidence for its efficacy. As single-case design
provides opportunities both to researchers and to clinicians who wish to develop the evidence-base, or to appease their own clinical curiosity, the wider applications of the approach will be discussed.

Cognitive biases in youth depression: Novel measures of assessing attention, interpretation and memory biases and their interaction with each other

The role of attention biases in youth depression: consequence and/or risk-factor?
Belinda Platt, LMU Munich, Germany
Numerous studies demonstrate that depression is associated with a tendency to attend to negative rather than positive information (attention bias). However, relatively few studies have investigated whether attention biases are a consequence of depression or a risk factor for the disorder, present before the onset of a disorder. The KROKO study compares attention biases in clinically depressed youth (n = 30), youth with a high risk of depression (children of parents with depression; n=43), and youth with a low risk of depression (children of psychiatrically-healthy parents; n=35). Attention bias is assessed via eye-tracking. Specifically, the extent to which participants' attention is directed towards negative versus positive words in ambiguous (scrambled) sentences (“Scrambled Sentences Task”). If a negative attention bias is observed in the clinically-depressed group only, the data suggest that attention biases are a consequence of depression. If the negative bias is also present in the high-risk (versus low-risk) group, the data suggest that attention biases represent a possible mechanism for the risk of depression. Data analysis is ongoing and will be discussed with reference to implications for theoretical models of youth depression as well as the assessment, prevention and treatment of depression.

Cognitive biases predict symptoms of depression, anxiety and wellbeing above and beyond neuroticism in adolescence
Eilidh Smith, University of Edinburgh
Background: Adolescence represents a period of vulnerability to affective disorders. Neuroticism, a well-known personality risk factor for depression, is not directly amenable to intervention. Therefore, it is important to identify the contributions of modifiable risk factors. Negative cognitive biases are implicated in the onset and maintenance of affective disorders in adults, and may represent modifiable risk factors in adolescence.
Aim(s): This study sought to assess to what extent cognitive biases are able to predict depression, anxiety and wellbeing beyond that of neuroticism in adolescents.
Methods: Adolescents (N=99) were recruited from Scottish secondary schools (54.5% female; mean age=14.7 years). Cognitive biases of autobiographical memory, self-referential memory, ambiguous scenarios interpretation, facial expression recognition, rumination and dysfunctional attitudes were assessed. Depression, anxiety, and wellbeing were indexed using the Mood and Feelings Questionnaire, Spence Children's Anxiety Scale and the BBC Subjective Wellbeing Scale respectively.
Results: Regression analyses demonstrated neuroticism to significantly predict depression, anxiety and wellbeing (r²=.40, .38, .36, all p’s <0.001, respectively). The addition of cognitive biases resulted in a significant increase of explained variance with final models explaining just over 50% of variances of depression, anxiety and wellbeing (r²=.52, .59, .55 all p’s <0.001, respectively).
Conclusion: This demonstrates that cognitive biases explain mental health symptoms over and above that of the stable risk factor neuroticism. Depressive symptomology was particularly related to self-referential memory bias, while anxiety was predicted by interpretive bias. Results may inform treatment, targeting specific biases based on diagnostic features may be of benefit in alleviating distress and promoting wellbeing.

Parent-Child Agreement on Symptoms of Adolescent Depression
Faith Orchard, University of Reading
The diagnosis of depression in adolescents relies on identifying the presence of specific core and additional symptoms. Symptoms can be identified using structured or unstructured interviews and a range of questionnaire measures, which are completed by the young person and by a parent or carer. However, these methods are only useful if they are valid and reliable. The aim of this research was to examine the inter- and intra-rater reliability of parent report and adolescent self-report of depression symptoms. In a sample of 46 dyads where young people aged 12-17 were referred to a
mental health service for depression we examined adolescents’ and parents’ independent responses
to a structured clinical interview (the K-SADS; Kaufman et al., 1997) and a standardised
questionnaire measure of depression (the MFQ; Costello & Angold, 1988). In the clinical interview
(K-SADS) diagnostic criteria were significantly more often met based on the young person’s report,
and young people endorsed significantly more symptoms of depression than their parents. Parent-
child agreement about specific symptoms was low on both the MFQ and the K-SADS. There was a
moderate positive correlation between the young person’s MFQ score and the number of symptoms
they endorsed on the K-SADS. However, there was no significant correlation between parent
completed MFQ score and the number of symptoms parents endorsed on the K-SADS. At a symptom
level, suicidal ideation was the only symptom of depression which adolescents reported consistently
across the interview and questionnaire measure. Parents did not consistently report any symptom
across the two methods of measurement. These results suggest that standardised methods to assess
symptoms of adolescent depression have significant psychometric limitations. The development of
more reliable and valid measures should be a priority for clinical and research purposes.

Exploring connectivity amongst cognitive biases with a psychometric network approach
Sam Parsons, University of Oxford
The combined cognitive bias hypothesis (CCBH) suggests that distinct patterns of connectivity
among attention, interpretation, and memory biases, contribute to psychopathology. However, it is
rare for an individual study to examine more than one cognitive bias, and the interrelationships
amongst cognitive biases has gone largely untested. As research begins to examine multiple biases
we can begin to investigate these interrelationships and, importantly, their role in mental health. In
this presentation I introduce a psychological network analysis as a useful, data-driven, approach to
develop novel hypotheses in relating cognitive biases (and their interrelatedness) to adolescent
mental health. This approach to visualizing connections amongst cognitive biases offers an
informative way to visualize and investigate the combined cognitive bias hypothesis. Data drawn
from the CogBIAS project (total n = 504 adolescents) suggest that low mental health is characterised
by greater connectivity amongst biases. I discuss how these results and network approaches can
inform cognitive bias modification research and offers a novel methodology to examine the role of
combined cognitive biases in adolescent mental health.

Panel Discussion: Schema and personality change across the life-span: Why we need to
radically reconceptualise our views of schema and core beliefs

Ian James, Northumberland, NTW NHS Foundation Trust; Arjan Videler, Tilburg University,
the Netherlands; Alan Howarth, Northumberland, NTW NHS Foundation Trust; Ian Kneebone,
University of Technology Sydney, Australia; Laura Bell, Northumberland Community Team,
NTW NHS Trust
The concept of schema has evolved over the years, but many clinicians still view them as merely core
beliefs as in Beck’s original model. Our debate is likely to dispel this rather simplistic and
mechanistic view. This presenters will each examine the concept from both practical and critical
perspectives. All the speakers work in the older people’s speciality, which provides a unique
perspective on how schema change over time and through the life-cycle. The five presenters have
some competing views on the utility and problems associated with working at the level of schema in
therapy.
Laura Bell provides information on schema in relation to personality disorders in older people; Ian
Kneebone will discuss recent empirical work on with respect to schema theory and schema
identification; Arjan Videler provides an update on the nature of schema therapy, providing unique
insights; Alan Howarth reports on his empirical work on redefining the concept of schema; Ian James
discusses the dangers of misapplying the concept in clinical work.

The role of developmental processes in psychological adaption to psychosis

Putting relationships at the heart of mental health services
Matthias Schwannauer, The University of Edinburgh
The emergence of psychotic experiences can be slow, non-specific and closely linked to developmental challenges of adolescence and young adulthood. Psychotic experiences are often distressing and have an impact on an individual's interpersonal network which is crucial in facilitating recovery processes. This presentation examines adaptation to psychosis within a developmental context and considers how individuals' styles of adapting may vary according to attachment patterns of interpersonal relating and emotion regulation. An overview of the key evidence will be provided alongside recent empirical data from a Scottish context.

Tracking young people's responses to daily hassles - The impact of developmental factors on stress sensitivity in young people at-risk of psychosis
Laura MacLean, The University of Edinburgh

Research has shown that individuals experiencing difficulties with their mental health show increased sensitivity to daily hassles or stressors. This finding has been replicated in a number of studies exploring depression, bipolar disorder and psychosis. It is not clearly understood what causes this increased reactivity to daily stresses, and this study has been designed to explore whether developmental factors play a role in influencing individual responses to everyday hassles. The primary research question is whether young people with insecure attachment and reduced ability to mentalise will show increased sensitivity to stress? Additionally, this study will examine the role of developmental factors in relation to stress sensitivity in the context of psychosis, and will examine whether these processes predict experiences of psychosis in a group of young people across Edinburgh.

Participants will be recruited through student populations and NHS services, and will be asked to track their emotions and their daily experiences using a mobile phone app. In addition, participants will complete the Adult Attachment Interview and Comprehensive Assessment of Mental States as well as questionnaires looking at coping and emotion regulation. Multilevel linear regression techniques will be used to analyse the data.

The role of attachment processes in the development of social withdrawal for young people with psychosis
Alice Thomson, The University of Edinburgh

Features of social withdrawal (e.g. low motivation and enjoyment in social interactions) have been associated with a range of poor outcomes for people attending services for support with psychosis (e.g. McLeod et al. 2014). There is little existing empirical support for specific psychological processes in the development of social withdrawal. There is a strong theoretical argument for the role of attachment processes such as mentalization (the ability to reflect on mental states of self and others) and emotion regulation in the development social withdrawal (Gumley & Schwannauer, 2006).

The present study examined whether insecure attachment styles were associated with social withdrawal for young people with psychosis. A secondary question considered whether the relationship was mediated by mentalization and emotion regulation. These questions were addressed in two studies: a large-scale analogue investigation and a cross-sectional cohort study of help-seeking young people attending services in Edinburgh, UK. Young people were recruited from a range of services including mental health services and homelessness support services. Participants completed self-report questionnaires and interviews including the Adult Attachment Interview (AAI) and Comprehensive Assessment of At-risk Mental States (CAARMS). Data was analysed using quantitative methods including multiple regressions and structural equation modelling (SEM). Findings will be discussed in relation to service provision for a vulnerable group of young people.

Working with adolescents distressed by psychosis: focus on anhedonia and 'negative symptoms'
Helen Griffiths, NHS Lothian Early Psychosis Support service and University of Edinburgh

There is increasing empirical support for the role of attachment and mentalization processes in the development of social difficulties such as anhedonia and 'negative symptoms'. Therefore, such
processes are highlighted as important targets for treatment which may prevent and alleviate social difficulties for those distressed by psychosis. Recently, research has demonstrated the role that clinical services can play in promoting wellbeing for so-called ‘hard-to-reach’ young people using a mentalization based team approach (Bevington et al. 2013, Griffiths et al. 2017). This case-study applies the latest findings from clinical research to the treatment of a young person experiencing reduced motivation and enjoyment in social interactions. Here, such ‘negative symptoms’ are understood within a developmental framework of adaptation to life adversity. Treatment is discussed in terms of fostering self-understanding through building mentalizing skills

Effective elements in CBT

Cognitive Behaviour Therapists’ Self-Assessment of Competence: Accuracy and impact of training
Sarah Beale, King’s College London, Institute of Psychiatry, Psychology & Neuroscience

Accurate self-appraisal of therapeutic competence is proposed to impact professional development and delivery of effective interventions (Tracey et al., 2014). Studies of experienced and trainee therapists have generated inconsistent findings regarding the accuracy of self-asessments and change in self-assessed competence with training, with some identifying overestimation of competence and poor accuracy (Perlesz et al., 1990; Brosan et al., 2008; Mathieson et al. 2010) and others demonstrating trends towards greater agreement and decreased self-overestimation with training (Loades & Myles, 2016; McManus et al., 2012). Methodological issues including non-validated measures and small sample size preclude conclusions. This study aimed to investigate the relationship between self-assessed and expert-assessed competence in a large longitudinal sample of CBT trainees using a validated measure of therapeutic competence.

Trainee therapists (n=150) completing a one-year postgraduate diploma in CBT submitted recordings of treatment sessions at baseline, mid-training, and end-of-training. All recordings were self-rated by the trainees and rated by an expert marker on the Cognitive Therapy Scale – Revised (Blackburn et al., 2001). Preliminary analyses addressed the following: change in self-ratings, expert-ratings, and self-versus-expert difference scores across training; relationships between self and expert ratings at each time point; and self-ratings and difference scores at each time point for therapists judged competent versus non-competent by expert markers.

Preliminary findings are presented. Both self-rated and marker-rated competence increased significantly across training, though rates of change differed. Relationships between self-ratings and marker-ratings varied across training; however, findings indicated that self-ratings of competence were accurate by the end of training. There was no overall trend towards over-estimation of self-rated competence. Both self-ratings and self-versus-expert difference scores varied considerably across time for competent and non-competent trainees, and trends were examined for each group.

Features of the subset of non-competent trainees who self-overestimated competence by the end of training were investigated.

Findings are compared with the literature and conceptual and methodological limitations are addressed. Implications of the present study are developed in relation to CBT training and practice, and extensions for future research are proposed.

With long-term CBT training, therapists tend to develop self-assessments of therapeutic competence that correspond to expert ratings. Findings support and inform the role of evidence-based training in developing therapists’ self-representations of competence.

Modifying key illness beliefs in early psychosis carers: Pilot study of a Sole-Session group format plus comparison with a Three-Session format
Natasha Lyons, Harrow and Hillingdon Early Intervention Service, Central & North West London NHS Foundation Trust

Carers beliefs about psychosis appear to play an important role in their emotional and behavioural outcomes, as well as impacting on patients. However, little is known about what constitutes optimal approaches to providing information in the early course of psychosis. In the context of limited NHS financial resources, the current pilot study sought to investigate the effects of a Sole-Session, psychoeducational intervention for early course psychosis, which included an explicit focus on improving key illness beliefs of the carers. There were three main study aims: First, to test if carers
The components of a talking therapy designed to explicitly target suicidal thoughts and acts: Cognitive Approaches to combating Suicidality (CARMS)

Daniel Pratt, University of Manchester

Suicide fatalities are highly prevalent in those with mental health problems, including those experiencing psychosis. A meta-analysis illustrated that psychological therapies are effective in reducing suicidality as long as they target suicidality. Based on this work, we have developed a psychological "talking" therapy (CARMS) to reduce suicidality. This therapy is founded on an evidence-based psychological model of suicidality, namely, the Schematic Appraisals Model of Suicide (SAMS). Work indicates that the pathways to suicidality involve appraisals of social isolation, emotional dys-regulation, and dysfunctional problem solving which lead to defeat, entrapment and hopelessness culminating in suicidality. CARMS therapy addresses these appraisals. The aim is to describe and illustrate the components of CARMS therapy.

A narrative description of the components of the CARMS talking therapy with illustrations from case examples of people with recent suicidal experiences together with psychosis. CARMS therapy is a recovery-focused, time-limited, socio-emotional-cognitive intervention and is formulation driven. It has six components: Component 1 works on engagement which aims to raise the understanding of psychological therapy and motivate participants to attend appointments; components 2, 3 and 4 focus on changing negative appraisals of inter-personal problem solving, emotional regulation, and social support which give rise to perceptions of defeat, entrapment and...
hopelessness; component 5 cements ways of not feeling defeated, trapped and hopeless; and component 6 focuses on ending therapy and maintaining well-being.

The development of the CARMS therapy is an important step in advancing psychological therapies for people with severe mental health problems which target pathways to suicidality, and which are also grounded in evidence-based psychological theories. Many CBT therapists experience suicidal clients on a weekly, even daily, basis. This paper provides detailed description, illustrated with case examples, of a newly developed intervention for this risky clinical group.

**Acceptability, Efficacy and Effectiveness of Group Behavioural Activation for Depression among Adults: A Meta-Analysis**

*Mel Simmonds-Buckley, University of Sheffield*

The evidence base for behavioural activation (BA) as a frontline treatment for depression is grounded in individual delivery. No valid previous meta-analytic reviews of the efficacy of BA delivered in groups have been conducted. Furthermore, efficacy of group BA established in trials does not necessarily indicate how effective group therapy is delivered in naturalistic settings. This study therefore examines outcomes and acceptability of group BA in terms of efficacy from trial outcomes and effectiveness from practice-based evidence.

Efficacy and effectiveness studies of group BA were identified using a comprehensive literature search. Depression outcomes at post-treatment/follow-up, recovery and drop-out rates compared to controls and other active therapies were extracted and analysed using a random-effects meta-analysis. Treatment moderators including depression severity, population type, number of sessions and setting were analysed using meta-regression and subgroup analyses. Twenty-seven studies were quantitatively synthesized. Depression outcomes post-group BA treatment were superior to waitlist and treatment as usual (TAU) controls (SMD 0.72, CI 0.46 to 0.98, k=21, N=830) and were equivalent to other active group therapies including cognitive behaviour therapy (CBT) (SMD 0.14, CI -0.18 to 0.46, k=15, N=526). Group outcomes were maintained at follow-up and moderators of the treatment effect were limited. Efficacy studies produced a large effect (N=12; SMD 0.82), which reduced to a moderate effect for practice-based effectiveness studies (N=9, SMD 0.63). Drop-out rates were equivalent when comparing group BA to passive controls and active therapies.

This study provides further support for BA as a standalone treatment for depression with additional evidence for the adoption of group delivery. Group BA appears to be acceptable, produce sustained outcomes and works for a broad population of patients, appearing clinically equivalent to the frontline treatment for depression, CBT. Furthermore, outcomes for group BA produced in controlled trials translate well into routine practice settings, albeit with a slightly smaller effect. Group BA should be considered an appropriate treatment option. Further research is needed to refine the conditions for optimum treatment delivery and also define robust moderators and mediators of outcome.

**Understanding and working with Hoarding Disorder across contexts: research, primary care and secondary care**

**The Role of Intrusive Imagery in Hoarding Disorder**

*Nick Stewart, University of Bath*

Frost & Hartl (1996) proposed a model of Hoarding Disorder (HD) in which hoarding behaviours (i.e., acquiring, clutter and difficulty discarding) are maintained by a mixture of positive and negative emotions. These emotions are in turn driven by the activation of specific beliefs about objects (i.e., utility, beauty and sentimental value) and the self (e.g., as vulnerable or responsible). While several studies have attempted to document verbal cognitions relating to these beliefs (see Frost & Hartl, 1996), no study has yet examined the potential role of mental imagery in the development and maintenance of HD. Recurrent or intrusive mental imagery is a feature of a broad range of mental health disorders (Brewin, et al., 2010). Vivid and distressing recurrent images have been found to be common in people with OCD, and these images frequently corresponded to memories of earlier adverse events (Speckens et al., 2007). Given that traumatic histories are common in people with both HD and OCD (e.g., Landau et al., 2011; Cromer, Schmidt, & Murphy, 2007), people who hoard
might reasonably be expected to experience negative intrusive images and memories. This present study aimed to investigate the prevalence and characteristics of mental images experienced by individuals who meet the DSM-5 criteria for HD (n=25) in comparison with a community control (CC) group (n=25), using a mixed cross-sectional and experimental design. Participants were asked about the everyday imagery they experience using a questionnaire adapted from those used in similar previous studies (e.g., Gregory, Brewin, Mansell & Donaldson, 2010) before then being asked about the images they experience in response to two recent real-life examples of discarding: (1) an object of low subjective value, and (2) an object of high subjective value. These findings will be the first to address whether intrusive mental imagery is implicated in HD, and more specifically in the maintenance of a key hoarding behaviour (i.e., failure to discard).

**Investigating categorisation in Compulsive Hoarding Disorder: making it meaningful**  
*Alice Kilvert, University of Bath; James Gregory, University of Bath*

Compulsive Hoarding Disorder (CHD) is characterised by having a “persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions” and is seen to have a detrimental effect on “emotional, physical, social, financial and even legal” aspects of their life (DSM-5; American Psychological Association, 2013). Amongst other important factors, Frost and Hartl (1996) proposed that hoarding arises from deficits in information processing and in particular deficiencies in categorization/organization, memory and decision making. The present study aimed to further our understanding of categorization through a replication and extension of previously conducted studies examining categorization (e.g. Grisham et al. 2010). Hoarding (n=30) and non-clinical (n=30) participants were asked to categorise personal and non-personal items using different sorting instructions and were asked about the decision making underpinning their category choices. Participants also completed standardized neuropsychological categorization tests from the DKEFS battery to test whether any categorization problems were specific to objects or to a general deficit. The findings and clinical implications of this study will be presented and discussed. It is hoped the study can further enhance our understanding of CHD, providing further evidence on the existence of information deficits or otherwise, and offer recommendations for future treatment approaches in this area.

**Emotions and hoarding: a Q-method exploration**  
*Stephen Kellett, University of Sheffield*

No abstract received.

**Treating Hoarding Disorder in IAPT and the development of a multiagency approach**  
*Helen Lofthouse, Brighton and Hove Wellbeing service, Sussex Partnership NHS Trust*

The treatment of Hoarding Disorder (HD) often falls between Primary and Secondary care mental health services with people more likely receiving support from agencies such as social services, environmental health, housing and the fire service. The complexity of the problem and the requirements of treatment protocols can be prohibitive within Primary Care IAPT services but patients can also be excluded from accessing support in secondary care due to not meeting HONOS clustering or the services not being funded or configured to work with this group of clients. Accessing mental health services for problems relating to HD can therefore be challenging for both clients and multi-disciplinary professionals working with clients. This presentation will outline a service model for the treatment of Hoarding Disorder currently operating within a Primary Care IAPT service in Brighton and Hove. The ways in which treatment has been adapted and how the interventions have been complemented through multi-agency working will be described.

**Innovative partnership work between social care and secondary care mental health for hoarding problems**  
*Victoria Bream, South London and Maudsley NHS Foundation Trust*

This presentation will outline a variety of work disseminating and encouraging a non-stigmatising, CBT informed approach to hoarding problems. This includes work with the London Borough of Southwark multi-agency working team; this multi-disciplinary team works with people severe hoarding problems in social housing who often ‘fall through the cracks’ of other services or are reluctant or unable to engage with services. Support and encouragement for people with hoarding
problems can be difficult to access; the work of an open access support group will be described. Hoarding treatment groups can promote change often in the face of considerable difficulty; this presentation will report on a group for people with hoarding problems in secondary care.

Examining cultural influences in the development, presentation and treatment of psychopathology

Cultural Influences on Self-Defining Autobiographical Memory Specificity
Lawrence Yu, University of Oxford
Reduced autobiographical memory specificity (AMS) has been found to predict greater post-traumatic stress symptoms after traumatic events (e.g., Kleim & Ehlers, 2008). There is a lack of studies on the influence of culture on AMS. The present study aimed to assess the specificity of self-defining autobiographical memories in a cross-cultural context. Self-defining memories are more strongly associated with self-identity (McAdam, 1989) and self-discovery (Singer & Moffit, 1991, 1992) than other memories, and therefore might be especially important in predicting clinical outcomes after stressful events. A total of 115 participants aged 18-30 from Taiwan, Hong Kong and the United Kingdom took part in this study. The results showed that British participants recalled a significantly greater number of specific self-defining autobiographical memories than their Taiwanese and Hong Kong counterparts. These findings will be discussed in relation to cross-cultural theories and cognitive models of responses to stress.

Nothing’s gonna stop me: Post-event processing in social phobia
Osamu Kobori, Swansea University
Individuals with social phobia engage in post-event processing. Even after they leave social situations, they review the situation to see if anything went wrong or anyone was offended by their behaviours. Because this review is biased by their own beliefs (e.g., “I am boring”), post-event processing is believed to maintain and exacerbate their social phobia.

The present study employs qualitative approach to gain in-depth understanding of post-event processing in social phobia. 21 Japanese individuals with social phobia took part in this study. The mean age was 39.2 years old (SD=6.2), and 16 of them were female. After the semi-structured interview, the transcripts were analysed using thematic analysis.

We have identified 3 overarching themes. Firstly, the motivation for post-event processing is mainly to improve their social performance, which is sometimes functional in some situations. Secondly, post-event processing is unstoppable because they have positive beliefs about reviewing, because it is intrusive, and because it is difficult to obtain any conclusions about how to improve their social performance. Finally, post-event processing maintains their social phobia by confirming their negative beliefs, increasing their anticipatory anxiety, and helping them to develop new safety behaviours.

These results will be discussed in relation to cognitive theory of social phobia, and compared with depressive rumination and reassurance seeking in OCD.

Adaptations to and the efficacy of cognitive behavioural therapy for social anxiety disorder in Japan
Naoki Yoshinaga, University of Miyazaki, Japan
We have been incorporated/adapted the theoretical orientations underlying cognitive models of social anxiety disorder (SAD) and treatment interventions developed in Western cultures (e.g. Clark & Wells model, 1995) into Japan. More specifically, at first, we developed a treatment protocol of cognitive behavioural therapy (CBT) for SAD and evaluated its feasibility in an exploratory (pilot) study (Yoshinaga et al., BMC Res Notes, 2013). Then, we clarified the clinical effectiveness of CBT for patients with SAD who remain symptomatic following antidepressant treatment (Yoshinaga et al., Psychother Psychosom, 2016). Through these clinical trials, we also published case study presenting a detailed argument that CBT developed in Western cultures may be effective for Japanese SAD patients with some considerations of cross-cultural influences (Yoshinaga et al., Cogn Behav Therapist, 2013). In this presentation, the cross-cultural differences of SAD and adaptation of CBT for Japanese patients will be discussed.
Disseminating Internet-based Cognitive Therapy for Social Anxiety Disorder: A pilot case series in Hong Kong
Graham Thew, University of Oxford
Providing evidence-based psychological therapies via the internet is a rapidly-developing field of research with a good deal of empirical support for its efficacy. One of the many suggested benefits of internet interventions is an increased ability to transport treatments to areas of high demand, which may span international, linguistic, and cultural boundaries. However, at present, research into the efficacy of internet interventions in cultures outside of where they were developed is at an early stage.
This presentation will discuss the implementation and results of a dissemination case series, where six participants from Hong Kong undertook online Cognitive Therapy for Social Anxiety Disorder, treated by local therapists. It will outline the process of therapist training and supervision in delivering the intervention, and reflect on the linguistic and cultural factors observed in conducting this work. In general the clinical outcomes of this patient cohort were extremely promising; these will be presented and discussed, along with consideration of the implications for how we culturally adapt psychological interventions.

Psychopathology and treatment of anxiety-based disorders

Tracking Symptom and Process Change in Generalized Anxiety Disorder: Evidence from CBT and Mindfulness Meditation
Maree Abbott, The University of Sydney, Australia
Generalized Anxiety Disorder is a common and debilitating disorder that is often difficult to understand and treat. The results of a tracking study will be presented assessing session-by-session ratings for symptom (worry; depression; life interference) and process variables (probability, cost and coping estimates) rated weekly over the course of a 12-week cognitive-behavioural treatment program for GAD. Lastly, the results of a randomized control trial comparing CBT for GAD with a Mindfulness Meditation program and waitlist control group will be described. Ninety-six participants with a principal diagnosis of GAD, as assessed by the ADIS-IV, were randomly assigned to either CBT or Mindfulness Meditation or a waitlist control group. Both active treatments were delivered in a group format of twelve weekly sessions. Measures of GAD severity, worry frequency, metacognitive beliefs, life interference and depression were assessed at pre-treatment/waitlist, post treatment/waitlist and at six and eighteen-month follow-up. GAD symptoms and processes were assessed weekly across two sites for 78 Ps completing group CBT.
Both active treatments showed significant reductions in symptoms at post treatment, which were maintained at 6-month follow-up. However, Mindfulness Meditation resulted in greater diagnosis free rates, lower clinician rated GAD severity and lower depression scores at post treatment, although these group differences resolved at 6-month follow-up. Weekly tracking data showed significant linear improvement in symptom and process scores throughout CBT.
The enhanced outcomes shown by both active treatments are significant in providing a range of current evidence-based approaches for treating GAD.
The results contribute to enhancing contemporary evidence-based treatment for GAD in a range of public and private treatment settings.

Banning Pre-Event Rumination in Social Anxiety Disorder: A Preliminary Randomized Trial
Maree Abbott, The University of Sydney, Australia
Pre-event rumination has a clear role in maintaining social anxiety according to cognitive models. However, it is unclear what specific strategies can address pre-event rumination for individuals diagnosed with SAD. The current study aimed to determine the effectiveness of a brief intervention on multiple aspects of pre-event rumination, state anxiety and performance and threat appraisals. Additionally, the trajectory of pre-event rumination was investigated over four days.
Participants with SAD were informed they would be required to complete a speech task in four days’ time and were randomised to an intervention (n=27) or a non-active control group (n=25). The intervention group were instructed to “ban” pre-event rumination using a
metacognitive therapy technique known as detached mindfulness. All participants completed daily measures of pre-event rumination that assessed frequency, uncontrollability, engagement and distress associated with pre-event rumination. On the day of the speech task, participants also completed state and cognitive measures before delivering the speech task. The intervention group reported reduced frequency, uncontrollability and distress associated with pre-event rumination, compared to the control group. There was no difference between groups for other measured variables. Rumination is a stable and robust process in the four days before the speech task, with an increase in frequency and associated distress 24 hours before a feared social situation. The lack of an active control group precludes comparisons to more traditional cognitive-behavioural therapy strategies for pre-event rumination. Pre-event rumination is a durable process but banning pre-event rumination using metacognitive therapy techniques shows promise for specifically addressing this maladaptive process. Metacognitive techniques may enhance contemporary CBT by impacting rumination before and after social and performance situations for socially anxious individuals.

Do emotion regulation difficulties affect PTSD outcomes and improve with cognitive processing therapy for PTSD?
Jenna Boyd, McMaster University, Canada

Posttraumatic stress disorder (PTSD) is characterized by a cluster of symptoms including reexperiencing, avoidance, negative alterations in mood and cognition, and heightened arousal and reactivity. In addition, emotion regulation difficulties (ERD), including regulating which emotions are experienced, when they occur, and their expression, has been associated with posttraumatic stress symptoms (PTSS) across various trauma types (Seligowski et al., 2015). Despite emerging research suggesting that evidence-based treatments for PTSD, including cognitive processing therapy (CPT), are effective in reducing ERD, some have argued that these treatments may lead to symptom exacerbation and treatment drop-out among those with PTSD and significant ERD (Cloitre et al., 2011). Accordingly, the current study sought to determine the impact of pre-treatment ERD on treatment efficacy (e.g., reduction in PTSD symptoms) and treatment drop-out in a sample of individuals receiving group CPT. Additionally, this study sought to add to the nascent literature investigating the efficacy of CPT in reducing ERD by assessing change in ERD over the course of treatment.

Fifty five individuals (% female = 74.5; mean age (years) = 40.0 (SD = 13.0)) receiving group CPT for PTSD at a specialty anxiety disorders clinic at an academic hospital in Ontario, Canada, participated in this study. PTSD symptoms were measured using the PTSD Checklist for DSM-5 (PCL-5) at each treatment session. ERD were measured using the Difficulties in Emotion Regulation Scale (DERS), which assesses six dimensions of ERD (awareness, clarity, emotion regulation strategies, inhibition of impulsive behaviours, goal-directed behaviours when emotional). Hierarchical linear modeling was used to assess the impact of DERS total and subscale scores at pre-treatment on change in PCL-5 score over the course of treatment. Logistic regression was used to assess the impact of pre-treatment DERS and PCL-5 scores on treatment drop-out. Repeated measures t-tests were used to assess changes in DERS and PCL-5 scores from pre- to post-treatment. HLM models revealed no significant effect of pre-treatment DERS total or subscale scores on change in PCL-5 scores over the course of treatment (ps>.05). Logistic regression analyses demonstrated that neither PCL-5 total, nor DERS total or subscale, scores significantly predicted dropout (ps>.05). Results of the t-tests showed that PCL-5 and DERS total and subscale scores significantly reduced from pre- to post-treatment (ps<.05).

The results of the present study indicate that both PTSD symptoms and ERD significantly improved with group CPT. Additionally, ERD did not impact treatment outcome or treatment completion for individuals with PTSD participating in group CPT. These findings suggest that CPT can be effectively delivered in a group setting among those with a wide range of ERD and can also lead to significant improvement in ERD.

This study has implications for the treatment of PTSD using a cognitive behavioural therapy, cognitive processing therapy (CPT), in everyday clinical practice. In particular, our findings indicate that CPT in a group format is associated with reductions in emotion regulation difficulties among individuals with PTSD. Further, our study suggests that emotion regulation difficulties are not
associated with reduced treatment efficacy (e.g., reduction in PTSD symptoms) or increased treatment drop-out among a sample of individuals receiving CPT for PTSD. Thus, clinicians treating individuals with PTSD who are exhibiting emotion regulation difficulties may use CPT as one therapeutic approach leading to reductions in symptoms of PTSD and difficulty in emotion regulation.

**Adult attachment, worry and reassurance seeking: the mediating role of intolerance of uncertainty**

Gavin Clark, University of New England, Australia

Adult attachment dimensions of attachment anxiety and attachment avoidance have been demonstrated to be associated with a variety of anxiety symptoms, including worry and reassurance seeking. A variety of research has indicated that intolerance of uncertainty (IOU) predicts level of worry and reassurance seeking. The relationship between attachment, worry, reassurance seeking and IOU has not been subject to investigation. The present paper reports the results of two studies investigating these variables within a community sample.

Study 1 recruited 281 participants to complete an online survey in which participants completed the Intolerance of Uncertainty Scale, the Experiences in Close Relationships Scale-Revised, and the Penn State Worry Questionnaire. Study 2 recruited 308 participants to complete the same questionnaires with the addition of the Threat-related Reassurance Seeking Scale.

The results of both Study 1 and 2 demonstrated that attachment anxiety and attachment avoidance were positively correlated with IOU and worry and threat-related. In both Study 1 and Study 2, the relationship between attachment anxiety and worry was mediated by IOU. The relationship between attachment avoidance and worry was also found to be mediated by IOU, though this relationship was found to be nonsignificant when controlling for attachment anxiety.

Study 2 demonstrated that attachment anxiety, IOU and worry were correlated with threat-related reassurance seeking, though attachment avoidance was not associated with reassurance seeking.

IOU is likely to play a key role in the relationship between attachment anxiety and worry, as well as the relationship between attachment anxiety and reassurance seeking. Future research should aim to determine whether adult attachment difficulties predispose individuals to IOU.

**Prevalence and treatment of Health Anxiety in Chronic Fatigue Syndrome/ME**

Jo Daniels, University of Bath

Prevalence and treatment of Health Anxiety in Chronic Fatigue Syndrome/ME Excellence Award: True Proposed stream: Behavioural Medicine

Abstract: Chronic Fatigue Syndrome (CFS) is a debilitating condition that affects 0.2–0.4% of the population.

First-line treatments are Cognitive Behaviour Therapy or graded exercise therapy; however, these treatments yield only moderate effect sizes. Emerging research suggests that anxiety about health is common across medical complaints and may be common in CFS.

Health anxiety treatment models demonstrate good therapeutic outcomes, however, this model has only been applied to a single case study in CFS. Results demonstrated case to non-case status in both CFS/ME and health anxiety, however this represents only N=1.

This paper describes the assessment of prevalence of health anxiety in CFS and the application of a novel cognitive behavioural approach to the treatment of both physical and anxiety in a case-series sample of patients with CFS, furthermore presenting a conceptual hypothesis regarding the mutually maintaining relationship between these two co-occurring conditions.

Part 1 employed a cross sectional questionnaire based study in a specialist CFS service to assess prevalence of health anxiety in CFS (N=172). Data were taken from the Short Health Anxiety Inventory (SHAI) and the Hospital Anxiety and Depression Scale to identify incidence of anxiety, depression, and health anxiety. Other measures included the SF-36, for physical functioning and Chalder Fatigue Scale for Fatigue.

Part 2 employed a consecutive case-series design (N=10) to treat CFS and health anxiety related symptoms using the cognitive behaviour therapy health anxiety model. Treatment consisted of 12 sessions of intervention, with 6 weeks baseline monitoring to establish stability of symptoms.
Measures included those detailed above. Participants were those who scored in the clinical range on the SHAI (>18) in the specialist CFS service, with positive diagnosis of CFS and consented to treatment. The intervention was driven by an individualized formulation developed collaboratively with the patient. The SHAI was found to be reliable for use in this clinical population (α=.869).

Part 1: 38% of the CFS sample demonstrated clinically severe health anxiety (>18). Stepwise regression analyses indicated that in a single factor model, physical functioning accounted for 12% of the variance in fatigue. Health anxiety, anxiety and depression were non-significant predictors. For physical functioning, a three-factor model including depression (r²=.21) fatigue (.057) and health anxiety (.023), accounting for 28.3% of the variance. There were significant relationships between health anxiety and physical functioning, fatigue and mood; general anxiety, physical functioning and mood. Sleepiness was correlated with physical functioning and mood, but not fatigue.

Part 2: All ten patients completed 5 or more sessions of therapy, with two participants (20%) withdrawing at session 6. Of those who completed a full course of therapy, 100% achieved reliable and clinically significant change in both fatigue and health anxiety excepting one who did not achieve significant change in fatigue (Reliable Change Index). Half of those who completed therapy no longer met criteria for CFS on a Fukuda checklist. Reliable change was also seen in domains of functioning and depression. Completion of therapy by 80% of recruited sample suggests both acceptability and clinical utility in this model.

Health Anxiety is common in this CFS population and rates are significantly higher in comparison to other medical populations (up to 25%, Tyrer et al. 2011). An adapted cognitive behavioural approach to treating CFS and health anxiety yields positive results and shows promise for application to the broader CFS population, the majority of which may have commonly unidentified clinical needs. These results suggest use of this model in the CFS population is both agreeable and effective.

This is the first substantial study examining prevalence of health anxiety in CFS, acting as a large scale replica of earlier studies by the same group. This study supports the use of an empirically grounded CBT model for co-morbid problems; the health anxiety model can now be confidently utilised in other CFS services and build on current findings.

**New developments and applications of Cognitive Bias Modification in addictions**

**Relapse prevention in abstinent alcoholics by cognitive bias modification: Modification of approach bias, attention bias, or both?**

*Mike Rinck, Radboud University Nijmegen, The Netherlands*

Alcohol-dependent patients show an attentional bias for alcohol-related stimuli and automatic approach of these stimuli. Consequently, computerized Cognitive Bias Modification (CBM) programs have been developed to re-train these biases. Re-training of alcohol-approach tendencies has already yielded significant reductions of relapse rates in previous studies, and re-training of biased attention towards alcohol is another promising approach. Therefore, the current large-scale study compared the beneficial effects of these training methods – separately and in combination – to those of sham trainings and a no-training control. Participants were 1405 alcohol-dependent patients of an inpatient rehabilitation clinic. In addition to treatment as usual, they received 6 sessions of alcohol-avoidance training, 6 sessions of alcohol-attention training, a combination of 3+3 training sessions, variants of sham trainings, or no training. Effects of the training methods were evaluated by measuring treatment success at 1-year follow-up. The 3 active training groups had higher success rates at 1-year follow-up than the 2 groups receiving sham trainings or no training. There were no significant differences between alcohol-avoidance training, alcohol-attention training, or the combined training. The latter may have failed to be even more effective because it involved only 3 sessions per training.

**Modification of Automatic Alcohol-Approach Tendencies in Alcohol-Dependent Patients with Mild or Major Neurocognitive Disorder**

*Eni Becker, Radboud University Nijmegen, The Netherlands*
Computerized Approach-Avoidance Training (AAT-Training) have shown effective in relapse prevention for alcohol dependence. Whereas regular treatment procedures are highly dependent on reflective and explicit memory capacities, AAT-trainings might offer an intervention option that asks for less cognitive control. They might therefore be suited for patients with alcohol-induced neurocognitive disorders, who are faced by poor treatment outcome and an increased risk of relapse. To examine the applicability of an alcohol-avoidance training procedure in patients with alcohol dependence and alcohol-induced neurocognitive disorders, we included two groups that differed in the degree of cognitive impairment: One group fulfilled the DSM-5 criteria for Alcohol-Induced Mild Neurocognitive Disorder, and one group was diagnosed with Korsakoff’s syndrome (Alcohol-Induced Major Neurocognitive Disorder, Confabulatory/Amnesic subtype; DSM-5). 51 Patients with a mild neurocognitive disorder and 54 patients with Korsakoff’s syndrome received six training sessions (including pre- and posttests) on a computerized implicit alcohol approach-avoidance task. Neurocognitive variables were available from the standard assessment procedure of the clinic. The alcohol-approach bias decreased for both groups in each session (F(1,82)=17.72, p<.001, ηp²=.18). Better learning results over time were obtained in participants with a larger baseline alcohol-approach tendency (F(5,45)=6.73, p<.001, ηp²=.43). Learning effects were positively related to age and implicit (non-declarative) memory functioning. No relation between training effects and executive or explicit memory functions were present. An AAT-Training can be successfully applied in patients with alcohol-dependence and alcohol-induced neurocognitive disorders.

**Combining avoidance training with go/no-go training to prevent relapse in alcoholdependent patients**

**Edwin Schenkel, Radboud University Nijmegen, The Netherlands**

Alcohol-dependent individuals tend to selectively approach alcohol cues in the environment, known as approach bias. This reinforces alcohol consumption and contributes to maintenance of the addiction. Likewise, they have stronger positive implicit automatic attitudes towards alcohol. The positive evaluation of alcohol elicits the tendency to approach alcohol due to its rewarding value. This strengthens the existing positive evaluation of alcohol, increasing consumption. Hence, reducing consumption requires reductions in both approach bias and evaluation of alcohol. The Approach-Avoidance-Training (AAT) successfully reduces approach bias, decreasing consumption in heavy drinkers and relapse rates in abstinent alcoholics. An effective approach to modify behavior via changes in evaluation is the Go/No-go-Training (GNGT). During active GNGT, participants have to rapidly respond (button presses) to pictures of nonalcoholic drinks but inhibit their responses to pictures of alcoholic drinks. During sham GNGT (control group), the contingency to press or not to press a button in response to pictures of alcoholic or nonalcoholic drinks is equal. In earlier studies, the inhibition of responses to alcohol pictures was found to lead to devaluation and reduced consumption of alcohol. Since devaluation appears to initiate changes in approach towards and consumption of alcohol, augmenting AAT with GNGT might intensify decreases in consumption and relapse. The present study investigated whether the effects of AAT on reductions in approach bias and relapse can be amplified by GNGT. For six sessions, alcohol-dependent inpatients received AAT followed by either active (active training) or sham GNGT (sham training). Active versus sham training is expected to more effectively reduce approach bias and evaluation of alcohol. Further, we examined the effects of active versus sham training on relapse assessed three months after training. Active versus sham training is expected to more effectively reduce relapse.

**Nicotine-avoidance training as an add-on treatment to achieve smoking cessation**

**Charlotte Wittekind, Ludwig-Maximilians-University Munich, Germany**

Although tobacco dependence is associated with severe negative consequences on health and most individuals want to quit, only a minority achieves long-term abstinence, even after receiving treatment. Evidence-based treatments either aim at a pharmacological substitution or at the modification of strategic types of information processing. However, automatic processes, such as an automatic approach tendency for smoking-related stimuli, are ascribed a central role for the onset and maintenance of tobacco dependence, but are not taken into account in current treatment approaches. The aim of the present study was to evaluate the efficacy of a nicotine-avoidance training as an add-on intervention to a well-established German therapy program. Participants with
tobacco dependence were randomly allocated to one of two conditions (condition 1: treatment-as-usual + avoidance training; condition 2: treatment-as-usual + placebo training). The pre-post interval was four weeks, the post-follow-up interval six months. In both add-on training conditions, participants were instructed to push or pull neutral and smoking-related pictures depending on the color of the picture frame. While all smoking-related pictures had to be pushed in the nicotine-avoidance training condition, the contingency was 50:50 for the placebo training. Final data of the study will be presented. Results provide important insights into the effectiveness of add-on trainings in smoking. CBM trainings hold the potential to be easily disseminated and cost-effective.

“Push it!” or “Hold it!”? Comparing nicotine-avoidance training to nicotine-inhibition training in smokers motivated to quit smoking

Alla Machulska, Ruhr-University Bochum, Germany

Although smoking is considered the leading cause for preventable death and disease worldwide, prevalence rates for cigarette smoking and nicotine dependence are alarmingly high. In addition, even following effective smoking cessation treatment, sustained abstinence is difficult to achieve. This might be due to the fact that most interventions fail to directly target automatic processes associated with smoking. Recent research supports this notion by linking automatic tendencies to approach smoking cues to cigarette smoking, especially when executive cognitive functions, such as response inhibition, are low. The present study compared two different interventions, namely nicotine-avoidance training and nicotine-inhibition training, in terms of their effectiveness to modify implicit approach tendencies and to reduce nicotine consumption. Smokers motivated to quit smoking received a brief smoking cessation counselling and were randomly allocated to one of two experimental conditions (nicotine-avoidance training or nicotine-inhibition training) or to one of two placebo conditions. During the nicotine-avoidance training, participants were implicitly instructed to make an avoidance movement in response to smoking-relates pictures and to make an approach movement in response to smoking-unrelated pictures by pushing or pulling a joystick attached to the computer. During the inhibition training, participants had to ignore smoking-related pictures and to respond to smoking-unrelated pictures by moving a joystick to the left. In the placebo conditions, no contingency between picture content and arm movements existed. Trainings were administered in five sessions. Smoking behaviour and smoking-related approach biases were measured before and after training. Preliminary results will be presented and discussed.

Digital Delivery of Imagery Based Interventions

Computerized positive mental imagery training as an adjunct to inpatient mental health treatment: a feasibility trial

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Enhancing the capacity to experience positive affect could help improve recovery across a range of areas of mental health, and positive mental imagery may provide one route to achieve this. Experimental psychopathology research indicates that a computerized cognitive training paradigm involving generation of positive mental imagery can increase state positive affect, and more recent clinical studies have suggested that this training could be used as an adjunct treatment module to target symptoms related to positive affect deficits, specifically anhedonia. This feasibility randomized controlled trial (clinicaltrials.gov: NCT02958228) investigated the feasibility of adding a positive mental imagery computerized training module to treatment for patients in inpatient mental health settings, with a focus on increasing positive affect and reducing anhedonia. The positive mental imagery training (PMIT) was added to treatment as usual (TAU) in the inpatient setting, and compared to TAU alone, or TAU plus an alternative cognitive training module not hypothesised to increase positive affect, cognitive control training (CCT). Patients admitted to one of two inpatient mental health treatment clinics in Germany were randomized to PMIT + TAU, CCT + TAU or TAU. PMIT or CCT consisted of an introductory session followed by up to 8 full training sessions over two
weeks. All three arms (including TAU) included regular completion of mood measures over the two-week period. Outcome measures were completed pre and post the two-week training/monitoring period, and at two-week follow-up. Data on feasibility and outcomes from the study will be presented. The study will inform feasibility of conducting a fully-powered randomized controlled trial investigating the addition of the positive mental imagery training as a treatment adjunct to inpatient treatments for mental health, including preliminary indications of the likely range of effect sizes.

**Imaginator: a brief intervention for young people who self-harm supported by a smartphone app**

**Martina Di Simplicio, Imperial College London;** Elizabeth Appiah-Kusi, Paul Wilkinson, Emily Holmes, David Kavanagh

Self-harm behavior has a UK prevalence of 9-23% in young people, with substantial personal impacts and increased risk of suicidality. It occurs both in the absence of a mental disorder and across mental disorders. Disorder-specific treatments can reduce self-harm, but these have long duration and do not suit everyone. Hence, there is a need for effective transdiagnostic short therapies for self-harm, with a specific focus on young people. The Imaginator trial tested a new brief psychological intervention (functional imagery training, FIT) for 16-25 year olds who self-harm. FIT trains to use adaptive behaviour and to achieve goals via mental imagery practice (Andrade, May, & Kavanagh, J Exp Psychopathol 2012). The intervention protocol included two face-to-face sessions alongside treatment as usual (TAU), followed by 5 follow-up calls and supported by the Imaginator app. The Imaginator app was developed together with young people with lived experience of self-harm. Participants with minimum 2 self-harm episodes in the previous 3 months were randomized to Immediate FIT+TAU, or Delayed FIT+TAU after three months waiting. Outcomes were measured at 3 and 6 months.

Thirty-eight young people (31 female, mean age = 19.5) were recruited via self-referral (e.g. social media) or referred by mental health services / schools. Thirty-six participants were included after screening, with a 23.7% attrition rate at three months assessment, and 36.8% at six months. Of 32 starting therapy, 61% completed face-to-face sessions and at least one phone follow-up call. Over six months the number of self-harm episodes diminished across the whole sample, and self-harm reduction positively associated with motivation to stop self-harming at baseline. FIT supported by the Imaginator app reduced the number of self-harm episodes occurring over three months and effect was maintained after six months. FIT appeared most beneficial for those who still wanted therapy after waiting three months and who completed at least three follow-up phone calls. Young people reported the following advantages of using FIT (i.e. imagining positive goals and using imagery at times of distress): private, engaging, motivational, optimism inducing. Use of the Imaginator app was helpful, although difficult to remember at times of acute distress.

In summary, the Imaginator trial showed that offering a brief intervention focused on self-harm allows to reach young people who do not otherwise access mental health support. While self-harm behaviour can reduce spontaneously, a brief imagery-based intervention with a digital app could be helpful for young people who continue presenting with self-harm over longer periods. Future studies should improve treatment adherence and identify strategies to optimize and maintain engagement with the digital app over time.

**Project Soothe: A research and public engagement hybrid creating a bank of soothing images for use in psychotherapy**

**Stella Chan, University of Edinburgh;** Matthias Schwannauer, Angela McLauglin, Michelle Mok, Johannes Millowitsch, Elysia Lancaster, Tamara Cabrera Malthess, Leigh Robertson, University of Edinburgh; Fiona Ashworth, Anglia Ruskin University; Stephanie Allan, University of Glasgow; Roger Hyam, Royal Botanic Garden Edinburgh

Project Soothe is a unique project combining research and public engagement, bridging the boundaries between art and science. The ultimate goal is to create a bank of images for future use in psychotherapy. We specifically collect images that make people feel 'soothed', an important – yet poorly understood - concept in the theory and practice of Compassion Focused Therapy. Breaking from traditional researcher-led laboratory-based methods, we adopted the citizen scientist model and invited members of the public to submit images that make them feel soothed. Since its launch in
2015, the project has collected over 700 images from 24 countries. These images depict scenes around five top themes: landscapes, water features, plants and flowers, sky, and animals. Based on responses from over 1000 participants, we found that viewing 25 soothing images randomly drawn from our collection led to a robust significant increase in positive affect and reduction in negative affect. Mood changes were unaffected by levels of depressive symptoms, suggesting that individuals with and without psychological distress could both benefit from the potential therapeutic effects of these images. Findings further suggest that the feeling of ‘soothed’ is distinct from ‘excited’ or ‘anxious’, supporting Gilbert’s model of the three affective systems: Drive, Threat and Soothe. Based on participants’ narratives and memory recall, we found that being in solitude and affiliated with others are both important factors for feeling soothed; connection with nature also emerged as an important theme. Our result has been transformed into a poem “The Offering”. We are currently conducting further thematic analyses directly contrasting participants’ narratives for images that they consider as most soothing versus least soothing; results will address the fundamental question of what features in imagery make people feel soothed. As part of our commitment in public engagement, we held a one month public exhibition – ‘What Soothes You?’ - at Royal Botanic Garden Edinburgh. We collected further data through interactive activities and tasks at the exhibition, which replicated our findings (https://stories.rbge.org.uk/archives/27616). Our next exciting step is to further evaluate the long term benefits of these images. Continue embracing the Citizen Scientist model, we are about to run focus groups with young people, and recruit young citizen scientists, to help us explore ways to develop these images into clinical resources – as self-help tools and / or clinical interventions. Results will be shared in the presentation. In addition to covering the theoretical background of ‘soothe’, research findings and development of clinical applications, this talk will conclude with a reflection on the joy and challenges of integrating public engagement in research. Please feel free to browse our online gallery or submit your own images via www.projectsoothe.com and engage with us via Twitter @ProjectSoothe.

Affect and Imagery
Matthias Schwannauer, University of Edinburgh; Alexander C Wilson, University of Edinburgh; Alexis B Guerrero, University of Edinburgh; Matthias Schwannauer, University of Edinburgh; Angela McLauglin, University of Edinburgh, Fiona Ashworth, Anglia Ruskin University; Stella W.Y. Chan, University of Edinburgh

Mental imagery is closely related to felt emotion, emotion regulation and indicators of psychological wellbeing. As a key component of processing of experiences, mental imagery plays a key role in the development and maintenance of psychological distress and psychopathology. Guided Mental Imagery is a core component of many psychological therapy techniques and approaches; however, many individuals can find it very difficult to generate mental imagery and this can have a limiting effect on the implementation and effectiveness of these psychological therapy approaches. Based on the images collated as part of Project Soothe we carried out two proof of concept studies, examining the use of pictorial images to test the effects of imagery on participants’ mood. In Study 1, we systematically compared the responses of 135 young people to externally presented images to those solely mentally generated by participants, both conditions reduced negative affect and the processing of externally presented images significantly enhanced the increase in positive affect when compared to mental imagery. These effects were independent of depressive symptoms or emotional regulation. In a second study we hypothesised that an individual’s ability to construct vivid positive, but not negative, mental imagery would predict positive emotional responding to positive visual stimuli, independently of depressive symptoms. 214 adult participants completed an online study including validated questionnaire measures, mental imagery tasks, and a picture-rating exercise. Only Positive Imagery Vividness and Self-compassion were significant predictors of positive responding to the soothing pictures, even controlling for depressive symptoms, and Negative and General Imagery Vividness. These findings provide evidence for individual differences in a positive processing tendency shared across mental imagery-based and perceptual representations. Through the clear impact on both individual mood and emotional states in both adults and young people and the clear conceptual link with self-compassion, these proof of concept studies in non-clinical participants clearly indicate the feasibility and potential utility of using externally generated and presented images as part of imagery based interventions.
The use of Project Soothe images in patients with brain injury: An Evaluation Study
Fiona Ashworth, Oliver Zangwill Centre and Anglia Ruskin University
The aim of this paper is to present a pilot study evaluating and exploring the soothing quality of images generated from Project Soothe with an acquired brain injury sample. People with acquired brain injuries (ABI) often struggle with significant cognitive and psychological difficulties. Cognitive difficulties following ABI can affect an individual’s ability to engage with and benefit from psychological therapies. Such difficulties include executive functioning as well as the ability to generate imagery, which is a tool commonly used in some psychological interventions. Psychological Therapies that incorporate intervention elements that place less demands on cognitive abilities, especially executive functioning, could prove to be helpful adjuncts and/or stand-alone tools for such a population. This is the first study to investigate Project Soothe images in this population. In this study we have two key aims: (1) to explore whether the Project Soothe images are soothing for a sample of people with acquired brain injuries, and (2) to further explore the perceptions, thoughts and feelings that this clinical group experience in relation to these soothing images. We are also interested in exploring if and how these images may be used to benefit this population including whether these images could be used as part of psychotherapy with people with brain injury in the future. The study utilised a mixed methods approach – participants rated how soothing they found 25 images from the Project Soothe database. Participants also completed pre and post measures of mood in relation to completing this rating questionnaire of the Project Soothe images. Five Focus groups were conducted to explore participants views including their thoughts and feelings about Project Soothe images. Participants were recruited from Headway across the adult age range with a variety of ABIs including traumatic brain injury, stroke and encephalitis. The focus groups were facilitated by a qualified clinical psychologist and an assistant. The focus group qualitative data were analysed using thematic analysis. Additionally, ratings for the images were analysed using quantitative analysis to determine whether particular images were found to be universally soothing or more individually soothing. Pre and post comparisons of mood measurements were also conducted. This talk will present the results of the analysis, discussing key findings, their clinical implications and future directions for research relating to Project Soothe images in this clinical population.

Panel Discussion: A process of change: integrating physical and mental health into IAPT

Trudie Chalder, King’s College London; Jo Hudson, King’s College London; Georgina Miles, University of Sheffield; Nicholas Wilkinson and Jenni Burns, Sheffield IAPT Health and Wellbeing Service
Trudie Chalder, King’s College London
Over the last year 22 Early Implementer projects across England have led the way to integrating psychological therapies and physical healthcare. This panel discussion will focus on what has been learned from this first year from a curriculum, training, and service delivery perspective with expertise from each of these three areas represented on the panel. People with common mental health problems often also have physical long term conditions such as diabetes or cardiovascular disease. When mental and physical health problems are treated in an integrated way people can achieve better outcomes. This panel brings together a range of experts including an expert in CBT and LTC, Professor Trudie Chalder who was a member of the curriculum group, Dr Heather Salt who is the national lead for LTC and who was an editor of the PWP curriculum. Also on the panel is Dr Jo Hudson who has led on the delivery of the High Intensity LTC training in London and Georgina Miles who has led on the PWP LTC training in Sheffield. The service perspective is represented by Nicolas Wilkinson who has set up an LTC service in the Sheffield area.

Using Imagery when working with Psychosis: Recent Developments and Case Examples

iMAgery focused psychological therapy for persecutory delusions in PSychosis (iMAPS): a case series
Christopher Taylor, University of Manchester & Pennine Care NHS Foundation Trust; Penny E. Bee, James Kelly, Richard Emsley and Gillian Haddock

Background: Many people with psychosis experience persecutory delusions and report negative schematic beliefs and intrusive mental images which may be maintaining factors for psychotic symptoms. This study aimed to examine the feasibility and acceptability of a new psychological therapy targeting schemas and images (iMAPS therapy). Methods: Participants with first episode psychosis were randomised using a multiple baseline design with 2-5 assessments. An average of six sessions of therapy, comprising a combination of imagery techniques and imagery rescripting techniques were used. In each session, participants completed a Mental Imagery in Psychosis Questionnaire (MIPQ). Delusional beliefs (PSYRATS) were also measured sessionally. Results: Five participants with first episode psychosis completed the baseline visits and attended all therapy sessions. One participant declined the final assessment. Results demonstrated significant improvements in negative schematic beliefs, delusions, characteristics of images, and other measures of schema. Discussion: Although multiple baseline randomisation strengthens the study, it lacked a control arm and blind assessments. Conclusions: iMAPS appears a feasible and acceptable treatment for psychosis and further evaluation is indicated. Funding: UK National Institute for Health Research Fellowships Award (DRF-2012-05-211)

Imagery Rescripting and Psychosis
Craig Steel, University of Reading

An update and overview of recent work in which using imagery has been integrated with working with psychosis will be presented. Issues related to the use of imagery rescripting with people suffering from psychotic symptoms are discussed and a single case presented.

The Nightmare Intervention Study (NIteS): a pilot randomised controlled trial treating nightmares for patients with persecutory delusions
Bryony Sheaves, University of Oxford

Nightmares bring to mind vivid and highly distressing imagery that interrupts restorative sleep. In psychosis, this imagery often plays out paranoid fears and threats made by voices, hence maintaining psychotic experiences. The nightmare intervention study tested a four-week cognitive behavioural therapy targeting nightmares, through a pilot randomised controlled trial with twenty-four patients. This presentation will share the theory underpinning the treatment, the key elements of therapy and some initial results. This is a popular treatment with patients, targeting a symptom that is usually neglected in psychiatry.

Attachment-based imagery with voices and paranoia: A case example
Katharine Newman Taylor, University of Southampton & Southern Health NHS Foundation Trust

Many people with psychosis report serious adversity in childhood. Attachment theory assumes that early patterns of interaction influence our ability to manage internal experience, and form secure relationships in adulthood. This is not inconsistent with CBT formulations of psychosis, which emphasise the role of formative experience in the development of beliefs about self and others, and linked affect and behaviour.

Kip presented with derogatory voices, paranoia and emotional dysregulation, following a complex trauma history. Having learnt skills to manage her emotions more effectively, she sought help for her voices, paranoia and trauma symptoms. The principles of attachment theory informed our CBT formulation and highlighted key areas to target in therapy. Towards the end of this work, a number of persistent flashbacks remained highly distressing. These bore clear resemblances to her voices. To enable Kip to engage in exposure and reliving of these memories, we drew on an attachment-based means of facilitating ‘felt security.’ This involved recalling a secure relationship, and holding the associated self-image vividly in mind to increase her sense of interpersonal safety. Used before and after reliving sessions, this allowed Kip to tackle her remaining intrusions without becoming overwhelmed. Attachment theory may enrich our understanding of distressing psychosis, and shape therapeutic interventions.
Panel Debate: Working toward “win-win”: Pragmatic approaches to integrating research into clinical practice

Gary Brown, Royal Holloway University of London; Shirley Reynolds, University of Reading
J.D. Smith, Northwestern University, USA; Jaime Delgadillo, University of Sheffield
Stephen Kellett, University of Sheffield; Suzy Syrett, University of Glasgow

Bridging the research/practice divide is arguably the holy grail of psychotherapy research. Central concepts in the field—the nomothetic/idiographic distinction, the scientist-practitioner model, evidence based practice (and its complement, practice based evidence)—are all geared to this effort and testify to the importance of this challenge.

Although clinical research is aimed ultimately at improving services, the day-to-day practical implementation of research within clinical practice is often regarded as being at cross-purposes with service delivery. The fact that research findings need to be “translated” into practice is just one reflection of this dynamic. Moreover, the controls required within research, which are particularly evident in outcome studies, frequently highlight the gap, often increasing a sense of alienation between research and practice, potentially causing clinicians to feel that their pragmatic skills are not valued and that research only offers knowledge relevant to highly artificial contexts divorced from what they encounter daily.

However, there are grounds for hope that further progress can be expected that will build on identifiable trends, including:

1. The move away within psychotherapy research from the perceived need to emulate medicine, with its elevation of the randomized controlled trial as the pre-eminent vehicle for developing the evidence base. With a weakening of the dominant conception of RCTs as the sole "gold standard" methodology, emphasis has grown correspondingly on efficacy within pragmatic contexts as the ultimate goal of outcome research.

2. A greater appreciation of the reciprocal relationship between academic research, clinical applications, and service user experience and expertise, in place of viewing innovation as largely flowing from scientific experts disseminating and translating empirical knowledge. Particularly noteworthy in this regard is the welcome shift to user involvement such that most research, at least within the NHS, must now demonstrate substantive input from experts by experience as a condition of funding.

3. Steady advances in empirical understanding of formulation as the central vehicle of translating general evidence to the individual case

4. Advances in single case methods (e.g., meta-analytic techniques) that, among other capabilities, could enable a more “bottom-up” approach to accumulating knowledge about therapeutic efficacy that better harmonises with everyday clinical practice.

The proposed session will focus on efforts to bridge the gap between laboratory and clinic by making research more relevant and responsive and, from the service side, empowering clinicians to routinely conduct or participate in systematic examination of clinical practice. Participants in this panel represent different groups who play a role in psychotherapy research: researchers (including a small N design methodologist), trainers, service managers, and experts by experience, who will offer their perspectives on how this gap can be better bridged, share solutions that have shown promise, and invite a free exchange of ideas with attenders.

The loss of interest and pleasure – What is it, what are its affects and how can we change it?

What is Anhedonia? Exploring Loss of Interest and Pleasure in Adolescents
Rebecca Watson, University of Reading

Anhedonia, the loss of interest or pleasure from previously enjoyable activities, is a core symptom of Major Depressive Disorder and a negative symptom of schizophrenia. Losing the ability to experience pleasure has particularly negative consequences during adolescence, and is associated with suicidal ideation, independent of overall depression. Despite this, anhedonia in young people is rarely assessed directly and there is a lack of appropriate measures, suitable for use with young people. The aim of this study is to explore the experience of anhedonia in young people. Data from this qualitative study will then be used to construct a valid and reliable measure. We interviewed
22 adolescents (10 females; 12 males) aged between 13 and 18 recruited from secondary schools in the South East of England. Participants were recruited using purposive sampling based on elevated scores on the Mood and Feelings Questionnaire, a standardised measure of depression for adolescents. Individual semi-structured interviews were conducted to elicit in-depth accounts of adolescents’ experiences. Results were analysed using thematic analysis. Four major themes that identified distinct aspects of anhedonia emerged: Disturbed Affect, Motivation, Connectedness, and Sense-Making. These data suggest that adolescents experience anhedonia as multi-faceted and pervasive. In addition to reduced positive affect, many young people reported an absence of affect and feeling ‘numb’ as central to the experience of anhedonia. This disturbance of affect was amplified by feelings of amotivation, isolation and confusion. We are currently recruiting a sample of adolescents with a diagnosis of depression, who will be treated using Brief Behavioural Activation. We will interview them before and after treatment to examine if treatment that aims to improve rewards has any impact on adolescents experience of anhedonia.

The impact of dampening and amplifying appraisals on positive emotion experience in young people
Merve Yilmaz, University of Exeter

There is increasing interest in understanding the psychological mechanisms that drive reduced positive emotion experience in depression (anhedonia). The adult literature has demonstrated that the tendency when depressed to engage in dampening appraisals during positive events (e.g. think ‘this is too good last’) reduces positive emotion experience (Burr et al., 2017). Conversely, there is less evidence that engaging in amplifying appraisals during positive events (e.g. think ‘this is a sign of good things to come’) increases positive emotion experience. It is less well understood whether positive appraisal style also modulates positive emotion experience in young people. This talk will present a series of PhD studies exploring this question. First, data from survey studies will examine whether dampening and amplifying cross-sectionally and prospectively predict positive affective experience in young people. Second, an experimental study manipulating use of dampening and amplifying appraisals during positive memory recall in young people will be discussed. Third, an experimental study manipulating use of dampening and amplifying appraisals during a schedule positive activity (listening to music) in young people will be presented. Implications for targeting dampening and amplifying appraisals when working with depressed young people will be considered.

Looking forward to the future: targeting positive future imagery in adolescent depression
Victoria Pile, King’s College London

Background: Brain reward systems change and develop during adolescence (Giedd, 2008; Pizzagalli, 2014). The positive affect system guides people to anticipate and approach rewarding situations and disruption of this system is implicated in depression (Dunn, 2012; Taylor, Lyubomirsky, & Stein, 2017). However, our understanding of why anticipation for rewarding activities is impaired and how to cognitively target this process is limited. One avenue of exploration is mental imagery, which aids us in simulating rewarding events in our future (Holmes, Blackwell, Heyes, Renner, & Raes, 2016). In adults, data suggests that imagining positive events can increase positive affect as well as motivation and approach behaviour (Chan & Cameron, 2012; Pictet, Coughtrey, Mathews, & Holmes, 2011). Yet there has very little investigation of prospective mental imagery in adolescent depression. Here, we investigate this relationship in a series of studies.

Methods: Firstly, we explore the relationships between prospective imagery and depression in an adolescent sample (n=375; age 11-16). In addition, we examine whether positive future imagery could protect against depression following a negative life event. Second, we investigate whether cognitive responses to prospective imagery are associated with depression (n=870, age 16-18). Finally, we discuss novel cognitive techniques (developed in a recent feasibility randomised controlled trial) to target positive future imagery and the qualitative outcomes associated with this.

Results: Symptoms of depression were associated with having less vivid positive and more vivid negative mental imagery. Vividness for images of positive future events moderated the relationship between negative life events and depression. Development of the imagery techniques for enhancing positive future images will be discussed as well as emerging themes from the interviews, such as motivation and enhanced approach behaviour.
Conclusion: These findings suggest novel approaches to strengthen interventions for adolescent depression and highlight the importance of considering positive prospective cognitions in the assessment and treatment of adolescent depression.

**How Does Mindfulness Based Cognitive Therapy Bolster Positive Affect and How is This Related To the Prevention of Depressive Relapse?**

**Barney Dunn, University of Exeter**

It is increasingly recognised that Mindfulness Based Cognitive therapy (MBCT) builds positive emotions. However, how this comes about at a mechanistic level is poorly understood and it is largely unproven whether this relates to the relapse prevention effects of MBCT. The talk will present a range of published and unpublished studies examining this issue. First, data from survey studies examining associations between anhedonia and the observing, describing, acting with awareness, non-judging and non-reacting components of trait mindfulness (Jell et al., submitted; Yilmaz et al., in prep). Second, a secondary analysis of an existing RCT will examine whether changes in any of these components of trait mindfulness mediates the repair of positive affect in depression following MBCT relative to a waitlist control condition (Dunn et al., submitted). Third, findings from a series of experimental studies examining the impact on positive affect experience of manipulating the acting with awareness and observing components of mindfulness will be reported (Gadeikis et al., 2017; Jell et al, in prep). Implications for the refinement of MBCT to more explicitly target positive emotions (and the integration of mindfulness techniques into other acute treatments) will be discussed.

**Optimizing extinction learning mechanisms to enhance exposure therapy**

**Shira Meir Drexler, Ruhr-Universität Bochum, Germany**

Extinction learning, which creates new safety associations, is thought to be the mechanism underlying exposure therapy, commonly used for the treatment of anxiety disorders and post-traumatic stress disorder. The relative strength and availability for retrieval of both the fear and safety memories after extinction determine the response in a given situation. While the fear memory is often context-independent and may easily generalize, extinction memory is highly context-specific. ‘Renewal’ of the extinguished fear memory might thus occur following a shift in context. However, studies suggest that the success of the treatment can be improved by the use of cognitive/behavioral modification or pharmacological adjuncts, such as stress hormones. In the recent years, we have been investigating how the timing of stress exposure affects the return of extinguished fear using the fear conditioning paradigm. Our findings demonstrate a crucial role for stress timing (i.e., before or after learning or retrieval) in determining these effects. For instance, we found that stress induction after extinction learning enhances the contextualization of extinction memory, thus leading to an enhanced renewal. In contrast, stress exposure prior to extinction learning leads to a stronger, more generalized extinction memory, which is resistant to relapse following context change. Our findings support research investigating the use of glucocorticoids (stress hormones) or stress induction in exposure therapy and suggest the right timing of administration in order to optimize their effects.

**Angiotensin regulation of amygdala response to threat in high-trait anxious individuals**

**Andrea Reinecke, University of Oxford**

The antihypertensive drug losartan has been shown to improve memory in humans as well as learning and fear extinction in rodent models, highlighting its potential to have similar synergistic effects on exposure-based cognitive-behavior therapy (CBT) for anxiety disorders. This study investigated the effect of losartan on neural correlates of processing threat versus safety stimuli in highly anxious individuals, to identify potential pathways of how the drug might facilitate psychological treatment. 30 healthy volunteers high in trait anxiety were randomly assigned to a single dose of losartan (50mg) versus placebo, before undergoing functional magnetic resonance imaging. We measured brain response to happy and fearful faces presented for 80s, to assess emotional processing and habituation over time. The placebo group showed similarly high left amygdala activation early on during presentation of fearful and happy faces, which decreased over time. In contrast, losartan reduced amygdala response to happy faces early on. In response to fearful
faces, the drug prevented habituation, caused sustained amygdala activation, and led to increased activation in other brain areas associated with threat processing, such as the insula and putamen. Our findings suggest two distinct effects of losartan on emotional processing, including an improvement of early discrimination of stimuli as threatening versus safe, and facilitation of threat processing. Both these processes are known to be relevant for successful exposure, highlighting two potential pathways by which losartan might exert facilitative effects on psychological treatment.

The Role of Hours-Since-Waking and Sleep Quality in Facilitating Fear Extinction Learning and Reinstatement in PTSD
Daniel Zuj, Swansea University
Impaired fear extinction learning and memory are considered important theoretical constructs underlying the development and persistence of fear-related symptoms of Posttraumatic Stress Disorder (PTSD). Fear reinstatement refers to the return of fear following unsignaled encounters with an aversive stimulus, and in a clinical setting can be understood as the return of fear-related symptoms following spontaneous panic attacks. Poor sleep quality is a hallmark symptom of PTSD, and is shown to impair the learning of conditioned fear contingencies. Here, participants with PTSD, trauma-exposed controls, and non-trauma-exposed controls underwent a standardized fear conditioning, extinction, and reinstatement paradigm, and reported subjective sleep quality. There are three key findings that we wish to discuss. First, we found that hours-since-waking was a significant moderator between impaired extinction learning and PTSD symptoms. Second, greater PTSD symptom severity was associated with increased reinstatement of fear and greater sleep disturbances, and greater PTSD symptoms were also significantly associated with increased fear reinstatement and longer sleep onset latency. These results suggest that hours-since-waking and sleep quality (namely sleep disturbances and sleep onset latency) are important boundary conditions of fear extinction learning and reinstatement in PTSD, and may be important factors to take into account in clinical settings.

Self-efficacy as a potential mechanism to promote emotional learning in the therapy context
Armin Zlomuzic, Ruhr-Universität Bochum, Germany
Self-efficacy (SE), the perceived belief to cope successfully with demanding situations, is involved in the maintenance and treatment of phobic avoidance. Positive changes in SE have long been proposed as an important element of a successful cognitive-behavioral treatment. An increased SE improves adaptive emotional and behavioral responding in the context of anxiety-provoking situations, yet this conclusion is derived from studies which utilized correlational designs. The present talk provides an overview of our recent experimental studies which collectively investigated the causal relationship between SE, extinction memories and exposure-based treatment outcome. We will first present different approaches on how increased SE levels can be experimentally induced. These involve positive verbal persuasion and the reactivation of positive autobiographical memories. We will show how these experimental manipulations of perceived SE affect fear extinction learning and extinction retrieval. Our results suggest that an increased perceived self-efficacy is associated with enhanced acquisition and consolidation of extinction memories, evidenced on the psychophysiological and subjective level. In the next step, we will demonstrate how these preliminary findings can be translated into a useful clinical application to promote the success of exposure therapy in height phobia. Here, we will present data from a recent study comparing the effects of exposure (as a stand-alone treatment) versus exposure in combination with an intervention aimed at increasing SE. Our data suggest that acrophobic participants who had received an SE intervention in addition to exposure showed greater reductions in fear and avoidance of heights relative to those who had completed exposure as a stand-alone treatment. We will finally provide evidence on how an increased SE during exposure might contribute to enhanced generalization of exposure-based fear reduction across different stimuli and contexts. Our findings accord with recent translational research on the beneficial effects of enhancing SE to foster the acquisition and consolidation of extinction memories rendering it a promising strategy to improve the efficacy of exposure-based therapies for anxiety disorders.

Bringing Network Science into Cognitive Behavioural Therapy and Research
Potential applications of the network paradigm to familiar clinical research problems
Gary Brown, Royal Holloway, University of London

Knowledge and understanding of the network approach to psychopathology is growing among clinical researchers, who are just beginning to explore its potential. The approach was developed by methodologists with an interest in clinical applications, and the initial set of papers largely has used archival datasets and focused on psychiatric symptoms. Broader familiarity within the established clinical research community can be expected to result in the application of this new approach to cast new light on more familiar questions. Following a basic introduction to the approach and its main applications to date, three applications of network techniques are described. The first study is the closest to prior applications of network psychometrics and examines potential items for inclusion in a broadened PTSD scale to enable measurement of complex PTSD according to ICD-11 criteria. The second study considers validity data for a new measure of risk avoidance relative to measures of anxiety-related constructs. The final study examines the relationship of transdiagnostic cognitive biases in adolescents to a spectrum of symptom scales. Results are discussed in relation to potential future avenues of application, as well as potential pitfalls.

Personalized network analysis and risk for suicide: A case series of bereaved adults with complicated grief and suicidal thoughts
Donald Robinaugh, University of Amsterdam, the Netherlands

Complicated grief (also known as Prolonged Grief Disorder) is a bereavement-specific disorder characterized by prolonged, intense, and impairing grief. More than half of individuals seeking treatment for complicated grief report suicidal thoughts. However, the mechanisms by which complicated grief confers risk for suicidal thoughts are unclear. In this pilot study, we assessed the patient-specific relationships among complicated grief symptoms and their relation to suicidal thoughts in nine patients undergoing therapy for complicated grief. Patients completed assessments of nine complicated grief symptoms and the severity of suicidal thoughts via a smart phone application five times daily for two weeks before treatment, two weeks after treatment, and throughout a sixteen-week treatment protocol. We used vector autoregressive modeling on data from the first three weeks of data collection (up to 105 assessment points per patient) to assess intra-individual baseline complicated grief structure. In addition, we used time-varying vector autoregressive modeling to assess complicated grief and suicidal thoughts for the full duration of the study (up to ~840 assessment points per patient). We found that there were differences in network structure across patients, including differences in overall connectivity and in which nodes were most central to the network. Of particular interest, we found that the symptoms most strongly associated with suicidal thoughts also differed across patients. For example, for one patient, emotional pain, thoughts about the deceased loved one, and thoughts about the loved one’s death were each contemporaneously associated with suicidal thoughts whereas, for another patient, intense yearning to be with the deceased was the strongest contemporaneous predictor of suicidal thoughts. In addition, we consistently observed a negative association between grief-related approach behavior and suicidal thoughts, suggesting this symptom may in fact lower suicidal thoughts for a brief time. Together, these findings suggest that individual symptoms of complicated grief relate differently to suicidal thoughts and the mechanisms by which complicated grief confers risk for suicide may differ across individuals. Moreover, they suggest that personalized network analysis may be one tool by which clinicians and researchers can identify patient specific risk factors for suicide. Given this possible application, this talk will conclude with a discussion of the challenges faced in collecting and analyzing the data for this pilot study with the aim of informing future efforts to bring this method closer to routine clinical and research application.

Network models for clinical practice?
Laura Bringmann, University of Groningen, the Netherlands

In an effort to bridge the gap between clinical research and practice, more and more clinicians and researchers are using some form of experience sampling method to study, for example, individuals with depression in real time. These kinds of intensive longitudinal data give a wealth of information, but also lead to many new methodological challenges. In the recently popular network approach, the focus is on the dynamics between symptoms: Studying networks of causally interacting symptoms will give information on which symptom one should intervene. However, others have argued that
the network models used can get overly complicated, and that the focus should be more on the symptom scores themselves. On this approach, the important symptoms are those with a high average score, and they can be found through, for example, visualization techniques. In this talk, I will present and discuss both approaches. On the one hand, I will explain the newest kind of dynamic model (the time-varying vector autoregressive model) for inferring dynamical networks, and on the other hand, I will present new visualization techniques that can highlight the importance of items in research and clinical practice. Additionally, I will discuss advantages and disadvantages of both sides, and discuss new ways of thinking about the relative importance of symptoms for interventions.

Getting a grip on your mood: Implementing personalized feedback using experience sampling methodology (ESM) in the treatment of bipolar disorder
Fionneke Bos, Department of Psychology, University of Groningen, the Netherlands
Research has shown that the experience sampling methodology (ESM) offers unique and valuable insights into the daily lives of patients with psychiatric disorders. For patients with bipolar disorders especially, who are characterized by seemingly unexpected and uncontrollable fluctuations in mood, personalized information on their mood and the factors that influence it may benefit both patients and clinicians. In the present study, ESM was used with the aim to 1) identify warning signals for manic or depressive episodes, and 2) provide patients and clinicians with insights that may be helpful for the treatment and daily life of patients with bipolar disorder.

Twenty bipolar type I/II patients completed ESM questionnaires five times a day for four months (average 500 observations per person). Next, the treating clinician (i.e., psychiatrist, psychologist, or psychiatric nurse) discussed personalized ESM-derived feedback with the patient. This feedback included (1) variation in mood and symptoms, (2) mood in relation to activities, (3) characteristic symptoms for manic or depressive episodes, and (4) time-lagged associations between symptoms and behaviors (i.e., in a network). After three months, patients and clinicians were interviewed to qualitatively assess how ESM and ESM-derived feedback affected the patient’s treatment and daily life. Of the twenty participants, sixteen patients reported one or more manic episodes; depressive episodes were reported by fourteen patients. Interviews indicated that mood-monitoring as well as the personalized feedback increased insight and awareness in patients, and that these insights helped patients to make behavioral changes in daily life. Potential undesirable effects that were described included burden of assessment and negative reactivity to the assessments. Clinicians further mentioned ESM was helpful for shared decision making, identifying new targets for treatment, and increasing understanding between clinician and patient. To conclude, preliminary findings suggest ESM monitoring and ESM-derived feedback may be helpful treatment tools for patients with bipolar disorder. The utility of ESM for clinical practice will be discussed.

New developments in IAPT services

Using technology to help us understand what good CBT looks like in IAPT: Introducing the ‘8 Stage Model’
Sarah Bateup, Anglia Ruskin University
Cognitive Behaviour Therapy is an evidenced based psychological intervention that is widely recommended as the treatment of choice for common mental health disorders such as anxiety and depression. The effectiveness of CBT is widely documented with recovery rates in large scale randomized controlled trials ranging from 40% to 60%. Unfortunately, recovery rates in real world clinical settings, such as the UK’s Improving Access to Psychological Therapy (IAPT) programme are somewhat lower with some services reporting recovery rates as low as 18%. The variance in recovery rates has received much attention resulting in a range of hypotheses. However, very little is known about what NHS therapists are doing in the therapy room and many of the current hypotheses are based on conjecture rather than fact. One new method of delivering CBT online, using written communication, results in a therapy transcript for every session attended. This large data set of live therapy material is unique within the field of psychotherapy and provides the opportunity to answer a number of questions about what good CBT looks like in real world settings. The therapy transcripts of 238 BABCP accredited CBT therapists treating 7000 patients have been examined in order to answer the following questions:
Why are some CBT therapists better than others?

What therapist variables correlate with good clinical outcomes?

6 Clinical supervisors with previous experience of teaching on IAPT High Intensity Training Programmes were asked to rate therapy sessions using the CTS-R. In addition the raters were asked to identify which (if any) disorder specific treatment protocol the therapists were using. The Roth and Pilling disorder specific competencies were used to identify specific treatment protocols.

A clear correlation between fidelity to the CBT model and adherence to the evidence base was identified in the best performing therapists (top 10% with recovery rates in excess of 60%). Closer examination of the transcripts revealed 8 areas of the therapy process which, when executed poorly, resulted in low recovery rates. These areas have been defined as 'The 8 Stage Model'.

It is clear from previous literature that recovery rates are enhanced when clinicians provide CBT with fidelity to the model. However the lack of access to sufficient live therapy material has made it difficult for previous researchers to understand what CBT therapists are doing in the therapy room, within IAPT settings. The availability of written therapy transcripts resulting from Internet Enabled CBT delivered by Ieso Digital Health therapists (www.iesohealth.com) has, for the first time ever, provided the opportunity to understand more about therapist variables. It is clear that not all therapists are delivering CBT in alignment with the IAPT training curriculum and that there is often significant therapist drift. The '8 Stage Model' has been successfully used as a top up training method for accredited CBT therapists to support fidelity to the CBT model and adherence to the evidence base.

Supporting CBT therapists to deliver evidence based interventions with fidelity to the model has the potential to enhance recovery rates in services such as IAPT. The '8 Stage Model' is a simple and effective training tool that can be used to prompt and support therapists to provide effective treatment for patients.

“I'm not well” - Resilience building; ignorance, arrogance or common sense

Elaine Davies, Coventry University

There are those that say IAPT is more business than therapeutic model. Whether we accept these terms or not, the world of therapy has its challenges, especially those that sit in large organisational structures like the NHS.

Therapist resilience is becoming ‘a must have’; resilience training is left to trainers, supervisors and managers to build this process. For some of us resilience has never been developed, for some constant pressures can help it dwindle.

This paper will discuss the current literature on the well-being of staff and the retention rates in IAPT services. There will be anecdotal experiences by the author and anonymous feedback from staff and managers around the country. This discussion will not advocate building of resilience in place of discussing distress but offer some common sense of reality in the current world of psychotherapy.

By drawing on the work of Fava & Tomba (2009) and Padesky & Mooney (2012) this paper demonstrates by building in but not replacing treatments of evidence-based practice it will not only help the client but the therapist themselves. Working with heavy case-loads, outcome target driven therapy often just out of training we can forgive ourselves for easily forgetting that we were once resilient even if it was in another area of our life.

This paper is aimed at all who work in the talking therapies. For those who work in IAPT services this will be helpful to gain new knowledge and application skills from the inside out (Bennett-Levy 2015). It is also an opportunity to put your view across if what the critic say of IAPT is not the experience. Service managers, commissioners, therapists alike are encouraged to attend this open paper.

If we are to ignore the distress of our staff then this WILL have an implication for the service but more importantly the client. If we are to believe in the reasons for therapy then we have to act now in building new ways of coping and re-engaging with the old ways of communicating.

IAPT LTC Training: An overview and evaluation of the courses to date

Georgina Miles and Sarah Wilson, University of Sheffield

The need to improve outcomes and reduce over-use of services for patients with long term health conditions and medically unexplained physical symptoms (LTC/MUS) is an increasingly important
policy driver and concern for services. Thirty percent of the general population suffer from one or more LTC (Department of Health, 2011a). Co-morbid anxiety and depression symptoms are very common among this patient group, often creating increased ongoing health economic costs and poorer health outcomes (Edege and Ellis, 2010). LTCs can include diabetes (type 1 & 2), heart failure and Irritable Bowel Syndrome, to name a few. These patients also present a challenge to traditional physical and mental health services (which naturally either focus on the physical or psychological symptoms), as their needs span both disciplines. Evidence has been shown from pathfinder sites that IAPT services (with appropriate investment and support) can create stepped care systems and quickly adapt to working with LTC/MUS patients (Kellett et al, 2016). In 2017, HEE commissioned and funded LTC/MUS training for IAPT staff to support services in offering psychological interventions in physical health contexts. This paper presents the evaluation of the IAPT LTC/MUS training for the Yorkshire and Humber region. The training aimed to equip IAPT staff with extra knowledge, skills and confidence to work with the psychological health in the context of physical health. This paper will present the specific adaptations to the curricula, novel tools developed and evaluation data from the attendees.

National curricula have been developed for Psychological Wellbeing Practitioners (PWPs; 5-day course) and Cognitive Behavioural Therapists (CBT; 10-day course), otherwise referred to as low and high intensity CBT respectively. Two cohorts of two courses (N= 68 PWPs and N=72 CBT) were developed and delivered by N= 6 clinicians with a wide range of experience and expertise in providing low and high CBT in the context of physical health conditions. The learning objectives of the courses were to increase confidence in using extant low and high intensity CBT competences and to increase understanding around the management of chronic health conditions. Learning outcomes and evaluation forms were used throughout the courses to garner attendee feedback. University of Sheffield teaching evaluation tools were completed after each day of teaching (e.g. example items; usefulness of teaching content and relevance to clinical practice). Learning outcome questionnaires (e.g. example items; formulation and adaptation of extant CBT change methods) were completed pre and post training. Qualitative feedback from attendees was also gathered.

All courses were evaluated positively. All learning outcomes item scores when compared pre and post training demonstrated a statistically significant increase. For example, there was a significant increase in attendees' confidence in working with patients with LTC/MUS, use of formulation and also application of low and high intensity CBT change methods. Over 90% of attendees agreed or strongly agreed that the content was stimulating, relevant to clinical practice and felt encouraged to share their own clinical experiences with the group. The condition specific information was well received and reflected the largest perceived extant gaps in the participants' knowledge. Qualitative feedback focused on the themes of; appreciating the sharing of clinical knowledge and group discussions, valuing the variation in teaching methods (didactic, video clips, patients sharing their lived experience and role plays), the usefulness of specific theories and adaptations, valuing the experience of the teaching team and the helpfulness of being able to discuss the difficulties and complexities of working with this patient group.

The evaluation data suggests that LTC/MUS courses were positively rated by course participants in terms of both their delivery and content. There was wide ranging evidence of participants achieving the LTC and MUS learning objectives across the CBT and PWP course. There was a significant and positive change in clinical competencies needed to intervene psychologically with these client groups. All aspects of the course were well evaluated and evidence of individual learning across the programme was clear. For potential future cohorts, consideration is needed on how to incorporate the clinical experience already gained within services, the role of clinical; supervisors, balancing the needs of the service providers and also the design of the course to enable the best attendee experience (e.g. delivering the teaching over a few months in order to shape the participants clinical practice versus, delivering it over a few weeks to train the staff as soon as possible). A further area for research would be the development of low and high intensity CBT competency scales with LTC/MUS populations.

• Bespoke training increases the competency of IAPT qualified staff and increases their confidence in working with this specific patient group
• Short courses are appropriate
• Existing skills are easily built upon and adapted to meet the needs of the patient group
• CBT models appear useful and relevant in formulating the emotional distress in these clinical populations

**Accessible Depression and Anxiety Psychological Therapies for Long term Conditions (ADAPT for LTCs)**

Leeanne Nicklas, NHS Education for Scotland

This Transforming Primary Care project aims to test whether training graduates of the MSc in Psychological Therapies in Primary Care (MSc in PTPC) in competencies for working with persistent physical symptoms (PPS, Roth & Pilling, 2015) will improve the physical and mental health of people with long-term conditions (LTCs) and co-occurring anxiety and/or depression. The project aims to provide accessible, effective, person-centred, integrated care in primary care settings. The outcomes of training (e.g. knowledge, confidence, satisfaction) are evaluated, as well as patient uptake, satisfaction and clinical outcomes of the intervention (e.g. anxiety, depression, goals, quality of life) across one year. This project contributes towards NHS Scotland’s 2020 Vision with respect to Quality of Care: Improving our approach to supporting and treating people who have multiple and chronic illnesses (p. 9, 2013). The training enables staff to bridge the gap between mental and physical health services, creating joined up, accessible provision within primary care setting. The project aims to facilitate the delivery of the Scottish Mental Health Strategy model of ‘ask once, get help fast’ (Scottish Government, 2017). This pilot is delivering outcomes currently and the ambition is to expand the delivery for the future.

The project evaluates outcomes at all levels of the Kirkpatrick training evaluation hierarchy e.g. 1) outcomes of training (e.g. knowledge, confidence, satisfaction); 2) goodness of fit of the service (staff and patient satisfaction, referral rates) and 3) clinical outcomes of the intervention (e.g. anxiety-GAD-7, depression- PHQ-9, goals, quality of life-W&SAS, patient global improvement scale) allowing comparison with IAPT services and previous similar research such as the COINCIDE trial (Coventry et al. 2015).

Interim results:  
a) Nine graduates trained in the competencies for PPS. Immediate statistically significant changes (p<.001) in most knowledge and confidence items between pre- and post-training (expected to further increase at the end of the coaching period, March 2018). Very high satisfaction reported with training and coaching.  
b) Training delivered to 30 trainees on the current MSc in PTPC programme. Data analysis underway.  
c) Data for 45 patients with anxiety and/or depression, and co-occurring diabetes, heart disease and/or chronic pain collated and analysed to date (80 anticipated in analysis by June 2018). Very high satisfaction with intervention reported. Of those completing the intervention, 33% showed recovery from clinical anxiety and depression post-therapy, whilst 89% reported positive change in their quality of life after the intervention.

Graduates of the MSc in PTPC can be upskilled in the PPS competencies and provide a service with which patients with LTCs are highly satisfied, and from which their mental health can benefit considerably. Discussion will involve comparison outcomes with IAPT pathfinder sites and the results of the COINCIDE trial as well as consideration of how the project can be expanded in the Scottish primary care setting.

The training in this programme expands the CBT competencies of graduates of the MSc in Psychological Therapies in Primary Care to include many of those outlined in the Roth and Pilling competency framework for working with people with persistent physical symptoms, and in line with the IAPT curriculum for LTCs, expanding access to effective treatment for a wider range of patients. Training the practitioners involved in transdiagnostic CBT approaches for physical symptoms (Chalder, 2016) is an interesting implication for the everyday clinical practice in CBT, linking the range of CBT techniques applied in physical health by thinking of the underlying processes. In contrast to the COINCIDE trial or PWPs, the MSc graduates are high intensity therapists, providing brief CBT intervention in primary care based on case formulation and problem formulation (in line with White, 2001).

**An investigation into the predictors of burnout in IAPT therapists**

Lucy Turnpenny, University of Southampton

Improving Access to Psychological Therapy (IAPT) was launched in 2006, including investment in a new mental health workforce. Therapists operate within a context of target-driven work and high rates of client contacts. Unsurprisingly, researchers have started to investigate the levels of burnout
in this workforce (Steel, Macdonald, Schroder & Mellor-Clark, 2015). They discovered that Psychological Wellbeing Practitioners and High Intensity Therapists presented with signs of burnout. Their findings could be attributed to the infancy of IAPT. The current study extends this work to a more established workforce four years later, as well as to an exploration of further predictors of burnout. The General Model of Burnout (GMB: Maslach, Schaufeli & Leiter, 2001) proposes three components: emotional exhaustion, depersonalisation and (reduced) personal accomplishment. We hypothesised that IAPT therapists would still exhibit high burnout and that age, experience, job demands, healing and stressful involvement and general self-efficacy would be predictors.

A cross-sectional design was employed, using a web-based quantitative questionnaire to explore burnout and predictors of burnout in 112 IAPT therapists. Burnout was measured using the Maslach Burnout Inventory (MBI, Maslach, 1996). Data was collected from Psychological Wellbeing Practitioners and High Intensity therapists across four IAPT settings. A high level of burnout was exhibited; independent-samples t-tests confirmed emotional exhaustion and depersonalisation were significantly higher than that of five comparison samples including that of Steel et al. (2015). Regression models indicated emotional exhaustion was predicted by psychological job demands and stressful involvement; depersonalisation was predicted by experience, supervisor support and stressful involvement; personal accomplishment was predicted by healing and stressful involvement with clients.

Results indicate that staff burnout may represent a significant challenge for IAPT services. Previous studies of mental health staff have linked burnout with higher rates of sick leave, poor job commitment and performance, and increased staff turnover. Burnout has also been associated with quality of care delivered by staff (Salyers et al., 2015). It may be timely to take action to reduce burnout within the IAPT workforce. Therapists’ perceptions of their relationships with clients may represent a promising area for intervention. Future research should assess the role of control within IAPT therapists’

Results suggest that IAPT therapists are on a worrying trajectory of burnout; services are encouraged to address this with staff, and some recommendations are discussed.

Clinical and service level interventions and outcomes for people with intellectual disabilities who offend

No abstracts provided

How does attachment theory enrich CBT for psychosis?

**Katherine Newman-Taylor, University of Southampton & Southern Health NHS Foundation Trust**

Attachment theory assumes that the development of bonds in early life influences our ability to form trusting and secure relationships in adulthood. Arguably, psychosis is an inherently interpersonal set of experiences – paranoia is characterised by threat beliefs, and voices are by definition experienced as ‘other.’ We know that people with psychosis are more likely to report early adversity, often struggle to maintain stable adult relationships, and can find it hard to engage therapeutically. Attachment theory may help us make sense of psychosis in developmental context, and target interpersonal beliefs and behaviours that maintain distress.

In a series of preliminary experimental studies, we have examined the impact of attachment-based imagery in people with high levels of non-clinical paranoia. These studies indicate that priming secure attachment can reduce paranoia and anxiety, and that insecure attachment imagery can have the opposite effect. These studies are limited in terms of follow-up data and exploration of mechanisms of change, and have not yet been tested robustly in clinical groups. Nevertheless, the results are promising and provide a reasonable basis for suggesting that attachment theory and linked paradigms could enrich CBT for people with distressing psychosis.

The impact of imagery on non-clinical paranoia
Alison Bennetts, University of Southampton
Mental imagery is implicated in the maintenance and treatment of persecutory delusions, and yet there is limited experimental evidence for the specific role of imagery in paranoid ideation. This study investigated the impact of mental imagery in an analogue group with high levels of paranoid ideation. We anticipated that positive interpersonal / secure attachment imagery would reduce anxiety, paranoia and negative beliefs about self and others, and that negative interpersonal / insecure attachment imagery would have the opposite effect.
Twenty-four university students took part in a 3 x 3 mixed model design. The study compared the impact of three types of imagery (positive / secure, negative / insecure and neutral) across three time points (pre, post and one week follow up) on measures of mood and cognition associated with the maintenance of paranoia.
Imagery priming yielded large effects on state and trait measures of mood, paranoia and beliefs about self and others. Although the study was underpowered, the effect sizes indicate that imagery had a clear impact on mood and cognition hypothesised to maintain paranoid ideation. Rates of attrition suggest that the experimental procedure was burdensome and should be improved. Replication with a simplified procedure and a clinical sample is now warranted.

Attachment-based imagery for people with first episode psychosis: A single case series
Cathryn Pitfield, University of Southampton
Paranoia occurs along a continuum across clinical and non-clinical populations, and is one of the most common experiences of psychosis. It has been suggested that an insecure attachment style constitutes a vulnerability to later psychosis and an impediment to recovery, through problematic beliefs about self and others, and affect regulation. Priming secure attachment may be an effective means of accessing alternative interpersonal beliefs and therefore attenuating paranoia. Building on experimental studies in analogue groups, this study aimed to assess the impact of attachment priming on paranoia and anxiety in people with clinical levels of paranoia. We used a single-case series to determine whether a simple attachment-based imagery task reduces levels of paranoia and anxiety in people with psychosis. This design allowed us to examine session by session change over baseline, intervention and follow-up phases. We also sought feedback from participants on the experience of the imagery task. These subjective comments complement the quantitative data, and inform clinical and research implications.

Using attachment theory to inform whole team formulation: A prospective study
Andrew Gumley, University of Glasgow
Background: Based on our previous findings that insecure attachment is associated with poorer recovery over the 12-months following a First Episode Psychosis we developed and evaluated an Integrated Care Pathway for early psychosis that facilitated (a) early problems in services engagement, (b) multidisciplinary formulation of their needs, and (c) the development of a formulation based approach to multidisciplinary intervention. Methods: We designed a prospective cohort study of individuals with a first episode of psychosis and routinely assessed service user, carer and service based outcomes. Results: We identified and followed up 80 participants. Of this group 52 (65%) met our apriori criteria for Poor Engagement (PE) and 28 (35%) meeting criteria for Good Engagement (GE). We found that of the PE group identified at 3 and 6-months, 40.9% showed improved engagement at 12-months. The Improved Engagement (IE) had significantly more improvement in PANSS emotional distress and PANSS Total. We also noted that in comparison to our previous research improved access to psychological therapies during the 12-month follow-up. Conclusions: The use of attachment based formulation to support co-ordinated multidisciplinary care for those with a first episode of psychosis appears feasible. We also noted that important signals of improved service engagement were associated with improved outcomes. Staff valued the role of formulation in shaping their understanding and response to service users. Service users and their families valued the role of stable and reliable relationships in developing trust and collaboration.
Online Cognitive Behavioural Therapy: Examining its acceptability, effectiveness, and implementation in UK care contexts

Development of COMPASS – Navigating your long-term condition online cognitive behavioural therapy programme for people experiencing depression and anxiety in the context of a physical health condition
Katrin Hulme, King’s College London

Digital tools are increasingly recognized as having a promising role in modern mental healthcare (Hollis et al, 2015). Assessment is one significant area which could benefit. Within psychological therapy services such as IAPT, assessment is a crucial function, to determine patients’ suitability for, and allocation to, various treatment options. Within IAPT, over 900,000 people are assessed each year and this is forecast to rise by a further 50% over the next three years. However, the quality of problem descriptor identification is variable, and has been found to be predictive of improved treatment outcomes (Clark et al, 2017). Therefore, tools (including digital tools) which could assist with timely and accurate problem identification may be valuable. However, such digital initiatives are not without implementation challenges; some technical innovations never make the transition from laboratory to clinical setting and uptake of eHealth initiatives is often low (Mohr et al, 2017; van Limburg et al, 2011).

This talk will describe the early development phase of a project to develop an intelligent, online assessment tool to assist in accurate problem identification and tailored care planning. Central to the early conceptual stage is establishment of stakeholders, and constructive involvement from staff and service users. More broadly, an iterative development methodology was chosen, allowing for multiple rounds of feedback.

A variety of illustrative stakeholder feedback will be presented, formative to the project development, including on service needs, putative design, usability and acceptability of the interface, personalisation and patient choice, safety and ethical considerations, and service integration and interoperability requirements. Plans for the next iterations of development and evaluation stages will also be reported.

As will be discussed, there are multiple challenges to address in such a project. Digital tools hold enormous promise to help streamline and improve services and the personalisation and quality of the services they offer to patients. With the right approach, it is envisaged to create an acceptable, safe, personalised and effective system, with widespread potential to improve clinical care.

“I see myself as a little warrior”: Patient perceptions of online-CBT for distress in haemodialysis
Joanna Hudson, King’s College London

Psychological distress is common in haemodialysis. However, access to cognitive-behavioural therapy (CBT) tailored specifically to manage distress associated with haemodialysis is limited. Online CBT is a pragmatic solution. This nested qualitative study explored the utility and acceptability of the improving distress in dialysis (iDiD) online CBT programme among haemodialysis patients randomised to either the therapist supported or unsupported arm.

Nested semi-structured interviews within the iDiD feasibility randomised controlled trial were performed on 14 haemodialysis patients (11 supported arm; 3 unsupported arm). Interviews occurred either face-to-face or over the phone post-treatment. Thematic analysis was performed. Four distinct yet interrelated themes were identified. Two themes centred on utility. First, patients valued the tailoring of iDiD CBT “active ingredients” to the renal context. Second, patients commented on downstream improvements on health outcomes – notably confidence, agency, and resilience with limited reference to changes in negative affect. Two themes related to acceptability. First, patients identified external (e.g. time) and psychosocial barriers (e.g. emotional readiness) to sustained engagement. The second theme highlighted the value of human cognitive and emotional intelligence gleaned from patients in the supported arm. An overarching theme also emerged: haemodialysis illness trajectory. Opinions about iDiD were contextually linked to current and past illness stressors.

iDiD was perceived as a useful intervention. The most commonly reported patient gains were an improved self-concept of their ability to manage multimorbid illness rather than distress specifically. Framing iDiD as a self-management support tool rather than an intervention for psychological
distress may promote uptake and the therapist plays a core role in tailoring the content to the idiosyncratic needs of patients. These findings suggest that when measuring the effect of online CBT for psychological distress in long-term conditions (LTC) it is likely important to simultaneously explore its impact on processes that support a patient in self-managing their LTC, including improved confidence, agency, and resilience. Provision of therapist support alongside online CBT will help to personalise the content of online CBT to the evolving needs of patients with LTCs.

Regul8: Web-based cognitive behavioural therapy (CBT) for treating irritable bowel syndrome (IBS)
Rona Moss-Morris, King's College London
Introduction: Prevalence of IBS is around 12% of the population. There is accumulating evidence that CBT reduces symptom severity, interference of illness on life roles, and distress in patients with IBS, but access to CBT is currently limited and therapy costs can be high. To potentially expand availability of CBT we developed a web-based CBT self-management programme called Regul8. This presentation will outline the development process, key features of Regul8 and adherence data based on two randomised controlled trials (RCTs).
Method: Regul8 was based on an existing manualised programme developed around an empirical cognitive behavioural model of IBS. LifeGuide software was used to develop the website. As each module was developed, ‘Think Aloud’ interviews were undertaken with four patients with IBS to ensure that the website was relevant, understandable, and user friendly. Feedback was used to modify the site. The intervention consisted of 8 sessions. Interactive, tailored components were designed to personalise the treatment and to help users to remember advice, reflect and provide a “substitute” for the therapist. In each session participants review key points from the previous session and their homework, thereby reinforcing previous learning. Regul8 was first trialled in the primary care based MIBS three-arm pilot study (n=135) where patients were randomised to either Regul8 with a 30-minute introductory telephone session with a primary care nurse, Regul8 alone, or treatment as usual (TAU). A second three-arm RCT (ACTIB) (n= 558 recruited from primary and secondary care) elaborated on in the next talk, included a Regul8 arm with three 30-minute telephone sessions with a trained CBT therapist over 9 weeks + two 30 minute boosters at 4 and 8 months (2 1/2 hours therapist time).
Results: Qualitative data from the MIBS trial suggested most participants felt the web format was easy to follow. Three types of engagement were identified (1) limited/no engagement, (2) engagement with content on practical lifestyle changes, and (3) engagement with content on how emotions and thoughts affect IBS (as well as lifestyle changes). Compliance was defined as completing 4 or more sessions. 51% participants randomised to Regul8 only and 61% randomised to Regul8 plus nurse support complied. In ACTIB, treatment compliance was defined as taking part in 1/3 phone sessions and accessing at least 4 web sessions. Approximately 88.1% of participants allocated to the WCBT arm completed at least one phone call, and 69.8% completed 4 web sessions. ACTIB qualitative data suggest patients valued having therapist support alongside Regul8, enhancing their engagement and outcomes. The perceived high quality of the intervention itself also facilitated adherence.
Discussion: Regul8, developed based on theory, empirical evidence and user led feedback was perceived to be relevant and high quality. Patients in both primary and secondary care found it an acceptable way to receive CBT for IBS. CBT therapist or nurse support appear to enhance engagement.
Conclusion: Future trials should explore the optimum number of therapy sessions to maximise Regul8 effectiveness and compare support by CBT therapists to support by nurses receiving basic training to support the website.

Assessing therapist delivered cognitive behavioural therapy and web-based self-management versus treatment as usual in irritable bowel syndrome (ACTIB): a randomized trial
Trudie Chalder, King's College London
Introduction
Cognitive behavioural therapy (CBT) is an evidence based treatment for people with irritable bowel syndrome (IBS). This randomised controlled trial (RCT) explores the clinical effectiveness of two forms of CBT for refractory IBS.

Method
We recruited patients with refractory IBS from 74 general practices and three gastroenterology centres in the UK. Participants were randomly allocated to receive therapist delivered telephone CBT and a self-management manual (TCBT), web based CBT (WCBT) with minimal therapist support or treatment as usual (TAU). Primary outcomes were the self-rated irritable bowel syndrome symptom severity score (IBS SSS) and the Work and Social Adjustment Scale (WSAS) at 12 months after randomisation. Outcome measures were participant self-completed. Intention to treat analyses with multiple imputation were conducted. The therapist delivered CBT group received a CBT manual and six, 1 hour telephone CBT sessions with trained therapists over 9 weeks and two booster sessions at 4 and 8 months. The WCBT group received access to the interactive, CBT website with 8 online sessions over 9 weeks at home, with similar content to the therapist CBT, and received three, 30 minute therapist telephone CBT sessions and 2 boosters at 4 and 8 months. The trial is registered: ISRCTN44427879.

Results
558/1452 (38.4%) patients screened for eligibility were recruited. 186 were assigned to TCBT, 185 to WCBT and 186 to TAU.

Primary outcomes: Compared to TAU (IBS SSS score of 205.6 at 12 months), IBS SSS scores were 61.6 (95% CI 89.5 to 33.8) points lower (p<0.001) in TCBT and 35.5 (95% CI 58.0 to 13.1) points lower (p<0.001) in WCBT at 12 months. WSAS score in TAU was 10.8 at 12 months and was 3.5 (95% CI 5.1 to 1.9) points lower (p<0.001) in TCBT and 3.0 (95% CI 4.6 to 1.3) points lower (p<0.001) in WCBT.

Secondary outcomes: Global improvement of symptoms and patient enablement were also significantly improved (p<0.001) in the CBT arms.

Discussion
The findings from these studies concur with the UK National Institute for Health and Clinical Excellence guideline for IBS.

Conclusion
Both TCBT and WCBT showed significant improvement compared to TAU for patients with refractory IBS at 12 months.

Clinical-effectiveness, cost effectiveness and acceptability of low-intensity interventions in the management of obsessive-compulsive disorder: the Obsessive Compulsive Treatment Efficacy Trial (OCTET)
Judith Gellatly, University of Manchester

Obsessive compulsive disorder (OCD) is a significant cause of disability. Cognitive behaviour therapy (CBT) with a specialist therapist is recommended (NICE 2005), but patient access is poor because of limited numbers of therapists. CBT can be delivered in less intensive forms using written or online materials with support from less specialist staff. These 'low-intensity' CBT interventions include computerised CBT (cCBT) or guided self-help with written materials. Low-intensity CBT interventions can be provided more quickly, which may provide more rapid symptom relief, reduce the need for costly therapist-led CBT, and improve long-term outcomes.

We tested the clinical and cost-effectiveness of two forms of low-intensity CBT prior to therapist-led CBT, in adults meeting DSM-IV OCD criteria. A randomised controlled trial (n= 473) with three arms in patients with OCD was conducted. All patients were on a waiting list for therapist-led CBT (treatment as usual). Two groups additionally received one of two low-intensity interventions while waiting for therapist-led CBT: cCBT (OCFighter, CCBT Ltd) with telephone support, or guided self-help (Lovell & Gega 2011 - Obsessive Compulsive Disorder: A Self-Help Book), with written materials and weekly support. Support was provided by a trained Psychological Wellbeing Practitioner (PWP). The primary outcome was OCD symptoms at 3, 6 and 12 months, measured using the Yale Brown Obsessive Compulsive Scale (YBOCS, Goodman et al 1989). Secondary outcomes included health-related quality of life and costs. Acceptability of the two interventions among patients and professionals was also explored in qualitative interviews.
At 3 months, guided self-help demonstrated modest benefits over waiting list in reducing OCD symptoms (adjusted mean difference = -1.91, 95% CI -3.27 to -0.55). cCBT did not meet clinical significance (adjusted mean difference -0.71, 95% CI -2.12 to 0.70). At 12 months, neither guided self-help nor cCBT led to differences in symptoms, but significantly reduced the uptake of therapist-led CBT which did not appear to compromise outcomes. Guided self-help was more expensive to deliver than supported cCBT, both were cheaper than high intensity CBT. At 12 months there was a greater probability of guided self-help and cCBT being cost-effective compared to waitlist from health and social care perspectives and societal perspective (80%). In exploring the acceptability of the interventions with patients and PWP's they were regarded as increasing service flexibility; overcoming intervention access barriers and sustained, where desired, a sense of anonymity or privacy in care. Patients were more satisfied with guided self-help.

This study is the largest trial of OCD psychological therapies worldwide. Despite the lack of clinically significant differences in outcomes, the economic analyses suggest an important role for low intensity interventions in the care pathway for OCD.

Providing low-intensity interventions may simplify delivery and infrastructure needs, reducing pressure on therapist-led CBT services and is likely to be cost-effective.

Panel Discussion: Should we be depressed about the effectiveness of CBT for Depression?

Jon Wheatley, Homerton University Hospital NHS Trust; Speakers: Stirling Moorey, Kings College London; Shirley Reynolds, Charlie Waller Institute, University of Reading; Barney Dunn, Mood Disorders Centre, University of Exeter; Stephen Barton, University of Newcastle; Ioana Cristea, Babes-Bolyai University, Romania; Steve Hollon, Vanderbilt University, USA

With new NICE guidelines on the treatment of depression published this year and recent meta-analyses questioning the effectiveness of CBT, it’s time to debate just how good we are at treating what Richard Layard has called the UK’s ‘biggest social problem.’

A meta-analysis (Johnsen and Friborg 2015) that was widely covered in the national press reported a significant negative relationship between publication year and the effect sizes of cognitive-behavioral therapy for depressive disorders, suggesting that its effectiveness was falling. In 2017 a more complete analysis of the RCTs of CBT for depression concluded that there are no indications that the effectiveness of CBT for depression is reducing and that the ‘fall’ suggested by Johnsen and Friborg was most likely spurious (Cristea et al, 2017).

Whether its effectiveness is falling or not, even the best randomised controlled trials of CBT only achieve 50% recovery rates. Many of those who do recover are still left with residual symptoms which are a well-established risk factor for relapse (Paykel et al, 1995). Even in 'gold standard' studies of acute treatment, under half sustain response over 12 months (Hollon et al, 2005, Arch Gen Psychiatry). Depression is often recurrent: 50%, of patients with one episode of depression will have further episodes, after 2 episodes this rises to 80%. These outcomes are considerably worse than the recovery rates achieved for most of the anxiety disorders.

The panel speakers will draw from their extensive experience working with depression in adults, children and young people, offering perspectives from clinical practice, supervision, training, outcome research and basic process research. The panel will consider the following questions: What recovery rates can we hope to achieve and what can we do to prevent relapse? Do we know enough about the key cognitive and behavioural processes that cause and maintain depressive episodes? Why are CBT treatments for anxiety disorders more effective than our treatments for depression and what can we learn from them? Does our outcome data so far mean that a healthy dose of depressive realism is needed or does recent research suggest that we can look forward to a brighter future?

Experiences of psychological and physical health problems

Culture specific factors related to disordered eating in India and the UK: A qualitative investigation

Latika Ahuja, University of Exeter

Eating disorders (ED) are severe mental conditions; marked by physiological, psychological and social impairment, distress and reduced functionality. The extant literature provides prevalence
rates of ED in India between 15.4% to 20.8%; a surprisingly high rate given that thinness has not previously been a culturally valued attribute in India. Most research examining factors associated with ED in India have primarily investigated Western correlates; there is little examining Indian specific factors. For this reason, we conducted a qualitative study that aimed to explore factors associated with disordered eating in UK and India; and if culture specific factors are related to disordered eating.

Using a semi-structured interview scale, fifteen interviews were collected from each country. The data were analysed using thematic analysis, adopting an inductive approach. The findings suggest that the participants conceptualized disordered eating differently across the two cultures. Five main themes, each with sub-themes were identified: communication of thoughts and emotions; positive distinctiveness; pressure of achievement; control and freedom to choose and rejection.

Indian participants defined disordered eating more narrowly, while British participants defined it more broadly. This difference was due to the awareness of eating disorders. Though the emerged themes were common to both the countries, the developmental pathway of disordered eating varied due to culture.

Understanding the source of disordered eating and the core beliefs that individuals with ED have in a culture specific context, will contribute in tailoring of culturally adaptive interventions. This work will also contribute in designing culturally aligned preventative strategies for high risk population.

Development and Validation of the Southampton Acceptance Scale (SAS)

Zoe McAndrews, University of Southampton

Existing measures of acceptance have been subject to critique regarding content validity, discriminant validity, and conflation of process and outcome. Dimensionality of acceptance and non-acceptance is also yet to be satisfactorily determined, which raises questions for the validity of many existing acceptance measures whose questions are almost exclusively reverse scored. The present research describes the development of a new measure of acceptance, the Southampton Acceptance Scale (SAS). In a series of studies, we explore the factor structure, validity and reliability of this new measure.

In study one, ACT experts rated the face and content validity of 120 items, which resulted in the initial 52-item pool, and non-experts gave feedback on these items. For study two, a non-clinical sample (N=269) completed the item pool. Exploratory factor analysis suggested a theoretically coherent two-factor solution, labelled as “openness and willingness” and “control and avoidance” for an 18-item version of the SAS. In study three, an independent non-clinical sample completed the refined 18-item SAS, in addition to measures of theoretically related and unrelated variables. A confirmatory factor analysis was performed, in addition to assessments of internal consistency, concurrent, convergent and discriminant validity. Study four utilised another independent sample to determine test-retest reliability.

Results will be summarised and implications discussed.

Measuring cognitive-affective processing: The critical need for estimation and reporting of reliability

Sam Parsons, University of Oxford

Cognitive measures of emotional processes are widely used in the investigation of emotional disorders. An often neglected, yet important, issue with cognitive assessment in psychology is the internal consistency, or reliability, of task outcomes. While it is common practice to report the internal reliability of questionnaire measures in psychology, it is the exception rather than the rule to report task reliability for cognitive measures (Gawronski, Deutsch, & Banse, 2011). Given that the internal consistency of a measure directly influences the precision of our statistical analyses and
therefore the confidence we can place in our results, we recommend that researchers routinely estimate and report the internal consistency of their cognitive-affective measures. We describe several useful tools that have been developed for this purpose. We propose that the practice of routinely reporting the internal consistency of our measures will significantly improve the development of measures and researchers' ability to assess the robustness of empirical findings in affective science.

Volunteers’ experiences of helping hoarders and hoarders’ experiences of being helped
Kirsty Ryninks, University of Bath
Compulsive hoarding is widely thought of as difficult to work with and evidence suggests that services face substantial challenges in treating clients (Turner, Steketee & Nauth, 2010). Studies repeatedly report modest successes and high rates of drop out when working with this client group (Steketee & Frost, 2007). It is important to understand the factors that act as barriers and facilitators in supporting people with compulsive hoarding but few studies have examined this. The present study aimed to qualitatively explore the experiences of compulsive hoarders and volunteer helpers within the context of a UK-based charity providing support to older adults with hoarding difficulties.

A total of seven volunteers and four clients were recruited and interviewed using a semi-structured interview, designed to explore experiences of providing and receiving help. All clients self-identified that they had a problem accumulating and saving numerous possessions for which they had never previously sought professional help. The Clutter Image Rating Scale (CIRS; Frost, Steketee, Tolin & Renaud, 2008) was used to confirm presence of hoarding difficulties. Volunteers had worked in the project for an average of 11 months (ranging from 4 to 24 months) and all had completed training as part of their induction. Qualitative analysis of the interview data was performed using Interpretive Phenomenological Analysis.

Four superordinate discrete, but interacting themes were identified. The relationship that formed between client and volunteer was crucial in providing a trusting foundation from which clients felt able to move forward. Volunteers provided a space for clients to talk, and reported that appropriate self-disclosure helped to build a relationship. The informal and ‘non-professional’ status of volunteers enabled clients to take the lead and feel more in control of the therapeutic process. Volunteer flexibility and lack of time constraints were also seen as important and contributed to clients ‘making space’ in their lives and in their homes. The support from the volunteers enabled clients to ‘live life again’ and created a domino effect, bringing about improvements in other areas of both of their lives. A number of challenges were also identified. This study provides a detailed exploration of volunteers’ experiences of helping hoarders and hoarders’ experiences of being helped. The findings will be discussed in relation to the training of health professionals to work with people with hoarding difficulties and the implications of the findings for treatment approaches and service provision.

The association between knowledge of HPV and feelings of shame, depression and anxiety in women with cervical cancer
Amy Caswell, University of Bath

Close to 100% of cervical cancer cases are associated with high-risk strains of HPV, a common infection transmitted through intimate skin to skin contact during sex. Cervical cancer is therefore considered a "preventable" cancer. Women with cervical cancer are at particular risk for poor mental wellbeing. There is some preliminary evidence that the sexually transmitted nature of HPV may be associated with increased shame, depression and anxiety in women with cervical cancer, however this has never been directly explored.

The current study used a repeated measures design to explore whether information about HPV being sexually transmitted is associated with increased levels of shame, and whether information that HPV is very common is associated with reduced shame. 110 women with cervical cancer read different levels of information about HPV and cervical cancer, before completing measures of shame and wellbeing.

The results indicated that information that HPV is sexually transmitted was associated with increased state shame, lower mood, poorer wellbeing and increased anxiety. Higher levels of shame
were associated with increased depression and anxiety and poor wellbeing. Information that HPV is very common was not associated with reductions in depression. The current study suggests that knowledge of HPV is associated with shame, depression and anxiety, and therefore has important implications for the wellbeing of women with cervical cancer. The findings indicate that women with higher levels of shame may be at particular risk for increase depression and anxiety. These results suggest that the presentation of HPV information to patients should be considered carefully, to reduce experiences of shame, and that women who are experiencing high levels of shame should be considered to be at risk of depression and anxiety. The study has implications for the application of CBT in "preventable" health conditions. The study indicates that accurate knowledge of the causation of the condition may be associated with increased shame and low mood. This suggests that the application of CBT should include addressing shame and mood associated with said knowledge.

Developing treatments for children and young people

First episode psychosis: a comparison of caregiving experiences in parents caring for the same child
Caroline Floyd, Harrow and Hillingdon Early Intervention in Psychosis Service, Central and Northwest London NHS
The first onset of psychosis can be a traumatic event for many service users but can also impact negatively on family carers. Family carers are diverse; however, many parents will assume this role. Though we have a good understanding about the impact of caregiving in psychosis, very little is known about how parents within the same household appraise their child’s difficulties. Thus, in a sample of parental dyads caring for the same child with first-episode psychosis, the current study assessed their similarities and differences in key caregiving experiences. The study employed a cross-sectional design. 44 mothers and 44 fathers caring for the same child, accessing an early intervention in psychosis service, completed a series of self-report measures on caregiving experiences, illness beliefs, coping styles and affect.
Parents of the same child tended to report similar levels of emotional dysfunction and conceptualise the illness in broadly similar ways. Significant differences, however, were identified in approaches to coping and beliefs about the timeline of the illness. Mothers recorded significantly higher levels of emotion-focused coping compared to fathers (p=.028), and were also more likely view the illness as cyclical (p=.021).
Following a first-episode of psychosis, parent caregivers of the same child are likely to report similar caregiving appraisals with exception of coping styles and beliefs about the illness timeline. Efforts to ensure staff awareness of the potential areas of divergence in parental caregiving appraisals and exploring the implications for quality of the caregiving relationship and patient outcomes are indicated. Implications for service provision will be discussed.
1. As mothers and fathers were so similar in beliefs and emotions, we will know what unassessed parents are likely to be experiencing outside services knowledge. Parents will have similar beliefs and levels of risk for negative outcomes such as burnout, anxiety, depression and subjective burden.
2. We do not need separate interventions for mums and dads.
3. Couple interventions, as opposed to individual interventions, could be a clinically efficient way to help both parents.

Using imagery rescripting to treat spider phobia in a young person with autism: The case of Dame Wash-a-Lot and friends
Mia Foxhall, University of Bath
The report presents the case of a 15 year old female with an extreme phobia of spiders that contributed to extreme anxiety when leaving home. Her phobic reactions were multi-modal, including spontaneous, distorted images of spiders and physiological responses associated with disgust. Whilst verbal cognitions are readily recognised and managed in CBT, imagery rescripting as a supplement to in-vivo exposure may promote changes to such sensory experiences.
The single case design describes a CBT intervention incorporating in-vivo exposure supplemented with relaxation training and imagery rescripting. Measures of anxiety from client and parent were employed at assessment and review, and subjective units of distress were recorded throughout. Outcomes indicate that the treatment paradigm successfully reduced phobia intensity, and indicated a reduction in generalised anxiety, though the latter remained within clinical limits. Anecdotally, the client reported that imagery-rescripting was the most helpful element in aiding comfort with the intervention. Outcomes indicate that the intervention helped reduce specific phobia, generalised anxiety and overall anxiety and depression in a young person with autism. The latter two both reduced below clinical threshold, although remain within a borderline range. It was not possible to isolate the effects of the imagery rescripting, but anecdotal evidence from the case study provides promising evidence and indicates the need for further research. The results are discussed in the context of the client’s idiosyncratic presentation, before considering limitations and directions for future research. Imagery techniques for the treatment of anxiety may be well-suited to younger clients but are infrequently used. They may be particularly appropriate for those with fearful images associated with phobic stimuli. To our knowledge, this is the only available study exploring the use of imagery rescripting to supplement traditional CBT treatment of childhood specific phobia, and recommendations about how this can be implemented creatively. This is a simple technique that can be used readily by practitioners and may support future treatment of childhood phobia where imagery contributes to the cognitive and behavioural experience.

A pilot controlled trial study of life skills classes for young people with low mood and anxiety in Pakistan
Amna Khalid, Fatima Jinnah Women University, Pakistan
Low mood and anxiety are serious mental health problems affecting children and adolescents. In Pakistan, about 17% secondary school adolescents report symptoms of depression while 21.4% report feeling anxious. Cognitive behavioral therapy (CBT) is a recommended treatment for low mood and anxiety however access in Pakistan is limited. Living Life to the Full (LLTTF) is an eight weeks intervention based on CBT which has been used in UK and is effective and cost-effective (Williams, 2017). This study aimed at examining the feasibility of Urdu version of LLTTF for use with adolescents in Pakistan in class room settings. Intervention was delivered through guided self help in group format in two secondary schools (one boys and one girls school). 26 participants were randomly assigned to treatment group while 23 were assigned to control group. Urdu version of the Generalized Anxiety Disorder Scale (GAD-7), Patient Health Questionnaire (PHQ-9) and Client Satisfaction Questionnaire were used at baseline, post-intervention and three months follow-up. A comparison of baseline and post-intervention assessment suggests that intervention was helpful in significantly reducing the symptoms of anxiety GAD – 7 (U=20, p < 0.05) and depression (U=101, p<0.05) in the treatment group as compared to the controls. The results from generalized linear model show that the effect of intervention retained at the three months follow-up. Mean score of CSQ-8 was estimated to be 30.15 (SD = 10.99), from a total range of 8-32 indicating that the treatment group was highly satisfied with the Urdu version of LLTTF intervention. Urdu version of LLTTF intervention was found to be feasible for use in a guided self help format with Pakistani adolescents for treating low mood and anxiety. The initial roll-out and learning /evaluation of the Urdu version of LLTTF shows that this interventions can be effective for treatment of low mood and anxiety among Pakistani secondary school adolescents. CBT can be an effective intervention for treatment of low mood and anxiety among adolescents in Pakistan and similar settings. Low intensity CBT based interventions can be effectively delivered through guided self help in school settings. Recruitment of participants and delivery of intervention is feasible in schools in low to middle income countries.

CBT for misophonia in an adolescent: a single case experimental design
Sally McGuire, University of Bath
This case report describes using CBT with a 15 year-old white British female, who was referred to Child and Adolescent Mental Health Services (CAMHS) for misophonia. The client experienced discomfort upon hearing sounds generated by other people, such as breathing, chewing and swallowing. The client avoided these sounds, an approach which particularly affected her ability to participate in family life.

A single-case experimental design with A/B phases was used to determine whether CBT was effective, where Phase A was the assessment and Phase B was the formulation and intervention using a CBT approach. A maintenance cycle was developed collaboratively with the client which showed that the client experienced anger in response to a misophonic trigger, which was responded to with avoidance behaviours. This, together with beliefs about the perpetrators, was hypothesised to be maintaining the problem. The intervention consisted of exploring the role of thoughts, feelings and behaviours in this cycle, and experimenting with different strategies to test out whether “responding” rather than “reacting” could reduce the symptoms, as measured on the Amsterdam Misophonia Scale (A-MISO-S).

The intervention was not found to be effective, and scores did not decrease on the A-MISO-S. The client and her mother were offered a family therapy intervention to explore some of the systemic ideas discussed, but opted instead for a referral to a local audiology clinic. The client did not find the CBT ideas relevant or helpful. Despite appearing motivated to attend therapy, formal homework was not regularly completed by the client meaning that some ideas were not formally tested. There was evidence that the systemic context was important for understanding the development and maintenance of the problem for this client.

Misophonia is a poorly understood condition and this case study contributes to the development of our understanding of what might be helpful for adolescents experiencing this difficulty. This case highlights that it may be important to consider systemic factors when working with adolescents who experience misophonia. It may also be helpful to focus on anger, an emotion typically experienced in this condition.

Killing three birds with one stone: Training teachers and CBT therapists to deliver ‘Stress Control’ to pupils, parents and teachers

Jim White, Stress Control Ltd

With around 50% of adult mental health problems beginning before the age of 15, and with child/adolescent services able to see only the tip of the iceberg, schools have a vital role to play in teaching skills to help combat existing or future problems. This study looked at whether ‘Stress Control’, a widely-used, evidence-based CBT didactic class approach for adults with common mental health problems in the NHS, could be adapted for schools.

As an early intervention/prevention approach, Pastoral Care teachers were trained to deliver a revised version of Stress Control to 4th Year pupils (15 years old) over 8 weekly school periods in one of the most deprived areas in the UK (n=113). This ensured ‘hard-to-reach’ pupils had to attend. Sessions were built around PowerPoints, video, downloadable relaxation/mindfulness and short written summaries. Pupils worked in pairs or as a class on various interactive tasks using the ‘think, pair, share’ teaching strategy. Simultaneously, parents and teachers were able to attend the (adult version) Stress Control evening class in the school as a way to promote synergy and, in the case of teachers, to potentially reduce absenteeism and presenteeism.

Using the Revised Children’s Anxiety and Depression Scale and the WEMWBS, pupils completed measures at pre-, post- and 9-month follow-up. 40% of pupils were either in the ‘Borderline’ (19%) or ‘Clinical’ (21%) categories at pre. This dropped to 21% at follow-up. Wellbeing, at pre, was well below Scottish average, probably due to the impact of deprivation. Highly significant change was found at post on all main measures and this improvement was maintained at follow-up. The adult class was highly evaluated by both teachers and parents.

This pilot suggests that teachers, trained over 5, one-hour sessions can deliver a cost-efficient and clinically-effective intervention to those with existing problems and, perhaps, help prevent problems in those currently coping. Having teachers run these classes within (timetabled) personal and social education (PSE) means the approach can be easily rolled-out. We should also be able to report on a controlled trial in a school in an equally deprived area. If time permits, we will look at the developing stepped-care model from primary schools to CAMHS services.
In an area where demand hugely outweighs supply, we must look at other delivery-systems. This study is an example of CBT's great but, perhaps, relatively neglected ability to develop new interventions, test them and train non-mental health professionals to deliver evidence-based approaches capable of reaching far greater numbers than we could ever reach as therapists.

Panel Discussion: Contemporary developments and issues in anger treatment and research

John Taylor, Northumbria University and Northumberland, Tyne & Wear NHS Foundation Trust,
Speakers: Raymond Novaco, University of California, USA; Ray DiGiuseppe, St John’s University, New York, USA
No abstract received.

Clinical Skills Classes

Creating and implementing effective behavioural experiments

Freda McManus, University of Stirling
Behavioural experiments are planned experiential activities based on the patient’s active experimentation or observation. The primary purpose is for the patient to obtain new information to test the validity of existing beliefs and construct and/or test new, more adaptive beliefs (Bennett-Levy et al., 2004). Behavioural experiments are one of the most powerful means to change in cognitive behaviour therapy (CBT). They are now used in all contemporary CBT approaches. This workshop will help participants learn how use behavioural experiments most effectively with their patients. It will describe when and how best to set up and debrief from behavioural experiments and introduce a structured recording form. Video material will be used to give clinical examples and participants will have the opportunity to plan their own behavioural experiment. There will be opportunity for participants to reflect on their own work and to discuss how to overcome obstacles to effective use of behavioural experiments.

The aim of the workshop is to enhance participants' skills and confidence in implementing behavioural experiments in routine clinical practice, across the range of disorders.

Dr Freda McManus is a Consultant Clinical Psychologist and has been Director of the Oxford Cognitive Therapy Centre, and a Clinical Research Fellow in the University of Oxford’s Department of Psychiatry. She is currently Joint Course Director of the University of Stirling / Dundee MSc in Psychological Therapies programme. Freda has worked clinically for 20 years and has a range of experience in developing and evaluating CBT interventions for anxiety disorders as part of research teams at the University of Oxford and at the Institute of Psychiatry, Kings College, London. She has published widely in both clinical and academic texts, in the areas of CBT for anxiety disorders, and on training healthcare professionals to carry out CBT interventions.

Cognitive Therapy: From Action to Insight and Back Again

Steve Hollon, Vanderbilt University, USA
No abstract provided.

How to Teach DBT Skills to Adults and Young People – Focus on Emotion Regulation and Distress Tolerance

Catherine Parker, Derbyshire Healthcare NHS Foundation Trust and Marie Wassberg, North London Priory Hospital
DBT Skills Training is an essential part of the DBT treatment programme developed by Marsha Linehan for the treatment of Borderline Personality Disorder over 30 years ago. Since then, there
have been numerous studies exploring and validating this approach for different populations. DBT is cited by NICE as a treatment of choice for women with a diagnosis of BPD who self harm. This approach is based on a formulation which hypothesises a deficit in self management skills, particularly in emotion regulation. This workshop will briefly introduce the DBT Skills and how they fit into a DBT formulation. We will focus in more detail on two sets of skills, Emotion Regulation and Distress Tolerance, which respectively represent "change" and "acceptance", a central dialectic that DBT attempts to resolve. There will be demonstrations of DBT Skills teaching for both adult and adolescent groups, and a chance for some in-session practice. We welcome clinicians with no prior DBT experience, as well as those who would like to brush up on their DBT Skills teaching.

Didactic - brief introduction the theory and formulation underpinning DBT, and how DBT Skills training is a central feature of the DBT intervention programme. We will then introduce all 4 sets of DBT Skills, with a particular emphasis on Emotion Regulation and Distress Tolerance.

Experiential - we will demonstrate the teaching of several key DBT Skills, inviting members of the audience to join us in role plays of a DBT Skills Group, and Skills teaching practice.

Reflection - we will end by inviting participants to reflect on the usefulness for their own practice.

- To introduce DBT Skills Training in the context of the DBT formulation, which hypothesises skills deficits in people with BPD.
- To introduce the 4 DBT Skills with particular emphasis on Emotion Regulation and Distress, Tolerance, and how these are tau

DBT with Suicidal Adolescents by Alec Miller, Jill Rathus & Marsha Linehan (Guilford Press, 2007)

While DBT was initially developed for patients with Borderline Personality Disorder, many of its principles and practical interventions have been used trans-diagnostically, to good effect. In our experience, emotion dysregulation and distress intolerance can interfere with the progress of CBT therapy across disorders. If these deficits are integrated into CBT formulations, it can be effective to weave DBT skills into the intervention plan to ensure that therapy stays on track.

Catherine completed intensive DBT training in 2001, and became a founding member of the Derbyshire DBT Service. She has run DBT skills groups for over 15 years, supervised DBT practitioners, and delivered introductory DBT training both in-house and at local universities, as well as Symposium presentations at Conference. She has been the Chair of the DBT SIG since 2013.

Marie completed intensive DBT training in 2010. She has been running a DBT-skills based programme for children/adolescents and parents/carers, and helped develop a DBT-approach programme for adolescents who display harmful sexual behaviours. Marie has been a guest lecturer at universities, workshop facilitator at NOTA Conferences, and has trained and supervised professionals who work with young people. She recently joined the committee of the DBT SIG as Treasurer.

**Behavioural experiments in PTSD treatment - why, when and how?**

Sharif El-Leithy, Traumatic Stress Service and Hannah Murray, Oxford Centre for Anxiety Disorders and Trauma

Behavioural experiments are a core component of cognitive therapy for PTSD (Ehlers & Clark, 2000). When well designed and implemented, they are a powerful way to help clients evaluate and modify beliefs about the trauma and its consequences. They can provide new information with which to update memories, help promote alternative coping strategies, and support and enhance in-vivo tasks. Importantly, behavioural experiments can be integral to overcoming common obstacles in PTSD treatment.

This skills class will begin with an overview of the “off the shelf” behavioural experiments commonly used in PTSD treatment, focusing on each element of a typical cognitive formulation. Building on this, and using case vignettes, clinical material and video excerpts, participants will learn how to collaboratively implement experiments that are creative, conceptually rigorous, and highly personalised. This will include experiments conducted in and out of the office, using technology, as homework, and when returning to the scene of the trauma. The workshop will also discuss how to use experiments both in a planned and spontaneous way to support other elements of cognitive therapy for PTSD.
A range of clinical material including video excerpts and case vignettes will be used to illustrate the skills class. There will be a strong interactive element, with participants invited to generate ideas for experiments for a range of scenarios, and for overcoming stuck points. There will also be opportunities for participants to discuss and reflect on their clinical material.

- Understand the role of behavioural experiments in cognitive therapy for PTSD
- Learn how to implement behavioural experiments in a range of settings
- Practice designing creative and engaging experiments
- Learn how to use behavioural experiments to overcome common obstacles in PTSD treatment
- Be able to manage common difficulties with behavioural experiments


The skills class will help therapists treating PTSD to collaboratively design behavioural experiments that are effective, creative and highly personalised.

Dr Sharif El-Leithy is a Principal Clinical Psychologist based at the Traumatic Stress Service in South-West London. Dr Hannah Murray is a Research Clinical Psychologist at the Oxford Centre for Anxiety Disorders and Trauma. Between them they have 25 years of experience in working with complex cases of PTSD using trauma-focused CBT. They supervise, teach and research widely in the field.

Working with Adolescents with Eating Disorders: Making CBT and Family Based Treatment (FBT) Work Together

Glenn Waller, University of Sheffield and Mirin Craig, NHS Greater Glasgow and Clyde

This session will address the skills needed to plan services and deliver the optimum evidence-based therapy for adolescents with eating disorders. The case will be made that many of the skills are similar across the therapies, but that others differ with age, family structure, disorder, etc. This will not be a session on how to deliver the therapies, but will focus on key skills. The two presenters will use case material in order to outline the following skills:

- Deciding whether to use FBT or CBT-ED in the individual case.
- Ways in which FBT and CBT-ED can be sequenced for the individual case and their family.
- Setting up and managing services for younger people with eating disorders.
- Focusing on process issues (e.g., developing engagement, individuation, externalisation, and an effective working relationship)
- Delivering key techniques (e.g., formulation, weighing the patient)

Largely experiential and role play, based on case and service material

To learn how to plan services based on evidence-based approaches.

To identify common themes and differences across the two therapies
To learn the heuristics needed to decide which therapy to deliver to the individual case.


To maximise potential for full recovery.

To inform the attendees about developments and delivery of CBT-ED within the child and adolescent population.

Miring Craig (RMN, BSc. and CBT PGDip) is a Clinical Nurse Specialist, working in a specialist CAMHS ED team to deliver CBT-ED, primarily adjunctive to or following FBT. She also uses CBT-ED as the primary therapy, depending on the age or the patient and their presentation.
Glenn Waller is a clinical and academic psychologist, delivering and developing evidence-based, effective versions of CBT-ED. He was a member of the Guideline Development Group for the 2017 NICE Guideline on Eating Disorders.

The Strong & Curious CBT Therapist. Using the Self-Practice & Self-Reflection Approach to develop Loving-Kindness and Healthy Self-Doubt

Jim Lucas, University of Birmingham
Research in to Self-Practice/Self-Reflection suggests that deliberate reflective practices enhance both interpersonal and CBT-specific skills (Bennett-Levy, Thwaites, Chaddock and Davis, 2009). Therapists that effectively self-care and can practice healthy self-doubt achieve higher professional performance (Nissen-Lie et al, 2015). By contrast, when therapists automatically interpret clinical mistakes as an indication of incompetence, they are more likely to use non-constructive coping strategies. These methods undermine professional development and the creation of early therapeutic alliances.

This workshop focuses on teaching the CBT Practitioner ways to build genuine loving-kindness and healthy self-doubt through constructive coping methods based on the self-practice/self-reflection approach.

Jim Lucas is a Teaching Fellow at University of Birmingham on the PG CBT Programme and a BABCP Accredited Practitioner & Supervisor. He specialises in supporting healthcare professionals and educators overcome work-related stress and to recover from burnout. He has developed an online assisted-self-help programme called Self-Help School and he regularly publishes articles and interviews experts on self-help for his podcast Self-Help Sat-Nav.

Using Values to ACTivate Your Practice: Bringing meaning and purpose to therapy

Richard Bennett and Jim Lucas, University of Birmingham
ACT is a unique transdiagnostic psychological intervention that uses acceptance and mindfulness strategies, together with behaviour change strategies, to increase psychological flexibility. It is concerned with helping individuals identify what is important to them and taking committed action in order that their behaviour is more consistent with their values. ACT also promotes skills that help to change the relationship between an individual and their experience. It is rapidly developing a wide-ranging evidence base across numerous areas of clinical practice and there are now over 200 RCTs and 9 meta-analyses, pointing to ACT being equivalent in efficacy to more traditional forms of CBT.

This 2-hour clinical skills workshop is designed for therapists working in physical/mental health care who want to enhance and develop their practice by developing skills in values procedures. You will learn:

• To differentiate values from goals
• Techniques to engage clients in exploring their values to drive purposeful life change
• Techniques for promoting acceptance in the service of living a richer, fuller, and more meaningful life

The workshop will be highly interactive, involving a variety of methods including didactic teaching, experiential exercises, group work, and live/video demonstrations of therapeutic interventions. Participants will be invited to explore their own values, thereby learning ACT techniques from the 'inside'.

You will learn:

• To differentiate values from goals
• Techniques to engage clients in exploring their values to drive purposeful life change
• Techniques for promoting acceptance in the service of living a richer, fuller, and more meaningful life


Behavioural goal setting is a key part of therapy, although can put people in a 'deficit' state from the outset (e.g. by talking to them about what they have not yet achieved). It is supposed to be
motivating but can work in the other direction. By approaching goal-setting from the perspective of values, we can enrich the process for clients, starting from a point of what they already have, in terms of the knowledge of what gives their life meaning and purpose. Previous feedback from this workshop at last year’s conference (which was so full that people were sitting on the floor before we just had to stop people coming in!) was that therapists went away with a new perspective that they could use to enrich existing techniques like goal-setting, and activity scheduling. Both Richard and Joe work as Clinical Psychologists in academia and in private practice. Both have long NHS backgrounds in forensic mental health and adult mental health. Both run postgraduate CBT courses in Universities and have extensive experience of teaching and training therapists. Both are internationally known for ACT training and writing, and are recognised as Peer-reviewed ACT Trainers by the Association of Contextual Behavioural Science (ACBS).

Cognitive Behavioural Anger Treatment – Intellectual Disabilities and Beyond

Ray Novaco, University of California, USA and John Taylor, Northumbria University and Northumberland, Tyne & Wear NHS Foundation Trust

There are now 11 meta-analyses of the effectiveness of CBT anger treatment for reducing problematic anger, and our recent studies have also demonstrated reductions in various forms of aggressive behaviour, including physical assault, for detained patients with intellectual disabilities (ID). Anger treatment should be grounded in assessment of anger control deficits and be case formulated. Substantial validity and utility for a multi-modal approach to the assessment of anger among clients, including those with ID, has been obtained in clinical research, as integrated with anger treatment. Participants will be taught how to utilise multi-modal methods of assessment for case formulation. Selected from our fuller CBT anger treatment protocol, the skills class will focus on its cognitive restructuring, client self-monitoring, and stress inoculation provocation hierarchy construction components. Participants will be coached on implementation and guided in accessing the full protocol. The skills class will help participants to more readily achieve treatment engagement with chronically angry clients, which can be challenging, especially if clients are seriously disordered, historically assaultive, and/or have intellectual disabilities. This mini-workshop will enhance proficiency in case formulation and provide a skill set for several fundamental components of a larger anger treatment protocol.

Professor Ray Novaco pioneered the cognitive-behavioural treatment of anger and coined the term “anger management”. His ongoing research includes anger assessment and treatment studies in the US, UK, Australia, and Denmark with psychiatric patients and with combat veterans with severe PTSD. He also has projects on psychological trauma with women and children in southern California domestic violence facilities and on intimate partner violence as a women’s health care problem. Professor John Taylor is Professor of Clinical Psychology at Northumbria University and Consultant Clinical Psychologist and Associate Clinical Director with Northumberland, Tyne & Wear NHS Trust. With Professor Novaco, he has researched and written extensively on the assessment and treatment of anger problems experienced by people with mild and borderline intellectual and developmental disabilities.

Building working alliances with depressed patients

Stephen Barton, Newcastle University

Depressed patients present in a number of different ways and have various expectations of CBT. Some are sent by a doctor or family member. Some are desperate for help and will try anything. Others have found out about CBT, or have received it in the past, and have realistic expectations of it helping. This variety can make it challenging to form working alliances with depressed patients: for example, some patients have a definite idea of the help they need, such as to find out why they are depressed. Others have a more passive approach, waiting for the therapist to deliver the treatment and get them better. Others would like to feel better, but have not yet connected that to the need to change their thinking and behaviour.
This skills class will explore practical ways of responding to these different presentations, by considering three key issues that need to be approached in early phase treatment:

1. **Hope in treatment being beneficial.** It is usual for therapists to be more hopeful than their depressed patients, at least at the start of treatment. This needs to be factored into forming realistic goals that are not avoidant or pessimistic, nor are they overly optimistic or promising benefits that are uncertain.

2. **Responsibility for change.** Hopeful therapists need to take care they are not carrying too much responsibility for change. This is a very difficult balance to achieve, especially if patients are sceptical about progress, de-motivated, disengaged or highly ruminative. There are practical ways of encouraging patient engagement, so that responsibility is shared and early phase treatment has agreed tasks that are manageable for both parties.

3. **Balancing support and change.** Working alliances rely on a sufficiently strong personal bond, built out of accurate empathy, compassion and an emerging mutual trust. They also rely on task engagement: therapist and patient working together on agreed tasks. One of the challenges, especially with complex cases, is balancing bond and task so there is a compassionate response to the patient’s predicament, connected to practical hopefulness about improvement and recovery. It is an art finding the optimal balance for different patients, especially if the patient “pulls” for a preferred type of relationship that is unlikely to help them progress.

This skills class will use CBT models to understand these processes, firstly, to identify common pitfalls (e.g. avoidant goals, insufficient collaboration, too much bond and not enough task, etc), and secondly, to consider practical ways of building working alliances, especially when patients’ depression works against it.

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**When Acquiring, Collecting, and Saving become Hoarding Disorder: Models and Interventions**

**Gail Steketee, University of Boston, USA**

Hoarding Disorder is a DSM-5 OC spectrum condition defined by accumulation of objects, difficulty discarding and excessive clutter that interferes with normal use of living spaces and impairs functioning. Hallmarks features of hoarding include excessive acquiring, disorganization, difficulty making decisions, excessive attachment to possessions and strong negative and positive emotions. Following a pictorial description of hoarding features, a cognitive and behavioural model for understanding hoarding symptoms will include case examples. Examples of assessment methods will be followed by detailed information about applying hoarding-specific intervention strategies including motivational enhancement; skills training for organizing, problem solving and decision-making; direct practice sorting and discarding unwanted possessions; reduction of acquiring behaviors; and cognitive therapy to address problematic beliefs about possessions. Outcomes of these CBT methods from individual and group intervention will be presented, along with suggested roles for family members and community service providers.

Careful diagnosis is important to detect hidden hoarding and to distinguish hoarding disorder from OCD and other conditions. Likewise, a clear understanding of why people hoard possessions enables clinicians to identify primary targets for treatment, to collect information about person-specific beliefs and behaviours, and to plan and implement treatment that will facilitate progress toward decreasing ongoing acquisition and clutter that impedes functioning. Involvement of family members and community service providers may be needed to improve motivation, resolve related problems that impede work on hoarding, and facilitate clients’ efforts to advance their own personal goals.

Dr. Gail Steketee is Dean Emerita and a professor at the Boston University School of Social Work. She served as the 2016-17 President of the Association of Behavioral and Cognitive Therapies. She graduated from Radcliffe College in 1971, and received her MSW and PhD from Bryn Mawr School of Social Work. Her scholarly work has focused on developing and testing treatments for obsessive compulsive (OC) disorder and OC spectrum conditions, including hoarding disorder. She has published over 200 articles and more than a dozen books on these topics, including the best-selling book *Stuff*, co-authored with Dr, Randy Frost (Houghton-Mifflin Harcourt, 2010), and the Oxford Handbook for Hoarding and Acquiring (Oxford, 2014), the first edited scholarly volume on hoarding disorder. Her work has been featured in various media outlets, including the New York Times, New Yorker, Chicago Tribune, the Washington Post, U.S. News and World Report, and CNN.com.
Dr. Steketee was elected to the American Academy of Social Work and Social Welfare in 2012 and is currently Vice President of that organization. She has received several awards in recognition of her work, including the Outstanding Career Achievement Award from the International OCD Foundation in 2013. She serves on the editorial boards of several journals in social work, psychology, and psychiatry, and is a frequent lecturer and workshop leader on hoarding and related disorders for professional and public audiences in the U.S. and abroad.

How to get the most out of your CBT supervision - how be an effective CBT supervisee

**Steve Kellett, Maggie Spark, Dennis Convery and Paul Bliss, University of Sheffield**

No abstract provided.

Using technology to enhance face-to-face cognitive-behavioural therapy

**Richard Stott, King's College London**

Technology continues to transform many aspects of our lives. The majority of us use smartphones on a daily basis. Many of the core aspects of smartphone technology, communication, connection, access to information, personal monitoring, imagery and video, all have potential relevance to us as cognitive therapists. Furthermore, numerous apps purport to help us with our wellbeing or other aspects of our mental health. Few would deny the enormous potential of the smartphone, but there are also many pitfalls. To date, there has been relatively little guidance for therapists who wish to harness the best of this technology within their practice while remaining committed to the conceptual focus and discipline of cognitive therapy.

This workshop will offer an opportunity to learn from demonstrations and experiment hands-on with a range of smartphone tools and functions to enhance therapy, across disorders. In part, the expertise presented in the workshop derives from several years of innovating and experimenting with technology within the development of clinical trials of face-to-face and internet-based therapies for anxiety disorders. Participants are welcome whatever their fluency with technology and no special knowledge is required. This workshop will encourage a flexible, open-minded and creative attitude to embracing technology, within the bounds that any application of technology should be grounded in and driven by a coherent rationale and conceptualization.

The workshop will have a strong experiential component, using video and live demonstration, and role-plays. Audience participation is strongly welcomed. Participants may benefit from bringing along smartphones, tablets or laptops, but this is not a requirement.

Workshop participants will acquire the following skills:
1) Using smartphone technology to assist in evidence-based imagery interventions across a wide range of disorders.
2) Using smartphone apps to aid specific components of therapy e.g. behavioural experiments and personalised monitoring tasks.
3) Fluency in using a variety of online resources (both pre-planned and unplanned) e.g. Google Streetview, Youtube videos, online stats.
4) Using technologically mediated communication alongside sessions to improve therapy adherence.
5) An understanding of the contextual and ethical issues surrounding technology use – including privacy, confidentiality, security, the rapidly changing landscape of technology and patient expectations.


The workshop will have many elements which can be implemented into everyday CBT practice right away. It will also foster a framework for thinking about technology in a conceptually grounded way, allowing clinicians to experiment and innovate whilst delivering evidence-based therapy.

Dr Richard Stott is a Clinical Psychologist and Senior Lecturer in e-Mental Health at the IoPPN, King's College London and the Centre for Anxiety Disorders and Trauma at the Maudsley Hospital. He also
Sean Harper, NHS Lothian and Isabel Clarke, Southern Health Care NHS Trust

The workshop will be introduced by describing the foundation of the approach in the cognitive science based Interacting Cognitive Subsystems model of cognitive architecture. Further evidence based context to the workshop will then be provided by presenting preliminary research evidence underpinning the approach (Araci, D., & Clarke, I. 2016; Durrant, C., Clarke, I., Tolland, A., & Wilson, H. 2007) and more recent research derived from a meta-analysis of acute in-patient therapies and a feasibility trial of the CCC model conducted in NHS Lothian (Patterson C, Karatzias T, Harper S, Dickson, A, & Hutton, P; 2017, in prep).

This workshop will then provide opportunity for participants to become familiar with an adapted CBT model for working with acute mental health crisis, and enabling teams to work psychologically, pioneered by Isabel Clarke. There will be a specific emphasis on how to formulate the acute mental health crisis and how to adapt and devise CBT for working with acute presentations within the relatively short timescales associated with acute and crisis team environments.

- Clinical and theoretical application of the ICS model and third wave CBT approaches to make sense of acute mental health crisis
- Practical experience of acute crisis psychological formulations
- Skills based learning associated with individual and group therapeutic interventions
- Consideration of methods of working across the acute inpatient MDT to improve the therapeutic milieu

The workshop will be primarily skills based. Through providing an overview of the Interacting Cognitive Subsystems model of cognitive architecture, a powerful rationale for grounding therapeutic interventions in individual felt sense and accurate empathy (i.e. factoring in the impact of past trauma) will be conceptualised. This insight will be brought to life through an experiential exercise. Workshop facilitators will first demonstrate and then encourage participants to practice acute crisis formulations and associated third wave CBT interventions. There will also be opportunity to engage in reflective exercises, and group discussions, some of which will require participants to draw on personal experience in order to demonstrate operational aspects of the model. The scope of the workshop will include individual and group therapy work as well as consideration of support mechanisms required for the multi disciplinary team in order to maximise successful implementation of the model.

Clarke, I & Nicholls, H (2017) Third Wave CBT Integration for Individuals and Teams Comprehend, Cope and Connect. Routledge


This workshop will be especially suited to members of the CBT fraternity interested, or working in acute in-patient or crisis team environments, but with wider relevance to introducing a psychological perspective to mental health team working.

Dr Sean Harper is a Consultant Clinical Psychologist and Director of a Cognitive Therapy training programme. He is lead for the Psychosis and Complex Mental Health service in NHS Lothian where the application of the Comprehend, Cope and Connect model has been piloted and evaluated in acute services over recent years.

Isabel Clarke is a Consultant Clinical Psychologist with over 25 years’ experience as a therapist working with complex problems. Third Wave CBT Integration for Individuals and Teams:
Comprehend, Cope and Connect, published by Routledge (Clarke & Nicholls) covers her innovative approach to mental health, currently being applied in IAPT.

### Improving CBT outcomes using outcome prediction and feedback methods

**Jaime Delgadillo, University of Sheffield**

CBT is effective for the treatment of depression and anxiety problems; however, it is also known that at least 30% of patients do not show reliable improvement and some deteriorate. Outcome feedback is a prognostic technology developed to identify patients who are at risk of poor response to treatment. This method involves monitoring patients’ symptoms on a weekly basis and comparing them to the typical trajectory of change observed in hundreds of similar cases. Cases with symptoms that are more severe than those of ‘typical cases’ are flagged up as ‘not on track’. Several clinical trials demonstrated that using outcome feedback can prevent deterioration in ‘not on track cases’. Recent studies focusing on CBT have shown that using outcome feedback can accelerate improvement, attaining similar outcomes to usual CBT, but in a shorter period of time.

This skills class will focus on the integration of routine outcome monitoring, prognostic feedback, and clinical supervision in CBT. Participants will learn about the current evidence-base on outcome feedback and will also learn practical skills on how to (a) identify, (b) formulate and (c) address obstacles to improvement. The feedback model covered in this skills class has been empirically tested in a multi-centre randomised controlled trial.

Integrating outcome monitoring and feedback into routine discussions with CBT patients can enhance collaboration and enable the timely identification of common obstacles to improvement, thus improving the efficiency and quality of treatment. Jaime Delgadillo is a Lecturer in Clinical Psychology at the University of Sheffield and a CBT therapist in the NHS. His research focuses on outcome measurement, prediction and feedback. He has led the development and implementation of feedback and personalized care technologies in NHS psychological services.

### Using couple-focused interventions with long term health conditions

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

Cognitive behavioural approaches to couple therapy (CBCT) have experienced significant expansion in recent years in the UK and more widely. This is following strong empirical evidence that CBCT can be effective in alleviating couple distress and can also be an effective intervention when one or both partners are experiencing depression. An additional area of research has been the interaction of couple distress, individual psychological problems and long term health conditions (LTCs). Again, there is considerable evidence that couple-focused interventions can be effective in assisting individuals and couples to adapt successfully and to reduce psychological distress associated with a range of LTCs. The aim of this skills class is to introduce participants to key couple-focused interventions that can be used by both couple therapists as well as individually focussed CBT therapists. For those participants that have experience in couple therapy, the skills class will facilitate their knowledge and skills in working with couples where there may be a combination of LTC, depression and couple distress. For individually focussed therapists without couple therapy training or experience, the skills class will facilitate their knowledge and skills in how to include a partner in treatment where there may be depression and LTC as part of the clinical picture but where there is a minimum or no couple distress.

**Learning methods:**
1. Lecture
2. DVD based demonstration of interventions
3. Experiential practice of interventions by participants
4. Group discussion.

**Key skills that will be developed in the skills class will be:**
1. Assessing for when a couple focussed intervention may be warranted
2. Using communication interventions that focus on building and sustaining emotional intimacy and assisting couples in supporting each other in regards to the difficulties encountered when experiencing a long term health condition
3. Using communication interventions that focus on improving the couple’s ability to problem solve and make decisions related to coping with an LTC including, for example, needed behaviour and lifestyle changes, dealing with medical professionals and making decisions about treatments.

4. Knowing when to refer a couple for formal cognitive behavioural couple therapy.


There is currently an increased need for CBT practitioners to work with clients presenting with LTCs. Including a partner in treatment has been identified as a key competency for all therapists working with LTCs. This skills class will support both individual and couple focussed CBT practitioners to work effectively with this client group.

Michael Worrell and Sarah Corrie have been involved in the development, dissemination and evaluation of training in cognitive behavioural couple therapy since 2011. Michael Worrell has in addition been involved in the development of the specification of couple focussed competencies for the training if High Intensity workers for the national IAPT programme and the development of related couple focussed training. Michael has recently published the text Cognitive behavioural Couple Therapy: Distinctive features with Routledge in 2015.

Pictures that Stick: How to transform distressing images linked to death trauma and PTSD

Jennifer Wild, University of Oxford

Death trauma is perhaps the most difficult trauma to overcome and often leads to post-traumatic stress disorder (PTSD). Following traumatic loss, PTSD can be as high as 39%. National guidelines in the UK recommend trauma-focused CBT for PTSD when an individual presents with traumatic bereavement. A core component of TF-CBT is transforming unwanted memories and images linked to the trauma through updating techniques. Imagery techniques are an invaluable method to update distressing images and their meanings, and have been evaluated as effectively treating distress linked to traumatic memories (Wild, Hackmann, & Clark, 2007; 2008; 2011).

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

Tailored CBT to treat experiential avoidance in an adult with offending behaviours

Lucy Armstrong, University of Bath; Lucy Armstrong, University of Bath

RB entered adult secondary care services following a 20-year history of committing arson, theft and bomb hoaxes which had resulted in seven criminal convictions and several prison sentences. At the time of entering services, he was on probation, and referral information indicated an "unspecified disorder of adult personality and behaviour". Most offences had been triggered by stressful life events, and occasions in which RB had experienced significant rejections and betrayals. RB was committed to psychology therapy to understand his previous crimes and his fear of "opening up to others", to build adaptive coping strategies and prevent himself from committing further crime.

A collaborative longitudinal formulation of RB’s experience was built gradually from a timeline of significant life events and offences to date. RB’s previous instances of distress appeared to be triggered by unpleasant feelings of betrayal and rejection (which had been a common experience during childhood), and subsequent conflicting beliefs of both “needing to get bad feelings out” and “others will judge me negatively if I open up”. This may have led to feelings being suppressed and consequently accumulating, resulting in severe urges to externalise feelings by offending, or as RB phrased it “putting my feelings onto something else”.

Although offending behaviours were a serious consequence of RB’s difficulties, it was agreed that the intervention focus would be on underlying issues of experiential avoidance (EA). Phase 1 of treatment involved the use of cognitive-behavioural techniques including tailored psycho-education around emotions, the use of reflective diaries, and a therapeutic space to explore emotional awareness and expression. Phase 2 involved working through a DBT-based assertiveness module.

Formulating and understanding RB’s past played an integral role to the intervention and was “woven into” most of the phase 1 sessions. This also allowed the therapist to pace sessions and switch to and from a focus on practical information where RB was finding it difficult to express.

Levels of distress were captured over the course of treatment and were measured using the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer and Williams (2001)) and Generalised Anxiety Disorder questionnaire (GAD-7; Löwe et al, 2008). Tendency to avoid emotional experience was also measured by using the Brief Experiential Avoidance Questionnaire (BEAQ; Gámez et al, 2014).

Levels of distress reduced significantly in the first phase of treatment, from scores of 13 on both PHQ-9 and GAD-7 in week 1 to scores of 4 on both measures in week eight. EA also saw a significant reduction across the first eight weeks from scores of 71 to 37. Following the assertiveness training module, distress scores continued to reduce slightly (to scores of 2) whereas EA scores remained stable. Overall these results indicated that RB’s tendency to avoid emotional experience had significantly lessened along with his distress levels; these improvements mainly coincided with the tailored CBT approach used in phase 1. Throughout therapy RB became observably more expressive and relaxed. By the end of treatment, he had challenged himself to several stress-inducing situations (e.g. initiating difficult conversations) which he would have previously avoided, finding himself better able to cope with the feelings these provoked.

This case study supports the idea of using a tailored CBT approach to reduce distress and EA, which may reduce risk of further externalising behaviours. The intervention took a highly flexible approach, overlapping psycho-education around emotions with an extended longitudinal formulation period. This was crucial to build necessary rapport with RB, who was initially found emotions intolerable and expressing himself very difficult in sessions. Arguably this flexible, overlapping approach may make it difficult to generalise results to others, however researchers suggest that therapeutic alliance is central to socialisation to the CBT model, and may not be altogether separate from the intervention itself (Daniels & Wearden, 2010).

Research suggests that CBT approaches used in prisons mainly focus on anger management, risk reduction and building cognitive skills, without much focus on underlying emotional regulation. It was clear from RB’s formulation that emotional awareness and increased tolerance were crucial to his ability to express emotions appropriately (rather than through criminal acts), and that a cognitive/problem-solving approach may not have been helpful for this. With this in mind, prison-based CBT programmes that focus on underlying emotional intolerance and expressive avoidance may be more useful for treating some of the issues underlying externalised criminal behaviours.
Exploring the barriers to the implementation of Cognitive Behavioural Therapy for Psychosis (CBTp) in NHS Lothian

**Fiona Switzer, NHS Lothian;** Sean Harper, NHS Lothian
National guidelines recommend CBT for the treatment of schizophrenia (CBTp) (NICE Guidelines 2014) and (SIGN Guidelines 2013), despite this levels of access to CBTp remain low across the UK (Berry, K. & Haddock, G. 2008) The aim of this study was to identify barriers for people with psychotic spectrum disorders accessing CBTp in NHS Lothian. The overall goal of the study was to uncover emergent themes regarding barriers to access to CBT for patients with psychosis. In addition the influence of PSI (Psychosocial Skills Intervention) Training for psychosis (Brooker & Brabban, 2006) was explored and if completion of this training effected referral behaviours and attitudes to CBTp.

This study is a quantitative service evaluation project which used a questionnaire design to explore the factors that influence a clinician's decision to refer a patient for CBTp. Three qualitative questions were included for thematic analysis to allow the respondents to elaborate on their views on potential barriers. All appropriate Community Adult Mental Health Team (CMHT) staff in NHS Lothian were invited to anonymously participate in the study. 59 staff completed the questionnaire. Quantitative Methods: Yates CHI square and Fisher Exact Probability Test, two-tailed, p values were sought to examine associations between responses, PSI training and referral rate. The open ended responses were analysed using thematic analysis and a second independent rater applied the coding framework to analyse the data and draw independent conclusions.

CMHT staff in NHS Lothian hold favourable views of CBTp and would support an increase in access for patients with psychosis. Key barriers to access for CBTp identified in this study comprise of, little or no access to CBTp; lack of integration of services and unclear referral pathways. Further themes emerging from the study also included; improving multi-disciplinary communication and increasing CMHT staff knowledge and confidence in CBTp. PSI training was shown to have a significant effect on referral rates.

The results of this study highlight the difficulties that services face in trying to provide good quality and equitable access to CBT for people with psychotic spectrum disorders, when services are struggling with limited resources and limited staff with appropriate training. This study indicates that CMHT staff, in NHS Lothian, are supportive of an increase in access to CBTp however a lack of services or very low provision of services makes it very difficult for the SIGN (2014) guideline to be fully implemented. In addition to this the separation of services may have impacted on the ability of teams to facilitate close MDT working, which may in turn impact on awareness and confidence levels amongst staff. Closer MDT working or a closer integration of services may have a beneficial effect on these areas. The impact of waiting time targets was another factor that was highlighted as a concern for practitioners, feeling unable to take on patients with more complex mental health problems such as psychosis.

The value of PSI training, as a potential means of increasing psychological awareness and increasing confidence in CMHT staff could warrant further research in Lothian. The impact of waiting time targets on services for those with more complex or severe mental health issues would be a further area for future research.

Rumination and metacognitive beliefs in depressed and anxious patients

**Beatriz Rueda, National University of Distance Education, Spain;** Esperanza Valls, Actur Sur Mental Health Center
Rumination and metacognitive beliefs (MB) represent dysfunctional thinking styles increasing the vulnerability to depression and anxiety, respectively. Few clinical studies have addressed the differential effects that both Rumination and MB may have in patients suffering from either depression or anxiety disorders. The aims of this study were: (a) to explore the differences on rumination and MB between depressed patients and anxious patients; and (b) to examine how rumination and MB were related to psychological inflexibility (PI), depressive symptoms and anxious symptoms in each patient group.
Thirty-three depressed patients (DP) and 35 anxious patients (AP) participated in the study before receiving cognitive-behavior therapy (CBT) in a mental health centre. Results showed that DP scored significantly higher on brooding, low cognitive confidence, negative beliefs about worry and the need to control thoughts than AP. Brooding positively predicted depressive symptoms whereas the need to control thoughts was positively associated with PI in DP. In contrast, brooding positively predicted both depressive symptoms and PI in AP. No predictor was significantly associated with anxious symptoms in any patient group. These results highlight the toxic role played by brooding and the potential transdiagnostic implications that brooding and the need to control thoughts have for clinical intervention. According to these results, reducing brooding seems to be an important target for CBT because it can help to reduce depressive symptoms, not only in depressive patients but also in anxious patients. Disengaging anxious patients from brooding could also be particularly effective to decrease their inflexibility, whereas addressing the rigid need to control thought could be more helpful in depressive patients in order to allow them to learn more flexible ways of acting, thinking and feeling.

Evaluating the therapeutic effects for people with long-term conditions and their family caregivers attending mindfulness-based interventions together: a systematic review

Ben Parkinson, Glasgow Caledonian University; Maggie Lawrence, Glasgow Caledonian University; Evelyn McElhinney, Glasgow Caledonian University; Loukia Gkanasouli, Glasgow Caledonian University; Jo Booth, Glasgow Caledonian University

Long-term conditions (LTCs) are often associated with psychological difficulties 1. Stress, anxiety and depressive symptoms are common amongst people living with LTC 2 and their family caregivers 3. Mindfulness-Based Interventions 4 (MBIs) employ meditation and can improve psychological wellbeing, however, limited attention has been given to the effect of MBI for patient-family caregiver partnerships. This systematic review evaluates the therapeutic effects for people with LTCs and their family caregivers attending MBI together. In August 2017 electronic databases (n=5) and other sources were comprehensively searched using key words and subject headings. Bibliographic records were screened using pre-determined criteria and all selected studies had relevant data extracted. Quality was evaluated using the Mixed Method Appraisal Tool 5 and data synthesis undertaken to produce a narrative summary. The review aligns with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidance 6. The review identified 9 studies (475 participants) and included qualitative (n=2), quantitative (n=6), and mixed method research (n=1). Studies recruited people with different LTCs and included different forms of patient–family caregiver partnerships. All studies delivered MBI in group format and used protocols. Most studies were small-scale and methodological weaknesses were common. MBIs can improve psychological wellbeing by reducing stress, anxiety and depressive symptoms for some people with LTCs and their family caregivers. Tentative evidence suggests delivering MBI in a partnership might improve dyadic coping and/or engagement with MBI. Results were often small and sometimes contradictory. Positive outcomes were not always statistically significant or experienced by everyone. MBIs can improve psychological wellbeing for some people living with LTCs and might offer additional benefits when delivered in a partnership. Questions remain about the value of using MBIs within patient-family caregiver partnerships. Robust mixed method research is required to explore the use of MBIs within patient-family caregiver partnerships and when supporting people with different LTCs.

References
relationship between clinical variables and positive self-thought in patients with schizophrenia

Takeda Tomoya, Graduate School of Medical Sciences, The University of Tokushima; Masahito Nakataki, Tokushima University; Masashi Ohta, Tokushima University; Sayo Hamatani, Chiba University; Kanae Matsuura, Tokushima University Hospital; Reona Yoshida, Tokushima University Hospital; Tetsuro Ohmor, Tokushima University

The goal of schizophrenia treatment has moved from "remission of symptom" to "recovery in their life". Chung et al (2013) compared the clinical characteristics of patients with schizophrenia who recovered in their life with those who achieved symptomatic remission. Their study showed that better neurocognition and higher positive self-thought distinguished patients who have recovered from who have achieved only remission. It is commonly known that negative symptom associated with neurocognition. However, which clinical variables are associated with the positive self-thought still remain unknown. Therefore, we investigated the relationship between clinical variables and positive self-thought in patients with schizophrenia.

Thirty-six patients with schizophrenia and thirty-seven demographically matched healthy controls participated in this study. The patients were outpatients of the Department of Psychiatry of Tokushima University Hospital. We used the Japanese version of the National Adult Reading Test (JART), the Brief Assessment of Cognition in Schizophrenia (BACS), the Positive and Negative Syndrome Scale (PANSS), the Calgary Depression Scale for Schizophrenia (CDSS), the Defeatist Performance Scale (DPS), the Automatic Thoughts Questionnaire (ATQ) to assess the intelligence quotient (IQ), neurocognition, positive and negative symptom, depressive symptom, defeatist performance beliefs (DPB), negative and positive automatic thoughts, respectively. Data analysis was conducted using the PASW Statistics 18 software. The comparison of demographic indices between patients and controls was carried out using chi-squared test or two-sample t-test. Next, Pearson correlation coefficients were calculated to determine the relationship between DPB, negative automatic thought, positive automatic thought, and clinical variables.

We observed significant differences between the two groups in education (t(71) = -2.41, p <0.05), IQ (t(58.27) = -5.70, p <0.01), verbal memory (t(71) = -3.97, p <0.01), working memory (t(71) = -5.17, p <0.01), motor speed (t(71) = -4.45, p <0.01), verbal fluency (t(71) = -4.04, p <0.01), attention and speed of information processing (t(71) = -6.87, p <0.01), executive function (t(66.81) = -3.66, p <0.01), negative automatic thought (t(46.32) = 4.05, p <0.01) and DPB (t(71) = 3.05, p <0.01). Pearson correlation coefficients analysis showed significant correlation of DPB with duration of illness (r = 0.44, p <0.01), verbal fluency (r = -0.37, p <0.05) and depression (r = 0.41, p <0.05).

Negative automatic thought had significant correlation with motor speed (r = -0.33, p <0.05), depression (r = 0.50, p <0.01) and dose of antipsychotics (mg/day) (r = 0.55, p <0.01). Positive automatic thought had significant correlation with working memory (r = 0.37, p <0.05), motor speed (r = 0.46, p <0.01), attention and speed of information processing (r = 0.40, p <0.05) and verbal fluency (r = 0.58, p <0.01).

We showed the relationship between the negative and positive self-thought and clinical features. Depression was strongly related to DPB and negative automatic thought. This result corresponds with previous study (Hill et al. 1989). Furthermore, neurocognition has relationship with both
negative and positive self-thought. These results suggested that improving neurocognition and depression might lead to a change in self-thought and help to achieve recovery. The goal of schizophrenia treatment has moved from "remission of symptom" to "recovery in their life". Previous studies have shown that positive self-thought is necessary to achieve recovery. However, which clinical variables are associated with the positive self-thought still remain unknown. We believe that this research can provide which clinical variables should be treated as therapeutic targets, in order to strengthen positive self-thought for recovery.

**Evaluating the therapeutic effects for stroke survivors and their family-caregivers using an online mindfulness-based intervention together: a protocol**

**Ben Parkinson, Glasgow Caledonian University;** Maggie Lawrence, Glasgow Caledonian University; Evelyn McElhinney, Glasgow Caledonian University; Jo Booth, Glasgow Caledonian University

Stress, anxiety, and depressive symptoms are common amongst stroke survivors and their family caregivers. Research suggests the emotional wellbeing of the stroke survivor and family caregiver might be interconnected, which means optimum outcomes will only be achieved when they are supported as a partnership.

Mindfulness-Based Interventions (MBIs) can help psychological wellbeing, but usually involve people attending groups by themselves, which might not suit everyone. Sometimes accessing group-based MBI can be difficult and/or people might not want to learn MBI within a group environment. Web-based MBIs have become more readily available in recent years, but little attention has been given to partnership orientated web-based interventions. Research is needed to explore the potential effects of web-based MBI for stroke survivors and family caregiver partnerships. This study aims to explore the feasibility, appropriateness, meaningfulness, and effectiveness of web-based MBIs for stroke survivor and family caregiver partnerships.

Purposive sampling will be used to recruit community-dwelling stroke survivor-family caregiver partnerships (n=5 dyads). These partnerships will complete a four-week asynchronous tutor-led web-based MBI. The web-based MBI aligns with the eight-week Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy courses, but in a shorter format. The course involves ten online interactive videos (30 minutes each), twelve daily practice assignments (with supportive emails), five audio downloads, and online tools for reviewing progress.

The design will involve a mixed method multiple-case (A-B) design: two-week baseline, four-week intervention, and four-week follow-up phases. Stroke survivors and family caregivers will complete the Hospital Anxiety Depression Scale (HADS) weekly to evaluate psychological wellbeing and clinical effectiveness. Paired semi-structured post-intervention interviews will be completed at follow-up and Interpretative Phenomenological Analysis used to contextualize the results and explain the meaning associated with the findings.

The study aims to meet minimum quality standards for single-case designs by achieving a minimum of three complete replications. Recruitment and completion data will be reported using descriptive statistics to help evaluate feasibility and appropriateness. HADS outcome data for stroke survivors and family caregivers will be presented in individual graphs and using raw data to facilitate future meta-analysis. Visual and statistical analysis of outcome data will be completed to evaluate clinical effectiveness, effect size, and whether any changes were statistically significant.

The Interpretative Phenomenological Analysis will be reported using relevant themes and participants’ quotes to provide a coherent analysis of the feasibility, appropriateness, meaningfulness, and effectiveness of stroke survivors and family caregivers using web-based MBI. The protocol will be prospectively registered with ClinicalTrials.gov and aligns with the Single-Case Reporting Guidelines In Behavioural Interventions [SCRIBE] statement. The findings will inform the feasibility, acceptability, and clinical effectiveness of web-based MBI for stroke survivors and family caregivers partnerships. The study will explore the usefulness and meaning of learning MBI online and in a partnership. These findings could help determine whether using web-based MBI in a partnership has any therapeutic value for participants and help tailor such intervention for stroke survivor and family caregiver partnerships.

**References**


This study protocol will explore the feasibility, appropriateness, meaningfulness, and effectiveness of web-based MBI for stroke survivors and family caregiver partnerships. Findings from this work will inform whether web-based MBIs should be disseminated within the stroke survivor and family caregiver populations and help establish whether learning MBI within a partnership offers any additional benefits for participants. The findings will help guide future research into MBIs for stroke survivors and family caregivers.

A systematic review of the effectiveness of Acceptance and Commitment Therapy for women with anxiety

Munirah Alshebali, Princess Nourah Bint Abdulrahman University; Munirah Alshebali, Princess Nourah Bint Abdulrahman University

The figure for the recent global prevalence of anxiety is 7% (Baxter et al., 2013). Women have double the risk of developing anxiety compared to men as they overestimate threats and tend to expect catastrophic events and exaggerate the risk of harm. This could be due to factors relating to culture and upbringing in addition to biological differences.

Acceptance and commitment therapy (ACT) is a third wave intervention based on cognitive behavioural therapy (CBT) and it has been suggested that it has a desirable effect on anxiety. This systematic review investigated the effectiveness of ACT for women with anxiety.

We searched five electronic databases: Cochrane Library, Web of Science, Scopus, PsycINFO and PubMed. Using specific search terms we limited our search to randomized control trials (RCTs) published between 1994 and 2017.

As a result eleven RCTs were generated, and we interpreted the findings using a narrative synthesis and analysis. It was concluded that ACT in all its formats such as face-to-face individual ACT or group sessions ACT-G, an internet-based intervention iACT weather guided or unguided reduce the impact of mild to moderate anxiety disorders, improve psychological flexibility, and reduce experiential avoidance.

To our knowledge this is the first systematic review that investigates the effectiveness of ACT for women with anxiety.

The findings showed that individual sessions and ACT-G resulted in desirable improvement in women with anxiety and high motivation to recover. Satisfaction and adherence were at high levels among the participants. Although the changing mechanism was not clear, a reduction in experiential avoidance was highly correlated with recovery.

ACT-G was found to be effective in community settings where one-to-one treatment is lacking. It was also found that co-morbid mood disorders had no impact on recovery rates.

Although iACT needs to be more user friendly, it attracted educated women with anxiety who live in rural areas because they might not seek help otherwise.

In comparison to other therapies, ACT was as effective as well-established therapies for anxiety, like CBT and CT. However, CBT and systematic desensitization were favored over ACT in treating social phobia and mathematics anxiety due to the difficulty of the ACT tasks in the early stages of treatment, which was overwhelming for this group as they needed more support and less complex tasks.

The results were of direct practical relevance. It was concluded that ACT-G is effective as an early intervention with a wide range of approaches (Bohlmeijer et al., 2011). Additionally, ACT might benefit from adding a relaxation content and having more reliance on homework using descriptive rather than suggestive language. For example, "Maybe you would like to reflect about what was
discussed today before our next session and, if so, we can talk more about it then" (Zettle, 2003). It is important also to add that measuring improvements in the quality of life should not rely only on existing quality of life measures. Instead, self-reported experiences and the therapist’s observations should be taken in consideration because QOLI fails to measure changes that are value related. With regard to iACT, one comment was repeated, namely that the models were long and repetitive (Räsänen et al., 2016). Therefore, iACT could benefit from video and audio materials to achieve better engagement, especially as a population suffering from anxiety might not be able to tolerate reading materials and written tasks. Enhancing the structure and presentation and asking clients to upload audio and video responses instead of written assignments could result in better outcomes. Additionally, a direct messenger feature for emergencies might maximize the effectiveness of iACT. Commissioners and policy makers should increase the funding for ACT training to set a standard training protocol and spread the practice to help anxiety sufferers who have had to wait a long time for appointments before receiving much need psychotherapy. This is especially true considering that the results showed that ACT is as effective as CBT and CT in treating mild to moderate anxiety.

Evaluating the Stepps Programme in Renfrewshire

Sandra Johnston, Greater Glasgow and Clyde NHS; Hermione Thornhill, Greater Glasgow and Clyde NHS

Systems Training for Emotional Predictability and Problem Solving (Stepps) is a manualised treatment programme for people with Borderline Personality Disorder. It was developed by Blum et al. 2002 and consists of a 20 week programme of 2 hours weekly aimed at enabling people with Borderline Personality Disorder to learn skills to manage the symptoms of their illness more effectively. It is very much CBT focused in that clients are asked to look at the antecedents leading up to particular behaviours, encouraging them to analyse their mood, thoughts, behaviours and impulses. It has elements of a schema therapy focus derived from Young in that clients are encouraged to look more at the roots of thinking errors through not only a CBT model but by also asking them to make reference to early maladaptive schemas. The skills element of the manualised course has similarities to Linehan’s DBT techniques for personality disorders. This includes a checklist of skills used on a daily basis and continued monitoring of the effectiveness of such skills in any given situation. The sessions were based around 3 main areas. The first one being Awareness of Illness. This session outlines some of the difficulties commonly experienced by people with Borderline Personality Disorder. It consists of reading materials from BPD sufferers in terms of stories and poems about their illness. There is a useful analogy of Backpacking which is used to explain that if one is prepared for a trip then they can survive even the toughest terrain and conditions. It is what that person carries in their back pack, the tools they possess which enables them to be prepared for difficulties which may arise.

The second part of the training consists of emotion management skills. This looks at helping the person challenge unhelpful thoughts as well as noticing filters or schemas which may influence how they think about things.

The third part of the training consists of behaviour management training. This includes abuse avoidance, maintaining health relationships and also healthy eating, exercise and good sleep hygiene.

Patients attending the Renfrewshire/ Paisley Community Mental Health Teams with a diagnosis of Borderline Personality Disorder were referred to the Stepps group. The group is run by a psychologist and a CBT Therapist. Patients were given a screening assessment to assess the suitability for attendance in the group. Prior to the group the patients were assessed via a screening tool which consisted of questions with regards their presenting problems, emotional difficulties, current stressors and interpersonal relationships. Staff also asked about their current coping strategies and support systems. Risk factors were also discussed and the patients views on their ability to participate within a group. Staff checked out whether there were perhaps any narcissistic traits. Questions were asked such as “Do you find it easy to see things from someone else’s point of view? Can you put yourself in someone else’s shoes if they are emotionally upset? Do you take care not to hurt other people’s feelings? Do you feel hurt if you are not singled out as special in a group format?
Antisocial traits were ascertained by the following questions: Do you care what others think of you? Do you find yourself feeling guilty if you hurt others? Do you feel a lack of respect from society? Do you find you can generally get what you want by some means or another? The scales used were given at the first and last session of the group. It is also intended that a 3 months follow up will be done. The scales used was the Core 34 which is a client self-report questionnaire designed to be administered before and after therapy. It consists of 34 questions about how they have been feeling over the last week, using a 5-point likert scale. The items of the measure cover four dimensions: Subjective well-being, Problems/symptoms, Life functioning and Risk/harm. The Beck Depression Inventory which was developed by Beck is a 21 question multiple choice self report inventory which is used for measuring the severity of depression. The participant’s ability to regulate their emotions was ascertained via the Difficulties in Emotional Regulation Scale (DERS). A total of 20 people were referred and 12 completed the group. Reasons for the drop out rate varied from people not wanting to be in a group and others having to move out of the area so finding it difficult to travel. The Beck Depression Inventory, Core 34 and Difficulty in Emotional Regulation Scale were used at the outset of the group and again at the last session. There is also the intention to ask patients to complete at a three month follow up interval. The results were promising. At the outset the average BDI score was 35.2. A score of 31-40 indicates severe depression. At the end of therapy the average score was 19.25. This score falls within the range of "borderline clinical depression". With the BDI the minimal clinically significant reduction from baseline should be 17%. As can be seen the average Core 34 score at the start of treatment was 76.6 and at the last session was 57.75. The average DERS score at the start of treatment was 66.25 and after treatment were 27.4. The average BDI at the start of treatment was 35.2 and at the end of treatment the average BDI was 19.25. This is an improvement of 45%. At the end of therapy, patients did not feel that they needed any further support from the CMHT. 90 % had been self harming at the outset of therapy and none were self harming at the end. The rate of hospital admissions for this group of people also dropped significantly. This group shows promise with people with Borderline Personality Disorder. Results demonstrate significant improvements in patient’s mood, well being and emotional regulation skills, with the largest effects on the latter. The anecdotal information from the patients attending the group demonstrates that they found the skills training and the peer support extremely beneficial. They continue to meet up now after the group has finished. This is a cost effective way of treating patients with Borderline Personality Disorder. Most of these patients could easily have been seen for several months or years by CMHT members.

Reflective practice is key to promoting psychologically informed care. Are there ways in which reflective practice could be better integrated into Recovery Team working?

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Reflective practice is emphasised as important for healthcare professionals. However, research on the structure, content, utility and outcomes of reflective practice groups is limited, and primarily focuses on inpatient staff experiences. A key challenge described in the literature is staff attendance at reflective practice groups. The aims of this study were to examine the barriers and facilitators to reflective practice groups for staff working in a specific Secondary Community Mental Health Recovery Team. This mixed-methods study consisted of a focus group (n=6) and survey (n=19), to explore staff experiences of reflective practice sessions, and barriers and facilitators to attending. Data were analysed using thematic analysis, and descriptive statistics. Following this, recommendations around reflective practice were made to reflective practice facilitators. Participants reported that they felt reflective practice sessions were useful, but the majority indicated that they do not attend sessions. Barriers to attending sessions included practical and cultural barriers, anxiety, and not feeling safe to share in the sessions. Facilitators included having a safe space, and promotion by Team managers.
Recovery Team staff reported the usefulness of attending reflective practice sessions, however, the barriers to attending are numerous, complex and varied. Research in this area is hampered by a lack of theoretical underpinning and evidence base.

Supporting the Supporters: A CBT and CFT Case Study with a Military Wife Exposed to Trauma

**Daisy Walters, AWP Veterans Mental Health Services; Rachel Paskell, AWP Veterans Mental Health Services**

Ms X presented to a military veteran mental health service with Post Traumatic Stress Disorder (PTSD), alongside depression and serious thoughts of suicide and self-harm. Ms X had been living with PTSD symptoms since a bombing that occurred close to her military house over 40 years ago. These symptoms included nightmares, hypervigilance for risk/threat and avoidance of triggers, such as crowded, new and unpredictable places. In addition, Ms X was the wife of a veteran who had developed PTSD from active service, which had resulted in aggression, violence, abuse towards her and his suicide.

Ms X was wary of discussing the details of her traumas with non-military or non-veteran services due to their nature, which is not uncommon in the military community (including partners and family members of those who have served). She had sought advice from a military charity and they had requested she be seen by a specialist veteran mental health service. Through discussion with Ms X and the local mental health services, it was agreed that the most appropriate service to meet Ms X’s needs and engage her in therapy would be the specialist veterans’ mental health service.

Through the early stages of assessment, psychoeducation and grounding/soothing skills development; a lack of self-compassion; a history of and determination to put others first; and a habit of absorbing others’ issues to relieve them from emotional pain was identified as a potential barrier to therapy progression, and was hypothesised to be contributing significantly to Ms X feeling isolated and low in mood. To support Ms X to engage in therapy both in the room and outside it; process her traumas and learn to manage her emotions going forward, compassion-focused therapy tools were combined with the more traditional trauma-focused Cognitive Behavioural Therapy (CBT) approach.

Goals for therapy were to help her understand the pattern and function of her PTSD and depression symptoms; build her social support; reduce suicidal thoughts and intent; reduce anhedonia; reduce the distress from nightmares; and break the cycle of fear and avoidance, so she was more able to engage in activities that she enjoyed, e.g. holidays and driving.

Clinical outcome data were collected before, during and after therapy using the Patient Health Questionnaire (PHQ-9), the Generalised Anxiety Disorder (GAD-7) scale, the Phobia Scale, and the Dimensions of Anger Reaction assessment (DAR). Mid-treatment data showed marked improvement in all areas, with depression and anxiety falling into the mild category and no thoughts of self-harm and/or suicide. This improvement continued to the end of treatment with Ms X continuing to display no thoughts of suicide and/or self-harm and both anxiety and depression scores falling beneath the clinical cut off. Anger, phobia and impact on work and social functioning scores all also markedly decreased.

Additionally, approaching discharge, Ms X reported qualitatively that she felt ‘much better’ following her treatment; she no longer cried every day; and felt much better equipped to tolerate and cope with not only her own difficult emotions, but those of others. Ms X also reported that she had been able to talk to family and friends about her traumas for the first time; was asking for help and support from them, which they were providing; and was practicing putting her ‘oxygen mask on first’ as part of her efforts towards self-compassion. Each of the goals for therapy had been achieved at discharge.

The treatment approach employed here was found to be both effective in improving scores on the IAPT outcome measures used throughout treatment, but also on meeting the client’s co-constructed therapy goals. It is argued that the specialist contextual knowledge and understanding from the service supported engagement. Whilst the trauma-focused CBT, with a Compassion-Focussed Therapy (CFT) element, enabled early identification of lack of self-compassion as a potential barrier to treatment to be overcome pro-actively.

This adapted therapeutic intervention, through a specialist service, supported this military veteran wife to get the effective treatment that she may have otherwise not have had from a standard NHS
service delivering standard trauma-focussed CBT. It is recommended that therapists supporting non-veterans with PTSD obtained through military-acquired traumatic experiences, including partners of veterans with PTSD, would benefit from developing their knowledge and understanding of the military context; consulting with a specialist veteran mental health service, or referring their client into a specialist service if engagement is difficult or disclosure of military-related trauma’s is a barrier to progression. It is also recommended that aspects related to self-compassion be explored at assessment or early in therapy to identify if CFT approaches may also help to remove potential therapy barriers.

**An investigation into the efficacy of a CBT group for low self-esteem in a primary care setting**

**Sarah Beattie, Buckinghamshire New University; David Beattie, Solent NHS**

A number of studies have identified the efficacy of cognitive behavioural therapy in the treatment of low self-esteem based on the formulation and treatment trajectory developed by Fennell (1999). However, there has been little empirical enquiry into the efficacy of the programme delivered in primary care. Pack and Condren (2014) describe findings from their study investigating the efficacy of a CBT group intervention for low self-esteem delivered in an IAPT service. Results indicated that there were statistically significant improvements in levels of self-esteem following engagement with the group (p=0.0001). Statistically significant reductions on measures of depression and anxiety were also identified (p=0.0001, p=0.0001 respectively) with improvements being maintained at 3-month follow up. A number of recommendations were made by the authors including the need to recruit independent researchers to replicate findings. We therefore report on a study investigating the effectiveness of a CBT group intervention for low self-esteem delivered within an IAPT service conducted by an independent researcher.

Fifty-four participants attended a 9 week ‘Boost Your Mood’ (BYM) group programme; a CBT group based on Fennell’s (1997) cognitive behavioural conceptualisation of low self-esteem. Paired sample t-tests were conducted on pre- and post-group scores on measures of depression, anxiety and low self-esteem as measured by the Patient Health Questionnaire (PHQ-9; Spitzer et al., 1999), the Generalised Anxiety Disorder Assessment (GAD-7; Spitzer et al., 2006) and the Robson Self-Concept Questionnaire (RSCQ; Robson, 1989) respectively.

A Wilcoxon signed-rank test showed that there was a significant increase in levels of self-esteem following completion of the BYM group (z = -3.41, p = 0.001). Effect sizes were calculated using Cohen’s r (Rosenthal, 1991) and results yielded a large effect size (r = 0.62). Results indicated that there were significant improvement in levels of depression (t (41) = 4.05, p < 0.001) and anxiety (t (40) = 2.08, p < 0.05) following attendance at the BYM group. Improvements in depression and anxiety yielded medium effect sizes of d=0.7 and d=0.39 respectively.

Findings from the present study indicate that the BYM group was effective at reducing levels of depression and anxiety and increasing levels of self-esteem, echoing previous findings (Rigby and Waite, 2006; McManus et al., 2009; Morton et al., 2012). The current research draws parallels with the research conducted by Pack and Condren (2014) and serves to reinforce the assertions made by the authors regarding the effectiveness of group CBT for low self-esteem delivered in an IAPT service. The current study also substantiates previous findings that suggest a CBT group based on Fennell’s (1997) cognitive conceptualisation of low self-esteem may be a promising avenue for treating co-morbidity due to the reduction in both anxiety and depression following treatment (Morton et al., 2012; Pack and Condren, 2014).

There are a number of clinical implications of the present findings. Due to the reliance on IAPT services to deliver psychological therapies within primary care settings, preliminary evidence demonstrating the efficacy of a CBT programme for low self-esteem has implications for the dissemination of the programme across the service. The results of this study advocate the continued delivery of the programme for patients accessing IAPT services.

**An investigation into the mediating effect of anxiety on the relationship between low self-esteem and depression**

**Sarah Beattie, Buckinghamshire New University; David Beattie, Solent NHS Trust**

There is increasing interest in transdiagnostic presentations, as authors suggest the existence of shared underlying pathology across depression and anxiety disorders (Barlow, Allen and Choate,
2004). Research has identified low self-esteem as a transdiagnostic mechanism, being evident in the aetiology and maintenance of a range of clinical presentations (Gual, Perez-Gaspar, Martinez-Gonzallaz, Lahortiga and Cervera-Enguix, 2002). A number of theoretical models are proposed in the literature, to describe the way in which low self-esteem contributes to a presentation of depression. A large body of evidence indicates that the vulnerability model is most accurate in its description of the direct effect between these two constructs (Orth and Robins, 2013). Nima, Rosenberg, Archer and Garcia (2013) reported findings indicating that anxiety partially mediated the relationship between low self-esteem and depression, however, there continues to be a lack of empirical enquiry investigating the mediating effect of anxiety in this relationship (Nima et al., 2013). Aims: The present study investigated whether the strength of the relationship between low self-esteem and depression (direct effect) was affected by the inclusion of a mediator variable, namely, anxiety. Participants were identified following an initial assessment in which low self-esteem was identified as a contributor to other mental health diagnoses. Forty-three participants completed three psychometric measures prior to their attendance at a CBT group for low self-esteem (Fennell, 1997). Analyses were conducted on pre-group scores on measures of depression, anxiety and low self-esteem as measured by the Patient Health Questionnaire (Spitzer et al., 1999), the Generalised Anxiety Disorder Assessment (Spitzer et al., 2006) and the Robson Self-Concept Questionnaire (Robson, 1989) respectively.

Significant negative correlation coefficients were found between measures of anxiety and self-esteem ($r = -0.461, n = 43, p = 0.002$) and measures of depression and self-esteem ($r = -0.476, n = 43, p = 0.001$). A mediation analysis identified a significant indirect mediating effect of low self-esteem on depression through anxiety $b = -0.084 \text{BCa CI} [-0.136, -0.043]$. This represents a large effect, $k^2 = 0.304$, 95% $\text{BCa CI} [0.157, 0.457]$ (Preacher and Kelley, 2011). The direct path between low self-esteem and depression reduced from an initial significant effect ($b=0.138, p < 0.01$), to a non-significant effect ($b= -0.05, p = 0.13$) with the inclusion of anxiety as a mediating variable. Results therefore indicate that there is a large mediating effect of anxiety in the relationship between low self-esteem and depression.

Although previous research has identified a link between low self-esteem and depression, the findings here indicate a mediating effect of anxiety in this relationship corroborating previous findings reported by Nima, Rosenberg, Archer and Garcia (2013). This mediation affect may be explained within a cognitive vulnerability framework. Self-esteem has been identified as a buffer for anxiety wherein lower levels of self-esteem lead to increased anxiety (Crocker and Park, 2004). Low self-esteem is demarcated by negative automatic thoughts pertaining to the future and interpretative biases act to aggravate anxiety which has been found to precede the development of depression (Cole, Peeke, Martin, Truglio and Seroczynski, 1998). A prolonged anxiety response can lead to feelings of helplessness which is a cornerstone of the CBT model of depression (Beck, 1967). Similarly, low self-esteem and anxiety can result in avoidance behaviour which can reduce engagement with pleasurable and meaningful activities, further perpetuating low mood as identified in the model of depression (Beck, 1967). The findings reported here require additional empirical enquiry in order to gain further clarity regarding the role of anxiety in the relationship between low self-esteem and depression. It is important that clinical practice be responsive to such enquiry to ensure continued development of effective therapeutic programmes.

There are clinical implications of the findings regarding the mediating effect of anxiety in the relationship between low self-esteem and depression. Time limited therapy requires the delivery of the most effective treatment components to instil the greatest change in the shortest time. This is a pressing consideration of IAPT services which are tasked with delivering therapy to large numbers of patients in restricted time frames. Amendments and additions can be made to the treatment programme in order to target the mediating variable i.e. anxiety. The mediation effect reported here suggests that strengthening certain components of the programme, particularly those relating to anxiety, may lead to greater reductions in levels of depression post treatment.

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Service evaluation of the effectiveness and acceptability of Cognitive Behavioural Analysis Systems of Psychotherapy (CBASP)

Jonathan Linstead, South West Yorkshire Foundation Trust; Jonathan Linstead, South West Yorkshire Foundation Trust
Many people experience chronic depression, usually defined as a continuation of meeting the diagnostic criteria for major depression for at least two years. It tends to be associated with demoralisation, hopelessness and social and occupational problems and studies suggest about 20% remain depressed after two years. Recent draft NICE guidance for depression suggest that Cognitive Behavioural Analysis Systems of Psychotherapy (CBASP; McCullough, 2000) is a promising approach to the treatment of chronic depression and that it could be offered either combination with antidepressant medication or alone. CBASP is not routinely provided in Improving Access to Psychological Therapies (IAPT) services, so any introduction of CBASP should be evaluated in terms of its effectiveness and acceptability.

Pre and post therapy scores on the PHQ-9 and GAD-7 were collated and analysed for 27 clients that received CBASP from four therapists within an IAPT service between June 2010 and July 2014. Three patients were interviewed by an independent researcher on their experiences of the therapy and a thematic analysis carried out using the method outlined by Braun & Clarke (2006). All the therapists were accredited by the British Association of Cognitive and Behavioural Psychotherapy (BABCP).

There were significant reductions on the PHQ-9 between pre therapy (mean = 18.3; SD = 4.7) and post therapy (mean = 6.5, SD = 5.4) and on the GAD-7, between pre therapy (mean = 14.8; SD = 4.6) and post therapy (mean = 5.9; SD = 4.6). Effect sizes, calculated as Cohen's D and using the pre therapy SDs, were 2.5 for the PHQ-9 and 1.9 for the GAD-7. 20 of the 27 clients showed a reliable and clinically significant improvement (RCXI) in PHQ-9 scores (Jacobson and Truax, 1991), and 20 showed a reliable and clinically significant improvement (RCXI) in GAD-7 scores. Qualitative analysis revealed for main themes: Expectations of therapy; Overall experience; Aspects of therapy which could have been done differently or were not as helpful; Helpful aspects of therapy and outcomes.

This is a service evaluation, reporting uncontrolled effect sizes for CBASP in a single IAPT service. The effect sizes are large, but a number of limitations should be considered. The cases were selected by the therapists, rather than being identified from the outcomes database, and only three clients were interviewed so it is difficult to draw conclusions regarding the acceptability of the intervention and which aspects were most and least helpful. Nevertheless, this evaluation does provide encouraging evidence for the effectiveness of CBASP in an IAPT service. Future evaluations should be more systematic in monitoring outcomes for all clients being offered CBASP.

That a NICE guidance recommended evidence based intervention specifically developed to treat persistent depression is introduced in to IAPT services.

Can cognitive-behavioural interventions for low self-esteem effectively improve symptoms of depression and anxiety? A systematic review

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Low self-esteem (LSE) can be a vulnerability factor for the development of depression and may perpetuate symptoms of anxiety (Sowislo & Orth, 2013). The cognitive-behavioural model of low self-esteem (CBT-LSE; Fennell, 1997) incorporates both depression and anxiety. This approach may improve efficiency in treating this common comorbidity and assist in meeting the demand for psychological therapies. Initial evidence supports the efficacy of transdiagnostic CBT interventions for depression and anxiety (Newby et al., 2015). However, studies evaluating the efficacy of CBT-LSE have not yet been systematically reviewed. This review aimed to evaluate existing evidence for CBT-LSE to determine its efficacy for improving self-esteem and symptoms of depression and anxiety.

A systematic search was conducted using PsycINFO, CINAHL, MEDLINE, Embase, Scopus and Web of Science electronic databases and the BPS Clinical Psychology Forum up to 1st July 2017. Studies of CBT-LSE for adults with depression and anxiety were included. Studies involving participants who would be treated outside of primary care settings were excluded, such as those with severe and enduring mental health problems and primary physical health problems. Studies were evaluated using the Clinical Research Evaluation Schedule for Trainees (CREST; Peck et al., 2006).

Ten published studies were reviewed, with a total of 697 participants (80% female). Uncontrolled post-treatment effect sizes ranged from 0.28 to 2.34 for self-esteem, 0.46 to 3.61 for depression, and 0.19 to 1.7 for anxiety. CBT-LSE was superior to waiting list control. Gains were largely maintained
at follow-up, but duration was inconsistent across delivery type. Methodologic
al quality varied with
existing research shows some promising initial evidence to support the use of CBT-LSE for
improving LSE and symptoms of depression and anxiety. However, higher quality research is
required to clarify the efficacy of CBT-LSE for comorbid depression and anxiety. This should clarify:
- Efficacy for group interventions due to a lack of randomised controlled trials.
- Long-term efficacy particularly for group interventions due to a lack of published follow-up data.
- Efficacy for men due to the high gender bias in available research.
- Whether CBT-LSE is as effective or more efficient than the diagnosis-specific interventions
currently recommended for depression and anxiety, as they have not yet been directly compared.
Clinicians may wish to consider whether LSE is a predisposing or perpetuating factor in their
patients’ presentations. The protocols outlined in two of the reviewed studies (McManus, Waite &
Shafran, 2009; Waite, McManus & Shafran, 2012) may be helpful for developing individual
interventions based on CBT-LSE in everyday clinical practice.

ExPRESS-ing my symptoms: service user experiences of using a symptom monitoring app for six months

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Manchester; Richard Emsley, University of Manchester; Richard Drake, University of Manchester
Relapse of schizophrenia is common, has profound, adverse consequences for service users and is
costly to health services. Early signs interventions aim to use warning signs of deterioration to
prevent full relapse.
ExPRESS is a smartphone app which monitors early signs of relapse and psychotic symptoms on a
weekly basis. Smartphone apps have numerous advantages over the usual face-to-face or postal
assessments of early signs of relapse: they are less resource intensive, provide automatic reminders
and instant data upload and can be accessed at times and places convenient to the individual.
There is evidence that people with schizophrenia find smartphone apps an acceptable means for
self-monitoring in the short term (1 week). However this is the first study to gather in-depth
qualitative data from a sample of service users who used an app to monitor early signs of relapse in
the long term (6 months).
Individuals (n=18) who had experienced a relapse of schizophrenia within the past year were asked
to use the ExPRESS smartphone app once a week for 6 months to answer questions on their
experience of early signs and psychotic symptoms. Face-to-face qualitative interviews (n=16) were
then conducted to explore participants’ experiences of using the phone app. The topic guide sought
participants’ views on the following a-priori themes: item content, layout and wording; the way the
app looked; length and frequency of assessments; possible worries about using the app; how app
usage fitted with participants’ routines; the app’s extra features; other experiences of using the app.
Interview transcripts were analysed using the framework method which allows both a-priori and
emergent themes to be examined.
Interview participants had a mean age of 38 (age range X–Y). Overall their responses to a-priori
topics indicated that the app was acceptable. Participants suggested small changes that could be
made for future versions of the app. The following emergent themes gave further insight into
individuals’ experiences of using the app: accessibility and connection, barriers to app use, response
style, self-reflection, therapeutic value.
This study suggests that apps are an acceptable means of long-term symptom monitoring for service
users with a diagnosis of schizophrenia across a wide age range. Some reported finding the app
more accessible than visits from a clinician, since assessments were more frequent, more
anonymous and did not require the individual to explain their feelings in their own words.
Nevertheless, some barriers to using the app were reported. Despite the app containing no overtly
therapeutic components, some participants found that answering weekly questions on the app
prompted self-reflection which had therapeutic value for them.
CBT for psychosis often incorporates monitoring of psychotic symptoms and/or warning signs of
relapse, traditionally using a pen and paper diary. This study shows that monitoring using a phone
app is acceptable to those with psychosis.
Enhancing engagement in a clinical CBT service: audit of conventional vs new “therapeutic engagement” letter which utilises CBT engagement strategies

Chris Williams, Institute of Mental Health and Wellbeing, University of Glasgow.; Fraser Anderson, NHS Orkney; Chris Williams, Institute of Mental Health and Wellbeing, University of Glasgow

Despite the availability of effective psychological interventions for common mental health disorders, many individuals remain untreated. The Scottish Government is committed to increasing the availability of evidence-based psychological interventions, however, myriad barriers continue to prevent individuals from accessing services, and there is a well-established treatment gap and high rates of non-attendance even when access to a service is offered.

Previous efforts have been made to reduce Did Not Attend (DNA) rates, such as the introduction of patient-focused booking systems, text message appointment reminders and ‘easy cancellation’ systems. To our knowledge, no investigation of the impact of the content and tone of the initial appointment letter a patient receives on DNA rates has been conducted. Our aim was to examine whether new outpatient appointment DNA rates could be reduced by implementing a new appointment letter template that utilised CBT engagement strategies.

In the view that the initial appointment letter constitutes the first clinical contact, the authors designed a new letter template which both reflected the principles of a positive therapeutic relationship and acknowledges some of the factors which complicate attendance for individuals currently experiencing difficulty. Patients are given the opportunity to contact their practitioner ahead of their appointment to address any concerns or questions and are offered the option of attending with a trusted friend or family member. The letter contains no jargon, utilises friendly, warm language and has a reading age of 13 (Flesch Reading Ease = 67.1) – around that of the Scottish Sun.

The Psychological Therapies service within NHS Orkney designed a formal audit to pilot the new letter template. As part of an audit project, 25 patients will be offered an initial assessment using the new template and DNA rates collected. This data will be compared to that of DNA rate data for 26 historical patients.

Data collection is ongoing however initial results are promising. We have so far observed a DNA rate of 5.8% for the new letter template (n = 17, DNA = 1), compared to a historical DNA rate of 19.23% (n =26, DNA = 5).

Anecdotally, patients’ responses to the new template have been encouraging. Three patients stated that they only felt able to attend as a result of being able to bring a companion. One patient remarked positively on the letter specifically, stating that they had previously disengaged with services because of the nature of appointment letters. Further, we have found that patients who have decided not to engage with treatment have contacted to cancel, whereas previously they tended to DNA.

While it is not yet possible to draw generalised conclusions from our limited data set, our preliminary findings suggest that by making inexpensive, easily implementable and patient-focused changes to the way in which we make initial contact with our patients, we may be able to improve attendance and patient experience.

A fuller data set and analysis will be available for presentation at the conference if accepted.

What is Anhedonia? A Qualitative Study Exploring Loss of Interest and Pleasure in a Community Sample of Adolescents

Rebecca Watson, University of Reading; Rebecca Watson, University of Reading; Kate Harvey, University of Reading; Ciara McCabe, University of Reading; Shirley Reynolds, University of Reading

Anhedonia, the loss of interest or pleasure from previously enjoyable activities, is a core symptom of Major Depressive Disorder and a negative symptom of schizophrenia. Losing the ability to experience pleasure has particularly negative consequences during adolescence, and is associated with suicidal ideation, independently of depression. To date, no qualitative studies have explored the subjective experience of anhedonia.

Participants were twenty two adolescents (10 females; 12 males) aged between 13 and 18 recruited via secondary schools in England. Adolescents were purposely sampled based on depression scores (Mood and Feelings Questionnaire; >26 on the Long Version; or >7 on the Short Version), as
Individual semi-structured interviews were conducted by the researcher to elicit in-depth accounts of adolescents' experiences. Results were analysed using thematic analysis. Five major themes emerged, 1) Positive Emotion; 2) Motivation; 3) Connectedness; 4) Agency and Control; and 5) Reflection and Outlook. Adolescents spontaneously described their experience of anhedonia as feeling dull, grey, flat, blank, empty and deadening.

This study concludes that anhedonia is experienced as a difficulty with various aspects of reward processing. However, motivation plays a crucial role that is not recognised by current diagnostic criteria for anhedonia. Feelings of disconnection, lack of control and a narrowed perspective may conceptualise both the experience of anhedonia and depression as a whole, indicating potential benefits of targeting these common elements in treatment of depression.

Brief Psychological Interventions for Anxiety and Depression in a Secondary Adult Mental Health Service: An Evaluation

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Recently, there has been increased interest in the development of brief psychological interventions (BPIs). These interventions are usually manualised, short term (around eight sessions), and can be delivered by non-psychologists. This makes BPIs an attractive option for cost-effectiveness, as well as increasing access to psychological interventions. BPIs for anxiety and depression have been found to be helpful for clients with mild to moderate mental health problems (Cape et al., 2010). These interventions are usually based on CBT techniques, with the emphasis typically on behavioural change. This project will evaluate the introduction of BPIs for anxiety and depression in a secondary adult mental health service, with clients experiencing moderate to severe difficulties. The service developed manuals for anxiety (anxiety management) and depression (behavioural activation) BPIs. The BPIs were delivered by non-psychologists, but staff were offered training and group supervision by psychologists in the team. Measures of anxiety (GAD-7), depression (PHQ-9), wellbeing (SWEMWBS), and functioning (W&SAS) were completed at the start and end of treatment. We will report outcomes for clients that received anxiety and behavioural activation BPIs over a one-year period (March 2017-March 2018). We will also report on uncompleted interventions, to help understand the feasibility of BPIs.

BPIs have the potential to enable more clients accessing secondary mental health teams to promptly receive psychological interventions. Offering BPIs may also relieve pressure from psychological waiting lists, allowing clients in need of more intensive psychological support to receive this more quickly. If BPIs are found to be effective and acceptable, they would therefore offer benefits both for client wellbeing and cost-effectiveness. There is a need for further research investigating the effectiveness of BPIs for clients with more severe mental health problems. If BPIs are found to be effective and feasible, they could provide a way to introduce CBT techniques to more clients more promptly when accessing secondary mental health services. In doing so, BPIs could lead to reduced pressure on waitlists for full psychological interventions, both through increased options for less intensive support, and by offering preparatory work that could reduce the length of subsequent psychological treatment. Within this service model, psychologists/CBT therapists would also have an increased role in training and supervision for non-psychologists.

An evaluation of a Distress Tolerance Brief Psychological Intervention delivered by non-psychologists within a CMHT

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Brief Psychological Interventions (BPI) are short term therapies (usually up to 8 sessions) aimed at specific problems. They are manualised, suitable for delivery by non-psychologists and designed to target key areas found to be related to change in longer term therapies. One of those key areas related to change is Distress intolerance. Distress intolerance is a perceived inability to experience negative emotions and a desperate need to escape these (Simons & Gaher, 2005). This is a key feature for many patients, particularly clients with borderline personality disorder or post-traumatic stress disorder. Distress Tolerance is a key skill used in Dialectical Behaviour Therapy, and is taught as a standalone skill. In addition to this, preparatory distress tolerance is a key skill used in Trauma-focused CBT to enable exposure work in PTSD (Vujanovic et al, 2013).

A Distress Tolerance BPI has been developed in a community mental health team and is being delivered by non-psychologists. Measures of distress tolerance (Distress Tolerance Scale), anxiety (GAD-7), depression (PHQ-9), mental wellbeing (sWEMWBS) and functioning (WSAS) are administered to service users before and after Distress Tolerance BPI. We will report on whether there is a difference between clients’ scores pre and post intervention. This will be examined on an individual as well as group level. Comparisons will also be made between clients who complete all sessions and those who drop out.

Distress Tolerance BPI is a relatively inexpensive intervention, delivered by members of the CMHT who typically have shorter waiting lists than psychologists. If it is helpful to clients it may improve wellbeing in the short term and prepare them for full psychological intervention. There is a need for further investigation into efficacy and cost effectiveness of BPIs.

It may be beneficial for clients to be offered initial skills training by non-psychologist team members while they are on waiting lists for full psychological intervention. During this time they could learn coping skills (i.e. Distress Tolerance). This could potentially decrease the amount of preparatory work needed during full psychological intervention prior to implementing cognitive and behavioural strategies and thus decrease the amount of sessions necessary overall.

Reaching out to Carers of Someone with Schizophrenia or Psychosis: A Model for an Online Intervention to Improve Carer Wellbeing and Quality of Life

Amy Johnson, Northumbria University; Amy Johnson, Northumbria University; Markku Wood, Northumbria University; John Taylor, Northumbria University

Carers and family members of people with schizophrenia or psychosis provide an invaluable role in supporting their ill relative, despite this role potentially negatively impacting on carer health and wellbeing. Although support for carers has increased, many still report difficulty accessing this. The use of the internet and online resources can provide instantaneous access to information and the ability to communicate with other carers from any location (providing this has internet access). As such, this can increase access to support and could improve carer wellbeing and quality of life. This PhD project ultimately aims to develop a model for an online intervention by exploring carer’s online support usage. This also explores the views of both carers and professionals regarding online support use and views towards the development of an online intervention for carers.

A mixed methods design consisting of both qualitative and quantitative elements was completed. Eight carers (6 female and 2 male) of someone diagnosed with schizophrenia or a psychosis-related disorder and six professionals (3 males and 3 females) who regularly work with carers of someone with a severe mental illness participated in this study. Carers completed health questionnaires assessing wellbeing and quality of life (baseline and 6 weeks) a weekly diary (for 6 weeks) detailing online support usage before being invited to an individual interview. Professionals were invited to attend an individual interview. Interviews consisted of opinions and experiences of online support as well as views on developing an online intervention.

Data analysis is currently ongoing, with both carer and professional interviews separately analysed (with comparisons being made) using thematic analysis (Braun & Clarke, 2006). Preliminary thematic analysis results show a number of themes emphasising the importance of information provision, peer support, availability and the concept of change over time. For quantitative data, pre and post-test mean scores for carer wellbeing and quality of life were calculated. Finally, Qualitative Comparative Analysis (QCA) (Ragin, 2000) explored the influence of casual conditions (e.g. carer online support use over the 6-week period) on carer wellbeing and quality of life.
Understanding carer online support use and views with regards to developing an online intervention could increase understanding of carer support needs. These results could form the basis of the development of a model for an online intervention for carers of people with schizophrenia or a psychosis-related disorder.

This project could have implications for Cognitive Behavioural Therapy (CBT) as the results of this study could inform future online-related support (such as computerised CBT) as well as the acceptability of this medium for health interventions. Finally, this may also offer efficacy of treatment and rapid access to meet commissioning services.

Investigating the efficacy of a bipolar psycho-education group in a community setting for moderate to severe mental health difficulties

Katherine Parkin, Cambridge Adult Mental Health Locality Team (CPFT); Katherine Parkin, Cambridgeshire and Peterborough NHS Foundation Trust; Sophie Ames, Cambridgeshire and Peterborough NHS Foundation Trust; Lindsey Ridgeon, Cambridgeshire and Peterborough NHS Foundation Trust; Kim Masson, Cambridgeshire and Peterborough NHS Foundation Trust; Cambridge Adult Mental Health Locality Team

1-2% of the UK population experience a lifetime prevalence of bipolar and recent research suggests as many as 5% of us are on the bipolar spectrum. A diagnosis of bipolar disorder can equate to a loss of nine years of life, 12 years of normal health, and 14 years of working life (Prien & Potter, 1990). Furthermore, the estimated cost to the UK is around £5.2 billion (McCrone et al., 2008). NICE guidelines (2015) state that individuals with bipolar disorder may benefit from a psychological intervention that has been specifically developed for bipolar disorder. There are a number of evidence-based interventions for bipolar disorder, including cognitive behavioural therapy, family-focused therapy, interpersonal therapy, and group or individual psycho-education.

Since October 2014, bipolar psycho-education groups have been run by Cambridge Adult Mental Health Locality Team, a multi-disciplinary community mental health team for moderate to severe mental health difficulties. Each psycho-education group brought together up to 10 people with a diagnosis of bipolar, but with a range of types, from cyclothymia to Type 2 bipolar. Before the first session, service users completed a measure of Quality of Life with Bipolar Disorder (QoL BD) and Recovery from Bipolar (BRQ); these measures were then repeated in a follow-up session after the final group to measure any change. Adapted from a 10-session 'Mood on Track' course run by Birmingham and Solihull Mental Health Trust, the Cambridge group consisted of 6 weekly sessions, lasting 90mins each, with a different focus each week, including Understanding Depression, Understanding Mania, and Stress Management. This all culminated in the production of a person-specific Staying Well plan which focused on each individual’s relapse signature, including early and later warning signs and strategies to apply in the case of such warning signs.

A paired samples t-test was carried out to compare scores on the Bipolar Recovery Questionnaire (BRQ) collected pre- and post-group for 35 service users who attended the groups between October 2014 and July 2017. Out of a possible total score of 3600, the mean score rose from 1918 to 2158. Results showed a significant difference between the pre- and post-group scores, indicating that participants showed a higher level of self-rated recovery after the group; t(34) = -4.06 p = .001, effect size d = 0.69.

A paired samples t-test was carried out for a total score of Quality of Life in Bipolar Disorder Questionnaire (QoL BD) collected pre- and post-group. Out of a possible total score of 240, the mean score rose from 135 to 142. Although there was a rise in quality of life scores, the results showed a non-significant change between the pre- and post-group scores; t(33) = -1.47 p = .15.

Qualitatively, service users commented that, “It was really helpful to hear about the experiences of others and compare mine to these”, “It made me more aware of my early warning signs and prompted a conversation with my family about these” and “It made me feel differently about my problems where before I felt like I had no control over it”.

In an economic environment in which the NHS has to provide quality care which is also cost-effective, group interventions offer a fantastic way of supporting more people using fewer resources. Not only are groups a more cost-effective method compared to individual treatment, members of the various cohorts of the group expressed benefits of being able to meet and share experiences with people who may have had similar experiences. Conversely, there is benefit in being able to observe
how your individual bipolar signature may differ from other people’s by contrasting your experiences with theirs. Given that there appear to be some quantitative improvement following the bipolar psycho-education group, it highlights the possible place for group interventions within the NHS, even when working with a demographic who have moderate to severe mental health difficulties. Moreover, this was a shortened course, adapted from a 10-week programme, demonstrating that shorter courses can still be effective.

In future, it would be prudent to carry out follow-up sessions sometime after the psycho-education group in order to see whether these promising clinical improvements were maintained. Furthermore, other indices of recovery could be investigated, such as the number of manic or depressive episodes people experienced, frequency and severity of episodes, as well as the number of inpatient admissions post-group. Subsequent research projects could consider using a randomised-control trial design, including treatment-as-usual or individualised CBT. Alternatively, ethical considerations may mean that retrospective comparison groups would be more feasible, possibly comparing past results from individual CBT or treatment-as-usual with group intervention data.

This psycho-education group was based on a cognitive-behavioural model, allowing individuals in the group to consider how their thoughts, behaviours, emotions and physical symptoms all impact on one another, and which aspects may maintain their difficulties. For instance, a fear of becoming manic was a driving force for many of the group members to isolate themselves and use avoidance as a safety strategy, which could then exacerbate their symptoms of bipolar, especially depressive symptoms.

The promising results from this investigation highlight how a cognitive behavioural approach can be extended to a group setting, rather than being constrained to individualised CBT. Moreover, this held true in a community setting which works with moderate to severe mental health conditions, suggesting an IAPT approach may still be effective in secondary mental health settings rather than solely in primary care.

Cultural adaptations within the British Jewish Orthodox Community

**Raphael Kada, Manchester**

There is a national drive to increase access to psychological therapies across England, with a specific focus on underrepresented groups such as Black, Minority and Ethnic groups. Although prevalence rates for common mental health conditions such as depression and anxiety in British Jewry are less than those of the generic population in the United Kingdom, accessing services to help treating these conditions within this group are considerably less than other groups. This poster seeks to consider reasons to this as well as what adaptations, both from a therapist and service perspective, can be made to increase access within the Orthodox Jewish community with lessons to be made to other Black, Minority and Ethnic groups.

Adapting CBT allows for barriers in accessing treatment to be weakened as it enables the provider or practitioner to work towards understanding the particular group they are working with which in turn encourages greater partnership community working and trust that breaks down stigma. Adapting CBT also allows for CBT to be more accessible to individuals and communities who previously would not have accessed therapy.

Community engagement was trialled in 2011 in Salford and adaptations by both practitioners as well as the service were made. The service there noted a year on year increase in referrals from the Orthodox Jewish community following these adaptations and extensive dialogue between Rabbinical and communal leaders as well as members of the community. The creation of a pathway for Orthodox Jews to refer into an already existing IAPT service was therefore created.

Besides being a government initiative to promote therapy to BME communities, adaptation of CBT is something which requires minimal adjustment and effort yet can have far reaching positive consequences on individuals, communities and the wider community. Skills CBT therapists have such as flexibility, creativity and thinking out of the box can be utilised in communities such as the Orthodox Jewish client group to adapt and promote CBT which will subsequently enhance the lives of others. At times a lack of knowledge may prevent therapists from adapting appropriately and having an open and curious attitude allows the therapists to keep interested in patients material (McEvoy et al 2013) and see, learn and experience others ways of life.
Whether it is adapting CBT thorough offering therapy from a practitioner from within the community, which can be hard at times to source, or offering standard CBT with some minimal adaptations, a better interpersonal rapport will be created, resulting in improved outcomes for patients.

Patient Reported Outcome Measures in Community Mental Health: Pragmatic Evaluation of PHQ-9, GAD-7 and SWEMWBS

Paul Blenkiron, Tees Esk and Wear Valleys NHS Foundation Trust; Paul Blenkiron, TEWV NHS Foundation Trust and Hull York Medical School; Lucy Goldsmith, Population Health Research Institute, St George’s, University of London

Reliable and practical mental health outcome measures are a priority for specialist services. In secondary care, evidence based therapies such as CBT are now commonly integrated into community mental health teams.

The NHS quality agenda promotes three central themes: effective services, safety and a positive patient experience (Department of Health, 2011). Arguably, it is the users of services who are best placed to judge how they feel (Devlin & Appleby, 2010). Patient reported outcome measures (PROMs) are standardised questionnaires that eliciting subjective reports of health and illness. They aim to assess the personal impact of symptoms, functioning, problems, risks and general wellbeing upon an individual’s quality of life. However, no single PROM has evidence of validity across all areas of mental health (Coulter, 2017). Moreover, community mental health teams (CMHTs) are a key component of specialist mental health care, yet front line use of PROMs has not been systematically evaluated in this setting. It also remains unclear how outcomes vary across Mental Health Care Clusters – an important tool for delivering Payment by Results within NHS England’s Five Year Forward View for Mental Health (Trevithick et al., 2015; NHS England, 2016).

We evaluated routine use, acceptability and return rates for the Personal Health Questionnaire, Generalised Anxiety Disorder Scale and Short Warwick Edinburgh Mental Well Being Scale. Method Individuals referred to adult community mental health teams were invited to complete SWEMWBS, PHQ-9 and GAD-7. Measures were repeated 3 months later. Professionals recorded the setting, refusal rates and cluster diagnosis. We aimed to:

1) Assess completion rates and service user acceptability
2) Compare measures at initial assessment and review/discharge
3) Examine the relation between symptoms, functioning and well-being - across mental health superclusters, age and gender

245 individuals completed 674 measures, demonstrating good initial return rates (81%), excellent completion rates (98-99%) and low levels of refusal/unsuitability (11%). Only 13% (32) returned follow up measures. Significant improvements occurred in functioning, PHQ-9 and GAD-7 but not SWEMWBS. PHQ-9 and GAD-7 correlated significantly (r = 0.8) and across time. Final SWEMWBS showed no significant correlation with any initial measure. Supercluster A (non-psychosis) had higher initial PHQ-9 and GAD-7 (p<0.001) ratings and lower SWEMWBS (p=0.003) than Supercluster B (psychosis). Supercluster C (dementia) revealed the greatest functional impairment (p = 0.003).

We calculated clinical effect sizes for the observed improvements in symptoms (Cohen, 1988). The mean initial PHQ-9 score of 16.8 (SD 7.6) decreased on review to 12.6 (SD 8.6), representing a moderate effect size (Cohen’s d = 0.52) across the total sample. The mean initial GAD-7 score of 12.9 (SD 6.2) also improved at follow up to 8.1 (SD 6.1), indicating a large effect size (d = 0.77).

To examine whether there was any selection bias in follow up responses, we compared initial median scores for those who did (n=32) and did not (n=213) complete final measures. The Mann Whitney U test for independent samples showed no significant difference on the SWEMWBS (p= 0.91), PHQ-9 (p=0.42) or GAD-7 (p=0.78).

For both initial and final measures, older service users answered fewer questions on the PHQ-9 (r=- 0.52, p = 0.002) and GAD-7 (r= -0.31, p<0.001). Age correlated positively with initial SWEMWBS score (Spearman’s r = 0.36, p<0.001) and negatively with initial PHQ-9 (r = -0.15, p = 0.04) and ability to function (r = -0.17, p = 0.03). There was no significant association between age and any final outcome (SWEMWBS, PHQ-9, GAD-7, self-harm thoughts or functioning).

Superclusters
Tables 3 and 4 describe service users and their outcomes across the three supercluster categories (Trevithick et al., 2015). There were significant differences between PHQ-9, GAD-7 and SWEMWBS scores at initial but not final review. Individuals with non-psychotic disorders (Supercluster A) had lower initial SWEMWBS scores (p < 0.001), and high levels of anxiety and depressive symptoms that improved at review. Respondents with psychosis (Supercluster B) had the lowest PHQ-9 and GAD-7 scores (p = 0.003).

Outcomes should be validated for the population in which they are used. PHQ-9 and GAD-7 appear acceptable as routine PROMS. SWEMWBS is less sensitive to change. National outcome programmes need to ensure good follow up rates.

This is the first study to examine the pragmatic integration of the PHQ-9, GAD-7 and SWEMWBS within routine CMHT practice. For these three PROMs, we found good initial return rates (80%), excellent rates of scale completion (98-99%) and low rates (11%) of user refusal or unsuitability. After 3 months, service users reported significant improvements in symptoms of depression and anxiety, self-harm thoughts and functioning but not in subjective well-being or perceived ability to handle problems.

Decreasing anxiety scores were observed across superclusters A and B. Building on research in other settings (Lowe et al, 2008; Kertz et al, 2013), our study provides new evidence that the GAD-7, like PHQ-9, appears responsive to change in a community mental health population. A drop of over five PHQ-9 points is reported to indicate a significant and reliable clinical improvement (Richards & Borglin, 2011). We found an eight point reduction in PHQ-9 scores for individuals in supercluster A, which includes those diagnosed with depressive disorder. This effect is similar in size to that observed in large randomised treatment trials for depression (Gilbody et al., 2015). These findings suggest that both PHQ-9 and GAD-7 might be usefully adopted as PROMs within secondary mental health care in functional (non-dementia) populations.

We highlight a low collection rate (13%) for follow up measures. Nevertheless, our comparison of initial median scores for completers and non-completers of the final measures indicated that there was no significant selection bias in the final sample.

Consistent with previous research, individuals with psychosis rated their wellbeing on SWEMWBS higher than those with affective disorders (Blenkiron & Hammill, 2003). However, SWEMWBS scores did not change in this population and there was no significant correlation between initial and follow up SWEMWBS ratings.

There are several possible explanations for this finding. First, subjective well-being could lag behind improvements in symptoms and functioning. Second, SWEMWBS includes questions about areas such as feeling useful and close to people (Stewart-Brown et al, 2009) which could be measuring something different to other outcomes. Third, the psychometric properties of SWEMWBS may include lower internal reliability, and less sensitivity to clinical change than other PROMs.

Alternative wellbeing measures are currently being investigated. Recovering Quality of Life (http://www.reqol.org.uk) is a new national wellbeing PROM commissioned by the UK Department of Health. PHQ-9 and GAD-7 are widely used as part of the minimum data set within IAPT and other services offering CBT. This study confirms their pragmatic use in CMHTs and their sensitivity to change. SWEMWBS appears less sensitive to change and other measure currently now being evaluated, such as ReQoL may be useful as generic measures in mental health populations, including those offered CBT as a core intervention. Specifically designed to assess quality of life and recovery outcomes in adults with different mental health conditions, it has been tested in 6000 mental health service users (Brazier et al., 2016). The brief version (ReQoL-10) is now freely available for clinical and research use in the NHS.

Getting to Eating Disorders Earlier: Does Primary Care Hold the Answer?

Paul Jenkins, University of Reading

Eating disorders (EDs) are potentially life-threatening illnesses associated with significant morbidity and elevated mortality. They are characterised by a central belief that issues around weight and shape are critical in one’s self-evaluation, and common behavioural symptoms include dietary restriction, binge eating, and self-induced vomiting. Early intervention may improve the course of EDs, but relies on correct identification of these illnesses and effective treatment. Although EDs have
a mean age of onset around 18 years of age, disordered eating not meeting full criteria is more common in younger samples, and associated with significant risks and impairment in quality of life.

**Treatment Need**

With some studies suggesting that one in ten of those with an ED ever receives treatment, it has been argued that clinicians are only treating individuals at the “tip of the iceberg” (Mitchison et al., 2017). Recent initiatives, such as IAPT, are designed to meet the need for greater access to evidence-based psychological therapies within Primary Care, although the provision of ED care is not universally supported within IAPT.

**Improving Access**

This poster presents four ideas for improving care for individuals with EDs within Primary Care, supported by a brief discussion of the available evidence and suggestions developing these approaches:

1. Increasing awareness and improved identification of the early signs of eating pathology;
2. Programmes to educate families, GPs, teachers, and other professionals who may come into contact with those showing early signs of an ED;
3. Increased access to evidence-based psychological treatments for binge eating, such as guided self-help; and
4. Promotion of healthy eating, including a focus on reducing unhealthy weight control behaviours and ‘fat talk’.

**Conclusions**

Further work is needed to test the efficacy of these approaches, although some have shown promise in pilot work. Eating disorders are both serious and relatively common illnesses (affecting more than 725,000 people in the UK) and are more likely to affect certain ‘high-risk’ populations. It has also been suggested that EDs frequently emerge in younger age groups, progressing to more severe disturbance in early adulthood, and so early intervention (i.e., in Primary Care) may reduce subsequent morbidity, impairment, and healthcare use.

CBT has been shown to be an efficacious treatment for all types of disordered eating. Making use of this evidence base can help identify cases of disordered eating before they progress to a chronic course, and also inform training of professionals. Wider schemes can make use of CBT principles in, for example, campaigns to reduce stigma and encourage healthy eating.

**Tailored CBT to treat experiential avoidance in an adult with offending behaviours**

**Lucy Armstrong, University of Bath**

RB entered adult secondary care services following a 20-year history of committing arson, theft and bomb hoaxes which had resulted in seven criminal convictions and several prison sentences. At the time of entering services, he was on probation, and referral information indicated an "unspecified disorder of adult personality and behaviour". Most offences had been triggered by stressful life events, and occasions in which RB had experienced significant rejections and betrayals. RBS was committed to psychology therapy to understand his previous crimes and his fear of “opening up to others”, to build adaptive coping strategies and prevent himself from committing further crime.

A collaborative longitudinal formulation of RB’s experience was built gradually from a timeline of significant life events and offences to date. RB’s previous instances of distress appeared to be triggered by unpleasant feelings of betrayal and rejection (which had been a common experience during childhood), and subsequent conflicting beliefs of both “needing to get bad feelings out” and “others will judge me negatively if I open up”. This may have led to feelings being suppressed and consequently accumulating, resulting in severe urges to externalise feelings by offending, or as RB phrased it “putting my feelings onto something else”.

Although offending behaviours were a serious consequence of RB’s difficulties, it was agreed that the intervention focus would be on underlying issues of experiential avoidance (EA). Phase 1 of treatment involved the use of cognitive-behavioural techniques including tailored psycho-education around emotions, the use of reflective diaries, and a therapeutic space to explore emotional awareness and expression. Phase 2 involved working through a DBT-based assertiveness module. Formulating and understanding RB’s past played an integral role to the intervention and was “woven into” most of the phase 1 sessions. This also allowed the therapist to pace sessions and switch to and from a focus on practical information where RB was finding it difficult to express.
Levels of distress were captured over the course of treatment and were measured using the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer and Williams (2001) and Generalised Anxiety Disorder questionnaire (GAD-7; Löwe et al, 2008). Tendency to avoid emotional experience was also measured by using the Brief Experiential Avoidance Questionnaire (BEAQ; Gámez et al, 2014).

Levels of distress reduced significantly in the first phase of treatment, from scores of 13 on both PHQ-9 and GAD-7 in week 1 to scores of 4 on both measures in week eight. EA also saw a significant reduction across the first eight weeks from scores of 71 to 37. Following the assertiveness training module, distress scores continued to reduce slightly (to scores of 2) whereas EA scores remained stable. Overall these results indicated that RB's tendency to avoid emotional experience had significantly lessened along with his distress levels; these improvements mainly coincided with the tailored CBT approach used in phase 1. Throughout therapy RB became observably more expressive and relaxed. By the end of treatment, he had challenged himself to several stress-inducing situations (e.g. initiating difficult conversations) which he would have previously avoided, finding himself better able to cope with the feelings these provoked.

This case study supports the idea of using a tailored CBT approach to reduce distress and EA, which may reduce risk of further externalising behaviours. The intervention took a highly flexible approach, overlapping psycho-education around emotions with an extended longitudinal formulation period. This was crucial to build necessary rapport with RB, who was initially found emotions intolerable and expressing himself very difficult in sessions. Arguably this flexible, overlapping approach may make it difficult to generalise results to others, however researchers suggest that therapeutic alliance is central to socialisation to the CBT model, and may not be altogether separate from the intervention itself (Daniels & Wearden, 2010).

Research suggests that CBT approaches used in prisons mainly focus on anger management, risk reduction and building cognitive skills, without much focus on underlying emotional regulation. It was clear from RB's formulation that emotional awareness and increased tolerance were crucial to his ability to express emotions appropriately (rather than through criminal acts), and that a cognitive/ problem-solving approach may not have been helpful for this. With this in mind, prison-based CBT programmes that focus on underlying emotional intolerance and expressive avoidance may be more useful for treating some of the issues underlying externalised criminal behaviours.

Decades of Generalized Anxiety Disorder – A Case Study

Man Hon Chung, School of Nursing, The Hong Kong Polytechnic University; Man Hon Chung, School of Nursing, The Hong Kong Polytechnic University

A single Chinese man suffering from generalized anxiety disorder for more than 10 years since young age, with avoidant personality trait. He was anxiety prone and tended to avoid problem or anxious events. And he was unemployed for a few years due to his psychological issues. It is understandable that client came to view the world as uncontrollable and insecure as a result of the development of his childhood. He grew up under the influence of controlling but never appreciative traditional Chinese mother. Thus, he has no confidence in most of the situation, including interpersonal and daily life events. He has developed rigid assumptions for himself, such as “Uncontrollable thing will happen in the future”. To operationalize his assumption, he has developed avoidant and perfectionism as his behavioral compensatory strategies.

The present case study is an attempt to demonstrate skills that used in therapeutic intervention sessions by using cognitive behavioral techniques. Highlights of cognitive and behavioral strategies and Behavioral Experiments will be illustrated in the presentation.

A decreased in the level of anxiety and good at using recognize physiological alarm signal, thought stopping, socratic question and distraction by client were found after 12 individual sessions, and he received four follow up sessions for maintenance as well.

Client acknowledged and agreed his dysfunctional distorted thoughts but lack of confidence in the initial stage of therapy. However, client showed significant improvement after gained several successful experiences and continuous encouragement from therapist and girlfriend.

Behavioral experiment is important for client, especially with anxiety disorder, to gain successful experience and sense of control during therapeutic sessions.
Assessing the Usability and Acceptability of FaceIT@home: an online Intervention for People with Visible Differences

Alyson Norman, University of Plymouth; Joanne Veale, University of Plymouth; Heidi Williamson, University of the West of England, bristol

Face IT is an online psychosocial support tool currently available to patients via referral from a clinical psychologist. This tool has been adapted for use independently by users without referral (FaceIT@home). The aim of the present study was to assess the usability and acceptability of a new remote access version of the adult Face IT programme, FaceIT@home, a tool for addressing the appearance-related concerns of adults with visible differences.

79 participants were recruited across the three stages of the study. Study 1 consisted of 14 participants (3 males, 11 female) with a range of visible differences who viewed at least 2 sessions of FaceIT@home in their own homes and then took part in a semi-structured telephone interview. Study 2 consisted of 14 think aloud sessions (1 male, 13 female) with participants without a visible difference conducted under supervision of a researcher at the University of Plymouth. Study 3 employed 51 participants (47 female), 18 of whom reported having a visible difference to view at least 1 session of FaceIT@home and then complete an online survey to evaluate usability and acceptability. Changes were made to FaceIT@home after each study phase.

The user interviews, think-aloud studies and questionnaires identified a number of usable and acceptable aspects of the FaceIT@home online intervention that make it fit for purpose as a remote access intervention. Participants identified a series of small changes to the FACEIT@home program to improve usability.

Participants felt that FaceIT@home was an effective and useful tool for people with visible differences. Its online nature was thought to increase the accessibility of support and provide people with a much needed support tool. This new tool will provide a referral pathway for clinicians wanting to support adults with appearance-related distress.

A preventive intervention for safety behavior in students with subclinical social anxiety: A pilot study

Honami Arai, Graduate School of Doshisha University; Shin-ichi Ishikawa, Department of Psychology, Doshisha University; Kristina Korte, Massachusetts General Hospital | MGH; , Department of Psychology, Florida State University

Individuals with high social anxiety are likely to use safety behaviors (i.e., coping behaviors designed to keep them safe from perceived threat) in feared social situations (Mcmanus et al., 2008). Korte and Schmidt (2015) reported on the development and efficacy of a brief preventative intervention namely the Safety Behavior Elimination Intervention (SAFE) for those with subclinical social anxiety. Safe was adapted from the False Safety Behavior Elimination Therapy (F-SET) which is a transdiagnostic treatment approach for the anxiety disorders (Riccardi et al., 2017). The results revealed significant between group differences in the reduction of social anxiety symptoms, excessive worry, and levels of impairment with the active intervention group reflecting greater reductions compared to a health focused control group. However, no research has evaluated whether SAFE can be adapted cross culturally. The present pilot study adapted a Japanese version of SAFE and examined its acceptability and preliminary efficacy.

The SAFE manual was translated and backtranslated with the help of the original study authors. Six undergraduate and graduate students (3 men and 3 women with mean age ± SD of 25.17 ± 5.04), with high social anxiety participated in a one-session 120 min group SAFE program integrating the identification and elimination of safety behaviors. Participants also meet the therapist for a brief check in at one week and one month after they participated in the program. Participants provided written informed consent. The study was approved by the Research Ethics Board at the university to which the first author belongs. The Social Anxiety Interaction Scale (SIAS) was used to measure social anxiety symptoms, the Beck Depression Inventory-? was used to measure depressive symptoms, the Penn State Worry Questionnaire (PSWQ) was used to measure excessive worry, the Sheehan Disability Scale (SDS) was used to measure disability/functional impairment, and the Anxiety Control Questionnaire (ACQ) was used to measure perceived control over anxiety.
There was a high level of acceptability based on no participant dropping out of the treatment. From pre- to 1-week post, social anxiety symptoms (41.00 to 36.33, d=.41), depressive symptoms (5.5 to 3.16, d=.86), excessive worry (54.17 to 44.17, d=.96), disability/functional impairment (9.83 to 4.17, d=1.04), and perceived control over anxiety (71.33 to 91.83, d=1.63) were improved. From pre-treatment to 1-month follow-up, social anxiety symptoms (41.00 to 28.67, d=1.04), depressive symptoms (5.50 to 1.83, d=1.71), excessive worry (54.17 to 44.17, d=.96), disability/functional impairment (9.83 to 4.17, d=1.10), and perceived control over anxiety (71.33 to 91.83, d=1.63) were improved.

The present study was a pilot trial of a newly developed treatment program in a sample of students with subclinical social anxiety in Japan. Results suggest the SAFE is promising for subclinical social anxiety. In the Korte and Schmidt (2015) study, the SIAS total score was reduced by 34% (29.29 to 19.84). The outcome result of present pilot trial, the SIAS score was reduced by 31%. This reduction is largely consistent with Korte and Schmidt (2015) study, suggest that SAFE for Japanese subclinical social anxiety is worthy of further investigation in larger trials.

This study provides the initial groundwork for future work in this area. Future research examining the use of the trans diagnostic approaches for subclinical symptoms.

**Preliminary Evaluation of a programme devised for IAPT non-responders, delivered within italk (Hampshire IAPT) between 2016 and end 2017**

**Peter Phiri, Southern Health NHS Foundation Trust;** Peter Phiri, Southern Health NHS Foundation Trust; Georgios Giannis, italk. Solent Mind; Hazel Nicholls, italk. Southern Health NHS Foundation Trust; Isabel Clarke, italk. Southern Health NHS Foundation Trust

In 2007 IAPT was launched across England to improve psychological therapies access for a wider population, initially with depression and anxiety, but now extended to more disorders. The UK government has invested over £400 million in IAPT services between 2011 and 2015 with further investments proposed for 2020 an IAPT offers a range of NICE approved therapies with an emphasis on CBT, for adults, older adults, and now extending to children's services. 2017 figures show that approximately 131,327 new referrals of which 71% entered into treatment, with 53% completing a course of treatment of which 81.9% waited less than 6 weeks and 98.8% waited less than 18 weeks to enter treatment. However, there is a 50.4% that show recovery meaning that nearly 49% remain depressed despite receiving IAPT interventions.

Our research group sought to investigate why recovery rates have characteristically hovered around 50%. In order to determine characteristics of the 50% that have shown poor outcomes, italk Hampshire conducted an audit in 2012, with the aim of designing an intervention to meet this group’s needs and improve outcomes locally.

The following characteristics were identified:

- Elements of complex trauma
- Long therapy history with little evidence of benefit gained
- Emotion management problems, particularly emotional avoidance
- Diagnostic complexity
- Relationship/attachment issues.

With a grant from South Central Strategic Health Authority an intervention previously piloted and evaluated in Acute services,(Durrant et al 2007, Araci & Clarke 2017), was adapted for this purpose. The Intervention and programme: Comprehend, Cope and Connect (CCC).

This consists of a trans-diagnostic, emotion and trauma informed formulation. Maintaining cycles are identified; interventions to break the cycles feature mindfulness, with others from DBT, ACT and CFT (Clarke & Nicholls 2018).

Following training and a pilot phase, the intervention was rolled out across italk Hampshire, it comprised:

- Four individual formulation sessions
- A 12 session skills teaching group
- Individual review
- Three month follow up.

Routinely collected outcome measures were collated for: PHQ9, GAD7 and the Work & Social Adjustment Scale at five time points: initial contact, after four formulation sessions, end of group, review after group and at 3 months follow up.
Data on (n= 45) individuals who completed these interventions is reported. Preliminary pre and post comparison shows improvement, including continuing improvement between end of therapy and 3 month follow up, in line with the core purpose of the programme to enable individuals whose lives have been dominated by mental ill health, frequently with long contact with services, to take control of their wellbeing.

This new, trans-diagnostic programme for IAPT non-responders is showing promising results for a group with complex presentation. Evidence suggests therapeutic gains are not only maintained post therapy but continue to improve. Evaluation is ongoing and further outcomes will be disseminated in due course.

Keywords IAPT, Trans-diagnostic formulation, comprehend, cope and connect.

References:

The problem posed by individuals whose presentation is too complex to fit within discrete diagnostic categories and who have failed to benefit from previous NICE approved interventions but continue to present to the service, is familiar to IAPT services. Theoretically they should come under Tier 4, but can be declined on grounds of insufficient risk or severity, or having not benefited from previous treatment. There is an urgent clinical need to establish an effective clinical intervention for this group. The current programme is a promising candidate.

Understanding the neurophysiological basis of interpretation in worry: ERP evidence of interpretation bias in high and low worriers

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Worry is a stream of negative thoughts about future events and can be maintained by the tendency to generate negative interpretations (i.e. interpretation bias) when encountering ambiguous information. No research to date has examined interpretation bias in relation to worry at neurophysiological level. Therefore, this study focused on the N400 component as an ERP (event-related potential) index, which represented the expectation violation of interpretation of ambiguous scenarios, to investigate the differences of interpretation bias between high and low worriers at a neurologic level.

A lexical decision task (LDT) was used as the interpretation bias measurement and combined with ERP measure. The LDT asked participants to determine as quickly as possible if the final words of the ambiguous sentences, which resolved the ambiguity of the sentences, is a real word or not. Negative interpretation bias in this task would be evident if individuals have faster reaction times to negative than benign words. We hypothesized that high worriers would show greater negative interpretation bias and less benign interpretation bias in all measures.

Consistent with our predictions, N400 showed the opposite amplitude patterns between high and low worriers when encountering benign and negative interpretations. However, reaction time did not reach significant criteria.

In summary, ERP measure supported that high worriers had a more negative interpretation bias and less benign interpretation bias compared to low worriers when encountering ambiguous information. ERP may be a more sensitive index of interpretation bias than the reaction time in the LDT.

The study showed that individuals with high and low worry have different interpretative styles from the very early automatic information processing stage. This indicates that interpretation bias is a fundamental phenomenon that affects the later cognitive process then contributes to the
maintenance of worry. Therefore, train individuals’ initial interpretations to be more benign may
decrease the levels of worry and brings benefit to individuals in a longer term.

“Put on your oxygen mask on before assisting others”: A CBT-based group for NHS hospital
staff experiencing sleep difficulties.

Sareeta Vyas, North Bristol NHS Trust; Olivia Donnelly, North Bristol NHS Trust; Cate Anderson,
North Bristol NHS Trust; Lois Coy, North Bristol NHS Trust
In a recent national NHS survey (1) 60% of staff reported working despite feeling unable to carry out
their job duties and requirements. 56% said they felt pressure to come in to work despite feeling
unwell. This survey highlighted the role of ‘absenteeism’ and ‘presenteeism’ and an overall need for
staff health and wellbeing support. Interestingly, one area that was not explored was the impact of
sleep disturbances amongst employees. Ad hoc discussions with North Bristol NHS Trust (NBT)
employees and managers highlighted that sleep issues were having an impact on wellbeing,
especially for shift workers. Sleep loss and sleep difficulties are known to have a profound and
widespread effect on quality of life, family wellbeing, performance, concentration and is associated
with higher rates of long term health conditions and time off work (2,3). Research using Cognitive
Behavioural Therapy for Insomnia (CBT-I) among shift workers have shown positive results with
self-reported improvements on sleep quality (4,5). Could additional support using CBT-I help staff
cope with sleep issues and enhance their wellbeing? We describe the survey results of a one-year
pilot project delivering CBT-I group intervention for NBT employees with self-reported sleep
difficulties.

The NBT Staff Wellbeing Project offered 1:1 and group support for a range of issues affecting staff
members. A pilot CBT-I “Improve your Sleep Course” was designed for staff experiencing difficulties
sleeping. The course was advertised through internal communication channels including trust-wide
emails, staff bulletin and message of the day and was open to all NBT staff. The course consisted of
three weekly sessions lasting one and half hours, covering a range of topics including: sleep hygiene,
stimulus control, and sleep restriction, relaxation, thought challenging strategies, goal-setting, and
setback planning. Throughout the course, participants were encouraged to self-monitor sleep using
sleep diaries. The course was delivered by a Clinical Psychologist and an Assistant Psychologist. An
additional three month follow-up was arranged to provide a review, consolidate skills and support.
Courses were organised at the end or start of the working day to increase attendance and
accommodate shift-work patterns.

Outcome measures were administered pre/post-intervention and included: General Health
Questionnaire 12, Chalder Fatigue Questionnaire, Insomnia Severity Index, Epworth Sleepiness
Scale. Participants were also invited to complete a qualitative feedback form.
Over a one-year period from March 2017- February 2018, 79 staff members showed an interest in
the course. Of these, 38 (31 female and 7 male) people opted to attend an “improve your sleep”
course. 4 courses were completed, 20 (19 female and 1 male) participants completed the
intervention (attended all 3 sessions), and 19 completed outcome measures pre- and post-
intervention. Job roles varied with highest representation from Nurses and Administrators. T-test
comparisons produced statistically significant (p<0.05) and positive differences on every measure,
indicating that those who attended the course had improved sleep, reduced fatigue and better
general health scores. This was supported by qualitative feedback given by participants, all of whom
stated benefits of engaging in the course. Furthermore, 100% of participants reported that they
would recommend the course to a colleague, highlighting both the effectiveness and acceptability of
the course.

Initial outcomes indicate that delivering CBT-I within a NHS staff population is feasible, acceptable,
and produces benefits in terms of individuals sleep quality, confidence, and overall health. Further
research is required to test the effectiveness of the intervention within a larger and more diverse
population, for example in the context of a randomised-control and multicentre trial (RCT) and to
identify what psycho-social factors from the course underpin improvements in sleep. Research could
also explore whether benefits are maintained long term by collecting data at 6 months post
intervention. This study indicated smaller representation from managerial and medical staff, and it
would be interesting to see if this reflects different experiences of sleep or perhaps barriers to
attending support (e.g. time to attend, or possible stigma of accepting help). Further research could also explore contextual factors within medical settings that may negatively and positively impact on staff members sleep quality and broader wellbeing. Preliminary data indicates that brief and tailored CBT interventions are effective in helping NHS hospital staff pro-actively manage their difficulties sleeping. Empowering staff to self-manage concerns, such as sleep, can leave them feeling more confident in their ability to carry clinical work, increase morale, and have a better work-life balance. Key to staff being able to take care of themselves is broader support from managers, for example to recognise difficulties early and to ask for support. Although self-management support including the 'Improve your sleep' course indicate clear benefits from individuals, a broader cultural shift is needed to enable individuals and teams to take care of themselves in order to take care of others.

References:

Kaori Osawa, Department of Human Sciences, Faculty of Letters, Konan University
Preparations in dealing with traumatic stress, particularly trauma-related negative cognitions, could be a protective factor of traumatic stress (Häller et al., 2009). Michael et al. (2016) argued the importance of obtaining functional strategies for the preparations. However, there may be a possibility that people’s negative cognitions towards traumatic memory recall (such as misunderstanding, prejudice, and stigma) and its related fear/anxiety prevent people from having an opportunity for the preparations. Although the strategies to improve people’s mental health literacy (Jorm et al., 1997) such as psycho-education may be effective in solving this problem, the empirical research is scant. Osawa (2017) conducted the universal psycho-educational program aimed to promote the reappraisal of traumatic memory recall among undergraduates. Osawa (2017) indicated that the program may have short-term effects of decreasing the fear of traumatic memory recall and improving the self-controllability of recall. This study intended to investigate the long-term effects of psycho-educational program.

Eighty-two Japanese undergraduates were assigned either to an intervention group or a control group. The intervention group participated in the psycho-educational program as a part of a psychological class, while the control group did not. The program was designed by applying principles of Trauma-Focused CBT and characteristics of involuntary autobiographical memories. A total of 2 sessions (60-70 minutes per 1 session, once a week) was conducted. The intervention group (N = 25) and the control group (N = 8) completed rating the degree of fear of recall (0–100), the degree of probability of coping with recall (0–100), the degree of probability of supporting traumatized people (0–100), 2 subscales (“Appraisal of threat”, “Appraisal of controllability”) of Cognitive Appraisal Rating Scale (CARS; Suzuki & Sakano, 1998) at pre- sessions, 1- and 18-month follow-up.

The group×time between-within repeated measures ANOVA results showed that there was a significant group×time interaction in the scores on “Appraisal of controllability” of CARS (F (2, 62) =
3.39, p< .05). The findings of test of simple main effect revealed that the scores of the intervention group were higher than that of the control group at 1-month follow-up. The effect size was large (d = 1.08). However, the scores between groups were not different at 18-month follow-up. According to the results of group×time between-within repeated measures ANOVA, the intervention group’s degree of probability of coping with recall was higher than the control group’s degree (F (1, 31) = 4.32, p< .05; 1-month: d = 1, 14: large size; 18-month: d = 0.71: medium size). However, the degrees between groups were not different significantly at 18-month follow-up. The results of this study suggested that the psycho-educational program may have long-term effects of promoting and maintaining the self-efficacy for coping with traumatic memory recall. It also suggested that participants’ negative cognitions about traumatic memory recall may be changed by the psycho-education. However, the effects were not as big as exceeding the effect on control group. Implications of this study for the development of psycho-education for preventing traumatic stress were discussed.

The psycho-educational program of this study might be useful for preventing traumatic stress from getting worse or chronic. The psycho-educational program also might have a possibility for people to accept Trauma-Focused CBT without most resistance even though they experienced a traumatic event by any chance and needed to receive treatments.

Coherence between attentional disengagement bias and state rumination following a negative lab event in formerly depressed adults: pilot data from a prospective eye-tracking design

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Background: Recurrent depressive episodes remain of extremely high clinical impact, with researchers anticipating major depressive disorder to become one of the leading global causes for life years lost due to disability and death (Murray et al., 1997 & 2012). Trait rumination has been shown to robustly predict future depressive symptoms and relapse (e.g. Treynor et al., 2013), with rumination being defined as “the occurrence of thoughts that focus one’s attention on one’s distress along with its possible causes and implications” (Nolen-Hoeksema, 1991). While rumination can be seen as a highly elaborate cognitive activity, research in recent years has linked this phenomenon to lower order cognitive processes, such as hampered attentional disengagement from emotionally negative stimuli (e.g. Grafton et al., 2016, Sanchez et al., 2016 & 2017). However, most studies focus on trait rumination and do not assess rumination in situ. Furthermore, the link between attentional disengagement bias and rumination has been assessed in depressed or dysphoric, but rarely in nonsymptomatic individuals after a previous depressive episode.

Objective: In a study currently running, we chose a short-term prospective design to assess rumination in situ after a lab stressor as a function of attentional disengagement capability. To test for cognitive vulnerability unconfounded by current depressive mood, this study only targets fully remitted individuals previously affected by a depressive episode. Measures: Main dependent variables are assessed using the BSRI (Brief State Rumination Inventory, Marchetti et al., 2018), and a modified version of the Breathing Focus Task (Hoorelbeke, 2015). Attentional disengagement is assessed using a visual detection task (Sanchez et al., 2013) while tracking participants’ eye movements. Preliminary results from this experimental setup will be presented and discussed.

The Efficacy of Imagery Rescripting Compared to Cognitive Restructuring for Social Anxiety Disorder

Maree Abbott, The University of Sydney; Alice Norton, The University of Sydney

Imagery rescripting (IR) aims to alter negative meanings associated with distressing autobiographical memories. The current study aimed to extend demonstrated benefits of IR for social anxiety disorder (SAD), including direct comparison of IR with cognitive restructuring (CR) to assess the relative impact of these interventions on symptoms and processes.
SAD individuals (N=60) were randomly assigned to IR, CR or control conditions, and completed two speech tasks, before and after their assigned intervention. Participants completed measures of symptomatology and state affective/cognitive variables in relation to the intervention and speech tasks.

Results support the benefits of IR for SAD, with both IR and CR yielding large and significant reductions in trait social anxiety. However, IR and CR may function via differing pathways. Outcomes suggest that IR may be most effective in the treatment of SAD when delivered across multiple sessions or preceded by CR to target verbal and imaginal self-representations. Imagery rescripting may be used in clinical practice to potentially enhance the effectiveness of contemporary CBT.

Anxiety and depression in Chronic Fatigue Syndrome: prevalence and effect on treatment, a meta-analysis

Amy Caswell, University of Bath; Jo Daniels, University of Bath

Comorbid anxiety and depression pose a risk for poor adjustment to illness and lower quality of life in patients with Chronic Fatigue Syndrome (CFS). They may also affect outcomes to treatment for CFS, with preliminary research indicating that depression is associated with poor outcomes to CBT. Despite the implications of these comorbidities and the acceptance that comorbidities are common, there is a lack of research on the prevalence on depression and anxiety in CFS. The current review aimed to (1) provide an accurate understanding of the prevalence of anxiety and depressive disorders in CFS (2) explore whether anxiety and depression moderate the effectiveness of treatment for CFS.

A systematic review and meta-analysis, including meta-regression was completed. We identified RCTs if CBT and Graded Exercise Therapy (GET) for adults with CFS, in which anxiety and/or depression were reported at baseline. A narrative synthesis was used to explore the prevalence of anxiety and depression within studies. We then ran a meta-analysis exploring treatment efficacy, before completing meta-regressions to explore whether anxiety and depression explained variance between study effect sizes.

Nine papers were included in the analysis. While measurement of anxiety and depression varied between studies, comorbidities were common with up to 55% of patients meeting criteria for depressive disorders, and 48% meeting criteria for anxiety disorders. Greater levels of depressive symptoms were found to be associated with reduced improvement in physical functioning.

The findings suggest that comorbidities are commonplace in CFS. It appears that rates of depression may affect treatment efficacy. The results indicate that for patients to experience good quality of life, and to receive high quality care, psychological difficulties need to be identified and treated. There is particular evidence that depressive symptoms need to be considered during treatment for CFS. The study has implications for CBT for CFS, suggesting that comorbid anxiety and depression should be routinely explored during assessment for CBT. The results suggest that depressive symptoms may have particular importance for CBT for CFS, and may affect treatment outcomes.

Effects of a Training in Mental Imagery on worry: Pilot study for Japanese undergraduates

Nanami Tomori, University of the Ryukyus; Nanami Tomori, University of the Ryukyus; Shinki Kamiya, University of the Ryukyus; Yoshinori Ito, University of the Ryukyus

Worry is characterized by a predominance of verbal thinking and relatively little mental imagery. This cognitive bias of verbal and abstract processing has been found to impair emotional processing of worry topics so that worrisome thoughts are maintained. On the other hand, engaging in mental imagery during the worry process fosters emotional processing of worry themes. Skodzik et al. (2017) developed a comprehensive training designed to foster the general use of mental imagery in everyday life (training in mental imagery (TMI)) and examined its efficacy compared to a waiting list control group (WL) in a sample of subclinical pathological worriers. And the results indicated that TMI led to a significant reduction of worry and impairment, assessed both one and five weeks after the training. Furthermore, in highly anxious participants TMI had beneficial effects on controllability of worry, state anxiety, and positive mood. Especially, it has been shown that the most of Japanese have the gene polymorphism that is related to have worry and anxiety (Murakami et al., 1999). So
the aim of the present study is to develop the Japanese version of a TMI and to investigate whether the Skodzik et al. (2017)'s study is replicated for Japanese undergraduate students with high trait worry.

Thirty-one undergraduate students who had a high trait worry were divided into two groups; 15 TMI group (M= 20.64, SD= 2.06) and 16 Control (C) group (M= 20.75, SD= 1.39). Participants were screened by the Japanese version of a Penn State Worry Questionnaire (Motooka et al., 2009). Participants in the TMI condition filled out a set of baseline questionnaires as a pre-training. They then attended the TMI and received three text messages per day as short reminders to think in mental images whenever possible on the following seven days. Eight days after the TMI session, participants filled out the post-training outcome questionnaires. Participants in the WL condition also completed a baseline measurement, but received no further intervention during the next ten days, after which they filled out the same questionnaires, paralleling the measurement interval in the TMI condition. Three weeks after the post-training measurement (that is four weeks after the TMI session), all participants were asked to answer another set of outcome questionnaires as a follow-up assessment (Follow-up).

The results indicated that TMI led to a significant reduction of verbal worry and a significant improvement in participants' ability to create vivid mental images and controllability of worry, assessed one or four weeks after the training. These results parallel the previous study (Skodzik et al., 2017) showing that a training in concrete, imagery-based thinking reduces another variant of repetitive negative thinking like depressive rumination that is also characterized by verbal and abstract thought activity.

It is a passion hoping to help people.

Self-pity mediates the relationship between shame and binge eating

Yu Nagahama, Tokyo Seitoku University; Marika Shiokawa, University of the Ryukyu; Yoshinori Ito, University of the Ryukyu; Ikuo Ishimura, Tokyo Seitoku University

“Shame-shame cycle” is a process model of binge eating (Goss & Gilbert, 2002). In this model, feelings of shame lead sufferers to use food/eating for affect regulation (especially avoidance) but both the binge eating and subsequent compensatory behaviour (e.g. vomiting) perpetuate feelings of shame and, therefore, reinforce attempts at affect regulation. However, in this model, it remains ambiguous “how” and “why” shame lead to affect regulation. We hypothesize that a self-pity mediates shame and binge eating. Self-pity is a prevalent response to stressful events such as personal failure, loss or illness. Self-pity is defined as a sympathetic, heartfelt sorrow for oneself prompted by one’s own physical or mental suffering, distress, or unhappiness (Stöber, 2003). Recently, Hoshino (2016) experimentally indicated that the self-pity reads people to indulging behaviors and binge eating and self-pity are positively correlated. On the other hand, Self-Compassion (SC) is expected to effective for reducing shame, self-pity and binge eating (Gilbert, 2002). SC involves being touched by and open to one’s own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one’s suffering and to heal oneself with kindness (Neff, 2003). In the present study, we aimed at examining the mediating effect of self-pity in shame and binge eating, and the impact of SC on them for Japanese undergraduate students.

We conducted a questionnaire survey for 407 undergraduate students (208 men, 198 women and 1 unknown with mean age ± SD of 19.88 ± 2.93). They completed the Binge Eating Scale, Only shame in Short Japanese version of The Test of Self-Conscious Affect-3, Self-pity tendency scale, Japanese version of Self-Compassion Scale-Short Form. Mediation analysis and structured equation modeling (SEM) were used to analyze the data.

Self-pity mediated the relationship between shame and binge eating. Furthermore, results of covariance structure analysis showed that SC has a negative impact on shame and self-pity.

The results of this study suggest that the self-pity is a critical factor in the shame-shame cycle. It may be effective focusing on the self-pity for treating binge eating disorder. And SC has a negative impact on shame and self-pity. It is suggested that compassion focused approach (i.e., Compassion Focused Therapy (Gilbert, 2010)) could produce the effect to binge eating disorder not only by decreasing shame but also self-pity.

It is a desire to help people.
Effectiveness and feasibility of group CBT for Hoarding Disorder in secondary care

**Helena Drury, South London and Maudsley NHS Trust;** Helena Drury, South London and Maudsley NHS Trust; Caroline Harrison, South London and Maudsley NHS Trust; Alice Kerr, South London and Maudsley NHS Trust; Ola Balogun, South London and Maudsley NHS Trust; Victoria Bream, South London and Maudsley NHS Trust

Hoarding Disorder (HD), a new diagnostic entity in DSM-5, is a psychiatric disorder characterised by persistent difficulties discarding possessions, leading to the accumulation of clutter that substantially restricts the use of active living areas, and associated clinically significant distress or functional impairment; these symptoms are not attributable to other medical or psychiatric conditions (American Psychiatric Association, 2013). Reviews of the literature into treatment of HD to date show that both individual and group CBT are effective treatments for HD, and that group CBT has similar treatment outcomes to individual CBT (Muroff et al., 2011; Tolin et al., 2015). Previous research has suggested that the group format of treatment may be particularly beneficial for HD, since it can help tackle social isolation and difficulties acknowledging the extent of the problems which are common in HD.

We piloted a 20-session CBT group for Hoarding Disorder in clients known to secondary care teams. The group was run by facilitators experienced in CBT and secondary care. Sessions incorporated feedback from previous primary care group alumni, a session where family, friends and carers are invited to attend, and individual home visits jointly with each client’s care co-ordinator. Session content will included education about hoarding and the CBT model for understanding hoarding symptoms, building motivation to engage with treatment, replacement of excessive acquiring with more adaptive patterns, cognitive strategies to reduce hoarding beliefs (e.g. thinking errors, downward arrow, taking another perspective), organising and decision making about possessions, identifying barriers to progress and relapse prevention.

Results will be presented of the feasibility of recruiting and retaining clients from secondary care teams to a CBT group, and key outcomes in terms of reductions in clutter and hoarding symptoms. We will also present our reflections on group dynamics and practical issues of running a CBT group in secondary care.

Group treatments are an effective treatment for Hoarding Disorder, and can help to tackle social isolation and limited insight into the extent of hoarding problems.

Therapy for childhood OCD in the context of a complicated grief reaction

**Nick Stewart, University of Bath**

A 10-year-old boy, TR, was referred to his local CAMHS service by his GP following concerns about anxiety and obsessive-compulsive behaviour. He was washing his hands and biting the tips of his fingers frequently, to the extent that his hands had become sore and required a steroid cream. TR appeared to have relatively strong responsibility beliefs which were activated when his younger brother – who he had not wanted – died. TR’s belief that his own negative thoughts towards his brother could have contributed to his death gave him ‘evidence’ that he would be responsible for preventing such a tragic event happening again. Furthermore, the tragic event served to make death feel real to TR, making him very attuned to the possibility of himself or the people he loves dying.

TR received CBT (incorporating externalisation exercises) alongside work aimed at helping him to process the complex cognitions and emotions that he experienced in response to a traumatic bereavement.

There was an overall trend towards lower scores on the RCADS for OCD during the course of therapy (a decrease of nearly one standard deviation). GAD scores showed a clear trend of decline over the course of therapy. Scores on the RCADS-P (t-scores) reduced from 70 to 61 for OCD and from 66 to 62 for generalised anxiety, shifting from above to below the clinical threshold in both cases. Although obsessive-compulsive disorder (OCD) is relatively common in children, empirical support for interventions in children is lacking. This case considers whether the recommended approach of CBT (incorporating Exposure and Response Prevention, plus systemic interventions if indicated) may need to be adapted in the context of a complicated grief reaction. Positive outcomes in this case
sugest that it may be important to pay attention to the underlying triggers for OCD symptoms in children. It may be important to pay attention to the underlying triggers for OCD symptoms in children.

It’s better together; health professionals working with patient tutors to deliver an ACT based course to support women recovering from breast cancer

Lois Coy, North Bristol NHS; Olivia Donnelly, North Bristol NHS Trust; Sareeta Vyas, North Bristol NHS Trust; Nicholas Ambler, North Bristol NHS Trust; Carol Chapman, North Bristol NHS Trust

Advancements in our knowledge of how to treat and control cancer means that cancer survival is at its highest ever (NHS England 2016). Breast cancer is the most common cancer in the UK, accounting for 15% of all new cancer cases in 2015 (Cancer Research UK). With a survival rate in England and Wales of 78% for 10 or more years (females only, 2010-11, Cancer Research UK), there is need to ensure that services don’t just help more people to live following a cancer diagnosis, but to live well (NHS England, 2016). The impact on quality of life across several domains, including physical function, psychological distress and social and family concerns has been well documented among breast cancer survivors (Meneses et al, 2007). Thus, there is a need for interventions that aim to address these factors and improve quality of life for people living beyond cancer. We describe the results of a Living Well Course (LWC), based on Acceptance and Commitment Therapy (ACT), which has been made available to all patients during cancer recovery in an NHS hospital setting.

The Breast LWC offers a proactive approach to maximising recovery, following a self-management group model, and covers topics such as managing fatigue, self-examination, and dealing with appearance related concerns. The content also incorporates various ACT principles and practices, including mindfulness exercises, values clarification and defusion (an approach that helps change the relationship with ‘reality cognitions’ e.g. ‘the cancer might come back’ that are less easy to address with more traditional thought challenging techniques). Goal-setting is also promoted with the aim to facilitate values-based action and re-engagement. The course currently consists of 5 weekly 2.5-hour group sessions, facilitated by a member of the psychology team, a clinical nurse specialist and a trained patient volunteer, using an ACT based manual and participant workbook. Recruitment was by self-selection, either from a patient information session at the end of intensive treatment or via a consultation with a health care professional.

Outcome measures administered pre/post-intervention: Functional Adjustment to Cancer Therapy-General (FACT-G), EQ-5D-5L, Hospital Anxiety and Depression Scale, Chalder Fatigue Questionnaire and The Patient Activation Measure.

Over the period June 2010-February 2017, 24 Breast LWC were completed. 183 (100% female) patients completed outcome measures pre- and post-intervention. T-test comparisons showed statistically significant (p<0.05) improvements for all comparisons, except for scores on the Self-Care and Pain/Discomfort subscale of the EQ-5D-5L, and the Social subscale of the FACT-G (p’s=>0.05). Qualitative feedback strongly supported the benefits of the Breast LWC.

Findings suggest that the delivery of Breast LWC, based on ACT and self-management principles, can help women move forwards with their physical and emotional recovery following treatment for breast cancer. The courses are consistently in high demand, and the involvement of the Clinical Nurse Specialist has been a key part of engagement and recruitment, highlighting the benefits of multi-disciplinary working. Furthermore, the role of the patient tutor within courses provides important bridge between patient experience and clinical approaches.

This model aligns with the UK national cancer survivorship strategy for developing stratified follow-up care for patients completing breast cancer treatment. This approach, which is offered to all women as part of their routine follow-up care, has demonstrated effectiveness, equity of access, and financial sustainability, as well as a positive impact on the wider medical team. A randomised control trial would strengthen these findings and explore potential cost savings compared to traditional 1:1 follow-up clinics. Furthermore, this approach highlights the benefits for patients, as well as teams, on the active involvement of a patient tutor in the development and provision of high quality ACT-based interventions that promotes cancer recovery. A ‘train the trainer’ programme could be developed to enable teams in other cancer centres to also deliver this approach.
The Effectiveness of ACT for Improving Wellbeing and Psychological Flexibility among Employees in a Hospital Setting

Lois Coy, North Bristol NHS Trust; Josh Hope-Bell, University of West England; Lois Coy, North Bristol NHS; Fabio Zucchelli, University of West England; Nick Hooper, University of West England

Stress and poor general wellbeing in the workplace is an issue affecting many in the UK (Health & Safety Executive, 2017). In particular, the health and social work sector has been found to have one of the highest work-related stress rates, perhaps due to the ‘high pressure’ nature of the work, organisational conflicts and ever increasing service demands (Health & Safety Executive, 2017; Ruotsalainen, Verbeek, Mariné & Serra, 2015). The results of North Bristol NHS Trust’s staff attitude survey (2016) reflected this, with 37% of staff reporting that they experience work-related stress and with the rate of ‘presenteeism’ reaching as high as 60%. As well as the well documented effects of stress on an individual’s health, high levels of staff stress can also impact workplace productivity, teamwork effectiveness and the ability to provide compassionate care (Weinberg & Creed, 2000).

Subsequently, there is a need for initiatives that focus on supporting staff to develop their psychological coping strategies and self-care skills. One such intervention, which has been heavily evaluated in the workplace context but less so with hospital staff, is Acceptance and Commitment Training (ACT), an innovative approach that helps people to handle difficult feelings and thoughts, and take steps towards what matters (Hayes et al., 1999). We describe the initial results of a pilot project delivering an ACT group intervention, with the aim to improve wellbeing and resilience among North Bristol NHS employees.

The content of the ACT course was based on a protocol developed by Flaxman, Bond and Livheim (2013), ‘The Mindful and Effective Employee’. The course consisted of 3 weekly 3-hour group sessions, facilitated by an experienced clinical psychologist. The content covered various ACT principles and practices, including values clarification, mindfulness exercises, defusion and ACT metaphors. The 'Wellbeing and Resilience course' was available to all North Bristol Trust employees, with up to 12 people per course. Recruitment was self-selection in response to advertisements about the course via internal communications. Outcome measures administered pre- and post-intervention included: General Health Questionnaire (GHQ), Valuing Questionnaire (VQ) and the Work Acceptance and Action Questionnaire (WAAQ). A feedback form was also given to provide greater insight into the participant's experience of the course.

From February – June 2017, 90 staff registered an interest and 4 courses were completed. 89% of staff who completed the courses (attended 3/3 sessions, n=35) were female, and reported ethnicities of participants were White British (n=32), White European (n=2) and Asian British (1). The average age of participants was 42. 26 complete pre- and post-data sets were collected. T-test comparisons showed statistically significant improvements across all measures from pre- to post-intervention (p<0.01), suggesting that attending the ACT course resulted in improvements in stress, connection with values and work related psychological flexibility. This conclusion is supported by the qualitative feedback gathered, which indicated that participants experienced positive changes both in their home and work life, were engaging with the ACT approach, and would recommend the course to a colleague.

Initial findings suggest that the delivery of an ACT course among NHS employees can result in improvements to staff emotional wellbeing, connection with values and work related psychological flexibility. Furthermore, the approach appeared feasible and acceptable within an NHS hospital setting. However, more research is needed to further evaluate the effectiveness, for example in the context of a randomised control trial. In addition, as certain populations (including senior management, medics and male staff) were under represented in this sample, ways to tailor the recruitment or the approach to better meet their needs could be explored. This project is ongoing – subsequently, further pre- and post-intervention data sets will be included in the final analysis, along with 3 month follow up questionnaires. Semi-structured interviews exploring the process and impact of taking part will also be completed and examined using thematic analysis. The results of this pilot study highlight clear benefits and acceptability of a brief ACT intervention for NHS staff wellbeing. What is more, these improvements have the potential to reduce staff burnout and enhance patient care; future research is needed to examine this assertion and to evaluate whether the benefits are maintained. The authors acknowledge, however, of the importance of not seeing resilience and coping as being an individual staff members responsibility alone but one that is
best influenced by the wider context. In other words, a broader cultural shift is needed at all levels of an organisation that recognises and nurtures employee wellbeing as paramount as part of providing compassionate and effective care.

Does the severity of anxiety, depression and sleep difficulties impact the effectiveness of CBT for menopausal symptoms?

**Lauren Cudney, McMaster University;** Eleanor Donegan, St. Joseph’s Healthcare Hamilton; Arela Agako, McMaster University; Benicio Frey, McMaster University; Randi McCabe, McMaster University; Sheryl Green, McMaster University

Women in the menopausal transition are at increased risk for physical and emotional difficulties, including hot flashes and night sweats (vasomotor symptoms), sleep disturbance, as well as anxiety and depressive symptoms (Katainen et al., 2018). Many psychological treatments for menopause focus solely on decreasing distress surrounding vasomotor symptoms, but do not explicitly address other related symptoms. Given the high prevalence of these related symptoms, our group developed a comprehensive group treatment program for menopausal symptoms (CBT-Meno) targeting depression, anxiety, sleep, urogenital complaints, and sexual concerns in addition to vasomotor symptoms (Green et al., 2013). Anxiety, depression, and sleep symptom severity may impede improvement of vasomotor symptoms across treatment in the menopause transition. As such, it is important to examine the role of these symptoms in treatment outcome. In the present study, we examine the extent that sleep disruption, anxiety and depressive symptom severity at baseline impacts the degree of menopause-related symptom change in peri-and post-menopausal women following group CBT-Meno.

Sleep difficulties, anxiety and depressive symptom severity, and vasomotor symptoms were measured at baseline and post-treatment in 19 peri- and post-menopausal women who received 12-week CBT-Meno group at the Women’s Health Concerns Clinic, St. Joseph’s Healthcare Hamilton, Ontario, Canada. Participants completed measures of anxiety symptoms (Hamilton Anxiety Rating Scale; HAM-A), self-report depression symptoms (Beck Depression Inventory; BDI-II), and sleep quality (Pittsburgh Sleep Quality Index; PSQI). Self-report vasomotor symptoms were measured with the Hot Flash Related Daily Interference Scale (HFRDIS), and broader menopause-related symptoms were measured with the Greene Climacteric Scale (GCS). The outcome of CBT-Meno on vasomotor symptoms was measured as change (?) from baseline to post-treatment in HFRDIS and GCS. Paired sample t-tests were performed between baseline and post-treatment. Pearson correlations between baseline measures of HAM-A, BDI-II, PSQI, and the outcome measures of HFRDIS and GCS were used to determine the relationship between severity of baseline symptoms and degree of treatment response.

Participants showed significant improvement in vasomotor symptoms on the HFRDIS and GCS (both p<0.05) by post-treatment. Significant improvements were also observed in anxiety (HAM-A), depressive symptoms (BDI-II), and sleep quality, PSQI (all p<0.05). Baseline levels of anxiety (HAM-A), depression (BDI-II), and sleep disruption (PSQI) were not significantly correlated with HFRDIS and GCS (all p>0.05).

CBT-Meno was effective in treating vasomotor symptoms, as well as anxiety and depressive symptoms, and sleep difficulties. As such, despite the fact that the focus of CBT-Meno is not exclusively on these related symptoms, we nonetheless see significant improvement over the course of treatment. Importantly, severity of anxiety, depression and sleep disturbance at baseline were not related to how effective CBT-Meno is for vasomotor symptoms (HFRDIS), or menopause symptoms overall (GCS). These results are encouraging clinically, as they indicate that CBT-Meno is an effective treatment for vasomotor and menopause symptoms regardless of the severity of affective and sleep symptoms prior to treatment. Therefore, the CBT-Meno treatment program is widely applicable, and many women are likely to benefit, even those who are experiencing more severe symptoms at the start of treatment.

This analysis shows that a comprehensive CBT for menopause symptoms is widely applicable, and many women are likely to benefit, even those who are experiencing more severe symptoms at the start of treatment.
Emotion dysregulation as a mediator of perinatal anxiety/depression and negative social outcomes during the perinatal period

Arela Agako, McMaster University; Eleanor Donegan, St. Joseph's Healthcare Hamilton; Lauren Cudney, McMaster University; Randi McCabe, McMaster University; Sheryl Green, McMaster University

The perinatal period, which includes pregnancy and the first 12 months post-partum, is a period of vulnerability for women as they experience an increased risk of developing an anxiety and/or depressive disorder. The presence of anxiety and depression during this time leads to adverse outcomes in both mothers and infants including impairment in functioning in the mother, and negative social outcomes such as decreases in marital satisfaction, perceived social support, and maternal bonding (Berle et al., 2005). However, the relationship between perinatal anxiety and depression and these negative social outcomes remains unexplored. Emotion dysregulation (ED) which refers to maladaptive emotional expression, reactivity and regulation, has been linked to numerous psychopathological conditions, including anxiety and depressive disorders and various facets of ED have been linked to impairments in social functioning (Keltner et al., 1998). This is due to the impairments in emotional expressivity and misinterpretations of other’s emotions that are part of ED which can greatly affect social interactions with others (Keltner et al., 1998). Different facets of ED could therefore explain the relationship between perinatal anxiety and depression and negative social outcomes.

The proposed study will investigate the impact of ED on various social outcomes that are specific to the perinatal period including marital satisfaction, perceived social support, parental sense of competence and mother-infant bonding. Data will be analyzed on a sample of perinatal women with a primary anxiety and/or comorbid depressive disorder who are enrolled in a randomized controlled trial (RCT) on CBT for perinatal anxiety currently underway at the Women’s Health Concerns Clinic, St. Joseph’s Healthcare Hamilton, Ontario, Canada (Green et al., 2015). Self-report measures of anxiety symptoms, depressive symptoms, emotion dysregulation, marital satisfaction, perceived social support, parental sense of competence and mother-infant bonding will be obtained as part of their baseline assessment prior to randomization.

Multiple regression and mediation analyses will be run on a projected sample of N=70 women who will have completed the baseline measures by June, 2018. We hypothesize that 1) ED will be negatively correlated with all measures of social functioning and 2) ED will mediate the relationship between anxiety/depression and social functioning outcomes. The findings from this study will shed light on ED as an unexplored variable that could help explain why perinatal anxiety and depression are associated with negative social outcomes. If ED is found to be implicated in social outcomes, then this will warrant adapting treatment strategies accordingly to target this variable in perinatal women. These results will shed light into an unexplored variable that could explain negative social outcomes in the perinatal period. Social support is very important during pregnancy and postpartum and new mothers can greatly benefit from support from others. Clinicians can target ED directly in CBT treatments with perinatal women in order to reduce the negative social outcomes and increase quality of life in women during this time.

Investigating the role of intrusive mental imagery in the social confidence of autistic people

Juliette Attwood, University of Bath; Ailsa Russell, University of Bath

Social Anxiety Disorder (SAD) is characterised by a severe and persistent fear of social or performance situations. Lifetime prevalence of SAD in the general population is estimated at 12%, however, a recent study of a non-treatment seeking autistic population found that 50% of adults also met diagnostic criteria for SAD (Maddox & White, 2015). Intrusive mental imagery is proposed as contributing to the onset and maintenance of social anxiety in the cognitive model (Clark & Wells, 1995), and observer-perspective images of appearing anxious in a social situation are commonly reported. Whilst there is some evidence that
autistic people have a tendency to think more in image form, and recent research with autistic and typically developing children has found an association between generalised anxiety and frequency, distress, but not intensity, of intrusive mental imagery in both groups (Ozsivadjian et al., 2016), it is currently unknown whether autistic people who experience high levels of social anxiety also experience intrusive mental imagery in social situations. This study aimed to investigate the applicability of the CBT model of SAD by testing the hypothesis that autistic people with higher levels of social anxiety will report experiencing intrusive mental imagery in social situations as more frequent and distressing, but not more intense, than autistic people with lower levels of social anxiety. The study also aimed to investigate if the images tend to be experienced from a field or observer perspective. The study used a between groups cross-sectional design. Inclusion criteria were that participants were aged 18 years or older and had a formal diagnosis of an autism spectrum condition. Data was collected in two stages. Firstly, participants were invited to take part in an online survey consisting of four multiple choice questionnaires: The Social Phobia Inventory (SPIN), The Brief Fear of Negative Evaluation scale (BFNE), the Generalised Anxiety Disorder 7-item scale (GAD-7), and the Spontaneous Use of Imagery Scale (SUIS). Secondly, survey participants were invited to take part in a follow-up telephone interview where an adapted version of the Mental Imagery Interview was used to explore the occurrence, experience, and content of mental imagery. 324 participants took part in the online survey. 31 participants who scored below or equal to 30 on the SPIN and 31 participants who scored above or equal to 33 took part in the Imagery Interview. Frequency, distress, intensity, and perspective (field vs. observer) of intrusive mental imagery in social situations will be compared between the high and low social anxiety groups. The findings will be presented in relation to how they fit with the CBT model of SAD and previous research. Methodological limitations, implications for clinical practice, and avenues for further research will also be presented.

The Effects of Mindfulness-Based Cognitive Therapy for Japanese Human Service Professionals. Part 2: Focusing on Work Stress and Mental Health Index

Marika Shiokawa, University of the Ryukyus; Mika Aniya, Graduate School of Humanities and Social Sciences, University of the Ryukyus; Yoshinori Ito, Faculty of Law and Letters, University of the Ryukyus

The suicide is a crucial problem in Japan. Although the numbers are decreasing year by year, more than 20,000 people commit suicide recent year. Particularly, work stress is the most influential factor of it. In the present study, we intended to examine the effect of the Mindfulness-Based Cognitive Therapy (MBCT) for Japanese human service professionals on the stress reduction and the improvement of their nature as the professionals. Especially, our presentation focuses on the effect of the work stress reduction and increase of mental health promotion by MBCT. The MBCT designed by Segal, Williams, and Teasdale (2002) for recurrent depression was partly modified for focused on human service professional’s stress and used for the present study. Thirteen professionals (Mean Age = 42.69, SD = 10.27, women = 9) participated in the MBCT. Participants completed Work Stressor and Stress Reactions Scale (WSSRS), Hospital Anxiety and Depression Scale (HADS) at one month before MBCT starts (Baseline), Pre- and Post-test, and one month Follow-up.

In the present study, we conducted the one-way ANOVAs with Time as within-subject factor (Control period, Pre-test, and Post-test). “Control period” was the mean of Baseline and Pre-test. Finally, analysis were conducted to eleven participants (Mean Age = 43.64, SD = 9.91, women = 7) because of dropping out. We conducted the one-way ANOVA of WSSRS and HADS score as dependent variables, due to examine the change in work stress and mental health. In WSSRS, the result showed a significantly main effect of Lack of ability and Tension
in the interpersonal scene (F (2,20) = 5.31, p < .05, ?² = .35; F (2,20) = 3.25, p < .05, ?² = .25),
and main effect of Anger was significant tendency (F (2,20) = 4.19, p < .10, ?² = .30). Post-hoc
analysis did not show any significant results. In HADS, the result showed a significantly main
effect of Anxiety (F (2,20) = 4.97, p < .05, ?² = .33). Post-hoc analysis did not show any
significant results, however Control-Post and Control-Follow effect size were large (d = 1.03;
d = .81). Furthermore, In the free descriptive comment that participants completed at the
final session, there were many contents like that “I was aware of my emotions” and “I was
able to put distance from anxiety”. Also, most participants rated that it was meaningful to
participate in MBCT (9.18 on the 10 point Likert scale).

The present study could not show the effects of MBCT on the work stress and mental health.
There were some possible reasons about it. First, most of participants had low work stress
and well mental health at Baseline in this study. It could be caused by a floor effect. Second,
statistical power were low because of fewness of participants. We need to add more
participants to test the effect of MBCT because some scales indicated large effect size. On the
other hand, it could be considered that the "third wave" of CBT does not regard only the
improvement of the symptom as the principal purpose (Hayes, 2004). However, the result of
free descriptive comment suggests MBCT may improve ability to notice of and cope with
stress.

The Effect of Mindfulness-Based Cognitive Therapy for Japanese Human Service
Professionals. Part 1: Focusing on Index Associated with Mindfulness

Mika Aniya, University of the Ryukyus; Mika Aniya, Graduate School of Humanities and
Social Sciences, University of the Ryukyus; Marika Shiokawa, Graduate School of Humanities and
Social Sciences, University of the Ryukyus; Yoshinori Ito, Faculty of Law and Letters, University of
the Ryukyus

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the stress reduction and the improvement of their nature as the professionals. Especially,
our presentation focuses on the results of the acquirement of the mindfulness skills by
MBCT.

The MBCT program designed by Segal, Williams, and Teasdale (2002) for recurrent
depression was partly modified for focused on human service professional’s stress and used
for the present study. Thirteen professionals (Mean Age = 42.69, SD = 10.27, women = 9)
participated in the MBCT program. Participants completed Five Facet Mindfulness
Questionnaire (FFMQ), Self-Compassion Scale-Short Form (SCS-SF), and Acceptance and
Action Questionnaire-II (AAQ-II) at one month before the program starts (Baseline), Pre-
and Post-test, and one month follow-up.

In the present study, we conducted the one-way ANOVAs with Time as with-in-subject factor
(Control period, Pre-test, and Post-test). “Control period” was the mean of Baseline and Pre-
test. Finally, analysis were conducted to eleven participants (Mean Age = 43.64, SD = 9.91,
women = 7) because of dropping out. We conducted the one-way ANOVA of FFMQ total and
each subscales score as dependent variables, due to examine the change in trait mindfulness.
The result showed a significantly main effect of FFMQ total and Observing and Nonreactivity
of subscales (F (2, 20) = 7.00, p < .01, ?² = 0.41; F (2, 20) = 5.07, p < .05, ?² = 0.34; F (2, 20) =
5.67, p < .05, ?² = 0.36). The result of post-hoc analysis showed that these significantly
increased at post-test (t (10) = -3.25, p < .05, d = -1.09; t (10) = -2.90, p < .05, d = -0.95; t (10) =
-2.94, p < .05, d = -1.00). And the result showed a significantly main effect of Describing (F
(2, 20) = 4.93, p < .05, ?² = 0.33), however post-hoc analysis did not show any significant
results (t (10) = -2.64, n.s., d = -0.71). Similarly, the result showed that a main effect of Acting
with Awareness and Nonjudging were significant tendency (F (2, 20) = 2.73, p < .10, ?² =
0.21; F (2, 20) = 2.60, p < .10, ?² = 0.21), however post-hoc analysis did not show any
significant results (t (10) = -1.94, n.s., d = -0.70; t (10) = -1.89, n.s., d = -0.55).
Rumination in China: Different structure, different consequences for depression

Andrew Ryder, Concordia University; Jiahong Sun, Concordia University (Canada); Xiongzhao Zhu, Central South University (China); Qiuping Tang, Central South University (China); Shuqiao Yao, Central South University (China)

Rumination refers to a style of coping that focuses on one’s depressive symptoms and problems in a perseverative fashion (Nolen-Hoeksema et al., 2003). Research in North American samples has reported a robust association between rumination and depression. For example, using an improved measure of rumination uncontaminated with symptoms of depression (ruminative response scale -10), Treynor and colleagues (2003) found a two-factor solution, namely brooding and reflection, that differentially associated with symptoms of depression in community samples from the US. Cross-cultural studies have also reported a positive link between rumination and depression in China, suggesting that rumination is a useful construct in understanding depression in the Chinese context. However, despite East Asians endorsing higher levels of rumination, a cross-cultural study reported a weaker association between rumination and measures of psychological well-being in Asian Americans compared to European Americans. Therefore, the cultural meaning and structure of rumination warrants further exploration.

The current study examines the factor structure of rumination in two samples of Chinese psychiatric outpatients (n = 308; n = 139) and its relation to depression. These outpatients were collected at the Second and Third Xiangya Hospitals in Changsha, China. All participants had a diagnosis of depression according to DSM-IV, ICD-10, or the Chinese Classification of Mental Disorders (CCMD), as established by structured clinical interview; potential participants were excluded if they reported past or present symptoms of mania, psychosis, or neurocognitive impairment. Participants completed an extensive self-report questionnaire as part of the study; the full item set of the Response Style Questionnaire (Nolen-Hoeksema, 1991) was included in this package, and is the focus of these analyses. Principal axis factor analysis with promax rotation was performed on both samples, using the subset of items identified by Treynor and colleagues (2003). Our factor loadings did not resemble Treynor et al. (2003). Instead, we noted four sub-components, which we labelled as: self-analysis, self-isolation, self-criticism, and self-doubt. The four aspects in turn created two Chinese rumination factors, where factor 1 consists of self-analysis and self-criticism, and factor 2 consists of self-isolation and self-doubt. Chinese rumination factor 1 was negatively and non-significantly associated with symptoms of depression; whereas Chinese rumination factor 2 was positively and significantly associated with depression. The same analytical procedure was followed in the second sample of Chinese patients. With the exception of one cross-loading item, all results were replicated. Our findings suggest a different factor structure of rumination in the Chinese context, where self-analysis and self-criticism constitute a non-maladaptive factor of depression, whereas self-doubt and self-isolation formed a maladaptive factor of depression. Although expansion of each sub-component is needed in future research to make any strong claims about self-criticism and self-isolation, our study suggest that engaging in self-critical thinking is a culturally acceptable way of coping in China, whereas isolating one-self in order to think about one’s problems is culturally incompatible with the Chinese cultural context.

Implications for the science and practice of cognitive-behavioural therapy will be discussed. This project has potential implications for how clinicians use CBT cross-culturally. Most information that we have about how to understand a disorder like depression is based on research from North America and Western Europe. Through a 'Western' cultural lens, it might seem self-evident that going away to think about a problem is productive, whereas

The results indicated that 8 sessions MBCT for Japanese human service professionals helped acquiring some mindfulness skills including Observing and Nonreactivity. MBCT may be an effective intervention for addressing the improvement of the professional awareness in human service. On the other hand, these effects were disappeared after 1 months. We need to carry out an additional analysis to identify relating factors about it.
asking yourself how you could have improved in the future is potentially harmful. From the point of view of a collectivistic society, however, self-criticism is normative whereas self-isolation is not. In a narrow sense, this research may help CBT practitioners to more effectively identify problematic response styles in Chinese-origin clients with depression, and to propose more effective behavioural activation strategy. In a broader sense—and, we believe, more importantly, this research serves as a reminder to clinicians that cultural context can challenge straightforward assumptions of universality. In this presentation I will briefly discuss clinical techniques that can be used to ask questions more effectively, drawing out cultural aspects of mental health relevant to individual clients.