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**Keynote Addresses**

**Shattered Lives: Understanding and Treating Posttraumatic Stress in Children and Adolescents**

**Tim Dalgleish, University of Cambridge**

Around two thirds of children and adolescents will have experienced profoundly traumatic events before they turn 16. A significant proportion of those exposed to these experiences will suffer mental health problems, most notably posttraumatic stress disorder (PTSD). Over the past 25 years myself and my collaborators have sought to understand the nature of PTSD in young people and the factors that contribute to its onset, maintenance and remission. These insights have provided a platform for translational research developing and refining psychological interventions for this disabling condition, for children as young as three years right up to older adolescents. This talk reviews this translational journey from the laboratory to the clinic through to implementation, including recent work developing e-therapy interventions. The talk is ostensibly about a research programme on PTSD, but it also serves to illustrate the challenges and opportunities of clinical translational research in any domain of mental health.

**Precision Mental Healthcare: Learning from Population Data to Personalise CBT**

**Jaime Delgadillo, University of Sheffield**

Precision medicine refers to the delivery of interventions that are tailored to the individual, based on advanced prognostic methods that rely on clinical population data. The basic idea is that individuals are members of subgroups with similar characteristics – phenotypes – and similar patterns of treatment response. Information about an individual’s phenotype can therefore be used to prescribe treatments that tend to work well in similar cases, to monitor treatment response, and to adjust treatment in a timely way if it is not working as expected. This talk will focus on two novel approaches to personalise psychological therapy. Prescriptive models are based on the observation that patients with certain characteristics tend to respond better to some interventions and not others. Corrective models help therapists to identify and resolve obstacles to improvement in a timely manner. Evidence from observational and experimental studies will demonstrate how these approaches can improve the efficiency and effectiveness of CBT for depression and anxiety problems.

**Talking About Suicide Affects Us All**

**Gillian Haddock, University of Manchester**

Suicide is a major cause of death for people with mental health problems. In addition, persistent suicidal thoughts and acts are highly prevalent in people using mental health services as well as in the general population. The impact of these, often persistent experiences for those experiencing them and their families and friends is immense, causing great distress and disruption to all aspects of life. In addition, suicide is a major focus for services and staff with huge resources dedicated to preventing and reducing risk from suicide. Despite this, the occurrence of suicidal ideation and behaviours remains high amongst people with all types of mental health problems, and, such problems often result in heavy use of NHS services.

There are therapies and treatments to reduce the impact of suicidal thinking and behaviours (NICE recommends CBT for self-harm), however, their implementation is patchy and training programmes may offer generic training in applying CBT to specific mental health problems but do not always offer specific training in applying CBT to suicide.
This keynote will cover some of the theoretical underpinnings relating to applying cognitive-behavioural approaches to suicide and will describe a programme of work which has led to the refinement of approaches which are targeted directly on the factors which have been shown to underpin suicidal ideation and behaviour across a range of mental health disorders. Some of the key issues which relate to implementation of such approaches amongst service users and staff will be discussed.

Transdiagnostic Approaches to the Etiology and Treatment of Trauma-related Disorders: Promise and Pitfalls

Thomas Ehring, LMU Munich, Germany

For decades, research into psychopathology and its treatment has been dominated by disorder-focused theoretical models and disorder-specific interventions. There is no doubt that this approach has been very successful. However, it is increasingly recognized that mainly focusing on distinct disorders has also serious disadvantages. Therefore, there is an emerging trend towards transdiagnostic approaches in both etiological research and treatment development.

In this keynote presentation, the link between traumatic experiences and psychopathology is taken as an example to discuss advantages and disadvantages of adopting a transdiagnostic perspective. In the first part, evidence on the transdiagnostic link between trauma and psychopathology will be summarized, followed by a conceptual framework for studying processes mediating and moderating this link. In the second part, the utility of transdiagnostic approaches to treating trauma-related disorders will be discussed. The talk will conclude by focusing on specific challenges of transdiagnostic approaches to research and treatment.

Intergenerational Transmission of Anxiety Disorders: Parents Matter (for some)

Susan Bogels, University of Amsterdam, the Netherlands

I will give an overview of the results of a 7.5 years longitudinal study on the role of fathers, mothers, and their interaction, in the development of anxiety and other symptoms of psychopathology of their firstborn children from prenatally until the age of 7.5 years. We will look at parents own anxiety disorders, and the way they interact with their child separately and together as co-parents, and how that interacts with the child’s vulnerabilities and strengths (physiology, temperament, self consciousness and mindreading), in order to predict child’s outcome over time. Specific critical periods in development for parental influence will be highlighted. The consequences of the findings for the prevention and treatment of child anxiety disorders are discussed.

When is a Safety Behaviour Not a Safety Behaviour? Working with Anxiety in Adverse Life Circumstances

Georgina Charlesworth, University College London

The aim of this address is to highlight cognitive and behavioural strategies that can be used to address anxiety when clients are in adverse life circumstances. Firstly, I shall provide a brief history of the concept of safety-seeking behaviours and an overview of the literature on differentiating between (unhelpful) safety behaviours and (adaptive) coping strategies. Secondly, I shall describe case examples that illustrate ambiguities in behavioural function and consider the pros and cons of the ‘pragmatic truth’ approach to decision-making. Thirdly, I shall assert the value of focusing on the ‘denominator’ of the anxiety equation to build self-efficacy, resilience and coping resources, especially in scenarios where the probability of awfulness is high and represents a realistic catastrophe. I shall conclude by
emphasising the importance of ensuring that cognitive behavioural therapy protocols are suitable for people with multi-morbidities, including chronic or deteriorating physical health conditions.

Network Analysis in Psychopathology: Prospects and Challenges

Richard McNally, Harvard University, USA
I will first provide a brief overview of the conceptual, psychometric, and clinical strengths of the network perspective psychopathology, contrasting it with traditional latent categorical and dimensional models. Next I will present a series of studies to illustrate recent applications and extensions of network analysis to anxiety and related disorders. Finally, I will address critiques and challenges confronting this new approach to conceptualizing psychopathology.

Early Developmental Intervention in Autism Spectrum Disorder

Jonathan Green, University of Manchester
Recent developmental science has revolutionised our understanding of the dynamics of early autism development in the context of neurodiversity. I will discuss the conceptual and evidence background for intervention approaches rooted within this developmental science, giving a new perspective on early intervention in the condition.
Specifically I will address i) a prodromal intervention for ASD-risk in the first year (iBASIS-VIPP), with RCT follow-up to 3 years; ii) our dyadic social communication intervention for pre-school children diagnosed with ASD (PACT), with RCT follow-up to 10 years: both trials showing sustained improvement in autism symptom severity.
I will reflect on lessons from these trials about early social development, and how interventions of this kind can be embedded into the management of autism as an enduring developmental condition throughout childhood.

Delivering Complex Interventions: The MRC Framework as a Model for Clinical Service Development

Christopher Williams, University of Glasgow and Five Areas Ltd
As CBT clinicians and researchers we wish to more widely deliver evidence-based interventions. Yet when it comes to scaling up challenges from research trials to large scale implementation, there is often a lack of detailed information pointing exactly how to do this. Treatment manuals, when they exist, often focus on the content of therapy, with relatively less focus on the process of delivery. Widely different interpretations of how guidelines such as NICE and SIGN, the Scottish Matrix and Welsh Matric should be applied leave local commissioners and team leaders often choosing different ways in how their services are implemented locally.
The MRC Complex trials recommendations provide a model for research, development and evaluation of new interventions. It assumes that research is hard and that we cannot just make assumptions about what will work. The same principles can also help provide a framework to help clinicians establish a cycle of development and audit of service delivery at a local level to ensure services truly meet local needs whilst using an evidence-based approach to refining that approach. The MRC process often starts with systematic review to identify what is likely to be known and not known at present about intervention delivery with the target group being supported. In health settings, national treatment guidelines aim to achieve the same overview of evidence and recommendation. Next comes feasibility work to reduce uncertainty in delivery, and the approach to outcome assessment; then comes a pilot stage to prepare the grounds for a full RCT to establish the clinical effect. All these stages prepare the way for wider implementation of effective interventions. Numerous challenges occur in that implementation. For example, CBT is recommended for
mild, moderate and severe depression, yet how that is delivered in local services varies. For example, the relative emphasis placed upon high and low intensity work, and the modalities of support like face to face and phone approaches vary by local choice. Practitioner preference and beliefs affect what is offered across teams and locations. NICE and SIGN recommend that patient selection should include the needs and preferences of the person from a list of evidence-based approaches. However, what is included in that list and how it is delivered can be affected by practitioner beliefs. Are such beliefs always evidence-based and based on patient preference? How does this influence who is offered support, how that support is implemented, and how people who fail to attend are followed up?

We know that patients do best when they are offered a structured evidence-based/ manualised approach. Engagement and outcome is maximised when this focuses on problems of relevance to the individual. Finally, without an effective supportive and therapeutic relationship, even the most evidence-based approach can fail. The solutions to this lie in the decisions services and research trials make in how to balance structure and relationship. To date most trials and services focus on training practitioners in terms of structure - to deliver evidence based often CBT-based interventions. Although relationship is seen as important - this is often driven by tools such as the CTRS. Both high and low intensity CBT courses often spend more time on the therapeutic models than the clinical relationship. It can be argued of the two the latter has the greatest clinical effect, and that can be amplified by working to an evidence-based structure. I argue that we would benefit by understanding more about key implementation issues including support and relationship. Who is providing the support? What is their background, experience and knowledge? How are clients matched and acceptability assessed? How long should the support be in total minutes and frequency of sessions? What modality of support communication should be used - synchronous face to face, phone, class, live chat, or asynchronous – text message, email? How is the content/structure of the intervention communicated and taught. What should that content look like? What are the roles of books, worksheets, video, online modules as learning tools? Are these equally effective in teaching CBT skills? Does learning preference have a role to play? The teaching model of CBT argues that CBT - although a psychotherapy - is also a form of adult learning. People learn in different ways. How is the offer of these ways matched to the person’s learning needs. How are such approaches - and the type of support and the supporter themselves introduced? Is there a role for automated supports and reminders or for AI? How does research in these areas reflect the detail required by the MRC framework - and how are the important nuances of detail addressed within clinical teams?

Unwanted Intrusive Thoughts: Another Neglected Transdiagnostic Process with Clinical Implications

David A Clark, University of New Brunswick, Canada

Unwanted intrusive thoughts, images and urges are a transdiagnostic phenomenon especially pertinent to repetitive negative thoughts (RNT) like worry, rumination, obsessions and post-event processing. A key factor in the pathogenesis of unwanted intrusive thoughts is the perceived loss of self-control associated with this cognitive phenomenon. This keynote address will review theory and research on unwanted intrusive thoughts and their control with special reference to obsessions, worry and rumination. The clinical implications of this research will be highlighted, with guidelines and recommendations on how to incorporate interventions for intrusive thoughts that enhance treatment of the emotional disorders.

CBT for Personality Disorder: Occam’s Razor

Kate Davidson, University of Glasgow

CBT usually focuses on the here and now rather than the past. This does not help individuals with severe personality disorders who harm others and harm themselves. In CBT with other
disorders, historical events and developmental pathways are important but rarely assessed fully. CBT for personality disorders concentrates on the individual’s past in the initial stages of therapy to fully understand, engage and to “hear” the effect of past adversity. Hypersensitivity to rejection and relationship difficulties are major problems and both need to be a focus of therapy. Although considerable clinical skill is necessary, the structure and techniques used in CBT for personality disorders are not complex and it is by far the briefest of all the therapies for personality disorder. It is an effective therapy in borderline personality disorder and remains the only therapy with an evidence base in antisocial personality disorder. Some things are different though! We do a lot more listening and formulating to develop a coherent narrative and it is probably much less socratic that other forms of CBT.

**Psychological Interventions with Offenders with Intellectual Disabilities and/or Autism**

**Peter Langdon, University of Kent**

There is an increasing focus on discharging patients with intellectual and other developmental disabilities from inpatient forensic mental health services into community settings. All services offer psychological interventions to this population, but there have been few well-designed randomised controlled trials of interventions that are designed to address both mental health problems and criminogenic risk. A review of the existing evidence will be presented, along with the findings from an open-label randomised control trial of the Equipping Youth to Help One Another programme. This is an intensive group-based intervention that makes use of a peer-helping approach drawing on models from developmental psychology that aims to target distorted cognitions, social skills and social decision making. It is specifically adapted to meet the needs of offenders with intellectual and other developmental disabilities who have a history of forensic mental health problems.

**Symposia, Roundtables and Panel Discussions**

**Patient Experiences of Digitally-delivered Cognitive Behaviour Therapy**

**Patient Experience of Remotely Delivered Cognitive Behavioural Therapy for Repeat Unscheduled Care Users with Health Anxiety**

**Shireen Patel, University of Nottingham**

**Background**

Health anxiety is thought to occur in about 5% of the general population, making it at least as common as other major mental disorders. Health anxiety is persistent worry about health and can have a severe detrimental and debilitating impact on overall health. It can lead to an increased use of unscheduled/urgent care services with little patient benefit. Repeat users of unscheduled health care with severe health anxiety are challenging to engage in psychological help and incur high service costs. Psychological therapy delivered remotely (over the telephone or the internet) has been found to help patients where anxiety or stigma may cause reluctance to access mental health services face-to-face. Remotely delivered psychological therapy has equivalent rates of recovery and patient satisfaction to face-to-face delivery. Given the accessibility and cost benefits, remotely delivered therapy may be a suitable delivery option for this patient group.

We investigated whether clinical and economic outcomes were improved by offering remote cognitive behaviour therapy using videoconferencing or telephone (RCBT) compared to treatment as usual (TAU) to people with high health anxiety frequently accessing unscheduled care.

**Methods**

A randomized control trial (RCT) of RCBT for people who had two or more urgent care appointments in the last twelve months and met the eligibility criteria for health anxiety. Six to 12 CBT sessions were delivered via video calling or over the telephone. In addition
Findings

156 participants were recruited to the study. Compared to TAU, RCBT significantly reduced health anxiety at 6 months maintained to 9 and 12 months with significant improvements in generalised anxiety, depression and overall health at 12 months. In terms of economic outcomes there was savings of £1,000 per patient (over 12 months) in terms of reduced service usage and health benefits. A total of 29 service user and 18 service provider qualitative interviews were conducted. Key themes from the interviews highlight the facilitators and barriers to patient experience of overall study participation and receiving the RCBT intervention. Emerging themes include access to services, practicalities of receiving CBT remotely and establishing a therapeutic relationship. We also have eight video testimonials from participants who were involved in the study sharing their experiences of having health anxiety and receiving the therapy. These are available to view online and can serve as a helpful information resource for patients and service providers, as it provides a realistic and personal view on what can be expect from CBT for health anxiety and a clear idea of how remotely delivered therapy can work.

The Ieso Method: Examining Patients' Expectations, Perceptions and Experience
Sarah Bateup, Ieso Digital Health

The Ieso Method is one way of delivering CBT online. This method uses synchronous written communication in a secure virtual therapy room. Patient and therapist communicate through typed conversation in real time. The transcript of each therapy session, conducted in this way, is then held on a secure site for both therapist and patient to access at any time. In addition to a weekly CBT appointment, therapist and patient can also communicate with each other in between therapy appointments. This asynchronous communication can be used to amplify the effect of CBT by encouraging the patient to focus on out of session tasks, goals and consolidating learning that has taken place during a therapy session. This speaker will present qualitative and quantitative data collected from patients who have received treatment using this method. His presentation will include a discussion with a person who has received CBT using the Ieso Method and had previously also had treatment face-to-face. The discussion will explore the difference between the two methods from a patient’s perspective.

Supported Computerised Cognitive Behavioural Therapy in IAPT: Comparing Patient Experiences with Staff Expectations
Ramesh Perera-Delcourt, South London and Maudsley NHS Trust

Computerised cognitive behavioural therapy (cCBT) has been developed to address economic and clinical issues around limited access to evidence-based therapy. Supported cCBT (eCBT) has been developed to address issues with the effectiveness of, and engagement with, cCBT. This involves patients working through online CBT modules, with the support via asynchronous messages from a Psychological Wellbeing Practitioner (PWP). eCBT is increasingly being offered as a first treatment option within Improving Access to Psychological Therapies (IAPT) services due to capacity and waiting list issues. Despite evidence for its effectiveness, uptake in services was initially slow. Therapists’ beliefs about eCBT may constitute a barrier to offering eCBT to clients. In-depth qualitative exploration of the patient experience of eCBT might aid improving its effectiveness, as well as ensuring it is an acceptable intervention for patients and clinicians.

The presentation reports on a study carried out within one inner-city National Health Service (NHS) IAPT service. The first aim of the study was to explore patient experience of eCBT using a semi-structured interview and Thematic Analysis methodology. The second aim was to investigate therapist attitudes towards eCBT using a survey design. These data were analysed using descriptive statistics. 10 patients with a range of common mental health problems who had used eCBT took part in the interviews. Extracts from 4 themes that focus on the patient experience will
be presented: 1. Being Offered eCBT; 2. The Patient’s State of Mind; 3. The Relationship with the Supporter; 4. Preferring to Talk. The presentation will describe how service user participants in this study reported clinical benefit from the eCBT programme and online relationship, and acknowledged that accessing this immediately was valuable. Issues around the process of offering patients eCBT, negative emotional effects of eCBT, and the effects of mental health conditions on engaging with eCBT, are discussed. Patient participants indicated a preference for face-to-face talking therapy, but were clear that they could form a therapeutic relationship via asynchronous messaging. These findings are compared with the responses of the 33 therapists who took part in the survey. Most clinician participants believed that eCBT would perform ‘worse’ or ‘much worse’ than face-to-face interventions for a range of disorders. Assumptions about client expectations of therapy, and a perceived lack of a therapeutic relationship, were the predominant barriers to clinicians offering eCBT. The comparison of reported patient experience with clinician attitudes tends to suggest that therapists can hold negative beliefs about eCBT that do not match with client experience. Suggestions for how to address this within clinical services will be made, together with suggestions for future research.

**Immersive Technology for Mental Health - VR for Fear of Heights: Patient and Clinician Experiences From Use in Routine Clinical Practice (IAPT)**

**June Dent and Polly Haselton, Oxford VR**

Immersive virtual reality (VR) has the potential to substantially increase access to the best psychological interventions. Moreover, treatment can be automated, which alongside the fast decreasing cost of consumer VR hardware, will provide a low-cost way of providing effective interventions at scale.

A University of Oxford Spin out, OxfordVR, have developed and tested the efficacy of a fully automated, cognitive intervention for fear of heights. Participants use the latest consumer equipment and enter a virtual world where they are guided by an avatar/coach (animated using motion and voice capture of an actor) who guides them to approach increasingly complex and engaging height related tasks, and to challenge their unhelpful thoughts.

The speakers will briefly present the results from their recent randomised control trial, where 100 participants were randomly allocated to either automated VR treatment or to a waitlist control group. Those in the VR group received on average 2 hours of VR across 4 sessions. The average reduction in fear of heights, as measured by the Heights Interpretation Questionnaire was 70%, and these gains were maintained at follow up. Treatment uptake was very high, and dropout rate was very low, indicating that the VR intervention was well received.

Since the success of the trial, OxfordVR have developed partnerships with multiple IAPT sites, where outcomes and patient experiences have continued to be collected and monitored. The speakers will share qualitative and quantitative data to give an insight into the patient journey, starting with reporting average changes in the standard IAPT dataset (e.g. PHQ9 and GAD7). In addition to this, the speakers will demonstrate patient video clips, quotes and data from feedback forms gathered over the past 12 months. Data insights will detail overall patient satisfaction with the VR programme, patient feelings of safety within the programme, and whether the offering of a VR treatment (as opposed to a traditional talking therapy) made the idea of treatment more appealing. The speakers will lastly describe their own experiences and those of practitioners from the IAPT sites, offering suggestions for those who may consider adopting and incorporating VR technology into their services and practice.

It is hoped that practitioners will feel more confident endorsing evidence-based VR programmes as the talk offered helps to dispel assumptions and answer questions around its use in clinical practice, either as an alternative or in addition to traditional face to face cognitive behavioural therapy. This is timing given the fast reducing cost and increased accessibility of virtual reality headsets and mobile devices.
Clinical Roundtable: Working with Complex Cases: Perspectives from CBT, DBT and ACT

John Boorman, Homerton University Hospital NHS Foundation Trust; Isabel Clarke, italk (North West Area), Southern Health NHS Foundation Trust; Jess Kingston, Royal Holloway, University of London; Catherine Parker, Derbyshire Healthcare NHS Foundation Trust; Martin Wilks, Independent Practice, Flexible Psychological Solutions; Nicky Harding, Homerton University Hospital NHS Foundation Trust.

Third-wave therapies (sometimes known as process-based) are developing expertise in engaging complex clinical presentations. Such service users are often excluded from large-scale studies because of diagnostic complexity and a belief of deriving no benefit from standard therapeutic approaches. Processes-based modalities require practitioners to detect changes in key therapeutic processes, direct interventions towards, and continually evaluate and adjust to the service user's indications of progress (Hoffman & Hayes, 2018).

This clinical round table will begin by presenting a complex case, which will highlight some of the key therapeutic challenges when working with this group. These include: persisting effects of past trauma, emotional avoidance, and deep-seated problems with relationships.

Following the case presentation, attendees will be invited to join one of three groups: Dialectical Behavioural Therapy (DBT), Acceptance and Commitment Therapy (ACT) or Cognitive Behaviour Therapy (CBT). For the following 45 minutes, attendees will have the opportunity to work together in these small groups to (a) develop process-driven formulations from one of the three therapeutic orientations; (b) consider the course of treatment and specific therapeutic techniques; (c) discuss the role of the therapeutic relationship as a mechanism for fostering change; and (d) consider how each of the three therapeutic modes would describe the philosophy informing their encounter with our complex presentation of human suffering.

Each group will include a representative from the relevant Special Interest Group to offer facilitative guidance with group dialogue and pointing towards the learnings therein. For the remainder of the roundtable, groups will present their thoughts back to the groups with facilitators guiding the attendees in their consideration of the similarities and differences across the three therapeutic modalities and drawing attention to processes of change.

The arrival of a ‘third-wave’ of CBT claimed that a change was occurring in orienting assumptions within CBT, and that a set of new behavioural and cognitive approaches were emerging based on contextual concepts focused more on a person’s relationship to thought and emotion than on the content of those private experiences. Third-wave methods; emphasising such skills as mindfulness, emotions, acceptance, the relationship, values, goals, and meta-cognition; have been far less focused on protocols for syndromes, and more focused on evidence-based processes linked to evidence-based procedures. These newer concepts and methods now largely co-exist side by side with previously established ones; the dialectic between them can serve as a useful spur to theoretical and technological investigation.

Modern CBT and evidence-based therapy is becoming more open to the investigation of a wider range of approaches from humanistic, existential, analytic, and spiritual traditions. This promises over time to reduce the dominance within behaviour change intervention science of walled off schools of thought, or trademarked intervention protocols, and to bring different wings of the field together in an evidence-based search for coherent and powerful sets of change processes which may extend a more generous reach-out that can meet the suffering of the cohort of exclusion.

Acceptance and Commitment Therapy (ACT) for Long Term Conditions
Using ACT with Long-term Conditions and Chronic Disease: Why, How and What Does the Evidence Say?

Chris Graham, School of Psychology, Queen’s University Belfast

ACT is a newer therapy from within the cognitive behavioural school. Many have argued that it is particularly suited to helping people live well with chronic diseases or long-term conditions, and there is evidence that ACT is now used in routine clinical practice. In this presentation, I will outline the ACT model as it applies to long-term conditions, touching upon the functional contextualism philosophy that underlies the model. I will then describe the results of our 2016 systematic review of ACT for long-term conditions. Here we systematically searched several databases for all evaluations – RCTs, uncontrolled trials and case studies – of ACT for improving outcomes, such as QoL, mood or functioning, in adults and children living with long-term conditions. 18 studies were returned, of which 8 were RCTs. Across trials, results were very promising. However, it could be argued that these encouraging findings were simply due to the low methodological quality of the included studies. Moving forward from this systematic review, I will provide an update on trials of ACT in long-term conditions that recently have reported their results or that are ongoing.

ACT for Muscle Disease: Results of a Randomised Controlled Trial

Trudie Chalder, King’s College London

Background: Muscle disease (MD) is chronic and progressive and has no definitive cure. The disease causes wasting and weakness in muscles and is associated with reduced quality of life (QoL). The ACTMuS trial examined the effectiveness of Acceptance and Commitment Therapy (ACT) as an adjunct to usual care for patients compared to usual care alone.

Methods: This two-arm, randomised, multicentre, parallel design recruited 155 patients with MD (Hospital and Depression Scale ≥ 8 for depression, ≥ 8 for anxiety and Montreal Cognitive Assessment ≥ 21/30). Participants were randomised, using random block sizes, to one of two groups: usual care (n = 78) or to ACT in addition to usual care (n = 77), and were followed up for six months. The primary outcome was QoL, defined as a change of between 11.5 and 15.8 difference on each of the INQoL domains as measured at 9-weeks. Trial registration was NCT02810028.

Findings: 138 patients (89.0%) were followed up at 9-weeks and 109 (70.3%) at 6 months. At all three time points, the adjusted group difference favoured the intervention group and was significant with moderate to large effect sizes. Secondary outcomes also showed significant differences between groups at week 9.

Interpretation: ACT therapy in addition to usual care is effective in improving quality of life and other psychological and social outcomes in patients with Muscle Disease and these are maintained/reduced over six months.

Feasibility of Online Acceptance and Commitment Therapy for Chronic Pain

Whitney Scott, Health Psychology Section, King’s College, London

Acceptance and commitment therapy (ACT) is a form of cognitive-behavioural therapy that has a growing evidence base supporting its use for managing chronic pain. However, significant barriers remain in accessing ACT for chronic pain. The widespread availability of the Internet has led to the emergence of online treatment delivery which can enhance the accessibility of psychological therapies, including ACT. This talk will discuss the development and evaluation of online ACT for chronic pain. Data from a feasibility randomised-controlled trial of online ACT for people with chronic pain presenting at a specialty management centre in London will be presented. The implementation of online ACT as a standard treatment pathway within an NHS pain management service will also be discussed. Lastly, ongoing mixed-methods research aimed at tailoring and evaluating the feasibility of online ACT for people with HIV and painful peripheral neuropathy will be described. Taken together, these data support the potential feasibility of online ACT for chronic pain.
The Acceptance and Commitment Therapy Fidelity Measure (ACT-FM): Development Through Online Delphi Methods and Field Testing
Lucy O’Neil, University of Leeds; Gary Latchford, University of Leeds; Lance McCracken, Professor of Clinical Psychology, Uppsala University, Sweden; Christopher Graham, Queens University Belfast

Through two studies, we aimed to develop and test a new trans-diagnostic measure of therapist fidelity to Acceptance and Commitment Therapy (ACT). In study 1, thirteen expert ACT clinicians and researchers were recruited from across countries and specialities, approximately half of whom were ACBS peer reviewed trainers. Using Delphi methodology, the measure was created through three iterative rounds of online questionnaires. In the first two rounds, participants were presented with a preliminary draft of the measure and were asked to consider and rate the utility of items, the manual and the structure of the measure, and to generate new items for consideration. In the third round, participants provided final comments on the developed ACT Fidelity Measure (ACT-FM). Study 1 resulted in a 24-item measure structured around the three-part model of psychological flexibility (“Tri-flex”) with ACT-consistent and inconsistent domains. In study 2, nine ACT clinicians were recruited to trial using the ACT-FM to rate a videoed ACT therapy session. This preliminary investigation of the usability and preliminary psychometric properties of the ACT-FM found that the inter-rater reliability was moderate to excellent. Based on clinician feedback, the final measure was expanded to 25 items.

Mental Health Promotion in Schools and with Young People

A cluster randomised controlled trial of an intervention to improve the mental health support and training available to secondary school teachers – the WISE (Wellbeing in Secondary Education) project
Judi Kidger, University of Bristol; Nick Turner, University of Bristol; Richard Morris, University of Bristol; Sarah Bell, University of Bristol; Harri Fisher, University of Bristol, Backgrond

Schools are highlighted as an important context in which to support the mental health of children and young people. However teachers report feeling ill-equipped to support students due to a lack of training. Further, teachers themselves have poorer wellbeing and higher risk of common mental health disorders compared to other working populations. Failure to support teachers adequately may lead to serious long-term mental disorders. It may also jeopardise student mental health, as distressed teachers feel less able to perform well at work, and may struggle to develop supportive relationships with students. This paper reports the findings from a cluster randomised controlled trial of 25 secondary schools, in which teachers received mental health first aid (MHFA) training, and were given access to a confidential peer support service.

Methods
A cluster randomised controlled trial (RCT) with secondary schools as the unit of randomisation. Intervention schools received: i) MHFA training for staff nominated by their colleagues, after which they set up a confidential peer support service for colleagues ii) training in MHFA for schools and colleges for a further group of teachers, aiming to equip them to support student mental health iii) a short mental health awareness raising session and promotion of the peer support service for all teachers. Comparison schools continued with usual practice. The primary outcome was teacher wellbeing measured using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). Secondary outcomes were teacher depression, absence and presenteeism, and student wellbeing, mental health difficulties, attendance and attainment. Measures were collected at baseline, and at one and two year follow ups. An embedded process evaluation was conducted, using survey, observation, interview and focus group data to investigate implementation and acceptability of the intervention.

Results
There was no evidence of a difference in mean teacher well-being between the intervention and control groups over the course of follow up (adjusted mean difference -0.90, 95% CI -2.07, 0.27, p-value 0.130). There was also no evidence of differences between arms on any of the secondary outcomes, with the exception of teacher absence. There was weak evidence (p-value 0.042) that the intervention increased number of days of teacher absence by 4% compared to the control group. The MHFA training had high acceptability and was delivered with high quality and fidelity. The peer support services were more mixed in the success of their implementation, with activity waning over the course of the study.

Discussion
The WISE intervention did not have an effect on teacher or student wellbeing or mental health at a population level. It had a small effect on teacher absence: possibly increased awareness of mental health made individuals more likely to look after themselves when in difficulty by taking time away from work. The intervention was well received and had a positive impact for the individuals who engaged with the training and peer support service. However, in the context of the huge challenges faced by schools and their staff, the intervention was not sufficient to establish a meaningful and sustainable whole school improvement in mental health outcomes.

The effects of mindfulness-based interventions on cognition and mental health in children and adolescents – a meta-analysis of randomized controlled trials
Darren Dunning, University of Cambridge; Kirsty Griffiths, University of Cambridge; Willem Kuyken, University of Oxford; Catherine Crane, University of Oxford; Lucy Foulkes, University College London; Jenna Parker, University of Cambridge
Background: Mindfulness based interventions (MBIs) are an increasingly popular way of attempting to improve the behavioural, cognitive and mental health outcomes of children and adolescents, though there is a suggestion that enthusiasm has moved ahead of the evidence base. Most evaluations of MBIs are either uncontrolled or non-randomized trials. This meta-analysis aims to establish the efficacy of MBIs for children and adolescents in studies that have adopted a randomized, controlled trial (RCT) design.
Methods: A systematic literature search of RCTs of MBIs was conducted up to October 2017. Thirty-three independent studies including 3,666 children and adolescents were included in random effects meta-analyses with outcome measures categorized into cognitive, behavioural and emotional factors. Separate random effects meta-analyses were completed for the seventeen studies (n = 1,762) that used an RCT design with an active control condition.
Results: Across all RCTs we found significant positive effects of MBIs, relative to controls, for the outcome categories of Mindfulness, Executive Functioning, Attention, Depression, Anxiety/Stress and Negative Behaviours, with small effect sizes (Cohen’s d), ranging from .16 to .30. However, when considering only those RCTs with active control groups, significant benefits of an MBI were restricted to the outcomes of Mindfulness (d = .42), Depression (d = .47) and Anxiety/Stress (d = .18) only.
Conclusions: This meta-analysis reinforces the efficacy of using MBIs for improving the mental health and wellbeing of youth as assessed using the gold standard RCT methodology. Future RCT evaluations should incorporate scaled up definitive trial designs to further evaluate the robustness of MBIs in youth, with an embedded focus on mechanisms of action.

The MYRIAD (Mindfulness and Resilience in Adolescence) Project: A randomised controlled trial of a mindfulness training programme in UK secondary schools
Anam Raja, Department of Psychiatry, University of Oxford; Anam Raja, Department of Psychiatry, University of Oxford; Willem Kuyken, Department of Psychiatry, University of Oxford; Tim Dalgleish, MRC Cognition and Brain Sciences Unit, University
Adolescence is a time of vulnerability for the onset of mental health problems, with 75% of mental disorders beginning before the age of 24 and 50% by the age of 15. Mindfulness training (MT) has been shown to be effective in adults in enhancing mental health and reducing emotional distress, and the primary of the MYRIAD (Mindfulness and Resilience in Adolescence) trial is to evaluate the effectiveness and cost-effectiveness of MT delivered in a school context for young people.

**Design and Methods**

The MYRIAD trial is taking a public health approach to mental health and resilience in adolescence, looking at the whole population of young people, rather than simply those at high risk. Eighty-four mainstream secondary schools in the UK were recruited to take part in the trial, with half allocated to continue teaching as usual and the other half allocated to deliver MT. Teachers in the MT schools attended an eight week personal mindfulness course and a four day residential curriculum training. Teachers have begun teaching a 10 week course to pupils.

In these eighty-four schools, approximately 27,000 pupils aged 11-12 completed three primary measures during a baseline assessment prior to the randomisation of schools: depression, wellbeing, emotional and social functioning. Approximately 7,000 of these pupils are completing measures at four further time points, including a final two year follow-up at age 15-16. Secondary measures at these time points include cognitive functioning, self-harm and suicidal ideation, pupil perceptions of school climate and use of health services. Data collection will be completed in Autumn 2020. A secondary aim of the trial is to examine teacher wellbeing. Training which enhances the mental health of teachers that support and interact with pupils has potential for enhanced pupil wellbeing. In addition there is potential for this provision to support teachers to manage occupational stress that could otherwise negatively impact pupils. To investigate this, participating teachers are also completing wellbeing measures at the same 5 time points as the pupils.

**Discussion**

The trial is currently ongoing with delivery of MT training to pupils being completed this academic year. In addition to describing the trial design and methods, the presentation will include a discussion of lessons learned around conducting a large scale schools-based trial. For example, representative recruitment for a public health approach, building and fostering links with schools, monitoring implementation and fidelity measures, retention of pupils and teachers with natural attrition and movement through schools.

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**Imagery-focused cognitive behavioural therapy for nightmares for patients with persecutory delusions (the Nites trial)**

**Bryony Sheaves, University of Oxford**

Nightmares are a common cause of sleep disruption for patients experiencing psychosis, but rarely the focus of treatment. They might maintain persecutory delusions by portraying fears in sensory-rich detail. We tested the potential benefits of imagery-focused cognitive behaviour therapy (CBT) for nightmares on nightmare severity and persecutory delusions in an assessor-blind parallel-group pilot trial with 24 patients experiencing nightmares and persecutory delusions. All patients offered CBT completed treatment. CBT for nightmares led to large effect size improvements in nightmare severity (adjusted mean difference = -7.0; 95% CI, -12.6 to -1.3; d=-1.1) and insomnia (6.3; 95% CI, 2.6 to 10.0; d=1.4) at week four compared with treatment as usual. Gains were maintained at 8-week follow-up. Suicidal ideation was not exacerbated by CBT but remained stable to follow-up, compared with TAU, which
reduced (6.8; 95% CI, 0.3 to 3.3; d=0.7). CBT led to reductions in paranoia (-20.8; 95% CI, -43.2 to 1.7; d=-0.6), although CIs were wide. Three serious adverse events were deemed unrelated to participation (CBT=2, TAU=1). This presentation will share the CBT techniques alongside the patient experience of nightmares and their treatment from qualitative interviews. We conclude that patients are eager for help with these highly distressing experiences. Imagery-focused CBT may be highly efficacious for treating nightmares and comorbid insomnia for patients with persecutory delusions. It shows promise on paranoia, but potentially not on suicidal ideation.

Treating sleep problems in young people at ultra-high risk of psychosis
Felicity Waite, University of Oxford

Background: Historically, sleep problems have been understood as either a symptom of a psychiatric disorder or a non-specific epiphenomenon (secondary problem). Yet recent research has turned this traditional view on its head and instead shown that sleep disruption is one causal factor in the development of psychosis. In young people at ultra-high risk of psychosis sleep problems are widespread, with estimates of prevalence exceeding 75%. Sleep disturbance may represent a novel treatment target for the prevention of later transition to serious mental health problems.

Methods: A brief psychological intervention for sleep problems in young people at ultra-high risk of psychosis has been developed: the SleepWell intervention. Twelve young people at ultra-high risk of psychosis with sleep problems were offered the eight-session adapted CBT intervention for sleep problems. The core treatment techniques were stimulus control, circadian realignment, and regulating day-time activity. Participants were assessed before and after treatment and at a one-month follow-up. Participants were invited to participate in a qualitative interview at the end of the study.

Results: All eligible patients referred to the study agreed to take part. Eleven patients completed the intervention, and one patient withdrew after two sessions. Of those who completed treatment, the attendance rate was 89% and an average of 7.6 sessions (SD = 0.5) were attended. There were large effect size improvements in sleep. Post-treatment, six patients fell below the recommended cut-off for clinical insomnia. There were also improvements in negative affect and psychotic experiences. The thematic analysis of the qualitative interviews found that disrupted sleep timing and a lack of routine were the characteristic hallmarks of participants' sleep problems. Participants described holding negative expectations prior to therapy, however in line with the quantitative findings meaningful improvements were reported in relation to sleep, mood, and functioning.

Conclusions: The uncontrolled feasibility study indicates that treating sleep problems in young people at ultra-high risk of psychosis is feasible, acceptable, and may be associated with clinical benefits. The qualitative analysis indicates that the treatment of sleep problems is highly valued and has a meaningful impact on wellbeing in young people at ultra-high risk of psychosis.

Key references:

Applying a low-intensity sleep intervention in a youth mental health team
Rebecca Rollinson, Norfolk and Suffolk NHS Foundation Trust
Introduction: There is increasing evidence of a strong association between sleep and mental health difficulties in both adolescents and adults. CBT for insomnia is being applied to good effect with adults with mental health difficulties but there are few studies examining its applicability in adolescents with mental health services.

Method: We carried out a case series analysis (n = 15) looking at the feasibility, accessibility and impact of a low-intensity sleep intervention for young people (14 to 25 years) being seen by a secondary care youth mental health team in the UK. The intervention was based on CBTi and ACT approaches and involved six individual sessions delivered on a weekly basis by an Assistant Psychologist. Routine outcome measures were used to monitor insomnia, wellbeing and functioning with assessments taken at baseline, mid-intervention and one month follow up. Participants needed to score above clinical cut off for insomnia to be included in the study.

Results: High uptake, attendance and measure completion rates were observed. Large effect sizes were observed for insomnia, wellbeing and functioning. Twelve of the fifteen participants (80%) no longer scored above threshold for insomnia at follow up. All seven under 18’s no longer met threshold for clinical ‘caseness’ by follow up.

Discussion: The findings suggest that the intervention was well accepted by young people and feasible to apply within a secondary care mental health service. Strong effect sizes are encouraging but likely to be inflated by the small sample size, uncontrolled design and unblinded assessments. This has potential as a brief, transdiagnostic intervention that has good acceptability to young people with mental health difficulties. Further research is needed to better understand the prevalence and role of sleep difficulties in a youth mental health population as well as the effectiveness of CBTi in a larger sample.

Sleep and intrusive trauma memories immediately after a traumatic event: preliminary results with an emergency department sample

Lalitha Iyadurai, University of Oxford

Disrupted sleep in the weeks following a traumatic event is associated with an increased risk of developing post-traumatic stress disorder (PTSD). However, total sleep deprivation on the first night after an experimental trauma (viewing traumatic film clips) may reduce the number of intrusive memories of the film over the following week, although findings are mixed. The impact of sleep from the first night following a real-life traumatic event on immediate and later psychopathology is unknown. This prospective observational study assessed the relationship between sleep duration on the first night following a real-life traumatic event and intrusive memories in the subsequent week, as well as PTSD symptoms at two months. Here we will report preliminary results from this study. 100 patients were recruited from the emergency department on the day of the traumatic event: 87 returned outcome measures. A daily sleep and intrusive memory diary was completed for one week, and symptoms of PTSD, anxiety and depression were assessed at one week and two months. A U-shaped quadratic relationship was found between sleep duration on the first night and intrusive memories in the subsequent week: sleeping ‘too little’ or ‘too much’ was associated with having more intrusive memories. Participants who met CAPS criteria for PTSD at 2 months had three time more intrusive memories in the first week than those who did not. Sleep from the very first night following a traumatic event might impact later psychopathology. Monitoring sleep and intrusive memories following a trauma, using a simple diary, may help identify individuals who are more vulnerable to later psychopathology.

Improving insomnia treatment in prison: the development of a treatment pathway for insomnia in prison

Lindsay Dewa, Imperial College London
Background: Just over 60% of prisoners have insomnia, 6-10 times more prevalent than in the general population. The well-recognised relationship between sleep disruption and mental health makes it highly plausible that insomnia may increase the vulnerability to suicide in prison populations globally; treating insomnia may decrease this risk. Our study aim was to assess the feasibility of a new treatment pathway for insomnia in prison in one male prison in England.

Methods: We used a with-subjects pre-post design. The stepped-care treatment pathway included non-pharmacological interventions: a screen for insomnia, self-management with peer support, environmental aids and cognitive behavioural therapy for insomnia (CBT). Assessment measures were administered at baseline and upon exit from the pathway. Feasibility measures included recruitment and retention of participants, and treatment uptake. The primary efficacy outcome was the Sleep Condition Indicator after pathway exit. Other secondary efficacy health-related outcomes included objectively measured sleep-activity, psychological wellbeing, mood, anxiety, suicidality, overall health, sleepiness, fatigue and cognitive functioning.

Results: The majority of eligible prisoners were willing to participate (85.7%; n=36). A third left the pathway after self-management with peer support stage (31.6%), and ten percent left after environmental aids because their sleep improved (10.6%). The remaining prisoners went on to receive CBTi (n=11;57.9%). Just under half left the pathway, however, twenty-eight completed both baseline and post-assessments (77.8%). Almost all those who completed both baseline and post assessments showed improvements in their sleep (96.4%). Over half of these reported no clinically significant symptoms at the end of treatment (57.0%) and the effect size (ES) was large (d=1.81) at post-assessment. Large treatment benefits were found in all other health outcomes, with the exception of physical health which had a moderate effect.

Discussion: Using a treatment pathway in prison was feasible despite the challenging prison environment. Recruitment and retention was high. A non-pharmacological intervention may be a highly effective treatment for insomnia in prison and prisoner mental health and wellbeing.

Psychological Wellbeing Practitioners (PWPs): Decision-making, Drop-out, Resilience, Implementation Intentions and Self-practice/Self-reflection

Decision Making by PWPs in Stepped Care: An Experimental Investigation of the Role of the Heuristics and Bias
Ben Michael, University of Sheffield

An effective method for assessing and capturing the process of clinical decision-making remains sparse. Like most ordinary people, trained psychological therapists may also be susceptible to influence by heuristics and biases as part of their work-related judgments and decisions. Therapist variability will be assessed by evaluating the clinical decision-making of Psychological Wellbeing Practitioners (PWPs). Participants are randomized to either experimental or control conditions during completion of an evolving situational decision tree task concerning treatment suitability, fidelity and stepping up of clients accessing step 2 services. The convergent and discriminant validity of the decision tree will be assessed with reference to other established measures of decision-making style (Rational and Intuitive Decision Styles Scale measure), cognitive reflection (Cognitive Reflection Test), and personality (The Mini-International Personality Item Pool). It is expected that when PWPs complete the experimental condition they will follow a counter-normative decision making style. The primary outcome will be the difference between scores on the experimental and control scenarios on the decision tree.

Dropout from Large Group Psychoeducation at Step 2: A Nearest Neighbour Analysis
Nick Firth, University of Sheffield
The study aimed to investigate the impact of socio-demographic similarity on the probability of completing an adequate dose of a psychoeducational group intervention (≥4 of 6 sessions). The sample comprised 2071 patients who received ‘Stress Control’ as didactic group psychoeducation. Similarity indices were constructed to measure patient similarity to the rest of their group on four characteristics: age, gender, ethnicity, and neighbourhood deprivation (Index of Multiple Deprivation; IMD). Multilevel modelling found that those with greater IMD matching to the group had significantly higher probabilities of completing a sufficient dose of Stress Control. A cumulative effect of age similarity, ethnic similarity, and group size was also found, such that patients who were similar in age and ethnicity to their group had higher probabilities of completing the intervention. These results suggest that socio-demographic comparison (a.k.a. relational demography) consciously or unconsciously impacts on patients’ engagement with group psychoeducational interventions, particularly regarding indicators of socio-economic similarity. The clinical implications to be discussed include stratifying group composition and/or intervention content to maximise engagement and therefore clinical effectiveness.

Training Psychological Wellbeing Practitioners to Use Implementation Intentions with Their Patients
Paulina Gonzalez Salas Duhne, University of Sheffield
In routine clinical practice, psychological wellbeing-practitioners (PWPs) try to help patients set and achieve their behavioral goals. One technique that has been shown to help mental health service users to translate intentions into action is implementation intentions. These are specific if-then plans that link opportunities to act with suitable responses. However, prior research has shown mental health professionals do not use this technique routinely in their own clinical practice. A mixed methods study was used to evaluate the feasibility of delivering a three-hour workshop on implementation intentions to 69 trainee PWPs from the Improving Access to Psychological Therapies (IAPT) services. Participants were asked to complete measures of awareness, use and knowledge of implementation intentions at pre-training, post-training, one-month follow-up and six-months follow-up. PWPs showed a significant increase in their theoretical and practical knowledge of implementation intentions after the training. Three percent of the PWPs reported using implementation intentions with their patients before the training, which significantly increased to 32.5% at the one-month follow-up and 36% at the six-months follow-up (x² (2) = 23.52, p < .001). The mean percentage of patients prompted to form implementation intentions significantly increased from 0.68% at pre-training to 12.52% at six-months follow-up (z = -3.62, p < .001). Qualitative exploratory analyses revealed that PWPs found the training acceptable and helpful and specific recommendations were made to improve future training sessions. The evaluation of the training was limited by use of self-report measures, and future research may investigate the effects of training on competency and patients’ outcomes, and potential cost-effectiveness of integrating the training into IAPT’s curriculum.

Evaluation of a Resilience Intervention for Trainee Psychological Wellbeing Practitioners
Rosalind Nelson, University of Sheffield
Resilience is proposed to be a modifiable process which can benefit psychological wellbeing, protecting against workplace adversity and burn-out in health-care professionals and promoting more effective clinical practice in Psychological Wellbeing Practitioners (PWPs). If resilience is modifiable, psychological practitioners may benefit from direct resilience development during training to improve personal and professional wellbeing, but this has not been widely investigated. The primary aim of the current mixed methods study is to consider the feasibility and acceptability of a one-day resilience training for PWP trainees and the impact on resilience and other factors of wellbeing. It will also be of interest whether there is a relationship between
resilience and wellbeing variables across time. Fifty-six participants completed quantitative measures of resilience, burnout, wellbeing, depression and anxiety at pre and post-training and at ten-week follow-up. Self-report measures were used to investigate acceptability and views of the training. Eighteen supervisors also completed a supervisory relationship measure to explore the relationship between the supervisory relationship and trainee resilience and wellbeing. Statistical analyses will include t-tests to assess change in resilience and wellbeing over time and regression analyses to explore wellbeing outcome variables and the use of resilience as a predictor variable across time.

**Self-practice and Self-reflection (SP/SR) Groups for PWP**

**George Miles, University of Sheffield**

Whilst self-practice and self-reflection is a central part of many high intensity CBT training programmes, it is less well used on PWP training programmes. This talk will describe the development, structure and core content of SP/SR groups for trainee PWP. Ten groups have been conducted. Evaluation data will be presented in terms of satisfaction results, qualitative analysis and also communication letters between groups from different years. The results will be discussed in terms of what SP/SR offers to PWP, the need for fidelity to the PWP clinical method and general facilitation skills.

**Innovations in Cognitive Behaviour Therapy**

**Exploring treatment adaptations for co-occurring anorexia nervosa and autism spectrum disorders**

Emma Kinnaird, King’s College London; Catherine Stewart, South London and Maudsley NHS Foundation Trust; Kate Tchanturin, King’s College London;

Research suggests that up to 1 in 4 people with anorexia nervosa (AN) may be on the autistic spectrum, compared to a prevalence rate of around 1 in 100 people in the general population. Elevated autistic traits in AN are associated with more severe illness presentations and poorer treatment outcomes. However, at present there is no research on whether treatments require adaptations for patients with co-occurring AN and autism spectrum disorders (ASD).

We used a qualitative interview approach to evaluate the views of patients and clinicians on the need for treatment adaptations for this population. 9 clinicians from a variety of clinical backgrounds were recruited from an eating disorder (ED) clinical specialist service. 13 women with AN, either with diagnosed ASD or with clinically significant levels of autistic traits, were recruited from a variety of locations. Participants were interviewed individually on their experiences of either delivering or receiving treatment, and their views on the need for adaptations. Interviews were analysed using thematic analysis. Both clinicians and patients believed that current treatment approaches for AN require adaptation for people with co-occurring ASD. Patients experienced their ASD and AN as deeply interlinked and felt that their ASD influenced their ED in ways not accounted for by traditional treatment models. However, patients felt that these unique aspects associated with their ASD were commonly not recognised or met in treatment for two key reasons. Firstly, their ASD was often undiagnosed before they entered treatment. Secondly, both patients and clinicians experienced communication difficulties in the patient/clinician relationship, leading to patients feeling like their needs were not recognised. Clinicians similarly described ASD as influencing both AN and its treatment, but commonly felt that they lacked confidence or specific training in making adaptations.

These findings suggest that people with co-occurring AN and ASD experience unique needs associated with their ASD that are not being met by current treatment approaches. While treatment experiences may be improved by a recognition of the role of autistic traits in AN, at present clinicians typically lack specific training in this area and therefore may not feel confident making these kinds of adaptations. In addition, systematic screening of people...
with AN for autism when they enter treatment could assist clinicians in recognising potentially undiagnosed autism. People with co-occurring anorexia and ASD could potentially benefit from a systematic approach to treatment adaptations for the use of CBT in this population. Further research should explore implementing a standardised approach, including exploring adaptations such as facilitating autism recognition and diagnosis, and specific training for clinicians in the role of autistic traits in AN and implications for treatment.

**Exploring the barriers to the implementation of Cognitive Behavioural Therapy for Psychosis (CBTp).**

**Fiona Switzer, NHS Lothian/ Queen Margaret University**

Sean Harper, NHS Lothian/ Queen Margaret University; David Peck, University of East Anglia

The purpose of this study is to identify barriers for people with psychotic spectrum disorders accessing CBTp in NHS Lothian. Despite national guidelines recommending CBT for the treatment of schizophrenia (National Institute for Health and Care Excellence (NICE) Guidelines 2014) and (Scottish Intercollegiate Guidelines Network (SIGN) Guidelines 2013), levels of access to CBTp remain low. The overall goal of the study is 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) will be explored and if completion of this training effects referral behaviours and attitudes to CBTp.

This study is a quantitative service evaluation project which uses a questionnaire design to explore the factors that influence a clinician's decision to refer a patient for CBTp. Three qualitative questions are included for thematic analysis to allow the respondents to elaborate on their views on potential barriers. All appropriate Community Mental Health Team (CMHT) staff in adult mental health in NHS Lothian were invited to participate in the study even if there was no CBTp available in their area.

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. PSI training was shown to have a significant effect on referral rates. Despite staff holding favourable views on CBTp, key barriers to access for CBTp continue to exist. Where CBTp services are available, emergent themes discussed in this study highlight the potential benefits of improving multi-disciplinary communication and increasing CMHT staff knowledge and confidence in CBTp. Further research would be warranted to explore the influence of PSI training on CMHT staff confidence and knowledge in CBTp.

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 Efficacy of Adapted Cognitive-behaviour Therapy for Impulsivity in Patients with Brain Injury - Clinical Case Studies**

**Sirous Mobini, Priory Healthcare, University College London**

Impulsivity is a common feature of behavioural presentation after brain injuries which has many repercussions on the patient’s rehabilitation process and on the cost of healthcare (Kocka & Gagnon, 2014). Cognitive model is based on this assumption that maladaptive cognitive process plays a key role in emotional and behavioural problems (Beck et al., 1979). Therefore, maladaptive emotions and behaviours are amenable to change through cognitive distortions or unhelpful thinking patterns. There is growing literature suggesting that Cognitive-behaviour therapy (CBT) techniques can be adapted and used in the treatment of
mental health problems and in improvement of the quality of life in patients with acquired brain injury (e.g., Hsieh et al., 2012; Potter et al., 2016; Khan-Bourne & Brown, 2003; Gallagher et al., 2019). Therefore, it is important to adapt and use CBT with patients who present with impulsive behaviours in the context of other cognitive deficits and emotional problems associated with brain injury.

A combination of face-to-face and computerised CBT programme was used to treat impulsive behaviour in 3 patients with various forms of brain injuries in an inpatient brain injury unit. Face-to-face CBT focused on socialising the patient to CBT model and developing case formulation of impulsivity and discussed cognitive and behavioural strategies in managing anger and impulsivity. These individual CBT sessions were incorporated into Computerised C-CBT for impulsivity (C-CBT-IMP). The key behavioural presentations of these patients were difficulties in emotional regulation, impulsivity, and behavioural disinhibition. Brain scan indicates injuries to the frontal lobe of the brain. Neuropsychological testing indicated some mild to moderate attention, memory and dysexecutive difficulties.

Following 15 – 20 sessions of CBT treatment, there were marked improvements in the frequency and intensity of challenging behaviours as well as patients’ scores on measures of cognitive distortions scale and impulsivity measures. Behavioural observations indicated that they developed more adaptive self-management skills using cognitive and behavioural techniques. All patients practised these skills with the inpatient unit for brain injury rehabilitation.

The results indicated that CBT can be adapted and used in patients with brain injuries and help them to develop self-monitoring skills. There are challenges in this application of CBT in patients with brain injury, particularly within the inpatient unit. Patients often have significant neurocognitive deficits which make it difficult for them to complete CBT homework, apply the techniques and learn adaptive coping skills. These challenging and ways to overcome these difficulties are discussed.

CBT techniques can be adapted and used in patients with brain injuries.

Safety-seeking behaviours in Chronic Fatigue Syndrome / Myalgic Encephalomyelitis: a pilot experimental investigation

Samantha Lloyd, University of Bath; Jo Daniels, University of Bath

Despite considerable research, the aetiology of Chronic fatigue syndrome / Myalgic Encephalomyelitis (CFS/ME) remains poorly understood (Browne & Chalder, 2006). Whilst there is evidence that cognitive behavioural therapy (CBT) is associated with reduced fatigue and improved physical functioning (e.g., Castell, Kazantzis, & Moss-Morris, 2011; White et al., 2011) effect sizes remain moderate at best, with treatment outcomes significantly smaller than those achieved by cognitive behavioural therapies in mental health (Olatunji, Etzel, Tomarken, Ciesielski & Deacon, 2010) and some physical health conditions such as insomnia (Okajima, Komada & Inoue, 2010). It has been suggested that there is a lack of clarity concerning the therapeutic aim and strategies of CFS/ME treatment, along with the mediating and moderating processes underlying mechanisms of change (Knoop, Bleijenberg, Gielissen, van der Meer, & White, 2007; Van Houdenhove, 2006). In comparison, the development of cognitive behavioural models of anxiety disorders to include concepts such as safety seeking behaviours (SSB) has been suggested to have led to significant advances in the theoretical understanding and treatment of such disorders. Research supports the notion that anxiety disorders and CFS have overlapping cognitive behavioural maintaining factors (Surawy et al., 1995; Tyrer et al., 2011), and there is emerging evidence for the relevance of SSB across a range of physical health conditions. The aim of this study was to investigate the use of safety-seeking behaviours (SSB) in Chronic Fatigue Syndrome / Myalgic Encephalomyelitis (CFS/ME) in response to physical exertion.

An experimental design was used with N = 10 individuals with CFS/ME and N = 15 healthy controls (HCs) carrying out a physical task twice. Participants were recorded while completing the task and asked to identify strategies used during the task and the function of
these. Post-task self-reported measures of fatigue, pain, anxiety and mood were also taken, along with a number of baseline self-report measures. Significant differences in the number of strategies defined as SSB were found between groups, with the CFS/ME group using significantly more SSB during the second task. In the CFS/ME participants, whilst self-reported fatigue increased between the two tasks, anxiety was found to decrease. In addition, a significant correlation was found between the number of SSB utilised and increased score on a measure of health anxiety. Overall the pilot study provides novel evidence for the use of SSB in CFS/ME and describes the typology and function of such strategies. This has implications for the understanding and treatment of CFS/ME, with SSB representing an important potential target for cognitive behavioural interventions for this condition.

This has implications for the understanding and treatment of CFS/ME, with SSB representing an important potential target for cognitive behavioural interventions for this condition.

**Key dimensions of therapeutic lies in dementia care: a new taxonomy**

**Mithila Mahesh, Newcastle University; Rachel Mills, Newcastle University; Louisa Jackman, Newcastle University**

Research suggests that the use of lies and deception is prevalent within dementia care settings, despite ongoing debates raised about the ethics of this approach. There has been increasing exploration of when and why deceptive practices should be used, but the lack of clarity as to what constitutes a lie has caused difficulty in ensuring that lies are used ethically. The aim of this study was to widen our understanding of the key dimensions that underpin the use of lies, and further to use this information to develop a taxonomy of lies within dementia care settings.

A mixed methods approach was used for the study, which consisted of three phases: (1) obtaining examples of lies from experienced clinicians, (2) using expert advisors to standardise the examples, (3) asking independent participants to sort the examples into similarly themed groups. Hierarchical cluster analysis was used to produce clusters which led to the development of the taxonomy.

The results indicated that lies are mainly used in the best interests of people with dementia, often to reduce distress or manage difficult behaviour. From the developed taxonomy, there were two overarching clusters: the larger cluster was concerned with the welfare or activity of a family member/friend, and the second cluster was concerned with the welfare or activity of the person themselves.

These results highlighted that in order to use lies appropriately it was important for caregivers to have a good understanding of the person with dementia and their life experiences. An awareness of the potential problems in using deception is key, and it is recommended that communication training should be employed to support carers in the use of therapeutic lying as a person-centred and beneficial approach. The study also shows that lies are often used to deal with the needs of PWD who are expressing concerns about the wellbeing of others. This notion of the importance of ‘other-directed’ needs in PWD is a new and relevant finding.

This topic concerns the development of communication/therapy skills in the treatment of people with cognitive deficits. One of the key issues that seems to make the approach relevant is that the clients hold a different sense of reality to that of their carers. As such the lies are devices for entering the ‘world of the client’ rather than confronting it directly. Thus, although the approach has been studied mostly in relation to dementia care, the justification for the use of lies has relevance for other specialities too. This presentation will briefly discuss the role of lying in intellectual disabilities, psychosis, and child work. Some early data will be presented in relation to the latter.

**Maintaining Recovery After Depression: Predicting and Preventing Relapses**

**Predicting relapse following treatment in IAPT; a machine learning analysis**

**Stephen Kellett, Sheffield University; Jaime Delgadillo, Sheffield University**
Objective: Depression and anxiety disorders commonly recur after treatment, but less is known about what predicts relapse following successful treatment in stepped care services. Relapse is equally costly to both patient and service. The aim of this study was therefore to develop a model to predict relapse following successful psychological interventions.

Method: A longitudinal cohort study examined relapse rates for N = 2899 patients in remission from acute depression (PHQ-9) and anxiety (GAD-7) symptoms after completing a psychological treatment within an IAPT service. N = 968 cases were then re-assessed at follow-up review (mode = 4 months). Using a machine learning (ML) approach, an algorithm was trained to estimate relapse rates in the original full sample, including those who did not attend follow-up reviews. Multilevel modelling was also used to examine differential relapse rates between therapists.

Results: The ML model included the following predictors: age, employment status, number of treatment sessions, follow-up length, long-term medical conditions, baseline and post-treatment depression (PHQ-9) and functional impairment (WSAS) measures. ML predictions generalized to a statistically independent test sample (AUC = .62, OR = 2.67, p < .01). The standardised 6-month relapse rate in the full sample was 51.4%. Higher relapse rates occurred following high intensity treatments (56.4%) than low intensity treatments (42.6%). The variability in relapse rates was not statistically associated with therapist effects (ICC = 0.0).

Conclusions: Relapse appears a commonly occurring feature, but the study is limited to one IAPT service and therefore the results need to be interpreted with due caution. Relapse prediction models could be used to identify cases at high risk of relapse, who may benefit from targeted low intensity and cost effective relapse prevention interventions in the post treatment phase.

Risk factors for relapse of depression and how they operate: Evidence from systematic reviews and practice-based evidence from IAPT

Joshua Buckman, University College London; Rob Saunders, University College London

Background: A recent series of systematic reviews highlighted risk factors for relapse and recurrence of depression. Those reviews introduced a conceptual framework for understanding mechanisms of these risk factors and to guide future research in this area. Several of those risk factors have been further investigated in some clinical cohort studies in IAPT services, and show practice-based support to the review findings.

Aim: This talk will review the findings of the series of systematic reviews highlighting prognostic factors that predict risk for relapse, prescriptive factors that moderate treatment response, and mechanisms that underlie each with respect to relapse and recurrence, and consider findings from two recent clinical cohort studies that highlight the relevance and importance of these factors in the IAPT population.

Results and conclusions: This talk will discuss how childhood maltreatment, post-treatment residual symptoms and the trajectory of symptom change during psychological therapy, a history of recurrence, comorbid anxiety prior to starting psychological therapy, and deficits in attentional control for those treated in IAPT act as strong prognostic indicators of risk of relapse. It will discuss how each of these factors could be used prescriptively to indicate who might benefit most from continued or prophylactic psychological treatment. The cognitive and neural mechanisms that underlie the prognostic and prescriptive indices and the clinical implications of these will be discussed alongside avenues for future research to test the conceptual framework proposed by the review. Examples of the clinical implications are that psychosocial interventions that target the consequences of childhood maltreatment, extending pharmacotherapy or adapting psychological therapies to deal with residual symptoms, and using cognitive or mindfulness-based therapies for those with prior histories of recurrence and attentional control deficits, are indicated as likely to be beneficial. Future research that focuses on understanding causal pathways that link childhood maltreatment, or cognitive diatheses, to dysfunction in the neocortical and limbic pathways that process affective information and facilitate attentional control, might result in more enduring effects of treatments. It might also elucidate enhancements to treatment and means of selecting
Toward sustainable treatments with psychological interventions
Claudi Bockting, University of Amsterdam, AMCK

A crucial part of the treatment is the prevention of relapse and recurrence. Sequential cognitive interventions after remission, especially Mindfulness Based Cognitive Therapy (MBCT) and Preventive Cognitive Therapy (PCT) are helpful in preventing relapse and recurrence in recurrent depression. An overview will be given of the effectivity and cost-effectivity of PCT as studied in five Randomised Controlled Trials (Bockting et al., 2018, 2005, Klein et al., 2019, 2018 Biesheuvel-Lelieveld 2017, de Jonge et al., 2019 accepted). Specific ingredients of PCT will be discussed and demonstrated as well as the divers types of PCT, that is face to face PCT, tele-PCT, guided self help-PCT in primary care and guided internet-based PCT. Specific attention will be payed to the evidence for PCT as alternative for longterm use of antidepressants and the implications for pregnant women that use antidepressants as studied in a micro-randomized Controlled Trial (Bockting et al., 2018, Brouwer et al., under review). Clinical and research implications will be discussed.

References


Evidence for leading psychological theories of depressive relapse: A meta-analytic review of prospective studies
Marlies Brouwer, Amsterdam UMC, location AMC, University of Amsterdam, Department of Psychiatry; Alishia Williams, The University of New South Wales, Faculty of Science, School of Psychology, Sydney; Mitzy Kennis, Utrecht University, Department of Clinical Psychology; Zhongfang Fu, Amsterdam UMC, location AMC, University of Amsterdam, Department of Psychiat; Pim Cuijpers, Vrije Universiteit Amsterdam, Department of Clinical, Neuro and Developmental Psychology; Claudi Bockting, Amsterdam UMC, location AMC, University of Amsterdam, Department of Psychiat

Individuals with a history of major depressive disorder (MDD) have a high risk of relapse or recurrence and this risk increases with each subsequent episode. Psychological vulnerability factors hypothesized to account for relapse of MDD roughly originate from five main approaches: Cognitive, diathesis-stress, behavioural, psychodynamic, and personality-based. Given the high relapse and recurrence rates, the support for these leading theories, that inform on therapeutic target points, need to be investigated. A recent meta-analysis will be presented in which we investigated the prospective evidence for these theories in relation to
depressive relapse among individuals with an established diagnosis of MDD (Brouwer et al., under review). For the meta-analytic review, the included studies needed to establish history of MDD and prospective depressive relapse through a clinical interview, have a longitudinal and prospective design, and measure at least one theory-driven vulnerability factor prior to depressive relapse. Out of 43,586 identified records published up to November 2018, we found 43 prospective studies. Pooled odds ratios (OR) showed a significant relationship between the cognitive, behavioural, and personality-based approaches and depressive relapse (cognitive: k= 17, OR= 1.24, 95% CI = 1.10 – 1.40; behavioural, k= 8, OR= 1.15, 95% CI = 1.05 – 1.25; personality: k = 12, OR= 1.26, 95% CI= 1.02 – 1.54), but not for the psychodynamic approach (k= 4, OR= 1.29, 95% CI= 0.83 – 1.99). Pooled hazard ratios of the approaches were not significant. Remarkably, there were no articles identified for the diathesis-stress approach. Overall, there is a restricted number of prospective studies within the field of depressive relapse, and there was some evidence that vulnerability factors derived from the cognitive, behavioural, and personality-based approaches are related to depressive relapse. The clinical and scientific implications of these results will be discussed.

PProtect after depression: a pilot randomised controlled trial of a brief wellbeing intervention
Katherine Clarke, UCL; Rob Saunders, UCL; Joshua Buckman, UCL; Stephen Pilling, UCL
Background: The period after recovery from depression is important as the risk that a person will relapse decreases during this time. The PProtect intervention is a brief, wellbeing-focussed intervention that is offered at the point of first recovery, and aims to help people to stay well. The focus on wellbeing means there is no clinical language, or content related to symptoms or risks. The intervention was developed from a complex systems theoretical framework, which I will detail in the talk.
Aims: To test the feasibility and potential for efficacy of this novel intervention in an ecologically valid setting.
Methods: Participants were recruited following treatment completion in two psychological therapies services (IAPT), and randomly allocated to the PProtect intervention (n=41) or to be discharged (n=42). Interviews at baseline and 3- and 6-month follow-up included measures of depressive symptoms, anxiety symptoms, work and social functioning, and intervention uptake.
Results: The recruitment process was efficient and 86% of outcome assessments were completed. Most people who attended found the workshop useful and gave examples of its impact in their everyday lives (19 of 24). Blind outcome assessment indicated 3 intervention arm and 6 control arm participants had an episode of depression during follow-up. People in the control arm showed worse depression symptoms, anxiety symptoms and functioning than in the intervention arm (with small to medium effect sizes).
Conclusions: An appropriately powered trial using similar recruitment and outcome collection methods could test whether the PProtect intervention has a statistically significant impact on outcomes after depression. I will discuss the potential mechanisms underlying any intervention effects, and how a complex systems approach to interventions may give us a pragmatic shortcut to improving efficacy.

Predicting relapse using machine learning and network analyses
Ben Lorimer, University of Sheffield; Jaime Delgadillo, University of Sheffield; Stephen Kellett, University of Sheffield; Gary Brown, Royal Holloway, University of London; James Lawrence, Behavioural Insights Team
Many patients with depression relapse within one year of clinically effective cognitive behavioural therapy (CBT). It is therefore important to identify risk factors associated with relapse to target relapse prevention and enhance the efficiency of psychological services offered to patients. The identification of predictive factors of relapse could be aided by the emergence of two innovative analytical methods: machine learning and network analyses. Machine learning facilitates the discovery of results with enhanced reliability and
generalizability, while network analyses allow for relationships between specific depressive symptoms to be explored as potential predictors of relapse. This talk will discuss how these two innovative approaches can be employed to improve our understanding of relapse. This will be accomplished with reference to studies that have applied these methods to two different services within the Improving Access to Psychological Therapies (IAPT) programme.

The Use of Technology to Support and Deliver Interventions to Children and Young People with Mental Health Problems

Technology Delivered Interventions for Depression and Anxiety in Children and Adolescents: A Systematic Review and Meta-analysis
Rebecca Grist, University of Brighton; Abigail Croker, Oxford Health NHS Foundation Trust; Megan Denne, Oxford Health NHS Foundation Trust; Paul Stallard, University of Bath

Background: Depression and anxiety are common during adolescence. Whilst effective interventions are available treatment services are limited resulting in many adolescents being unable to access effective help. Delivering mental health interventions via technology, such as computers or the internet, offers one potential way to increase access to psychological treatment.

Aims: The aim of this systematic review and meta-analysis was to update previous work and investigate the current evidence for the effect of technology delivered interventions for children and adolescents (aged up to 18 years) with depression and anxiety.

Methods: A systematic search of eight electronic databases identified 34 randomized controlled trials involving 3113 children and young people aged 6–18. The trials evaluated computerized and internet cognitive behavior therapy programs (CBT: n = 17), computer-delivered attention bias modification programs (ABM: n = 8) cognitive bias modification programs (CBM: n = 3) and other interventions (n = 6).

Results: Our results demonstrated a small effect in favor of technology delivered interventions compared to a waiting list control group: g = 0.45 [95% CI 0.29, 0.60] p < 0.001. CBT interventions yielded a medium effect size (n = 17, g = 0.66 [95% CI 0.42–0.90] p < 0.001). ABM interventions yielded a small effect size (n = 8, g = 0.41 [95%CI 0.08–0.73] p < 0.01). CBM and ‘other’ interventions failed to demonstrate a significant benefit over control groups.

Type of control condition, problem severity, therapeutic support, parental support, and continuation of other ongoing treatment significantly influenced effect sizes.

Conclusions: Our findings suggest there is a benefit in using CBT based technology delivered interventions where access to traditional psychotherapies is limited or delayed.

Developing and evaluating ‘MoodHwb’, a Web-based psychoeducational intervention for adolescent depression
Rhys Bevan-Jones, Cardiff University; Anita Thapar, Cardiff University; Frances Rice, Cardiff University; Sally Merry, University of Auckland; Paul Stallard, University of Bath; Ajay Thapar, Cardiff University

Introduction:
Depression is common in adolescence, and leads to distress and impairment for individuals and families. Treatment and prevention guidelines highlight the key role of health information and evidence-based psychosocial interventions. There has been growing interest in psychoeducational interventions (PI), to provide accurate information and enhance self-management skills. However, there is a lack of engaging Web-based PIs for adolescent depression.

Aim:
To design, develop and undertake an early evaluation of a Web-based PI for young people with, or at high-risk of, depression and their families/carers, friends and professionals – as part of a National Institute for Health Research / Health and Care Research Wales doctoral fellowship programme.

Methodology:
The initial prototype of the programme was informed by: i) a systematic review of PLs for adolescent depression, ii) findings from semistructured interviews (n=12) and focus groups (n=6) with adolescents (with depressive symptoms or at high-risk), parents/carers and professionals, iii) workshops/discussions with a digital company and experts. For the mixed-methods evaluation, 44 adolescents and 31 parents/carers completed pre/post questionnaires, a subsample were interviewed, Web-usage was monitored, and there was a focus group with professionals.

Results:
The systematic review showed that existing PL studies were limited in number and heterogeneous. Key themes in the interviews/groups were: aims of the programme, design and content issues and integration/context. The prototype was designed to be person-centred, multiplatform, engaging, interactive and bilingual. It included mood-monitoring and goal-setting components, and was available as an ‘app’. The evaluation findings suggest that the programme and evaluation process were acceptable and feasible.

Conclusion:
The Web-based programme ‘MoodHwb’ (or ‘HwbHwyliau’ in Welsh) was co-developed with user-input and design, educational and psychological theory, in line with research guidelines. A feasibility randomised controlled trial is planned as part of a National Institute for Health Research/Health and Care Research Wales post doctoral fellowship, with the aim of implementation in health, education, youth and social services/charities.

Avatar Therapy for Children and Young People with Mental Health Problems
Caroline Falconer, MindTech, University of Nottingham; Rebecca Grist, Brighton University; Bethan Davies, MindTech, University of Nottingham; Paul Stallard, University of Bath

Avatar therapy is an emerging digital tool used to assist the treatment of common mental health problems. This may be an appealing means of facilitating face-to-face psychotherapies for young people given their ubiquitous use of digital technology. We will present two case examples of young people who used ProReal, a virtual reality and avatar package, to support their Cognitive Behavioural Therapy at a CAMHS outpatient clinic. Pre- and post-treatment outcome measures were completed, and qualitative interviews conducted to assess their experience. Thematic analysis showed that ProReal helped the young people express themselves, externalise their inner worlds, and reappraise their thoughts, feelings and experiences. Furthermore, ProReal facilitated communication with the clinician. Routine outcome measures also showed a reduction in distress. These results demonstrate how avatar therapy can be readily integrated into clinical practice and its potential therapeutic benefits, particularly for those who struggle to express themselves and engage in regular psychotherapy.

A Smartphone App (BlueIce) for Young People (Aged 12-17 Years) Who Self-Harm: Open Phase 1 Pre-Post Trial
Paul Stallard, University of Bath; Joanna Porter, Oxford Health NHS Foundation Trust; Rebecca Grist, Oxford Health NHS Foundation Trust

Background: Recent years have seen a significant increase in the availability of smartphone apps for mental health problems. Despite their proliferation, few apps have been specifically developed for young people, and almost none have been subject to any form of evaluation. Objective: This paper reports a preliminary evaluation of a smartphone app (BlueIce), coproduced with young people and designed to help them manage distress and urges to self-harm. We assessed the acceptability, safety, and use of BlueIce and effects on self-harm and psychological functioning. Methods: Open trial involving 40 young people aged 12 to 17 years attending specialist child and adolescent mental health services (CAMHS) who were currently self-harming or had a history of self-harm. Eligible participants were assessed at baseline and then given BlueIce. They were assessed 2 weeks later (post familiarization) and again at 12 weeks (post use).
Results: All core CAMHS professional groups referred at least 1 young person. Out of 40 young people recruited, 37 (93%) elected to use BlueICE after familiarization, with 29 out of 33 (88%) wanting to keep it at the end of the study. No young person called the emergency numbers during the 12-week trial, and no one was withdrawn by his or her clinician due to increased risk of suicide. Almost three-quarters (73%) of those who had recently self-harmed reported reductions in self-harm after using BlueICE for 12 weeks. There was a statistically significant mean difference of 4.91 (t31=2.11; P=.04; 95% CI 0.17-9.64) on post-use symptoms of depression (MFQ) and 13.53 on symptoms of anxiety (RCADS) (t30=3.76; P=.001; 95% CI 6.17-20.90), which was evident across all anxiety subscales. Ratings of app acceptability and usefulness were high.

Conclusions: Whilst our study has a number of limitations our findings are encouraging and suggest that BlueICE, used alongside a traditional CAMHS face-to-face intervention, can help young people manage their emotional distress and urges to self-harm.

Acknowledgement: This study was funded by the Health Foundation

The ‘Online Remote Behavioural Intervention for Tics’ (ORBIT) trial: Investigating a therapist-guided, parent-assisted remote digital behavioural intervention for tics in children and adolescents

Betrhan Davies, MindTech, University of Nottingham; Charlotte Hall, MindTech, University of Nottingham; Chris Hollis, MindTech, University of Nottingham

Background:
Tics and Tourette syndrome is a common, disabling childhood-onset condition. Recent guidelines recommend that behavioural therapy should be offered as first-line treatment for children with tics. However, there are very few tic-trained therapists and many patients cannot access appropriate care. Internet-delivered behaviour therapy may provide a platform to increase the availability of evidence-based treatment, but currently lacks randomised controlled trial evidence. This trial investigates whether internet-delivered interventions for tics (‘ORBIT’) can reduce severity of symptoms.

Materials & Methods:
This parallel-group, single-blind, randomised controlled superiority trial will recruit children and young people (aged 9-17 years-old) with tics over an 18-month period. Participants will be randomised to receive 10-weeks treatment of either online, remotely-delivered, therapist-supported behavioural therapy (Exposure with Response Prevention) for tics, or online, remotely-delivered, therapist-supported education on tics. Therapist support is provided remotely via the ORBIT platform, to help support participants’ engagement with intervention activities and tasks. Participants will be followed-up at mid-treatment, 3-, 6-, 12-, and 18-month post-randomisation. The primary outcome is reduction in tics as measured on the Yale Global Tic Total Tic Severity Scale. Secondary outcomes include a cost-effectiveness analysis, optimising of the intervention design, identification of the barriers and facilitators to implementation. An integrated process evaluation will analyse qualitative and quantitative data in order to explore the fully explore implementation of the intervention.

Results and Conclusions:
The findings will inform clinicians and healthcare providers about the clinical effectiveness of internet delivered treatment for children and young people with tics. As of January 2019, 100 children and their families have been recruited, consented, and randomised into the trial.
The ORBIT trial is a collaboration between The University of Nottingham, Nottinghamshire Healthcare NHS Foundation trust, Great Ormond Street Hospital for Children NHS Foundation Trust, Karolinska Institutet, and Priment Clinical Trials Unit. This research was funded by the NIHR Health Technology Assessment (ref 16/19/02). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.
Is Children and Young People's (CYP) Mental Health Policy and Training on the Right Track? An Evaluation of the Effectiveness of Low-Intensity Cognitive-Behavioural Interventions Delivered by Post-Graduate Trainees in Child and Adolescent Mental Health Service or School/College settings

Gavin Lockhart, University of Sussex; Christina Jones, University of Sussex/University of Surrey; Victoria Sopp, University of Sussex

Despite one in eight children and young people (CYP) experiencing diagnosable mental health problems (NHS Digital, 2018), levels of access to evidence-based psychological interventions for common mental health difficulties in CYP is low (Department of Health CYP Mental Health and Wellbeing Taskforce, 2015; Independent Mental Health Taskforce, 2016).

Recent policy and centrally-funded training have sought to increase access by training a non-traditional graduate workforce to deliver a range of evidence-based cognitive behavioural (CB) interventions to CYP and their families. Initially, this focused on delivery in CAMHS settings but following the recent government green paper “Transforming children and Young People’s Mental Health Provision” this will also include substantial expanded delivery in school/college settings. Previous research on CBT with CYP has utilised graduate workers, but often only trained in one specific manualised CB intervention for one type of difficulty. It is therefore essential to evaluate the effectiveness of interventions: i) delivered by graduates training in a range of CB interventions across common mental health problems; ii) delivered by these workers in both CAMHS and school/college settings.

Trainees undertaking a Post-Graduate Certificate in Low Intensity Psychological Interventions for CYP worked with CYP experiencing anxiety or mood-based difficulties using CB interventions in school/college or community CAMHS settings. Trainees were integrated into existing structures within placements. Self and parent-reported Revised Anxiety & Depression Scale (RCADS), Strengths & Difficulties Questionnaire (SDQ) and Goal Based Outcomes (GBO) were completed pre and post-intervention and analysed using paired t-tests and McNemar tests. The Experience of Service Questionnaire (CHI-ESQ) was used to determine satisfaction with care.

Data on 309 CYP seen by the 2016 and 2017 cohorts was analysed. The average age of CYP seen was 13½ years (range 5-18) with 56% female. CYP received under eight sessions on average. CYP seen in CAMHS placements demonstrated higher baseline scores. Significant improvements were demonstrated across all self-reported RCADS and SDQ domains and GBO (RCADS total anxiety and depression d=.96, SDQ total difficulties d=.60, primary GBO d=2.87). The effect on RCADS were corroborated in parent-reported measures (total anxiety and depression d=.55), along with SDQ emotional symptoms and total impact scores (d=.33 & .63 respectively). RCADS, SDQ and GBO improvements were in line with or above those reported in recent preliminary papers regarding Children’s Wellbeing Practitioner and low-intensity behavioural activation outcomes (London & South East CYP-IAPT Collaborative, 2018; Pass, Lejuez & Reynolds, 2018). Interventions were equally effective for CYP in schools and CAMHS settings (all ps<0.01). The number of CYP meeting clinical criteria for caseness dropped significantly post-intervention for RCADS depression (38% to 9%), anxiety (31% to 8%), anxiety and depression (34% to 8%) and SDQ total difficulties (31% to 11%) (all ps<0.001). Qualitative feedback from CYP and families was highly positive.

Results are extremely promising in terms of the capacity to train a graduate workforce to deliver a range of effective CB interventions to CYP experiencing depression or anxiety-based difficulties in either CAMHS or school settings, increasing capacity across the system. The current evaluation suggests that interventions in educational settings are equivocal in outcome to those in CAMHS, and effectively target earlier intervention. Further research is warranted in terms of long-term outcomes, comparing outcomes with the range of other emotional support available to CYP across these settings, evaluating other aspects of the
proposed role for this new workforce (e.g. psychoeducation, working with families, guided self-help), and evaluating outcomes delivered by practitioners following successful completion of these clinical training programs once they are part of the workforce. This paper relates to arguably the most significant and rapidly emerging area of CBT practice with CYP. Given the substantial national funding being devoted to this development and the change that it represents to the CBT workforce and delivery models, it is crucial for the profession to be systematically reviewing effectiveness. This paper has major implications in relation to current policy and training developments aimed at increasing access to cognitive-behavioural interventions for CYP experiencing common mental health problems. It provides indications around the success of existing training models, the effectiveness of delivering clinical interventions in school/college settings, and around the effectiveness of delivering targeted cognitive-behavioural interventions to sub-diagnostic-threshold common mental health difficulties.

Evaluation of a Non-Diagnostic "Psychology of Emotions" Workshop in a Youth IAPT Service

Lawrence Howells, Norfolk and Suffolk Foundation Trust

There is growing interest in youth mental health across the globe, with services increasingly being tailored to meet the unique needs of adolescents and young adults. A major issue for these services is the diagnostic model. There are issues with its reliability, validity, and utility, which have led leading proponents of youth mental health to conclude that it "struggles to fulfil its key purposes of guiding treatment selection and predicting outcome" (McGorry et al., 2007: p S40). The association of diagnosis with stigma is also recognised internationally as a problem for youth mental health (e.g. Patel et al., 2007). Perhaps the most significant issue is with its focus: as a model of illness it does not provide a framework within which young people can orient themselves towards living healthy, happy, and fulfilled lives.

In the Norfolk (UK) Youth Service, a Cognitive Behavioural Therapy (CBT) based psychoeducation programme was written, the 'Psychology of Emotions', which aimed to offer the benefits of CBT without using a diagnostic framework. Interventions were instead grounded in emotion science so that young people learnt not about disorders and symptoms, but about emotions, emotional 'traps' (CBT maintenance formulations) and how they could use CBT to bring about change. Workshops consisted of six sessions; an introductory session followed by five sessions focusing in detail on a specific emotion (fear, sadness, anger, emotional instability, and happiness). Each session outlined what the emotion was, its function, and outlined a 'trap', a cognitive behavioural formulation illustrating common difficulties with that emotion, along with associated interventions to get out of the trap. A workbook was provided containing a summary of the session as well as space to design homework tasks. The content of the workshops has been developed into a full CBT treatment manual which outlines the approach in detail (Howells, 2018).

This study aimed to evaluate the effectiveness of the 'Psychology of Emotions' workshop in a large sample of young people (aged 16 to 25 years) attending a youth IAPT service. Participants completed validated measures of depression and anxiety at each session and were invited to complete feedback forms at the sixth session. This study examined rates of attendance, demographic characteristics, change in symptom severity pre- and post-intervention, and participant views of the intervention.

From Jan-Sept 2016, 595 young people were invited to attend a 'Psychology of Emotions' workshop, of whom 350 (58.8%) attended at least one session. Young people who attended all six sessions experienced significant reductions in anxiety (d=.72) and depression (d=.58). Those who attended at least two sessions reported significant but smaller improvements in anxiety (d=.42) and depression (d=.45). There were similarly positive findings for movement from caseness to recovery. On questionnaires provided at the final session, participants provided largely positive feedback about their experience of the intervention. The findings suggest that it is possible to deliver effective CBT without using a diagnostic framework for young people with mild to moderate mental health difficulties seen within IAPT services. Further implications and limitations are explored.
The paper highlights the implications of a diagnostically-based approach to CBT and contrasts them with an approach founded on an understanding of emotion for young people. Evaluating the Children’s Psychological Wellbeing Practitioner (CPWP) project in a child and adolescent mental health service (CAMHS)

Mike Turnbull, Tees, Esk and Wear Valley NHS Foundation Trust and Northumbria University.

Mike Turnbull, Tees, Esk and Wear Valley NHS Foundation Trust and Northumbria University; Hayley Kirk, Tees, Esk and Wear Valley NHS Foundation Trust and Teesside University; Sarah Newton, Tees, Esk and Wear Valley NHS Foundation Trust; Lynne Howey, Tees, Esk and Wear Valley NHS Foundation Trust

In 2017 NHS England extended the Children and Young People’s Improving Access to Psychological Therapies (CYP-IAPT) project to train the first cohort of Children’s Psychological Wellbeing Practitioners (CPWP’s) to deliver low intensity Cognitive Behavioural Therapy (CBT). This paper aims to evaluate low intensity CBT interventions delivered by trainee CPWP’s for the treatment of anxiety and depression in a child and adolescent mental health service (CAMHS).

In 2017 NHS England extended the Children and Young People’s Improving Access to Psychological Therapies (CYP-IAPT) project to train the first cohort of Children’s Psychological Wellbeing Practitioners (CPWP’s) to deliver low intensity Cognitive Behavioural Therapy (CBT). This paper aims to evaluate low intensity CBT interventions delivered by trainee CPWP’s for the treatment of anxiety and depression in a child and adolescent mental health service (CAMHS).

The evaluation adopted a quantitative, within-subjects, cross-sectional design. The outcome measures of 98 service users aged 8-17 years were included in the evaluation. Service users were children and young people accessing specialist CAMHS in the North East of England. Outcome measures included The Revised Children’s Anxiety and Depression Scale (RCADS-47) and Goal Based Outcomes (GBO’s). Descriptive data relating to the types of interventions used, outcomes following CPWP involvement and service user feedback was also collected.

Analysis demonstrated significant improvements in low mood and anxiety subscale scores on the RCADS-47 as well as GBO’s post-CWPW intervention (p<0.05). Clinically significant and reliable change statistics showed that 41 service users were found to exhibit clinical meaningful change for depression and anxiety post intervention. Interventions carried out by CPWP’s coincided with recommendations by NICE, most cases were discharged from service (n=80) and positive service user feedback was demonstrated.

Findings demonstrate the efficacy of low intensity CBT informed interventions delivered by trainee CPWP’s, working routinely in a CPWP service/CAMHS setting, in reducing depression and anxiety in this population. That said, further routine evaluation is required to demonstrate the effectiveness of CPWP interventions post qualification.

Improving access to evidence-based treatment by developing a brief identification tool for anxiety and depression in adolescents

Jerica Radez, University of Reading

Anxiety and depressive disorders are the most common mental health disorders in adolescence. Cognitive Behavioural Therapy (CBT) is the most well-established treatment for anxiety and depression in young people, but only a minority access CBT. A failure to identify anxiety and depression when they first emerge presents a significant barrier to treatment access. Existing screening questionnaires are lengthy, making them impractical for routine use in community settings (e.g. schools, GP appointments). The purpose of this study is to develop and evaluate a short (10-15 item) self- and parent-report questionnaire to assess symptoms of DSM-5 anxiety and depressive disorders in adolescents.

The study combines two large (>200) samples of adolescents (age 11-17), and their parents: a community sample recruited through local secondary schools and a clinic-referred sample recruited through a University-based research clinic. Participants completed the Revised Child Anxiety and Depression Scale (RCADS) and the Mood and Feelings Questionnaire (MFQ); and the clinic-referred sample participated in a diagnostic interview. To develop the brief identification tool, we examine the functioning of RCADS and MFQ items. The short scale’s internal consistency, concurrent, convergent and divergent validity are evaluated, and ROC analyses are used to establish sensitivity, specificity and optimal cut-off scores.

The psychometric properties of the new short questionnaire will be reported, together with corresponding findings for the full-length RCADS for comparison purposes. Results of
Findings from the ROC analyses will illustrate the capacity of the short questionnaire to accurately identify young people with anxiety and/or depressive disorders. This new brief questionnaire has the potential to improve early identification of anxiety and depression in adolescents. Its brevity and easy administration will make it feasible for use in school and primary care settings, and self- and parent-report versions will facilitate application in situations where only a single informant is available. Future research should evaluate the new questionnaire's capacity to monitor change in symptoms over time and in response to treatment. Access to evidence-based treatment is reliant on accurate identification of mental health problems when they first emerge. A brief identification tool for anxiety and depressive disorders in adolescents has the potential for widespread use in community settings to help ensure those who may benefit from CBT reach the appropriate services. Subject to further research, in the future the tool could also be used to assess client and therapy progress in CBT with adolescents.

The State of the Evidence: Reducing Waste to Increase Value

No individual abstracts provided

Improving Access to IAPT for People in Later Life: Considering Carers, Communication and the Next Steps for Protocol Development

Supporting Carers of People with Dementia in IAPT: Learning from a Randomised Controlled Trial of Online CBT and Psychoeducation

Jane Fossey, Oxford Health NHS Foundation Trust on behalf of the “Caring for Me and You” Team

Carers of people with dementia experience physical, emotional and mental health needs that can adversely impact on their mental health. Carer support is not consistently available and barriers to accessing support include the types of provision, carer role responsibilities, constraints of travel, time and the associated costs. Psychoeducation for carers of people with dementia is a common approach and has some small benefits in reducing symptoms of burden and depression and CBT has also demonstrated benefits to mental health and reducing unhelpful thinking. In a recent study in the UK, structured psychological interventions that include cognitive-behavioural methods have also shown reductions in symptoms of anxiety and depression compared with treatment as usual. Delivering support online has the potential to mitigate some of the barriers experienced by carers. Caring for Me and You (CFMAY) was a 3-arm randomised controlled trial to investigate whether online CBT, with or without IAPT-delivered telephone support and an online psychoeducation package was effective in reducing stress and improving mood in family carers of people with dementia.

Methods: All packages were co-produced with carers of people with dementia in the content development and testing of the packages for technical and design features (Hales and Fossey 2017). The telephone support was delivered based on protocols for telephone support and supervision and safety monitoring drawing on existing IAPT guidance. The study team received specialist training for their role, which also included information on dementia care. People were recruited to the 3-arm RCT using wide-ranging channels and eligible to participate if they were experiencing mild-moderate anxiety or depression. Eligible participants were randomly assigned to one of the treatment arms. Participants completed measures of mood and coping at baseline, week 12 and week 26. The primary outcome measure was mood measured by the General Health Questionnaire (GHQ12) rating scale at 26 weeks.

Results: 1122 people expressed an interest in taking part of which 638 were eligible to join the study. Randomisation achieved a good balance in terms of socio demographic
and clinical characteristics and the study attracted a wide age range, including adults of working age and older adults. All packages improved the well-being of participants at 26 weeks compared to baseline as measured by the primary outcome measure GHQ-12 scores, with no differential benefit between the online education and CBT approaches. Education and supported CBT also showed benefits on some secondary outcome measures focusing on depression, anxiety, stress and coping. A further important finding was that the telephone supported arm of CBT achieved higher levels of engagement, with almost twice as many participants completing the outcomes at 26 weeks compared to the unsupported arms.

Conclusions: CFMAY has demonstrated that it is feasible to deliver effective online educational and CBT programmes to a geographically, demographically diverse range of carers of people with dementia with mild to moderate anxiety and/or depression. Telephone support from IAPT services is a viable route for delivery and future work to implement a programme more widely needs to consider: IAPT staff training needs related to dementia care; the development of further online materials relevant to the needs of carers of people with dementia; the best ways to enable flexible and adaptive IT with good technical support.

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Living with Dementia: Using Mentalization Based Understandings to Support Family Carers
Phil McEvoy, Six Degrees Social Enterprise, Salford

Family carers of people living with dementia are particularly susceptible to stress and depression due to the practical demands of caring, the impact of dementia upon the dynamics of their relationship and the challenging emotional adjustment involved. Mentalization is the process by which we make sense each other and ourselves. This presentation examines how mentalization-based understandings may be used to augment the support that is provided to family carers. The presentation (1) Identifies the difference between non-mentalizing and mentalizing states of mind, for example, the difference between carers who may consistently block out painful emotions because are feel overwhelmed and carers who may be more able to acknowledge their regrets and vulnerabilities. (2) Illustrates how mentalization-based understandings can be used in practice by enabling carers to connect with their state of mind. For example, naming issues that are close to the surface without being acknowledged can help carers to tackle troubling patterns of interaction, which contribute to the feeling of being chronically stuck. Bateman and colleagues’ (2017 Current Opinion in Psychology 21: 44–49) three channels of communication are highlighted as important facilitators of mentalization, and illustrations will be given of their relevance to carers. Communication channel one - the provision of a framework of understanding that can enable carers to identify and make sense asymmetric communications in which the person with dementia ability to communicate is impaired. Communication channel two - a space that enables carers to pause and reflect upon their ability to respond to changes in their relationship. Communication channel three - a safe environment that can sustain the carer’s capacity to process their emotional responses during what may be a long and challenging journey.

Staff Perceived Barriers and Facilitators to IAPT Access for People with Dementia or Mild Cognitive Impairment
Joshua Stott and Samantha Baker, University College London

People living with dementia as well as those living with mild cognitive impairment (MCI) commonly experience anxiety and depression. Cognitive behavioural therapy (CBT) may help to reduce anxiety and depression symptoms in both these groups. CBT is widely available through national Improving Access to Psychological Therapies (IAPT) services. Very little is known about how many people with dementia or MCI access IAPT treatments, but numbers are likely to be low. This presentation will start by outlining recent quantitative work (e.g. Stott et al, in press, International Psychogeriatrics) on how having dementia affects skills necessary to take part in CBT,
and potentially IAPT access as a result. The talk will then focus on methods and results from an ongoing interview study aimed at understanding what IAPT clinicians perceive to be barriers and facilitators to people with dementia or MCI accessing CBT in IAPT. For this study, an interview topic guide was developed in line with similar work with people with intellectual disabilities (Marwood et al., 2018, Journal of Applied Research in Intellectual Disabilities, 31, 76-86), theory, and in consultation with IAPT staff and implementation experts. Interviews were conducted with 14 IAPT staff about their thoughts on, and experiences of, offering psychological therapies to people living with dementia or MCI. Interviews were transcribed verbatim and data analysed thematically using Braun and Clarke's 6 steps (data familiarisation, data coding, theme generation, theme review, theme naming, report production) and appropriate credibility checks were undertaken. Data are still being analysed, but themes will focus on barriers and facilitators to accessing CBT. The clinical and practical implications of the extracted themes will be outlined and discussed in the context of IAPT delivery.

IAPT AHEAD: Action for Physical and Mental Health in Older Adults
Elisa Aguirre, Syed Ali Naqvi, Lindsay Royan, North East London NHS Foundation Trust
There is an age paradox in IAPT: older people are under-represented yet, for those who do engage, the recovery rate is better than it is for younger users. IAPT services have been criticised for not adequately addressing the issue of under-representation, even though this may be linked to cohort factors; an estimated one in four older people have a common mental health problem but fewer than one in six discuss their symptoms with their GP. The joint commissioning implementation plan for adults and older people identifies uptake of IAPT services by older adults as a key target. The IAPT AHEAD project is a local initiative in the London Borough of Barking and Dagenham with the aim of (i) improving uptake by older adults and (ii) better understand the predictors of treatment outcome. The borough has received particular attention from central Government due to poor physical health and high deprivation (achieving the dubious distinction of being the 12th most deprived of all 326 English local authorities). The access target is to improve the 2017/8 older adult (above 60 years of age) referral rate by 20% (an extra 100 referrals) within the 2019 year. As a first step, the B&D IAPT service linked with the secondary care memory service and community mental health team for older people, with a named link worker. A screening process was established, and a joint group was set up targeting mental and cognitive health for older people (the Mindfood programme). This resulted in an early increase in IAPT uptake, however, the differences in service operating procedures presented ‘real world’ challenges for the facilitation and administration of the joint group. Additional service initiatives will be initiated and evaluated over the course of the year, and findings used to improve engagement with subsequent services. The outcome predictors analysis of routinely collected IAPT data will use a repeated-measures linear model, with IAPT outcomes as dependent variable, age as a covariate, and living situation, marital status, gender and presence of a long-term condition as predictor variables. Findings for both the access initiative and outcome predictors analysis will be presented and discussed, with implications considered for further initiatives to increase age representativeness.

Novel Treatments Across Different Clinical Settings Targeting Emotionally Unstable Personality Disorder/Traits

Are Mindfulness Based Interventions Relevant to People Diagnosed with ‘Emotionally Unstable Personality Disorder’?
Alison Roberts, Sussex Partnership Foundation Trust & University of Sussex
The introductory talk of this symposium will outline some key issues in the development of novel approaches to providing interventions based on cognitive and behavioural theory.
Background:
This is a challenging clinical area in which to conduct research as even the most basic aspects of definition are much debated. However it is also an area which requires innovation given the impact of untreated or sub-optimally treated EUPD across a broad range of metrics such as cost of health service use, high rates of suicide and functional impairments (social, occupational, parenting) and on a personal level the consistently high levels of distress which many people diagnosed with EUPD experience. Given the poorly understood mechanisms and clinical heterogeneity it may be that targeting transdiagnostic processes which are seen as key to emotional instability could be a fruitful starting point for innovation. This could be seen as analogous to the more recent developments in the modular approach to treating psychosis.

Methods & Results: This presentation will outline the methods used to comprehensively and systematically review the existing research literature. A meta-analysis is described which sums the results from various trials where mindfulness based interventions have been compared to both active and inactive control interventions for people meeting diagnostic criteria for EUPD/BPD. These results are discussed within the context of what we know about emotional regulation as one of the core processes in EUPD.

Implications: Limitations of the existing research are discussed and future areas for research using a range of methodologies are proposed. Implications for innovation in clinical practice are highlighted along with some reflections on the need to balance innovation with the responsibility to practice in safe and effective ways.

Parent, Child and Practitioner Perspectives on Parenting in the Context of EUPD

Abby Dunn, University of Sussex

The emotional dysregulation, interpersonal challenges and sensitivity to stress present in individuals with Emotionally Unstable Personality Disorder associated traits (EUPD/T) can affect their ability to provide appropriate and nurturing care to their children. As such the disorder is associated with poorer outcomes for children from infancy into adolescence in terms of behaviour, affect, mental health and the parent-child relationship. (Petfield, Startup, Droscher, & Cartwright-Hatton, 2014). Children of parents with EUPD/T may in turn develop psychiatric symptoms potentially via the mechanism of parenting (Stepp, Whalen, Pilkonis, Hipwell, & Levine. 2011).

Unsurprisingly, this parent group experience low levels of parenting satisfaction and high levels of parenting stress, yet may struggle to engage with standardised parenting interventions (Maliken, & Katz, 2013). Understanding the parenting experience and support needs of this group is integral to the development of appropriate parenting interventions.

Methods
Qualitative research comprising interviews and focus groups with parents with EUPD/T (n = 12), young adult children of parents with EUPD/T (n = 3) and practitioners across disciplines with experience of working with this group (n=31). Interviews/focus groups explored experience of parenting/being parented/conceptualisation of parenting; support requested, offered and utilised; and targets for change and opportunities for support. Thematic framework analysis will generate a multi-faceted interpretation of parenting by individuals with EUPD and identify support needs and methods (Ritchie and Lewis, 2003).

Adapting Dialectical Behaviour Therapy Skills Groups for a Perinatal Mental Health Community setting

Rachel O’Brien and Anna Roberts, Sussex Partnership Foundation Trust

Women are particularly susceptible to experiencing mental health problems during pregnancy and in the first year after having a baby than at any other time in their life. Statistically 1–20 per cent of all newly delivered mothers experience postnatal mental health problems (Peindl, 2005; Royal College of midwives, 2007). Among this faction are a cohort with pre-existing psychiatric disorders (Knightly, 2008), some of whom have a personality disorder. Untreated perinatal mental health problems such as
postnatal depression, puerperal psychosis and maternal OCD have lasting impact on both maternal mental health but also on the longer term outcomes of the child, including cognitive, social and emotional. The significant economic impact of these longer term outcomes has led to an increase in mental health service provision for women and their babies in recent years.

Many clients currently supported by the SPMHS in Sussex Partnership Foundation NHS Trust present not only with a perinatal mental health problem such as PND or OCD but also have significant problems with emotional regulation. The first 3 years of a baby’s life are key in laying the foundation for understanding their own emotions, developing a sense of self and ability to understand others minds and behaviour, so important for later life and relationships. Women with problems with regulating their own emotions, sometimes due to their own attachments, early years experiences and past trauma can find it hard to mentalise and model emotion regulation for their baby. The perinatal period offers a unique window in which to break the cycle of intergenerational transmission of problems with emotion regulation and mentalisation.

The SPMHS in SPFT has recently been trained in offering level 3 Dialectical Behaviour Therapy (DBT) and now offers a 14 session DBT Skills training group including team consultation, phone coaching and an information session for partners, friends or relatives. The modules covered include skills in Mindfulness, Emotion Regulation, Distress tolerance and Interpersonal effectiveness and the overarching goal is to aid clients in building a life worth living. We will reflect on our experiences and the challenges of developing and adapting these groups for a community setting for mothers and babies and will share initial findings from our recent evaluation.

**STEPPS-EI as an Intervention for Sub-threshold BPD traits in a Primary Care Setting**

**Juliet Couche, Sussex Partnership Foundation Trust**

Improving Access to Psychological Therapies (IAPT) is the psychological therapy service in England for depression and anxiety. Although not intended for people with subthreshold BPD traits, in practice people with such traits are commonly seen in IAPT (1). Audits in IAPT show people with BPD traits are more complex, receive more interventions, have poorer engagement and poorer therapy outcomes than people with no/minimal traits (2,5). An alternative is needed for this group of people. We developed a lower intensity version of the 20-week STEPPS programme (3) in conjunction with the original authors. The 13-week programme (STEPPS-EI) is for primary care settings for patients with subthreshold BPD traits.

**Method**

This is an uncontrolled feasibility study of STEPPS-EI. Referrals were screened for BPD traits using the McClean BPD scale (4). Exclusion criteria were having a BPD diagnosis or inability to self-manage risk. Recruitment and retention figures were collected and outcomes evaluated on an intention-to-treat and per protocol basis. Qualitative feedback was collected.

**Results**

Findings from 10 STEPPS-EI courses show pre-post STEPPS-EI improvements in BPD traits, depression and anxiety, although effect sizes are modest. Qualitative feedback indicates STEPPS-EI is acceptable. Data analysis is being finalised and findings will be presented in full.

**Conclusions**

STEPPS-EI appears to be feasible for people with subthreshold BPD traits, with preliminary findings indicating acceptability and potential effectiveness. We now intend to review patient healthcare use following STEPPS-EI to evaluate cost-effectiveness. Next steps include a plan for an RCT to provide a rigorous test of clinical effectiveness.

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**(Complex) Trauma and Psychopathology in Children and Adolescents: Prevalence,
The Epidemiology of Trauma and Post-traumatic Stress Disorder in a Representative Cohort of Young People in England and Wales
Stephanie Lewis, King’s College London; Louise Arseneault, Avshalom Caspi, Helen L Fisher, Timothy Matthews, Terrie E Moffitt, Candice L Odgers, Daniel Stahl, Jia Ying Teng, Andrea Danese

Background: Despite the emphasis placed on childhood trauma in psychiatry, comparatively little is known about the epidemiology of trauma and trauma-related psychopathology in young people. We therefore aimed to evaluate the prevalence, clinical features, and risk factors associated with trauma exposure and post-traumatic stress disorder (PTSD) in young people.

Methods: We carried out a comprehensive epidemiological study based on participants from the Environmental Risk Longitudinal Twin Study, a population-representative birth-cohort of 2232 children born in England and Wales in 1994–95. At the follow-up home visit at age 18 years, participants were assessed with structured interviews for trauma exposure, PTSD, other psychopathology, risk events, functional impairment, and service use. Risk factors for PTSD were measured prospectively over four previous assessments between age 5 and 12 years. The key outcomes were the prevalence, clinical features, and risk factors associated with trauma exposure and PTSD. We also derived and tested the internal validity of a PTSD risk calculator.

Findings: We found that 642 (31·1%) of 2064 participants reported trauma exposure and 160 (7·8%) of 2063 experienced PTSD by age 18 years. Trauma-exposed participants had high rates of psychopathology (187 [29·2%] of 641 for major depressive episode, 146 [22·9%] of 638 for conduct disorder, and 102 [15·9%] of 641 for alcohol dependence in the past 12 months), risk events (160 [25·0%] of 641 for self-harm, 53 [8·3%] of 640 for suicide attempt, and 42 [6·6%] of 640 for violent offence since age 10–12 years), and functional impairment. Participants with lifetime PTSD had even higher rates of psychopathology (87 [54·7%] of 159 for major depressive episode, 43 [27·0%] of 159 for conduct disorder, and 41 [25·6%] of 160 for alcohol dependence in the past 12 months), risk events (78 [48·8%] of 160 for self-harm, 32 [20·1%] of 159 for suicide attempt, and 19 [11·9%] of 159 for violent offence since age 10–12 years), and functional impairment. However, only 33 (20·6%) of 160 participants with PTSD received help from mental health professionals in the past 12 months. We found that the risk of PTSD in trauma-exposed participants was increased in girls, those with lower childhood IQ, who had more childhood internalising or psychotic symptoms, who experienced childhood victimisation, who lived in more disadvantaged socio-economic conditions, or who were exposed to direct interpersonal index traumas, in bivariate analyses. Childhood victimisation and direct interpersonal index trauma remained significant independent predictors of PTSD in multivariate analysis (odds ratios 2·35 [95% CI 1·49–3·70] and 6·22 [3·96–9·75] respectively). We developed a PTSD risk calculator which had an internally validated area under the receiver operating characteristic curve of 0·74, indicating adequate discrimination of trauma-exposed participants with and without PTSD, and internally validated calibration-in-the-large of –0·10 and calibration slope of 0·90, indicating adequate calibration.

Interpretation: Trauma exposure and PTSD are associated with complex psychiatric presentations, high risk, and significant impairment in young people. The strongest predictor of PTSD in trauma-exposed young people is experiencing direct interpersonal types of trauma. Improved screening, reduced barriers to care provision, and comprehensive clinical assessment are needed to ensure that trauma-exposed young people and those with PTSD receive appropriate treatment.

Prevalence and Predictive Value of ICD-11 PTSD and Complex PTSD Diagnoses in Children Exposed to a Single Event Trauma
Caitlin Hitchcock, MRC Cognition and Brain Sciences Unit, Cambridge; Rachel Elliott, Anna MacKinnon, Tim Dalgleish, Richard Meiser-Stedman
ICD-11 made a number of changes to diagnosis of PTSD. Diagnostic criteria for Complex PTSD were introduced. Revised ICD-11 criteria for PTSD also sought to address criticism that the ICD-10 diagnostic threshold was relatively low and identified a high level of co-morbidities. This study explored the prevalence and 3-month predictive value of PTSD diagnosis using ICD-10 vs ICD-11 criteria in a sample of 226 children who presented at hospital following a traumatic event. We also explored whether children exposed to a single incident trauma may demonstrate symptoms of Complex PTSD, as the experience of repeated trauma was not included in diagnostic criteria for Complex PTSD, despite its original conceptualisation as a disorder experienced by those with complex trauma histories. Results demonstrated that fewer children were identified as experiencing PTSD using ICD-11 criteria, and interestingly, ICD-11 criteria were associated with a higher frequency of comorbid difficulties relative to ICD-10. 27% of children with PTSD also met criteria for 1 Complex PTSD feature and 18.18% met criteria for two Complex PTSD features. Only three children met full Complex PTSD criteria, all of whom had experienced mental health concerns before the traumatic event. Implications for the identification of trauma-related distress in young people are discussed.

Cognitive Predictors of (complex) PTSD and Wellbeing in a Longitudinal Sample of Young People in Out-of-home Care
Rachel Hiller, University of Bath; Sarah Halligan, Richard Meiser-Stedman, Elizabeth Elliott
Young people in care have commonly been exposed to multiple repeated traumas, often over a prolonged period of time. Despite trauma-exposure being a common experience, and rates of PTSD that are 12x higher than in their peers, there remains confusion around the best way to conceptualise, and thus address, trauma-related distress in this group. We conducted a longitudinal study following 120 10-17 year olds, who were under the care of 3 Local Authorities in England. Participants, and their caregiver, completed three assessments over a 1-year period, primarily via questionnaire batteries that explored core cognitive predictors of PTSD, including maladaptive appraisals, trauma memory qualities and cognitive coping. The majority of the sample were in foster care (86%), with 10% in a kinship placement and 4% in a residential care home. One-third of the sample experienced a placement breakdown between the first assessment and 1-year follow-up. 80-90% had been exposed to at least one Criterion-A trauma (M = 3.3). Findings showed existing cognitive and behavioural models of PTSD were highly application to this more complex group. Maladaptive appraisals in particular were a strong predictor of later PTSD symptoms and complex features. There was also high overlap (r = .86) between PTSD symptom severity and complex features severity. Core cognitive processes and (complex) PTSD symptoms were also moderate to strong predictors of child- and carer-reported wellbeing markers, including suicidality, behaviour difficulties, and school wellbeing. Overall, findings demonstrated the large proportion of young people in care who are struggling with elevated PTSD symptoms, including intrusive and distressing flashbacks of their maltreatment and an elevated sense of threat. That existing cognitive and behavioural models of PTSD applied to this group suggests existing treatment models, particularly trauma-focused CBT, should be seen as the first-line treatment for young people in care presenting with PTSD or complex PTSD. This talk will also include discussion on the usefulness of the new complex PTSD criteria, in relation to young people in care.

A Case Study of Treating a Young Person for Complex PTSD
David Trickey, Anna Freud Centre, London
This is a case study of the Trauma-Focused CBT (TF-CBT) completed with 16 year old girl with Complex PTSD. The client had witnessed ongoing domestic violence between her step-father and her mother and her brother died in traumatic circumstances. She then experienced a particularly vicious physical assault, which prompted the referral to an early intervention aimed at preventing PTSD (Child and Family Traumatic Stress
Intervention: CFTSI). During the assessment for CFTSI it immediately became apparent that her range of difficulties fulfilled the criteria for Complex PTSD and that the short preventative intervention for which she was referred was unlikely to be suitable, and that TF-CBT over at least 20 sessions would be more likely to be effective. We considered referring on to her local CAMHS for this longer piece of work, but her local CAMHS claimed that she would be unlikely to reach their threshold to accept the referral, even if she did they had a waiting list of more than 6 months, and that they would probably then initially offer 6 sessions of anxiety management. Given that many of her problems were associated with difficulties trusting others (adult males in particular), we were also concerned about how she would interpret being referred on to another service and therefore another therapist. We therefore offered up to 20 sessions of TF-CBT. Just as Complex PTSD consists of core PTSD symptoms plus additional complex symptoms, the intervention consisted of the core components of TF-CBT (processing the memories, creating more useful meaning of events and reducing avoidant coping) but with additional time and effort required to establish a good enough therapeutic relationship and to help her develop sufficient emotion regulation skills to engage in the trauma focused work. But this therapeutic relationship and emotion regulation were never considered to be sufficient in and of themselves; they were only ever considered as necessary precursors to the trauma focused work.

Hoarding Disorder: Prevalence, Cognitive-emotional and Familial Vulnerability Factors and Intervention

Prevalence of Hoarding Disorder: A Systematic Review and Meta-analysis
Stephen Kellett, University of Sheffield and Sheffield Health and Social Care NHS Foundation Trust
Currently there is uncertainty concerning the prevalence of Hoarding Disorder (HD) due to methodological issues in the evidence base. Estimates have widely ranged from between 1.5% and 6% of the general population. This systematic review and meta-analysis therefore aimed to summarise and reliably estimate the prevalence of HD by employing strict inclusion criteria and using studies with sufficiently large samples. A systematic literature search was conducted to identify all relevant prevalence studies. Inclusion criteria were studies that reported adult prevalence rates and had sample sizes of at least 1,009 participants. Eleven studies met criteria (n = 53,378), had low risk of bias and were originally based in developed countries. A random effects meta-analysis was then conducted, with subgroup moderator analysis and meta-regression. The pooled estimated prevalence for HD was 2.5% (CI 1.7-3.6%) and subgroup analyses revealed that prevalence rates were similar for both males and females. The prevalence rate for HD is relatively low. Guidance on the manner in which HD is assessed in future prevalence studies is provided and the clinical implications of the results discussed.

Expressed Emotion in Family Members of People with Hoarding Disorder
Juliana Onwumere, Department of Psychology, King’s College London
Hoarding Disorder (HD) can significantly impact the quality of close relationships and recent studies suggest that family members experience significant burden related to caring for someone with HD. Expressed emotion (EE), generally defined as the attitudes and behaviours expressed by a caregiver toward the person they care for, is a key measure of the family environment. High levels of EE are predictive of poorer patient outcomes across a range of psychiatric conditions, including psychosis, depression, eating disorders, and anxiety disorders. To date, however, EE is yet to be studied in HD. In this presentation we will present results from a study looking at EE, distress and caregiver burden in carers of people with HD. Fifty-three carers of people with HD were assessed, cross-sectionally, on measures of EE (Five Minute Speech Sample), caregiver burden (Experiences of Caregiving Inventory) and distress (Hospital Anxiety and Depression Scale). Participants were mostly adult children of people with HD, but also included partners/spouses and other family members. More than half (55%) of the
relationships were characterised by high EE, with the majority classed as high EE, critical type. Carers with high EE critical type presented higher rates of caregiver burden. High EE was also associated with higher levels of carer distress; 43.4% of HD carers reported clinical levels of distress (41% above cut-off for anxiety, 9.4% for depression). The results suggest levels of EE comparable to those found in carers of people with other severe mental health conditions. This study further contributes to the emerging evidence on the impact of HD on family members, and has important implications for the family treatment and management of HD.

Does Response Inhibition Training Reduce Compulsive Acquiring?
Helena Drury, Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Foundation Trust
Response inhibition training (RIT) has been found to reduce compulsive overeating (e.g. Lawrence et al., 2015), however this paradigm has not previously been assessed in compulsive acquiring, which is commonly reported in Hoarding Disorder (e.g. Frost et al., 2013). If effective, RIT could be a useful addition to existing treatments for compulsive acquisition, by targeting bottom-up responses to items associated with urges to acquire. An analogue sample (students scoring highly on measures of acquisition) was used to compare the impact of an active RIT task (where commonly acquired items were consistently paired with no-go responses) to an inactive version of the task (with inconsistent stimulus-response mappings). Active RIT significantly reduced the attractiveness of acquirable items to participants compared to the inactive version of the task. The RIT effect also generalised to images in the same category as those paired with an inhibitory response (but not items from other categories), indicating that RIT may be able to target specific categories of items commonly acquired by an individual. Findings will also be presented for a case series of individuals meeting criteria for Hoarding Disorder who also completed the RIT programme.

James Gregory, University of Bath
Excessive attachment to objects due to sentimental, instrumental and aesthetic valuation of objects is an important feature of Hoarding Disorder. Surprisingly, little research had been conducted to understand valuing of objects in people with Hoarding Disorder. This study aims to investigate whether there is evidence to suggest that people with Hoarding Disorder perceive greater value in objects compared to those without Hoarding Disorder. Using an online platform, participants completed a range of standardized psychometric questionnaires before assigning them to one of three groups (HD, OCD and nonclinical controls). Participants were then asked to rate the sentimental, instrumental, aesthetic and monetary value of thirty non-personal objects. The data will be analysed to investigate whether the hoarding group attributed overall higher value to objects and whether they specifically rated objects higher on sentimental, instrumental and aesthetic value in comparison to the other groups. The results may indicate the existence of a perceptual bias in regards to object value perception in HD and theoretical and clinical implications of this will be discussed.

The Role of Intolerance of Uncertainty, Anxiety Sensitivity and Distress Intolerance in Hoarding Disorder
Shemariah Hillman, Department of Psychology, University of Bath
There is a growing interest in Intolerance of Uncertainty (IU) and related constructs such as Distress Tolerance (DT) and Anxiety Sensitivity (AS) as vulnerability factors for Hoarding Disorder (HD). It is suggested that individuals with HD might experience higher levels of these constructs which may impact upon hoarding severity, however there is currently limited research investigating this other than in analogue studies (e.g. Timpano et al 2009) and to a limited extent in clinical HD populations (e.g. Mathes et al., 2017; Wheaton et al., 2016). To date research has not investigated IU, DT and AS in
HD compared to clinical and non-clinical controls. In the present study, standardised measures of IU, DT and AS were administered online to 210 participants belonging to one of three groups: Hoarding Disorder, Obsessive Compulsive Disorder and a non-clinical control. Group membership was based upon the clinical cut-offs of relevant standardised measures of psychopathology. Results will be analysed to understand the specific relevance of these constructs to HD. The findings will have the potential to identify specific relationships between IU, DT and AS and HD, or otherwise, to determine their relevance as transdiagnostic vulnerability factors. The theoretical and clinical implications will be discussed.

LGBT+ Mental Health: Historical Perspectives and New Research

**Childhood gender nonconformity, peer relationships, self-esteem and emotional problems: A prospective birth-cohort study**

Anna-Sophia Warren, Institute of Psychiatry, Psychology and Neuroscience, King’s College London; Kimberley Goldsmith, King’s College London; Katharine Rimes, King’s College London

**Objectives:** Childhood gender nonconformity (CGN) refers to behaviour exhibited by children which does not conform to the social norms expected for their assigned sex at birth. Childhood gender nonconformity has previously been found to be associated with poorer mental health outcomes in adolescence and adulthood, particularly in males. It has also been associated with a number of negative experiences, including lower self-worth, negative peer relationships (including peer rejection and victimisation), and feeling different from other children, which could be related to the negative mental health outcomes experienced. However, previous studies are limited by their use of retrospective measures of childhood gender nonconformity, which may be subject to various forms of bias. This study investigated whether gender-typed behaviour measured in childhood was prospectively related to emotional problems in later childhood and adolescence, and which factors may help to explain this relationship.

**Method:** Longitudinal data from the Avon Longitudinal Study of Parents and Children (ALSPAC) was analysed. Gender-typed behaviour was rated by carers in infancy (30, 42 and 57 months) and by self-report at 8 years. Parent-rated emotional problems were rated using the Strengths and Difficulties Questionnaire at 6, 9, 11, 13 and 16 years. Potential psychosocial confounders - including experience of bullying, perceived peer acceptance, feeling different from peers, and self-esteem - were assessed at various time-points. All participants were included who had data for gender-typed behaviour measures (parent-rated n = 11,192; child-rated n = 7,049). Multiple imputation was used to handle missing data. Linear mixed regression models were fitted to assess whether parent and child-rated gender-typed behaviour was associated with more emotional problems in childhood and adolescence. These models were repeated adjusting for each potential psychosocial confounder individually.

**Results:** For both girls and boys, more feminine parent-rated and child-rated gender-typed behaviour was significantly associated with more emotional problems after controlling for demographic confounders, although effect sizes were small. Lower self-esteem, subtle bullying victimisation, feeling different and feeling accepted by peers weakened this association for boys.

**Conclusions:** More gender nonconforming behaviour in boys is related to worse emotional outcomes in childhood and adolescence. Schools should consider the risk of bullying and rejection for gender atypical male students and consider interventions to minimise this risk. In contrast, more gender nonconforming behaviour in girls is related to better emotional outcomes. Research should investigate whether girls are typically encouraged to behave in ways that negatively impact on their mental health. As this was a 14-year longitudinal study, the relationships between gender-typed behaviour and emotional problems warrant further research, despite the small association sizes.
Testing a minority stress-adjusted cognitive behavioural model of distress in LGBTQ students: A prospective mediation study

Georgina Gnan, Institute of Psychiatry, Psychology and Neuroscience, King's College London; Qazi Rahman, King's College London; Katharine Rimes, King's College London

Background: LGBTQ students experience increased rates of depression, anxiety and suicidality compared to other students. The objective of this study was to investigate cognitive and behavioural processes that may contribute to depression/anxiety and suicidality in LGBTQ students. This study tested a hypothesised model that drew on both general cognitive behavioural approaches and Hatzenbeuhler's (2009) modification of minority stress theory to investigate factors. It was hypothesised that both general and LGBTQ-related negative beliefs about the self, others or the future would be associated with distress two months’ later, and that this relationship would be mediated by unhelpful general and LGBTQ-related cognitive and behavioural responses (e.g. rumination and avoidance) assessed at an intermediate time-point.

Methods: This was an online study of 385 participants who (i) self-identified as LGBTQ, (ii) were 16+ years of age, and (iii) were currently enrolled as a student at a UK College or University. Structural equation modelling was used to investigate the relationship between negative beliefs at baseline and depression/anxiety and suicidality two months later, via cognitive and behavioural response mediators assessed at an intermediate point, one month after baseline.

Results: Results supported the hypothesis that general negative beliefs about the self are prospectively associated with depression/anxiety and suicidality, and that LGBTQ-related negative beliefs are independently associated with these outcomes. Both general and LGBTQ-related cognitive and behavioural responses mediated the relationship between beliefs and these outcomes, although in the combined final model, LGBTQ-related rumination and concealment were significant mediators for only suicidality and not depression/anxiety.

Conclusions: The present findings indicate that a cognitive behavioural approach modified to take into account LGBTQ-related beliefs and coping behaviours may be helpful in understanding depression/anxiety and suicidality in LGBTQ university students. Both general and LGBTQ-related negative beliefs about the self, others and the world and unhelpful coping responses may be suitable targets for prevention and treatment interventions with LGBTQ students.

Hidden from history? A modern history of the psychiatric ‘treatment’ of female homosexuality in England

Sarah Carr, University of Birmingham; Helen Spandler, University of Central Lancashire

It is well documented that homosexuality was classified as a mental illness in the DSM until 1973, when it was replaced with the diagnosis of “sexual orientation disturbance”, and it is widely known that homosexual men in England were criminalized and risked imprisonment or aversion therapy in a psychiatric hospital. Far less is known about same-sex attracted women in England who were not subject court referral routes into psychiatric treatment. Although female homosexuality was not criminalized in England, it was still officially classified as a mental disorder (“sexual deviation”).

As part of a cohort of studies on the theme of Sexualities and Health funded by the Wellcome Trust, we conducted an archival study of women’s and lesbian, gay, bisexual, and transgender (LBG&T) archives in England to investigate what happened to same-sex attracted women in the mental health system from 1950’s until 1970’s. Documentation proved to be sparse and fragmented, and what little material we found presented us with some challenges to interpretation. A small number of psychologists and psychiatrists had various theories about female homosexuality and published examples of experimental ‘treatments’ to test out their theories, but it is not certain if or how these theories translated into practice.

Our archival research suggests that same-sex attracted women’s experience of treatment in England was probably even more complex than men’s. As there was no psychiatric consensus about whether female homosexuality could, or should, be treated, professional
opinions and practices appeared to vary considerably. In this presentation we will briefly explore the variety of practitioner attitudes and some of the psychological approaches to 'treatment' in England to be found in the archives. We will also discuss a Post-War construction of the 'problem' of female homosexuality, based on historical records, which may have provided some of the theoretical basis for attitudes and treatments.

**Psychosocial mediators of sexual orientation and depressive symptoms in a longitudinal sample of young people**

*Angeliki Argyriou, King's College London; Kimberley Goldsmith, King's College London; Alkeos Tsokos, University College London; Katharine Rimes, King's College London*

**BACKGROUND:** Sexual minority young people (e.g. those identifying as lesbian, gay or bisexual) have increased rates of depression compared to heterosexual youth. Previous research investigating reasons for this health inequality has almost always used cross-sectional designs. This is one of the first studies to test possible mediators that were assessed at an intermediate time-point between sexual orientation and depression assessment. The present study aimed to investigate three types of psychosocial mediators in the relationship between sexual minority status and depressive symptoms in young people; unhelpful attitudes about the self and others, lower self-esteem and poorer family relationships.

**METHOD AND DESIGN:** The sample comprised participants from the Avon Longitudinal Study of Parents and Children. Sexual orientation was assessed at 15 years and depressive symptoms were assessed at 18 years (Short Moods and Feelings Questionnaire). Mediators were assessed at 17 years and included: unhelpful attitudes (Dysfunctional Attitude Scale – Short Form); self-esteem (Bachman revision of the Rosenberg Self-Esteem Scale); and family relationships measured with four items assessing family relationships. Using Full Information Maximum Likelihood, data from 14,814 individuals were analysed. Multiple mediation using structural equation modelling was conducted, with family entered as a latent variable and the mediators examined in parallel. Potential confounding variables were entered as covariates. Sex was examined as a moderator.

**RESULTS:** Sexual minority youth had higher risk for depressive symptoms at 18 years than heterosexual youth. They also had poorer relationships with their family and higher levels of unhelpful attitudes, and there was weaker evidence suggesting lower self-esteem, especially for boys. Poorer family relationships and unhelpful attitudes mediated the relationship between sexual minority status and depressive symptoms, while there was weaker evidence to support self-esteem as a mediator. There was no evidence to suggest that sex moderated these relationships.

**CONCLUSIONS:** Results emphasise the importance of family relationships and unhelpful attitudes as mediating mechanisms of the depression inequalities for sexual minority youth and point to possible areas for prevention and intervention.

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**The Impact of the Core Professions in the CBT Role in Training and Practice Contexts**

No individual abstracts provided.

**Attachment Theory as a Means of Enhancing CBT for Psychosis**

No individual abstracts provided.

**Recruiting Mental Imagery for Challenging Trauma Cases**

**The power of anger: how to harness anger in imagery rescripting in refugees with PTSD**

*Sameena Akbar, Woodfield Trauma Service*
Feelings of anger are common in refugees who have experienced severe human rights violations. Recently, there have been encouraging papers (Arntz, Sofi & van Breukelen, 2013; Arntz, 2012) which suggest Imagery rescripting (ImRs) can be helpful in treating refugees with PTSD.

Imagery rescripting does not require a repeated detailed discussion of the distressing elements of a traumatic event. The intervention focuses on the patient being encouraged to imagine a rewritten version of the trauma narrative in which they feel less distressed, more empowered and can express emotions, such as anger, which were not possible at the time of the trauma.

Data and feedback from therapists conducting an imagery case series at the Woodfield Trauma Service suggest that enabling clients to feel anger during rescripts can unlock strong feelings of empowerment. This presentation will describe how to work with anger during imagery rescripts and discuss blocks and resistance to anger both from the client and the therapist. Useful advice and practical tips will be given to help other clinicians embarking on similar work in the future. We hope that this presentation will help clinicians overcome concerns about working with anger in imagery rescripting.

**Treating guilt in refugees with PTSD using imagery techniques**

**Zoe Chessell, Woodfield Trauma Service**
Treating guilt in refugees with PTSD using imagery techniques

Post-traumatic Stress Disorder (PTSD) often involves strong feelings of guilt about traumatic events (Lee, Scrugg, & Turner, 2001). Guilt is commonly characterised by a belief that one should have thought, felt, or acted differently during the traumatic events. People may hold themselves responsible for what occurred, both peri-traumatically and/or post-traumatically. In our experience peri-traumatic guilt can be hard to change with logic and research suggests that imagery techniques can assist (Arntz, Kindt, & Tiesema, 2007; Arntz, 2012). This presentation will describe how imagery techniques were used, in addition to cognitive methods, with a refugee client suffering with PTSD to multiple events, and experiencing strong feelings of guilt. The techniques used and his progress in therapy will be discussed. Useful pointers and advice will be drawn out for other clinicians embarking on similar work in the future. We hope that this case study will support therapists to use imagery interventions to alleviate feelings of guilt during trauma-focused therapy.

**The Power of the Imagination: Examining the prevalence of imagined ‘worst case scenario’ moments in trauma memories.**

**James Griffin, Grenfell Health and Wellbeing Service, CNWL; Cathryn Skerry, Grenfell Health and Wellbeing Service, CNWL**
A key part of Ehlers and Clark’s (2000) treatment protocol for PTSD involves the updating of the ‘worst moments’ or ‘hotspots’ during reliving. While treatment protocols do mention imagined hotspots (e.g. imagining one’s own death during a road traffic accident), the emphasis to date remains on verbal phenomena (e.g. thinking, “I am going to die.”) When discussing the meaning of hotspots, therefore, therapists do not always determine whether the client experienced any vivid mental imagery during trauma, tending to focus more on verbal cognitions.

Therapists working at the Grenfell Health and Wellbeing Service noticed that imagined ‘worst-case scenario’ moments were often present when they explored clients’ hotspots. This distinction is clinically significant as imagery is held to i) have a stronger impact on emotion compared to verbal cognition (Holmes and Mathews, 2005) and ii) have a perceptual equivalence to real experience (Kosslyn et al., 2001). Therefore, we explored the prevalence of imagery hotspots in clients who were being treated with TF-CBT in the Grenfell Health & Wellbeing Service. We hope that the findings will support clinicians in effectively working with imagery-based hotspots.

**The Power of the Imagination: How to elicit and treat imagery-based hotspots**

**Claire Gibson, Grenfell Health and Wellbeing Service, CNWL; Che Moore, Grenfell Health and Wellbeing Service, CNWL**
Distressing mental imagery has been shown to play a central role in the development and maintenance of Post-Traumatic Stress Disorder (PTSD). Our clinical practice and a recent audit demonstrated that mental imagery was present in many patients’ ‘worst moments’ during trauma. Traditionally in TF-CBT, the emphasis is placed on updating verbal cognitions to reduce emotional distress (Ehlers & Clark, 1999). However, in recent years, it has been demonstrated that imagery has a more powerful impact on emotions than verbal processing (Holmes & Matthews, 2010) and it would follow that distress associated with an imagery-based hotspot may not reduce with a verbal hotspot update alone. In Grenfell Health and Wellbeing Service, we began to use imagery re-scripting to reduce distress in image-based worst moments.

Through examining the prevalence of imagined ‘worst case scenarios’ in accounts of traumatic events, we have established that therapists do not always enquire about vivid mental imagery but tend to focus primarily on verbal cognitions. The aim of this presentation is in the first instance to demonstrate how to elicit imagery-based hotspots and why doing so might improve outcomes in CBT for PTSD. We will then demonstrate how to treat these vivid mental images using a case example. Throughout the audit, common themes in imagery-based hotspots have emerged. The case example that will be discussed is the result of combining these themes to create typical examples of imagery-based hotspots found during TF-CBT at Grenfell Health and Wellbeing Service.

Our hope is to share our findings on how to treat PTSD combining imagery with verbal techniques and also to demonstrate how to practically apply these findings during TF-CBT in a wide range of clinical settings.

Panel Debate: How Can We Make Sure We Are Doing High Quality, Effective CBT When We Work With Interpreters and Interpreted Materials?

Andrew Beck, University of Manchester; Michelle Brooks, University of Derby; Glorianne Said, University College London; Whitney Nyarambi, East London Foundation Trust; Dot King, Berkshire Healthcare Foundation Trust

Diverse societies often mean that mental health services are asked to provide therapies to service users who do not have enough English language skills to be able to do complex therapy work in English. There is also a clear need to engage communities where English language skills are limited and to provide information and written resources in other languages. NICE guidelines identify how interventions should still be offered in spite of differences in culture and language spoken, making use of interpreters or bicultural therapists where possible (NICE guidelines for PTSD 2018). There is limited evidence that CBT can be effective when provided through an interpreter (D’Ardenne et al 2007) and excellent general guidelines around the use of interpreters in mental health settings (Tribe and Thompson 2008) however there remains considerable challenges within IAPT and other services in terms of implementing these approaches and adapting them specifically for CBT within these settings (Beck 2016). More consideration is also on working more closely with interpreters to consider their needs and well-being as staff members in support of good practice; particularly when offering CBT interventions to vulnerable clients with distressing histories (Weir et al 2018).

This Panel Debate brings together researchers and practitioners from a variety of service settings, who are working with children, adolescents, refugees, adults and forensic populations, to reflect on challenges, share good practice, demonstrate key skills and answer questions from attendees.

How Can We Do Trials Better? Methodological Developments in Reducing Waste and Improving Efficiency in Trial Design

Evidence-based trials for evidence-based healthcare
Heidi Gardner, Health Services Research Unit, University of Aberdeen

Randomised controlled trials are the gold standard for evaluating medical and healthcare interventions; they are designed to alleviate bias in order to produce evidence that can be used to inform decisions made by healthcare professionals, patients, policy-makers and funding bodies. The way that trials are conducted is far from evidence-based, as eloquently explained by Dr Monica Shah MD, from the University of Maryland School of Medicine, in the quote below:

“There is a peculiar paradox that exists in trial execution – we perform clinical trials to generate evidence to improve patient outcomes; however, we conduct clinical trials like anecdotal medicine:

1) We do what we think works;
2) We rely on experience and judgement, and;
3) Limited data to support best practices.”

The ‘How can we do trials better? Methodological development in reducing waste and improving efficiency in trial design’ symposium will open with a talk encompassing a multitude of projects under the umbrella of Trial Forge. Trial Forge is an initiative to improve trial efficiency, led by the Health Services Research Unit at the University of Aberdeen and encompassing global collaborations to improve the evidence-base for how randomised controlled trials are designed, conducted, analysed and reported.

Heidi will introduce the concept of research waste, presenting data on the scale of trial inefficiencies and waste as a result of methodological issues that, on the surface at least, appear solvable. Ultimately, if we as researchers fail to recruit the number of participants that has been calculated by trained statisticians, then our trials are vulnerable to type II error; or put simply, we have been known to invest time, effort and money into trials that do not produce reliable evidence to effectively inform the health decisions.

Following this we look to the literature for help; Heidi will present data from a trio of three recent systematic reviews aiming to evaluate methods to improve the process of participant recruitment. Collectively referred to as a ‘TRINITY package’ these three reviews include: A systematic review of randomised evaluations of participant recruitment methods (led by Prof Shaun Treweek); a systematic review of non-randomised evaluations of participant recruitment methods (led by Dr Heidi Gardner); a qualitative synthesis of factors that impact on participant recruitment (led by Dr Catherine Houghton). Using these three reviews together as a TRINITY package ensures that the evidence currently held in the literature is effectively synthesised, and that the nuances that may or may not impact on the success of those recruitment methods from the perspective of potential trial participants are captured, and can therefore be used to inform the generation of future recruitment methods.

We end the talk with a look to the future of methodological work; specifically, where researchers can work to improve the evidence-base using embedded studies within trials (SWATs). Examples of SWATs will be suggested based on the PRioRiTy and PRioRiTy II studies that used a James Lind Alliance Priority Setting Partnership to prioritise unanswered questions around participant recruitment and retention respectively.

Routine data and outcome assessment in psychological therapy trials
Alexandra Wright-Hughes, Clinical Trials Research Unit, University of Leeds; Amanda Farrin, Clinical Trials Research Unit, University of Leeds; David Cottrell, School of Medicine, University of Leeds

Designing and analysing clinical trials in psychological therapy trials involving behavioural interventions is complex, especially as dropout from treatment and follow-up is common. This results in missing data, which can reduce statistical power of analyses, bias estimates and treatment comparisons, and affect the generalisability of results. The choice of primary outcome and method of data collection is therefore of particular importance in protecting against such biases.

Data collection methods in clinical trials tend to rely on data designed, generated, and collected specifically for trial purposes. However, the use of patient-level routinely collected electronic health data within trials is increasing and is endorsed by the National Institute for
Health Research and other funders to increase trial efficiency, notably to support follow-up data collection. Using the Self-Harm Intervention, Family Therapy (SHIFT) trial as an example, we discuss our choice of primary outcome and methods employed to maximise reliable data collection. SHIFT was a pragmatic, randomised, controlled trial, comparing family therapy with treatment as usual for adolescents who had self-harmed at least twice, with a primary outcome of repetition of self-harm leading to hospital attendance. This primary outcome was selected to provide an objective measure of self-harm which could be quantified using hospital records rather than relying on patient self-report. Our initial method of primary outcome data collection was, however, resource intensive, requiring researcher visits to many hospitals across England to interrogate local medical records. We therefore explored the reliability and accuracy of data collection from a routine source, Hospital Episode Statistics – collected by local trusts, collated, and distributed by NHS Digital, these data contains details of admissions, outpatient, and Accident and Emergency attendances within English NHS hospitals.

Comparing hospital attendances reported from Hospital Episode Statistics to those identified directly from hospital records by researchers, we assessed whether routine data provided a complete, accurate, and reliable outcome dataset. Key benefits included the acquisition of more systematic, comprehensive and timely trial outcome data; whilst challenges included governance requirements and uncertainty in the identification of attendances specifically due to self-harm. Our resulting primary outcome data collection strategy used routine data to identify hospital attendances supplemented by targeted researcher data collection solely for those attendances requiring further self-harm classification.

Based on findings of our comparison of data collection methods, we will discuss the benefits and limitations of using routinely collected electronic health data as trial outcome data. Further consideration will be given to the value of exploring routine data as a primary outcome data source, and conversely, when it may be necessary to rely on additional data collection devised specifically for a trial.

**Development and piloting a standard framework to assess risk of contamination in psychological therapy trial protocols**

*Jacobsen Pamela, University of Bath; Lisa Woods, University of Essex & North East London NHS Foundation Trust*

Contamination in randomised controlled trials is defined as an intervention intended for members of the treatment arm being actively received by participants in the control arm (Howe et al, 1997). This can lead to an underestimate of the true effectiveness of an intervention in a clinical trial. Using a cluster randomised design is often suggested where the risk of contamination is judged to be considerable. However, cluster randomised designs where groups, rather than individuals, are the unit of randomisation are not without their drawbacks. Torgerson (2001) has argued that cluster randomised trials usually require much larger sample sizes, making them more expensive and time-consuming, and are susceptible to recruitment bias. It is therefore important to first be sure that contamination is a real, rather than a hypothetical threat, before alternatives to individual randomisation are considered. This is a particular challenge in psychological therapy trials, which usually fall under the Medical Research Council’s definition of a complex intervention, having several, interacting components to the intervention. Likelihood of transmission of the so-called ‘active ingredients’, via therapists or participants in the intervention arm, will depend on several factors, including what the intervention is, and how it is delivered.

The aim of this study was therefore to develop and pilot a standard framework which could be used to assess risk of contamination in psychological therapy trial protocols. We adapted a framework, originally developed to evaluate risk of contamination in educational trials, to be suitable for use with psychological therapy trials. We then piloted this framework on a sample of psychological therapy trials registered on the ISRCTN registry (www.isrctn.com) over a 2-year period from 2016-2018 (N=101). All trial registry records were
independently double-rated by the authors, before cross-referencing and reaching a consensus on any ratings where there was a discrepancy. We first assessed all trial protocols using the TIDIER tool (Hoffman et al, 2014), which gives best-practice guidelines for comprehensively describing trial interventions. We then assessed all protocols as being low- or high-risk via 3 possible sources of contamination; 1) participant in control arm, 2) participant in intervention arm, 3) therapist in intervention arm. We will present data on the proportion of trial protocols which were considered high-risk for contamination, from which source, and whether any measures were put in place to mitigate any possible risks (e.g. use of a cluster design, fidelity checks in both arms of the trial). We will end with plans for future development and evaluation of the framework, and the implications for improving psychological trial design in the future.

The Elephant on the Couch: Why we ought to take ‘harm’ from psychological treatments seriously
Conor Duggan, University of Nottingham

While the possibility of harm is emphasised in the training in and research literature of psychological interventions, many argue that it, unlike the prescribing of medication, receives little more than lip service in either clinical practice or in the reporting of clinical trials. These, after all, are only ‘talking therapies, so what harm could ensue? Nonetheless, careful long-term follow-up of individuals in clinical trials employing such interventions have demonstrated that those in the active arm in the trial often fared worse than those in the no treatment control and that this occurred even when those receiving the active intervention believed that they had benefited from it. As the efficacy of psychological interventions become increasingly established and more widely employed, this potency ought to stimulate a parallel interest in the harm that they may cause.

Harm can arise from psychological interventions when (a) an ineffective treatment is used when a more effective treatment could have been chosen, (b) the ineffective implementation of an effective intervention due to a lack of competence by the therapist, (c) patient factors such as excessive dependency or masochism etc.

The literature from clinical trials evaluating psychological interventions is an obvious place to examine harm as here there ought to be (a) a systematic recording of a range of outcomes (including harm) and (b) the trial design controls for a number of potential confounders so that one can attribute a specific outcome to the intervention. Nonetheless, the data from several Cochrane Reviews and of Health Technology Assessment funded trials indicates that this is inadequate.

Finally, taking the possibility of harm from psychological interventions seriously may have a beneficial consequence. For instance, although many trials of psychological interventions show no difference between the experimental and control condition when only the mean effect is examined, this conceals the much greater variance in the active arm of the intervention than that of the control. This suggests that while more are damaged by the active intervention, a greater number also benefit compared with those in the control condition. The publication of this variance, rather than the mean, would allow an examination of the characteristics of those who are harmed (and who benefit) from the intervention thereby leading to an identification of what ‘works best for whom and under what circumstances’.

Community and Cultural Considerations

Engaging Black, Asian and Migrant Communities through race, culture, language and community engagement: Community Psychology in IAPT by another name
Naomi Mwasambili, Jessie Emilion, Chanua Health / The University of Liverpool | Guy’s and St Thomas’ NHS Foundation Trust

The paper discusses our experiences, including the development of the ‘community engagement model’ (Mwasambili 2011). In IAPT this model was used to effectively to engage minority ethnic groups and work in partnership with third sector organisations to promote access to psychological therapies. We will specifically discuss racism, bi-lingualism and
cross-cultural issues, and focus on how some minority communities in London were engaged through Intercultural and linguistically appropriate psychological interventions within the community.

The prevalence of mental health problems within Black, Asian and Minority ethnic (BAME) communities has been widely documented. Limited access to culturally appropriate services and information at an early stage is still a common experience for many accessing psychological therapy services and has been cited as a common experience of people and communities who have experiences of the mental health system. Culture, Race, Language and Religion play a key part in the development of self, personality and identity. Engagement or disengagement with mainstream mental health services are in turn highly influenced by these factors.

Race and racism often create a sense of alienation and exclusion in individuals and in minority communities. The minority communities we worked with had developed their own mechanisms to protect against alienation, by mutual exclusion and withdrawal from statutory services, leaving individuals within these communities isolated.

Language, as central to communication also plays a crucial part in the expression of distress and in the integration, positioning and acculturation of the individual in society. Religion, in its varied roles, is another key element in BAME communities.

The community engagement model is an approach that was developed in 2011 and implemented within Lewisham Improving Access to Psychological Therapies service. The model shows the 6 steps that must be passed for effective engagement at an individual, community and organisational level.

We will discuss two case examples including an African and Caribbean Women’s group and LifeGym, a college-based drop in service. Using this model resulted in increased engagement with people from African, Caribbean, Tamil, Asian, Somali and Vietnamese communities as a result of culturally adapted provision being offered. In addition we saw positive increases in access for groups who had low numbers in IAPT uptake including 18-25 year olds and older adults over the age of 65.

For true access to psychological therapies to meet the need of the diverse population of the UK, we must address mental health inequalities in relation to race, culture, disability, religion and spirituality, sexual identity, gender and age. Naming and understanding the stigma and shame around mental ill health, exploring the role of third sector organisations, community groups and understanding power dynamics between statutory and community-based organisations is central to work that must be carried out by IAPT and psychological therapy services.

This paper will provide practical ways that clinicians who practice CBT can engage and adapt their work for Black, Asian and Minority Ethnic communities. This can support one to one, group and also community based engagement.

A comparison between patients’ and clinicians’ opinions about the importance of CBT techniques – Results from a multi-cultural sample

Maria Elena Hernandez Hernandez, University of Sheffield; Glenn Waller, University of Sheffield

Cognitive behavioural therapy (CBT) has shown positive results for the treatment of several psychological disorders. However, CBT is not always effective. CBT’s effectiveness can be compromised by some clinician-related factors. Clinicians tend to underuse or omit some of the most demanding techniques of CBT. Such technique omission, conceptualized as ‘therapist drift’ (Waller, 2009) can be exacerbated if the clinician is anxious, or if they perceive their client as ‘fragile’ or ‘vulnerable’. Some concerns have also been raised about the generalizability of CBT’s effectiveness, given its Anglo/European origins. To address this, researchers and clinicians have recommended adapting therapy for patients from different cultural settings. However, there is a possibility that such adaptions can be over-used, or that these adaptions are not ones that the patient would want or need. Therefore, the main aim of this study was to explore the level of agreement about the important aspects of CBT according to both the patients’ and the clinicians’ perspectives, and to address how cultural background plays a role in such preferences.
To achieve the aims of this research, two groups of participants were approached – a group of clinicians (n=83) and a group of CBT patients (n=167; 52.6% Anglo/European). An online survey with a list of 18 techniques commonly used in CBT was developed for each group, where they indicated the importance they attributed to the techniques. Additionally, clinicians completed an anxiety measure, while non-Anglo/European patients completed an acculturation measure. The data were analysed with a combination of t-tests and correlational analyses.

Patients and therapists had different opinions regarding the importance of several CBT techniques. Clinicians valued all the 'behaviour change' techniques and several 'cognitive-relational' techniques more than the patients did. However, clinicians considered all the techniques equally important for both Anglo/European and non-Anglo/European patients. Highly anxious clinicians attributed a lower importance to techniques such as 'behavioural experiments' and 'exposure'. Patients from non-Anglo/European origins had a higher preference for 'behaviour change' techniques compared to Anglo/European patients. Finally, highly acculturated patients from non-Anglo/European origins considered a wider range of techniques to be important.

In conclusion, planning the therapy in collaboration with the patient and discussing the rationale for the techniques used is encouraged. Clinicians are also encouraged to consider acculturation before modifying CBT, as acculturated patients might consider such modifications less necessary.

Acknowledging the discrepancies regarding what clinicians and patients consider important within CBT, and working towards reducing such discrepancies, might improve some aspects of therapy (e.g. retention rates, increase patients’ satisfaction, and even therapy fidelity).

**The Impact of an Integrated LTC IAPT Service on Healthcare Utilisation and Wellbeing**

Angela Cooke, NHS (LIFT Psychology); Aileen McArthur, NHS (LIFT Psychology); Jon Freeman, NHS (LIFT Psychology); Lucy Kozlowski, NHS (LIFT Psychology)

IAPT identified a need to integrate support for long-term physical health conditions (LTCs) into IAPT services (National Collaborating Centre for Mental Health, 2018). This is important for many reasons, including the fact that long-term health conditions take 70% of the healthcare budget (Five Year Forward view, 2014). Farrand and Dickens (2012), highlighted the likelihood of increased prevalence of LTCs due to an aging population in England and unhealthy lifestyle choices, which further raises the importance of looking at long term health conditions in a way that could help to reduce the pressure on the NHS and make treatments offered as effective as possible. Naylor et al (2012), found that 12–18% of NHS expenditure for long-term conditions links to mental health. This is an important link to highlight as it provides a rationale for the incorporation of mental health services, such as IAPT, into an integrated approach with physical health. Depression has been found to be two to three times more likely to occur in people with CHD (Gunn et al, 2010) and diabetes (Vamos et al, 2009), than in the population without CHD or diabetes. COPD has also been found to be linked with increased rates of panic than those without COPD (Livermore et al, 2010). The increased rates of depression and panic in these conditions illustrates the relationship between physical and mental health and raises questions of whether having a mental health problem can increase the likelihood of having various health conditions, or if certain health conditions increases the risk of developing mental health difficulties. There are a variety of confounding factors that affect that relationship between physical and mental health, some of which include an individual’s socio-economic status or gender; as well as behavioural factors that may occur. For example, an individual’s coping strategies for a mental health problem may include a lack of motivation, which could affect attendance of medical appointments or a withdrawal from activities that could lead to a reduction in physical activity, which in turn can impact physical health (Farrand and Dickens, 2012).

There is therefore a need to offer evidence-based interventions to this client group, however, research in this area has been limited. Whilst there have been few trials on the effectiveness of psychological treatments for LTCs, findings have been encouraging (Coventry et al, 2015). Dickens et al (2013) conducted a systematic review and meta-regression, which found CBT
to be a significant factor in improving depression in people with CHD; thus supporting the integration of people with LTCs into IAPT services. This paper helps contribute to the evidence base for the use of CBT in LTC populations as it demonstrates the impact of an integrated LTC IAPT service on both health care utilisation and client wellbeing.

As an early implementer of the integrated IAPT project, LIFT Psychology developed care pathways from physical healthcare settings. This focused on clients with diabetes, COPD, CHD and long-term pain accessing CBT based psycho-educational courses or one-to-one CBT appointments. The interventions offered included both low and high intensity CBT and adhered to NICE guidelines. A collaborative approach was adopted and adjustments made to accommodate any limitations of the long term health conditions. These adjustments were informed by training received from Exeter University, specifically for working with long term conditions at both low intensity and high intensity CBT. Clinicians received supervision from a Clinical Psychologist specialising in LTCs.

To develop the integration with physical healthcare and foster good relationships, LIFT Psychology attended a monthly drop-in service for diabetes, which is also attended by dietetics and nursing. A Clinical Psychologist from LIFT Psychology attended a consultant led, community based multi-disciplinary diabetes clinic for people with diabetes who are experiencing poor glycaemic control and have been difficult to engage due to motivation and involve individual care planning. Training was also offered to cardiac, diabetes, COPD and pain teams on areas such as motivational interviewing as well as sessions that helped enhance staff understanding of mental health conditions. These were delivered by Clinical Psychologists. The effectiveness of this project was measured by healthcare utilisation using the Client Service Receipt Inventory (CSRI; Beecham & Knapp, 2001), as well as DESC0 (Data Services for Commissioners Regional offices) analysis, linking to nationally held data records. There were also high levels of client acceptability for this integration of care, recovery rates were also examined.

Results from this pilot project show a correlation between the integrated LTC pathway and a healthcare cost saving of £763,822.92 per 1000 people seen. This represents an estimated saving of £3.60 for every £1 invested into this pathway. Whilst this is a significant saving, it should be noted that it is not possible to draw a causal relationship from the data available.

Due to targets around service delivery, a matched control sample was not possible for the project. In spite of these limitations, this project shows support for an integrated LTC IAPT service. Client recovery rates were encouraging; CHD- 59.6%; COPD- 47%, insulin dependent diabetes- 39.5%, non-insulin dependent diabetes- 49.3%, pain- 34.9%. The mean recovery rate across conditions was 46.06%.

The results of this pilot project show support for a cost saving argument for integrating LTCs into an IAPT service as the utilisation of various healthcare services decreased in the period of initial contact with LIFT Psychology and the three month follow up period post-interventions. Whilst it is not possible to identify causal factors in this, it could be suggested that engagement with CBT helped improve self-management of the conditions, and may have meant that multiple healthcare appointments were not necessary or were more effectively utilised. Factors that could be involved in this may include interventions that boost individual’s mood helped with things such as adherence to medications or lifestyle advice given to them by medical professionals. The CBT approach involved therapists acknowledging a client’s stage of change (Diclemente and Prochaska, 1998), which in turn informed interventions. This may have led to an increase in feelings of client empowerment when managing with a long term health condition, thus improving self-management.

The recovery rates found for clients show that CBT can be a useful intervention for this client group. It also highlights the need for further research into the factors that affect recovery rates for LTC populations that are not present in non-LTC populations.

It is important to reflect on the factors that enabled the development of this integrated pathway as many barriers needed to be overcome in order to make the integration possible. A crucial part of this project was the development of good relationships with physical health teams to develop referral pathways. It was found that in order for referrals to be made, or for clients to be encouraged to self-refer, then physical healthcare teams needed to understand the benefits a CBT service could offer.
This project has implications for the way in which IAPT offers psychological support to those with long term health conditions and supports the integration of LTCs into IAPT services. It supports the collaborative approach of CBT, which has everyday applications to clinical practice. Further research in this area would help to strengthen the evidence base for utilising CBT with long term health conditions, which can help to shape the way in which CBT is delivered and accessed in the future.

Learning that can be taken forward from this pilot project also includes the ways in which referral pathways are developed. A question to be taken forward may be whether the responsibility for developing these referral pathways sits solely with IAPT services, or whether it would be useful for there to be a reflection of the integration of physical and mental health care for LTCs at a commissioning level for all teams involved.

The integration of LTCs into an IAPT service has been associated with a reduction in healthcare utilisation across the NHS services in Swindon, which in turn has shown large cost savings of £3.60 per £1 invested in the integrated pathway. This reduction in healthcare utilisation suggests improvements in self-management of LTCs, as well as improvements in the wellbeing of these clients. The benefits observed for the individuals engaged in this pathway provides a good rationale for applying a CBT approach to those with long term health conditions, within an IAPT service.

As a result of these findings it can be said that future development of integrated pathways for LTCs in an IAPT service appears to be helpful for both individuals and services.

**Carer Coping after First Episode Psychosis: Types, prevalence, and demographic and clinical predictors**


Caregiving coping at first episode psychosis (FEP) may play a crucial role in a range of Carer and patient positive and negative emotional outcomes. However, previous coping research has involved samples which are small or which lack ethnic diversity, and which have tested very few demographic or clinical sample predictors of the coping in the same sample. This limits Early Intervention services capacity to understand what Carers are doing to cope, which Carers are doing what types of coping, when they are doing it (e.g. caring length), and in what circumstances (e.g. patient characteristics). The present study therefore aimed to illuminate the prevalence and predictors of different types of Carer coping after FEP, in a more thoroughly characterized sample which is the largest and most ethnically diverse sample in the world to date.

A cross-sectional design was employed to investigate coping in informal Carers (n=254) of FEP patients (n=198) in a London, United Kingdom Early Intervention in Psychosis service. All participants completed the Brief COPE inventory (Carver, et al., 1989; 1994) which assessed 15 types of coping, including typically less adaptive Avoidant coping methods. Furthermore, 17 Carer and patient sociodemographic and clinical variables were collected to investigate whether they predicted Carer coping strategies. Carers’ Coping frequency was divided into Low (never/rarely) and High (sometimes/a lot). Mixed Model Logistic Regression was used to identify independent predictors of the 15 types of coping. Carers were mainly (66.7%) non-White and middle-aged (m=49 years). Patients were young (m=23 years), early course (m=18 months), with a short duration of untreated psychosis (m=3.5 months). The frequency of the 15 coping styles was calculated. High use of Behavioural Disengagement Avoidant coping was already common (25%). Mixed model logistic regression analyses tested 17 sample predictors with 15 types of coping. Analyses found that seven Carer sociodemographic and patient clinical variables, including different
Carer religions, and different Carer ethnicities, as well as patient diagnosis, independently predicted six of the 15 types of coping. Our findings have theoretical implications for cognitive models of caregiving that further characterises how Carers cope after FEP. For example, a coping branch of a cognitive model specifically of caregiving at FEP. Our results also have therapeutic implications for Cognitive Behavioural Family Intervention cultural sensitivity that aims to promote adaptive coping mechanisms and prevent entrenchment of any emerging less adaptive coping. After FEP Carers’ do vary markedly in their coping behaviours and this variation is predicted by demographic and clinical factors which can be used to identify Carers with less adaptive coping and guide focused CBT individual and family interventions to improve coping. At FEP carers are already behaviourally disengaging from the patients they care for and some are even turning to alcohol and drugs to cope with the new caring role. Therefore, intensive CBT coping training is recommended for these carer. Intervention is particularly indicated if certain demographic or clinical factors are present in the caring situation. Early Intervention Cognitive behavioural family intervention coping therapeutic targets can also be informed by this new empirical coping data.

**What predicts recovery in IAPT Services?**

Irini Laura Verbist, IAPT, Greater Manchester Mental Health; Dale Huey, IAPT, Greater Manchester Mental Health; Hazel Bennett, IAPT, Greater Manchester Mental Health

Improving Access to Psychological Therapy (IAPT) services deliver evidence-based talking therapies, for common mental health disorders, to people throughout England. In 2017-18 over 1.0M attended at least one appointment, and more than 0.5M people, from 197 Clinical Commissioning Group (CCG) areas, completed therapy. Publically available data show considerable variation in treatment effectiveness between CCG areas. In order to better understand factors contributing to such variability we evaluated the relationship between demonstrated clinical effectiveness (recovery) and service- and client-related factors within our own IAPT services.

Data from a cohort of cases (n=1,333) from three CCG areas was collected as part of a routine service evaluation. Cross-tabulations and chi-square for significance, were performed to establish significant associations and differences between variables. A hierarchical logistic regression model was developed, using the service-related and client-related variables independently associated with recovery from anxiety and depression, to predict IAPT defined recovery.

A number of significant differences were found between client-related variables and recovery status. More specifically, increased recovery rates were found among those with a planned ending (62.2% recovered) in comparison to those deemed to have completed (attended two or more appointments involving therapy) but who had an unplanned ending, i.e. dropped-out (22.5% recovered); those who were employed (63%) in contrast to the unemployed (30.3%); and among clients rated, at their first session, as having high motivation to change (65.6%), in comparison to those perceived to have low motivation (30%). Our predictive model accounted for 34.8% in recovery variance. Six variables, three service-related and three client-related, contributed to the model. Time waited to enter treatment, number of previous IAPT referrals, unemployment and high number of presenting problems were negatively associated with recovery. Number of treatment sessions and high client motivation were positively associated with recovery.

Although low recovery for those with an unplanned ending was not surprising, the unexpected low recovery rates amongst unemployed service-users raises questions about how best to help this cohort of clients. Findings on service-related variables, that jeopardise recovery, are compatible with previous research within IAPT and highlight the importance of the way that psychological therapy services are delivered. A central finding of this study is the strong relationship between early motivation to change and eventual clinical effectiveness. Further assessment of motivation, using validated questionnaires, and investigation of how best to influence motivation over the course of treatment, is indicated.

A number of variables show clear relationships with recovery within our IAPT services. The strength of these relationships, and the underlying variability in demonstrable benefit,
warrants consideration of how best to adjust the process of therapy to better engage and enable all our clients to make the most of the opportunities available. Routine monitoring and evaluation of the needs of all service users, and how well they are being met, is important for delivery of high quality psychological therapy services. The results emphasise the importance of routine evaluation of variation in outcome in order to adapt treatment to individual needs.

Panel Debate: Research Clinics: What are They, What are They For, and What Next?

Kim Wright, University of Exeter; Barney Dunn, University of Exeter; Blake Stobie, South London and Maudsley NHS Trust; Catherine Gallop and Fin Williams, University of Exeter

Ray Percy, University of Reading

Over the past decade in particular, embedding research within the NHS has been a priority at a national level. Within the field of psychological therapies research there remain a number of challenges in supporting innovation. These include facilitating early-stage therapy development in a busy NHS system, maintaining high levels of fidelity in therapy delivery and supervision during evaluation, and when and how to disseminate the insights from innovation into clinical practice. Research clinics, often representing partnerships between academic institutions and the NHS, are a means of addressing some of these challenges. In this discussion leads from four research clinics (Adult and Young Persons’ AccEPT services, Exeter; AnDY research clinic, Reading; Centre for Anxiety Disorders and Trauma, London) will describe their service in terms of its mission and operation, what it delivers, and how it became possible. Discussion will focus upon lessons learned from these examples, what research clinics can and cannot offer research and patient care agendas, and what contribution they can make to the future of innovation in psychological therapy.

This debate will be of interest to practitioners working in research-facing settings, or who are curious about working as a trial therapist. It will also be of relevance to service leads and clinical academics who would like to develop platforms for clinical research.

Developments in CBT for Depression and Anxiety

Improving Outcomes in Group Behavioural Activation for Depression

Mel Simmonds-Buckley, University of Sheffield; Stephen Kellett, University of Sheffield; Glenn Waller, University of Sheffield

A considerable number of patients do not benefit from therapy, highlighting much more could be done to improve treatments. This project investigated whether attendance and clinical outcomes could be improved during the delivery of group behavioural activation. A practice-based sample was used to compare historical routine outcomes of an extant 8-session Behavioural Activation Group (BAG-) treatment with the delivery of an augmented version of BAG treatment (BAG+). BAG+ patients (N=31) were matched to BAG- patients (N=31) using propensity score matching. BAG+ was augmented with 1) dose-response psychoeducation targeted at increasing attendance and 2) ‘implementation intentions’ targeted at increasing between-session work compliance.

Attendance and improvements in functioning did not differ between the two BAG treatments, but significantly greater reductions in depression and anxiety were observed for BAG+. Significantly fewer patients failed to benefit from BAG+ treatment, due to increased rates of reliable improvement or full recovery.

Results support the effectiveness of BAG for depression, but shows treatment can be further enhanced to produce better outcomes. Meaningful benefits for individual patients were produced through small, easily implementable tweaks to an effective current intervention, without the need for large-scale changes, expensive developments or new therapies.

Findings advocate the augmentation of extant treatments as a simple and direct method of
improving outcomes. Future research should aim to identify low-cost theory informed strategies to enhance outcomes. Existing theory can be used to make treatments that we know work clinically, work better. Empirically supported strategies would be easily implementable by clinicians on the front line, allowing patients to experience benefits quickly. Small tweaks to clinical practice can produce meaningful benefits for patients.

A Randomised Feasibility Trial of a Low Intensity Intervention for Depression in Adults with Autism: The Autism Depression Trial (ADEPT)
Ailsa Russell, University of Bath; Stephen Barton, Newcastle Cognitive and Behaviour Therapies Centre; Kate Cooper, University of Bath; Daisy Gaunt, Bristol Randomised Controlled Trials Centre; Ian Ensum, Avon and Wiltshire Mental Health Partnership NHS Trust

High rates of co-occurring depression have been reported in Autism. Clinical guidelines recommend 'low intensity' psychological treatment based on cognitive behaviour therapy (CBT) as an effective treatment for mild-moderate depression. If adapted, CBT has been found to be effective in treating anxiety problems in children and adults with Autism. There has been less research into the usefulness of CBT as a treatment for co-occurring depression in Autism; several studies of group CBT showing mixed findings and no randomised controlled trials of individual, low-intensity CBT. There is a need to consider the feasibility of low intensity CBT for depression adapted for adults with Autism. The present study investigated the feasibility of adapting low intensity CBT for depression to meet the needs of autistic adults via a pilot randomised controlled trial (RCT) with a nested qualitative study. The adapted intervention (Guided Self-Help; GSH) based on Behavioural Activation comprised materials for 9 individual sessions with a graduate level psychological therapist. Autistic adults (n=70) with depression (PHQ-9 score ≥10) recruited from NHS adult autism clinics and volunteer research databases were randomly allocated to GSH or Treatment as Usual (TAU). There were no constraints on TAU. Outcome measurement, by researchers blind to treatment group, was 10, 16 and 24 weeks post-randomisation with 16 weeks presenting a practical treatment window. The analysis aimed to establish the rates of recruitment and retention for a larger scale RCT as well as the most appropriate measure of depression to serve as primary outcome.

Rates of retention in the study differed by treatment group, with more participants attending follow-up in the GSH group than TAU. The adapted intervention was well-received, 86% (n=30/35) of participants in GSH attended the pre-defined 'dose' of treatment and 71% (25/35) attended all treatment sessions. The findings of this pilot RCT indicate that low intensity CBT informed by Behavioural Activation can be successfully adapted to meet the needs of autistic people. Evaluation of the effectiveness of this intervention is now warranted.

Low intensity interventions for depression can be adapted to meet the needs of autistic people.

Comparing the impact of exposure without safety behaviours to exposure with safety behaviours on behavioural change in contamination fear
Francesca Muccio, Institute of Psychiatry, Psychology and Neuroscience; Blake Stobie, Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Trust; David Veale, Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Trust; Despite the evidence for the efficacy of exposure for anxiety, in clinical practice the dropout rates are high. Rates of refusal and drop out for exposure-based treatment range between 20% to 43% for OCD (Foa et al., 2005). Given their role in the maintenance of pathological anxiety, an argument has traditionally been made for the elimination of safety behaviours during exposure therapy. However, Rachman, Radomsky and Shafran (2008) presented the argument that the judicious use of safety behaviours during exposure could in fact increase acceptability, and therefore be beneficial for treatment gains. From a cognitive theory perspective, safety behaviours have been shown to prevent the disconfirmation of feared outcomes, and their use is regarded as detrimental to therapeutic
effectiveness. Despite these theoretical concerns, similar levels of fear reduction have been found in anxious individuals, following exposure either with or without safety behaviours. Studies focusing on contamination fear have shown that exposure with safety behaviours can be as beneficial as exposure without in terms of reducing anxiety and feelings of contamination (Rachman et al., 2011; van den Hout et al., 2011; van Uijen et al., 2017). Overall, however, the findings in this area remain mixed. A recent meta-analysis did not find conclusive evidence either for or against the inclusion of safety behaviours during exposure (Meulders, Van Daele, Volders & Vlaeyen, 2016). A review by Blakely and Abramowitz (2016) concluded that even though safety behaviours do not always hinder the beneficial effects of exposure, they can interfere with the therapeutic effects.

One of the reasons cited in the reviews for the mixed findings is the inconsistency in study design and methodological issues, making it difficult to draw firm conclusions for or against the use of safety behaviours. Many studies examining the impact of safety behaviours in exposure for contamination fear have used emotional change, mainly reduction in fear, as the key outcome (e.g. van den Hout et al., 2011; van Uijen et al., 2017). Indeed, this is in line with exposure theory in terms of the aim for habituation to anxiety but has been criticised by other models such as Craske’s Inhibitory Learning (Craske et al., 2008).

In clinical practice, successful change in therapy is often defined in terms of both distress reduction as well as functional improvement. Thus, it is important to consider whether incorporating safety behaviours in exposure-based therapy leads to behaviour change as well as improvements in anxiety.

Forty-five participants with contamination fear were randomly assigned to one of three conditions: exposure plus safety behaviours, exposure without safety behaviours, or no-exposure control group. Participants in the exposure conditions undertook a single session of exposure to a contamination related stimulus. All three groups were measured on ratings of contamination fear, as well as number of steps taken on a contamination-based behavioural approach task (BAT) at post-exposure and at a two week follow up, controlling for scores at baseline. Subclinical participants who scored high on the contamination subscale of the Vancouver Obsessional Compulsive Inventory (Radomsky et al., 2016) were invited to attend. Of these, 46 participants gave written informed consent and were randomly assigned to one of the three groups. One participant was excluded after baseline assessment, as they had been able to complete the whole task.

Both the BAT and the exposure sessions took place in a public bathroom located in a university building. This included a toilet and a sink. Participants were asked to complete up to 14 BAT steps of progressively increasing difficulty. The first seven BAT steps required touching the toilet seat with: one finger, one hand, two hands, two hands followed by touching arms, two hands followed by touching hair, two hands followed by touching face, two hands followed by touching lips. The following seven BAT steps involved touching the inside of the toilet seat, with the same seven stages as with the first seven.

Following randomisation, the two exposure groups took part in a single session of exposure, whilst the control group waited for half an hour. All groups were told that they would be retested on the BAT afterwards, where they would not be able to wash their hands. The participants in the two exposure groups were instructed to touch the exposure stimulus with the target exposure step across 5 exposure trials of 3 minutes each. The last step completed on the baseline BAT was the first target step for exposure.

Following the exposure, or wait, all participants completed the BAT again. They were then invited to attend a follow up session two weeks after, in which they were given the same post-exposure instructions.

All three groups demonstrated decreases in ratings of fear at post-exposure and follow up, compared to baseline. Across the groups, the reduction in fear was statistically significant post exposure compared to baseline (M = 25.79, SE = 3.32, p < .005) and at follow up compared to baseline (M = 27.46, SE = 3.32, p < .005). Despite there being a large effect size, there was not a statistically significant difference in mean fear ratings between intervention groups F(2, 37) = 2.31, p = .113, partial η2 = .111.
All participants were instructed before completing the BAT they would not be able to wash their hands afterwards. However, 35 participants (78%) refused this instruction after completing the BAT at post exposure, and 33 (81%) refused at follow up and were unable to leave without washing their hands. Following the post exposure BAT, only one participant in both the exposure plus safety behaviour group and the control group (7% of each group) completed the instructions and left without washing their hands, compared to eight of the exposure without safety behaviours group (50%). At follow up, one participant (7%) in the control group and seven of the exposure without safety behaviours group (47%) were able to leave without washing. In contrast, none of the exposure with safety behaviours group were able to leave without washing at follow up.

The finding that both exposure groups experienced a similar reduction in ratings of fear and contamination is consistent with previous studies (Rachman et al., 2011; van den Hout et al., 2011; van Uijen et al., 2017). It was also hypothesised that the exposure without safety behaviours group would demonstrate a greater increase in steps taken on a behavioural approach task following a single session of exposure, than a group who had received exposure plus safety behaviours and a control group who had received no exposure, and that this would be maintained at follow up. The findings of the current study did not conclusively support this hypothesis. Whilst both exposure groups demonstrated significant improvements from pre to post compared to the control group, there was not a statistically significant difference between the two groups.

Whilst there was no significant difference between the exposure groups on behavioural approach, the hypothesis in its entirety specified ‘when no safety behaviours can be used’. As highlighted in the results section, 78% of the participants refused to leave the experiment without washing their hands post exposure, and 81% refused this at follow up, despite the instructions clearly stating this at the start. Had there been no option to wash following the BAT, it may be that those who refused to leave without washing would have completed less steps in the first place. This would have meant a greater difference in behavioural approach between those who had used safety behaviours during exposure and those who had not.

Consistent with previous literature, this study found that exposure with safety behaviours does not prevent a reduction in contamination fear, nor prevent an increase in behavioural approach. However, when safety behaviours can no longer be used, participants who had undertaken exposure without safety behaviours were more able to complete the task.

The findings of the current study provide support for those in previous studies, that the inclusion of safety behaviours in a single session of exposure does not prevent significant reductions in contamination fear (Rachman et al., 2011; van den Hout et al., 2011; van Uijen et al., 2017). As concluded in such studies, one could suggest this implies support for the consideration of the judicious use of safety behaviours in exposure, as it still leads to significant reductions in anxiety at post assessment and also at follow up. Furthermore, the two exposure groups did not significantly differ regarding behavioural approach at post exposure and at a two week follow up. One the one hand this could imply further support for the inclusion of safety behaviours in exposure.

However, when you consider the results in conjunction with the finding that significantly more of the exposure without safety behaviour group were able to leave without washing their hands, it is arguably the more successful intervention group in this study. It may be that, in line with Inhibitory Learning Theory (Craske et al., 2008), the exposure without safety behaviours group demonstrated an increased tolerance of fear – in terms of their ability to leave the situation without trying to reduce their anxiety. It is important for clinicians and researchers to consider the difference between increasing approach behaviour during exposure, and the long-term effects regarding ability to tolerate distress. The results have implications clinically as to what is being aimed for in a ‘good’ outcome. In clinical practice, exposure response prevention in the context of cognitive behavioural therapy is often aimed at improving functioning, and around the setting of behavioural goals (NICE, 2005). Also, arguably specific to OCD, the compulsions themselves can cause distress (e.g. washing for long periods). Therefore, it may be more pertinent to consider the ability to
complete tasks without feeling as though safety behaviours have to be used in the context of OCD compared to other anxiety disorders.
The finding that many participants refused to leave without washing has interesting implications for clinical practice. It raises the question of 'when does exposure end'. It might have been that had there been no option for the group to wash following the BAT, then those who refused to leave without washing may well have been able to complete less steps. This also has implications for previous studies that have used BATs, and whether participants used safety behaviours immediately following the end of the study. It also has implications for clinical practice of CBT in terms of considering with clients explicitly when exposure ends (i.e. are they holding in mind they will wash their hands after the session).

A 'Making Friends with Uncertainty' Group Intervention
Layla Mofrad, Talking Helps Newcastle; Ashley Tiplady, The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Intolerance of Uncertainty (IU) has been identified as a psychological process which operates across a range of anxiety disorders. Individuals high in IU have a tendency to experience uncertain situations as aversive and often take a range of steps to reduce uncertainty in their lives, which may make them more at risk of experiencing anxiety disorders. The presence of common processes across multiple diagnostic categories has raised interest in recent years in the development of approaches which can be applied 'transdiagnostically'. It is thought that targeting one underlying process, such as IU, could have positive impacts across a range of symptoms of specific disorders. IAPT services are increasingly using groups to increase efficiency.
13 participants were recruited from a primary care service in the North of England. Participants presented with a range of anxiety disorders (excluding PTSD) and comorbidity. The group intervention was based on a framework from an earlier study developed by an expert group which sought to identify and target IU in individuals with presentations of one or more anxiety disorders and was entitled 'Making Friends with Uncertainty'. The group was delivered by a CBT therapist and a Clinical Psychologist, both with an interest in IU. By targeting Intolerance of Uncertainty, rather than perception of threat as is more common in CBT based interventions, participants were encouraged to experience uncertainty across various life domains, which were then expected to generalise into symptomatic improvement across a range of presenting problems.
12/13 participants who attended the sessions showed improvement on the GAD-7, with 11 also showing improvement on the PHQ-9. Of these, 6 reduced to subclinical levels on the GAD-7. Change was also seen on the IUS-12 measure of Intolerance of Uncertainty, which suggests that the intervention is indeed directly targeting IUS as predicted. Qualitative feedback suggests that the group intervention was acceptable to participants, even when Uncertainty was not initially identified as the presenting difficulty. Retention rates in the group were high and 11 of 13 participants required no further intervention on conclusion of the group.
The Making Friends with Uncertainty group was appealing to the IAPT service it was trialled in with the transdiagnostic aspect making it a good option for people with co-morbid anxiety presentation, in contrast to other disorder specific groups offered in the service. There is less requirement to be exact about which difficulty is the primary presenting problem, making this intervention appealing to clinicians completing brief screening assessments, and is reflective of the realities of clinical practice, in which co-morbidity is common.
A targeted group intervention focussing on Intolerance of Uncertainty appears to be an effective and acceptable stand-alone intervention for individuals presenting with a range of anxiety disorders presenting to Primary Care services. Targeting a common process means that the specificity of treatment can be retained in the face of disparate presentations.

Testing Differential Effects of Attention and Acceptance-Based Psychological Interventions with Longitudinal Experience Sampling in High Worriers
Liam Williams, University of Southampton; Ben Ainsworth, University of Bath; Alex Milton, University of Bristol; Matt Garner, University of Southampton

Negative elaborative thought processes such as worry and rumination are key transdiagnostic features within a range of mental health conditions including anxiety and depression (Watkins, 2015). Such ‘mind-wandering’, i.e. thoughts that are decoupled from current environment and activity – is associated with lower mood and worse negative affect in healthy individuals and particularly people with anxiety and depression (Ruscio et al., 2015). Mindfulness-based interventions (MBI) may manage worry-related symptoms in anxiety and depression by encouraging sustained attention to the present moment and acceptance of private experiences, reducing experiential avoidance. This study used digital experience-sampling methodology (ESM) to explore how attention and acceptance-based mindfulness components reduced worry and negative affect over 21 days of mindfulness practice (vs active progressive muscle relaxation [PMR] control).

75 participants with high worry completed baseline measures of worry (PSWQ; Brown et al., 1992), anxiety (GAD-7; Spitzer et al., 2006) and depression (PHQ-9: Kroenke et al., 2001) and were randomised to 18-day interventions of attention-based mindfulness, acceptance-based mindfulness or progressive muscle relaxation control (10 minutes daily practice). Every day at 6 time points (8am, 11am, 1.30pm, 4.30pm, 6.30pm and 8.30pm) participants were asked to complete online measures regarding 'future oriented negative thought intrusions (i.e. 'Is your mind wandering?' and if yes 'Was the thought related to the past or future?' as well as measures of anxiety and mood). Participants recompleted baseline measures at 21-day follow-up.

Mixed design ANOVA examined baseline vs. follow-up differences in worry, anxiety and depression across groups. For worry scores, a group x time interaction (F(2,72)= 3.268, p = .044, ηp² = .083) was subsumed by reduced follow-up worry in the acceptance group compared to PMR and attention (F(2,72)= 3.268, p = .025, ηp² = .097) with no differences in baseline worry. There were no group differences in baseline-follow up comparisons of anxiety or depression.

Mixed linear models explored the effects of intervention group and time on future-oriented negative thought intrusions (FONTs) and mood. There was no impact of group on FONT frequency (F(2,7146.499) = 0.414, p = .661), but in both acceptance and attention groups we observed a reduction in anxiety associated with FONTs vs. no change in PMR associations (F(2,4446.757) = 4.533, p = .011). There were no group differences regarding non-negative, non-future oriented intrusive thoughts.

As predicted, follow-up measures of worry were lower in people who practiced acceptance-based mindfulness vs. attention-based mindfulness and PMR. Notably, our novel ESM design suggests that these reductions in trait worry may be due to less momentary anxiety associated with worrying thoughts, rather than any change in the frequency of such thoughts. Although limited by low response rate, these findings can inform the components in mindfulness-based interventions that target transdiagnostic worry processes. By identifying efficacious intervention components, mindfulness interventions can be optimised and refined to increase effectiveness (as well as identifying individuals who are likely to benefit from specific techniques).

Clinical Skills Classes

The WISER MIND Model of Cognitive Behavioural Resilience and Therapy: A Method to Build Resilience and Treat Psychological Disorder

Rufus Harrington and Karen Taylor, University of Cumbria

Resilience is a growing topic of research interest in fields as diverse as psychology, education, and business. The 2018 meta-analysis of CBT/mindfulness resilience studies suggests resilience training can, with some caveats, demonstrate a moderate effect size.
The WISER MIND resilience process, is inspired by this previous research and is a development which can be used with individuals and groups. It can train resilience and treat psychological disorder. Using the process integrated with standard evidence based CBT skills, has helped achieve an over 90% recovery rate with individuals referred to the Cumbria police occupational health unit. This usually achieved in 3 to 8 sessions. Typical presentations including PTSD, GAD, and Depression.

The process borrows from emotional processing theory, neurobiological ideas related to the integration of cortical and emotional centres of the brain, attentional training, mindfulness, Dialectical Behaviour Therapy, compassionate mind, guided discovery and cognitive restructuring. However, it does so in such a straightforward way that the process is very easy to use, very easy to teach, patients really like it and usually find it immediately effective. Patients like using it for homework. It works in the real world of routine clinical practice and can be easily integrated with other CBT skills.

This skills workshop will teach participants how to use the foundation skill of the WISER MIND model to support their own resilience and how to use this skill in clinical practice. The skill teaches a person how to better integrate the emotional and thinking brain allowing a metacognitive state of mind/being to emerge that we call the WISER MIND.

Learning Objectives: By the end of the class, participants will be able to:

1. Understand the theoretical underpinnings of the WISER MIND model
2. Have viewed preliminary outcome data.
3. Been shown a video, and workshop demonstration, of the model in practice.
4. Have the opportunity to use the Model on themselves to enhance personal resilience.
5. Have the opportunity to use the Model with other workshop participants to learn how to use the model for clinical practice.

The potential implication for the everyday practice of CBT are:

1. This may be a very real way to improve clinical outcomes. The method has helped achieve a 90% recovery rate in an Occupational Health Unit (OHU) Clinic setting.
2. We have some evidence that CBT lecturers and CBT Supervisees taught the method have improved their clinical outcomes.
3. The method may be able to help practitioners get good results more quickly. At the Cumbria Police OHU clinic recovery is being mostly achieved in 3-8 sessions.
4. At a theoretical level the method provides evidence suggesting the value of integrating transdiagnostic methods of practice with more standard models of evidence-based practice.

The workshop is very enjoyable and includes:

1. A short 15 minute powerpoint presentation
2. A video demonstration of the method in practice with a patient.
3. A demonstration of the method by the workshop leaders.
4. Participants then use the method on themselves as a resilience building practice.
5. Participants then work in pairs using the method to practice the model’s clinical delivery. After each section of the workshop there will be opportunities for feedback and discussion. There will be a focus on helping participants integrate this process with established CBT skills.

The workshop is very practical. Participants will develop a concrete skill to take away from the training.

Rufus Harrington is IAPT Course Director at the University of Cumbria. He has contributed to and run 20 Postgraduate Diploma and Masters CBT training programmes, training over 250 CBT therapists. He is Consultant cognitive behavioural therapist to Cumbria Police where he is running an evaluation study of the WISER MIND Process for a PHD.

Karen Taylor is a lecturer in CBT teaching on the Cumbria IAPT programme. She has 20 years experience in the NHS and private CBT practice. She has worked with Rufus training the WISER MIND process with BAE Systems, Schools and the Army Medical Service Brigade.

Background readings:


“Turning Intentions into Actions”: CBT for Adult ADHD

Russell Ramsay, University of Pennsylvania Perelman School of Medicine, USA

A common problem in the treatment of adult Attention-Deficit/Hyperactivity Disorder (ADHD) is that, in addition to the myriad of functional impairments reported by clinic-referred adults, the disorder itself interferes with follow through on and consistent use of treatment recommendations, particularly the very coping skills that are central to the effective management of ADHD. In fact, adults with ADHD will often state that the crux of their frustrations is that they know what they need to do but are nonetheless unable to turn their intentions into actions. Existing diagnostic criteria do not fully capture the underlying problems related to the self-regulation, motivational deficits, and deficient emotional self-regulation (which is distinct from common co-existing depression and anxiety) experienced by patients that result in these performance problems, nor do these criteria sufficiently inform psychosocial treatment, namely cognitive-behavioral therapy (CBT) for adult ADHD focused on the implementation of the necessary coping strategies.

The aims of this proposed full-day workshop are (1) to describe the clinical significance of the self-regulation difficulties, motivational deficits, and deficient emotional self-regulation associated with ADHD, including review of common life impairments that lead individuals to seek treatment, (2) to briefly review in a clinician-friendly manner the recent etiologic models that provide a comprehensive and integrative framework for understanding the often diverse clinical presentation of adults with ADHD, (3) present the components of a thorough diagnostic evaluation for adult ADHD, (4) to illustrate how these models help to inform psychosocial treatment, particularly how cognitive behavioral therapy (CBT) adapted to adult ADHD continues to evolve to target the impairments often interfere with treatment progress. In addition to reviewing how different CBT intervention domains (cognitive modification, behavioral modification, mindfulness-acceptance, implementation strategies) are adapted to adult ADHD, specific tactics designed to help patients implement the necessary coping skills outside the consulting room will be reviewed, including the role of cognitions as a ligament between intention and action, and (5) to illustrate many of these strategies using a video example of a CBT session with an young adult with ADHD. The common clinical issue of procrastination will be used to illustrate specific interventions that are used to help adults with ADHD be better able to consistently engage in important endeavors and manage the effects of ADHD symptoms on their functioning.

Learning objectives: At the end of the workshop attendees will be able to:
1. Summarize the executive function model of adult ADHD and its relevance for understanding ADHD.
2. Select at least one useful clinical inventory used in the assessment of ADHD relevant to their practice setting.
3. Recognize and summarize the premises about the nature of ADHD and psychosocial treatment that provide the basis for the CBT approach presented here.
4. Recognize the central CBT intervention target in each treatment domain: cognitive, behavioral, emotional, implementation, and interpersonal.
5. Leave the workshop with at least three (3) new implementation-focused strategies to use in practice.

OUTLINE (assuming a 7-hour day):
Hour 1: Introduction, review of contemporary model of ADHD, impairments, and ADHD as an “implementation” problem
Hour 2: Review of the components of a comprehensive diagnostic evaluation for adult ADHD
Hour 3: Review of medical treatments, review of CBT model of ADHD (including premises about ADHD and CBT conceptualization), research support, review of intervention domains and interventions (using procrastination as a clinical example)

Hour 4: Continued review of intervention domains (cognitive, behavioral, emotional, relationship, implementation) and interventions

Hour 5: Review of video of CBT sessions and discussion

Hour 6: Review of video of CBT session and discussion (continued)

Hour 7: Miscellaneous clinical issues encountered with adults with ADHD, Q&A

Teaching Methods: Lecture/presentation regarding clinical significance of difficulties encountered by adults with ADHD and the contemporary models that explain these difficulties and guide clinical interventions. Case examples focused on the clinical issue of procrastination and other examples of “disengagement” will be used to introduce clinical interventions domains within a CBT framework. A review of a video of a CBT session with an adult with ADHD conducted by the presenter (which is from the American Psychological Association’s Psychotherapy Video Training series) will allow attendees to observe and discuss of the interventions presented. Questions and discussions will be encouraged throughout the workshop and as part of the debriefing of the session video.

One of the principles of this CBT approach for adult ADHD is to turn “coping with ADHD” into manageable pivot points at which clients are better able to employ known coping strategies. Similarly, for practicing CBT clinicians, the model reviewed in the proposed workshop and example in the session video illustrate a model and approach for adapting CBT to adult clients with ADHD who by definition have difficulties organizing behavior across time, including outside the consulting room. Thus, it hopefully provides clinicians with useful take away skills.

A Brief Integrated Motivational Intervention (BIMI) for Psychiatric Inpatients Experiencing Co-Occurring Severe Mental Health and Substance Use Problems

Emma Griffith University of Bath and Alex Copello, University of Birmingham

People with serious mental health problems commonly experience difficulties associated with the use of alcohol and/or cannabis. This can lead to experiencing a number of problems that can impact significantly on their mental health, such as repeated hospital admissions. People with these challenges are also more likely to have problems with physical health and die much earlier. It can be very difficult for someone to reduce alcohol and/or cannabis use. Admission to a mental health hospital can provide an opportunity (a ‘teachable moment’) for people to reflect on their life and consider whether they want to make changes. This period of reflection gives staff an opportunity to talk to people about benefits of reducing their alcohol/cannabis use, including mental and physical health benefits. The Brief Integrated Motivational Intervention (BIMI) aims to use the ‘teachable moment’ to opportunistically respond by engaging in a motivational dialogue with people affected. BIMI is an evidence based structured cognitive/behavioural/motivational approach developed to help people in these circumstances. It involves short structured conversations with staff to help people reflect on the impact of alcohol and/or cannabis use on their life and how this may affect hopes and goals for the future.

1) To understand the background to the development of the approach (including briefly outlining the prevalence and clinical correlates).

2) To understand the theoretical background underpinning the development of the BIMI.

30 To have practiced skills from the BIMI, including both engagement and the development of a maintenance cycle.

Greater understanding of the prevalence and impact of experiencing co-occurring severe mental health and substance use problems.

Knowledge of the evidence base in the area and the application of cognitive behavioural and motivational techniques to engage and work with this client group.

The training modalities will include both didactic and experiential methods, including role play and small/large group discussion.
Emma Griffith: lecturer and clinical tutor at the University of Bath, and Head of Therapies/Consultant Clinical Psychologist for Specialized Services, AWP. Emma published a number of journal articles, and is co-author of a book chapter. A paper outlining the qualitative analysis of the BIMI evaluation won the Research Impact Award at the Bristol and Bath Health and Care Awards, 2018.

Alex Copello is professor of addiction research at the University of Birmingham, and a consultant clinical psychologist and Associate Director of Research with BSMHFT. He regularly published in academic scientific journals, and has authored and edited many books.


How Our Schemas Can Get in the Way of Treating Complex Clients: A Basic Clinical Skills Class to Improve the Therapeutic Alliance When Working with Complexity

Ruth McCutcheon and Saskia Ohlin, Academy of Schema Therapy and Private Practice

This is an evidence-based workshop aimed at exploring how, as mental health practitioners. The workshop provides an opportunity for CBT therapists to explore their own schemas to improve and deepen therapeutic alliances in working with clients who present with complexity (typically with axis 1 and 2 symptomology). Using a Schema Therapy framework, the workshop is based upon evidence which indicates that practitioners with greater awareness of their schemas and modes can learn skills to attend to their own needs and increase personal and professional wellbeing. This includes increasing self-compassion by understanding schemas and modes impact upon work with clients. The workshop will also address being able to access healthy modes to deal with unhelpful schemas which might interfere with therapy alliances.

• To bring schema therapy further recognition in the wider CBT community to expand the CBT knowledge base
• To demonstrate theory and concepts practical techniques in ST to retain the integrity of the model to promote good practice
• To further the role of research and empirical basis for ST in the CBT community
- To provide a conceptual framework for clinicians to work with clients across a spectrum of complex presenting issues including limited reparenting, empathic confrontation, imagery and chair work throughout the workshop.

We are accredited CBT and Schema Therapists and would provide a workshop to integrate theory and practice via experiential role play exercises Enabling practitioners to have a range of skills, practical techniques and tools to work with complex cases.


The Strong & Curious CBT Therapist. Using the Self-Practice/Self-Reflection Approach to Develop Self-Compassion 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 self-compassion and healthy self-doubt through constructive coping methods based on the self-practice/self-reflection approach.

1. Describe the process of self-compassion and discover effective methods for self-care
2. Understand the impact of negative self-beliefs and rule-governed behaviours that prevent reflective practice

Practitioners who attend this workshop will gain knowledge and skills to help them develop both professionally and personally. They’ll know both what and how to build their resilience so that they can thrive in a busy healthcare environment. By building in simple self-practice/self-reflection strategies, practitioners can learn from their mistakes and improve their own emotional well-being.

Learning will be facilitated through presentation, experiential methods, role-plays and reflective-practice exercises. The trainer will model self-care and healthy self-doubt to create a safe and open environment for participants to explore their own experiences.

Jim Lucas is a Teaching Fellow at University of Birmingham on the PG CBT Programme, BABCP Accredited Practitioner & Supervisor and ACBS Peer-reviewed ACT Trainer. 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.


Whitney Scott, King’s College London

No individual abstract provided.
Assessment, Case Analysis and Intervention Skills: The Enhancing Parenting Skills Programme for Working with Parents of Children with Challenging Behaviour

Judy Hutchings, Bangor University

Professor Hutchings developed and evaluated the Enhancing Parenting Skills programme in the 1990s with parents of children with severe behavioural problems. It has subsequently been trialled with health visitors and been further developed and evaluated, strengthening its evidence base. The three phase programme, that is based on one-to-one weekly sessions with parents and also includes parent-child observation. It incorporates a detailed assessment, a case analysis and an intervention component. The programme has recently been published by Routledge as a practitioner manual and the workshop will provide participants with a copy of the manual and present the three phase of the programme with practical exercises.

Learning objectives
1. Be able to describe the components of effective engagement strategies
2. Understand the need for a range of strategies to collect the information to inform case analysis based on child and family history, the assets and skills that exist within the family for both parents and children, use of standardised questionnaires, behavioural observation of parent-child interactions and use of the parent-child constructional questionnaire (adapted from Goldiamond).
3. Recognise a range of possible functions of, and reason’s for, challenging child behaviour including reinforcement of challenging behaviour by attention or a range of tangible reinforcers, avoidance, developmental challenges making desired behaviour unachievable, etc.
4. Understand strategies for developing a case analysis based on functional analysis
5. Identify alternative behaviours that are realistic for both child and parents to achieve.
6. Learn to establish a contract specifying end goals of the intervention
7. Practice developing a week by week intervention plan towards terminal goals
8. Be able to describe the EPaS process and the rational for the process.

The workshop will cover the three phases of the EPaS process through
a) discussion of barriers to engagement of families
b) didactic input on the EPaS process, functions of problem behaviour, factors to consider in identification of realistic goals
c) role play practice in administering the various assessment phase measures
d) reviewing and analysing videotaped material of parent child interactions
e) This programme provides a step by step guide to an evidence based process of working effectively with parents of children with significant behavioural problems that is of potential value to health visitors, CAMHS primary care psychologists, nurses and other CAMHS clinicians, social workers working with child protection families and therapeutic social workers working with children in the looked after care system.
The manual provides a valuable reference source setting out the process in a clear and logical way to support delivery of the programme.


Rolling with Resistance: A Workshop for CBT Therapists Working with More Complex Presentations of OCD in Children, Adolescents and Families

Alice Farrington and Sasha Walters, Berkshire CAMHS Anxiety & Depression Team
It is estimated that Obsessive Compulsive Disorder effects between 1 and 3% of children and young people (Flament et al, 1988), and has been rated by the World Health Organisation as in the top ten of all disabling illnesses due to it’s impact on quality of life (Veale & Roberts, 2014). The most effective treatment for OCD is CBT which includes Exposure and Response Prevention (ERP; e.g. Abramowitz, Whiteside & Deacon, 2005). However, there can often be challenges to engagement with ERP tasks, particularly when there are high levels of anxiety, systemic complexities, comorbid presentations, and neurodevelopmental difficulties (e.g. Barrett et al, 2004; Merlo et al, 2009; Russell et al., 2013).
This workshop will offer a model for developing and delivering CBT to children with OCD and other comorbid difficulties, such as autism and systemic complexities. It aims to help CBT therapists use CBT methods creatively to help children, young people and families to engage with ERP tasks and will include practical resources and ideas to overcome barriers to engaging in ERP tasks. Different treatment methods for the delivery of CBT will be discussed, including family CBT, parent-led CBT, and intensive home based treatment packages.
Who is the workshop aimed at:
The workshop has been designed for CBT practitioners who are familiar with paediatric OCD who wish to develop their knowledge and skills in order to augment the treatment they offer.
Participants will acquire the following skills:
1) Developing a formulation which takes into account developmental factors, neurodevelopmental diversity and systemic issues.
2) Planning exposure and response prevention tasks
3) Knowledge of different methods to overcome barriers to treatment
The contents of this workshop will be taught through instruction, modelling, and practice (role-plays).
To help CBT therapists use CBT methods creatively to help children, young people and families to overcome barriers to engagement and improve effectiveness of treatment for OCD even when some complexities are present

The Equipping Youth to Help One Another Programme with Offenders with Intellectual Disabilities and/or Autism

Peter Langdon, University of Kent
The EQUIP Programme was originally developed in United States and has its roots within Anger Replacement Training. It is a multi-component programme making use of peer-helping group methods nested within developmental psychology to motivate and teach skills to offenders. It specifically targets cognitive distortions, social skills difficulties, and sociomoral developmental delays. It draws on methods of mutual help within the context of psychological therapies and aims to target developmental delays that exist within youth who are at risk of engaging in illegal behaviour. The group is intensive and takes the form of four sessions per week for 10-weeks. The programme has been adapted to meet the needs of offenders with intellectual and other developmental disabilities within secure care.

Implication for everyday clinical practice of CBT
Participants will learn skills to help engage those with intellectual and other developmental disabilities who are at risk of engaging in illegal behaviours within psychological therapies. Further, participants will be skilled in the EQUIP Programme, and following completion of the workshop, they will be in a position run EQUIP programmes within their own services.

Brief description of presenter(s)
Peter completed his undergraduate degree at Memorial University of Newfoundland, and went on to complete his Doctorate in Clinical Psychology at the Institute of Psychiatry, King's College, London as a Lord Rothermere Fellow. Following this, he completed his PhD at the Tizard Centre as an NIHR Research Fellow. Before joining the University of Warwick, he was Professor of Clinical and Forensic Psychology at the Tizard Centre, University of Kent and worked as an Approved Clinician within NHS medium-secure services with Hertfordshire Partnership University NHS Foundation Trust.

His research and clinical work focus upon the development and evaluation of psychological therapies and systems of care for people with intellectual and other developmental disabilities, including those who have come into contact with criminal justice. He has completed and is continuing to work on several clinical trials in this area, and is working to evaluate innovative technologies for use as adjunctive interventions to help improve the accessibility of psychological interventions for people who have intellectual disabilities and autism. He was twice previously a research fellow of the National Institute for Health Research, and is the Editor of the Journal of Applied Research in Intellectual Disabilities.

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**Turning Research Ideas into Reality: A Guide for Clinicians About How to Get Your Research Funded**

**Shirley Reynolds, University of Reading and Barney Dunn, University of Exeter**

No abstract provided.

**Design, Implement and Publish A Single Case Experimental Design**

**David Veale, King's College London**

Randomised controlled trials (RCTs) are designed to determine whether on average, an intervention is more effective than another intervention. This is often not good enough for clients and clinicians who want to know if an intervention is effective for them. Single Case Experimental Designs (SCEDs) can answer such questions, whatever the intervention or setting. They are characterised by individual(s) or group(s) acting as their own control. SCEDs have a rich history in behavioural therapies but are not widely used by clinicians nor often taught adequately during one’s training. This workshop aims to provide clinicians with the confidence to design and implement their own SCEDs in everyday practice. Each learning objective will be illustrated by exemplars. Resources on the internet, apps and publications for further reading will be recommended. Participants should bring a research idea for a SCED to discuss with another participant and present to the larger group.

By the end of the skills class, participants will

1) Understand the difference between a single case report, a case series and a Single Case Experimental Design
2) Be able to determine if a case has achieved reliable and significant change on standard outcome measures
3) Understand when a SCED is more appropriate design compared to a Randomised Controlled Trial
4) Understand the four basic research designs in a SCED (reversal, multiple baseline, alternating treatments and changing criterion) and the level of inference that may be made
5) Understand the use of visual analysis in a SCED
6) Consider guidelines for number of observations in each phase and number of cases for replication
7) Understand statistical testing in a SCED.
8) Consider when it may be necessary to apply to ethics for a SCED
9) Consider standard reporting to publish a SCED

Present research plan to a larger group for discussion.

It would be helpful for participants to bring a laptop and have access to the internet


Using Values to ACTivate Your Practice

Richard Bennett, University of Birmingham

Acceptance and Commitment Therapy (ACT) is an evidence-based trans-diagnostic intervention that has its origins in the behavioural tradition. It is concerned with helping individuals identify their values and taking committed action in the service of them. ACT identifies key processes that enable individuals to develop greater ‘psychological flexibility’ and teaches skills that help to change the relationship between an individual and their experience. Psychological flexibility has been shown to be a mediating variable for a range of health outcomes across a range of settings and presentations (see A-Tjak, Davis, Morina, Powers, Smits, & Emmelkamp (2014) for a meta analysis). This skills class will focus on helping practitioners develop their knowledge and skills around one aspect of the psychological flexibility model, namely helping clients to identify and clarify their values.

This work helps clients work out what matters most to them in life and can inform goals and between session tasks, making them more meaningful and purposeful.

By attending this skills class, practitioners will:
1) Learn about the psychological flexibility model and the concept of values
2) Learn specific techniques to help clients identify and clarify their values
3) Develop skills in translating values into goals and specific actions

Engaging clients in values work has been shown to increase client’s psychological flexibility and reduce defensiveness to self-threatening information. It has the capacity for increasing engagement in therapy goals and helps clients contact intrinsic reinforcers in respect of their day-to-day choices. Learning about values provides a means for therapists to supercharge their usual practice of goal-setting and the use of between-session tasks.

Didactic teaching
PowerPoint presentation
Experiential exercises
Group discussion

Richard Bennett works as a Clinical Psychologist and Cognitive Behavioural Psychotherapist. He worked in adult and forensic mental health services in the NHS for over 20 years before setting up Think Psychology, an independent psychology practice offering, therapy, supervision, and training. He also leads the PGDipCBT(HI) at the University of Birmingham. Richard is also an active member of the Association for Contextual Behavioural Sciences (ACBS) and the British Association of Behavioural and Cognitive Psychotherapy (BABCP). He is recognised as a BABCP accredited psychotherapist, supervisor and trainer, and an
ACBS Peer-reviewed ACT trainer. He is the co-author of ‘Acceptance & Commitment Therapy: 100 Key Points and Techniques’ (2019).

PACT (Paediatric Autism Communication Therapy) From Infancy to 10 years: Implementation for Everyday Practice in Local Services

Hannah Danvers, IMPACT CIC and Stockport NHS Foundation Trust
The Paediatric Autism Communication Therapy (PACT) is a theory-based, adult-mediated and video-aided intervention designed to improve social communication competencies in children with ASD. It has been rigorously tested to show sustained impact on the reduction in the severity of autism symptoms in children aged infant to 10 years. As PACT mirrors the definitions, terminology and skills outlined in ADOS-2, it will be of interest to speech and language therapists, psychologists, psychiatrists, specialist teachers and specialist social workers who deal with children with social communication issues. This presentation introduces PACT theory and methods, how PACT differs from other autism interventions, and how PACT works in clinical practice. The presentation include skills sets of key PACT principles and observing and measuring communication interaction on video clips illustrating elements of PACT delivery and awareness of the six PACT stages.

The presentation will provide awareness of PACT for professionals considering if PACT would be appropriate to their service models, with further opportunity to progress PACT training for those who wish to implement PACT in clinical practice. Key learning objectives:
1. Awareness of PACT theory and evidence
2. Understanding of PACT key principles
3. Awareness of PACT style of implementation
4. Observing social communication skills
4. Awareness of PACT progress stages

Communicating CBT Ideas Creatively and Effectively to Non-Therapists

Lucy Maddox, BABCP
Science communication and public engagement activities are increasingly valued by academic institutions but few training opportunities exist to help professionals think about how to tailor their communication for a non-professional audience without dumbing down. Communicating complex ideas in a simple but accurate way is a key skill and a potentially enjoyable way to share ideas from psychological theory with a wider audience. This workshop will give an overview of some of the key principles for good science communication and allow participants to evaluate a range of different examples of communication. It will then focus on writing for a lay audience and participants will have the opportunity to experiment with writing about CBT ideas or research for non-specialist readers. The skills class is open to all, including researchers, clinicians, trainees and people with a range of previous communication experience.
1. To consider what makes successful and less successful communication of complex scientific ideas
2. To experiment with communicating CBT ideas creatively and effectively for a non-specialist audience
3. To become aware of a range of resources to enable science communication to a wider audience

It is useful to be able to explain CBT clearly in the clinic room, and this workshop will help with that. It also aims to encourage clinicians and researchers to experiment with science communication and public engagement activities outside of the clinic or academic setting. The skills workshop will use a mixture of didactic and experiential methods.

Dr Lucy Maddox is a clinical psychologist and BABCP accredited practitioner, supervisor and trainer. She currently works with children and teenagers in Bristol and for BABCP as their senior clinical advisor. Lucy has a longstanding interest in communicating psychological ideas to a wider audience and has written for several publications including The Guardian, The Times, Science and Mosaic. Lucy has also written a popular psychology book about child development called Blueprint: How Our Childhood Makes Us Who We Are. Lucy produces the BABCP podcast: Let’s Talk About CBT. Lucy was a British Science Association Media Fellow in 2013. Lucy has taught about science communication at University College London, King’s College London and for Guardian Masterclasses.


Poster Presentations

Therapy discontinuation in a primary care psychological service: A thematic enquiry

Aisan Ghaemian, Solent NHS Trust; Mahdi Ghomi, Solent NHS Trust; Miles Wrightman, Solent NHS Trust

Dropout from treatment may have negative consequences both for patients and clinicians. Patients who leave treatment prematurely are unlikely to recover independently and are more likely to have a poor long term outcome.

It is difficult for clinicians, who may feel demoralized when patients leave therapy without any explanation.

Previous reviews revealed dropout rates from treatment in the IAPT services, who found negative experiences both for patients and the service. However, there is lack of evidence of how patients, in fact, felt better and as a result they did not need for further treatment.

Previous reviews have revealed a broad range of reported dropout rates from treatment in the IAPT services, who may have found negative experiences both for patients and the service. However, there is lack of evidence of how patients, in fact, felt better and as a result they did not need for further treatment.

Our study aims to 1) explore how patients perceive and experience treatment in the Talking Change psychological therapy services? 2) To investigate the reasons for discontinuing their treatment.

A qualitative approach was adopted using thematic analysis of semi-structured interviews carried out with 255 patients attended for treatment in the Talking Change from 2015 to April 2017, retrospectively.

This study revealed encouraging data: Six Main themes emerged: Theme 1: Felt better: I feel like a different person after a couple of sessions - treatment was life changing, it put me in a perspective that helped me to organise my life.
Theme 2: Issues with being in a group: It wasn’t for me, I didn’t talk once and couldn’t connect with the other people as they didn’t have the same or similar problems
Theme 3: Therapeutic alliance breakdown: I tried to explain it to the therapist but they didn’t listen. So I just stopped going.
Theme 4: Miscommunication: I receive a letter saying I have not been attending groups so they were discharging me. But I was still waiting to be contacted.

Theme 5: Symptoms preventing engagement: I’ve got physical problems and PTSD and they were all working against me to attend. It was difficult for me to get there due to my severe pain.

Theme 6: Impracticality: I had no choice but to stop therapy because of my baby, I couldn’t bring him.

The findings are emphases on dissatisfaction and inconvenient appointments. However, improvement in symptoms of depression and anxiety were also identified as key factors among patients. This recovery is known as “progress withdrawal” in which patients withdrawn from treatment early, due to good therapeutic progress and it can argue that therapy being delivered was rapidly effective.

- The use of feedback forms in mid-course of group therapies may encourage patients to express themselves explicitly.
- A higher rate of “progress withdrawal” could be associated with the higher rate of recovery for the service.

With regards to the effectiveness of the treatments provided at the IAPT service in Portsmouth. This service demonstrated the use of NICE recommended and evidence-based interventions supported by experienced therapists. These important factors are associated with better clinical outcomes (Gyani et al., 2011). This study further suggested the fact that patients could feel better if they dropout from treatment as they do not feel the need to continue their treatment (Gutner & colleague, 2016). On-going data collection is helpful in monitoring progress, emerging new themes, identifying the strengths and weaknesses of the services and unpacking the underlying factors.

Pilot review: Assessing the effectiveness of CBT for depression, anxiety and long-term conditions for adults over 65 years of age

Vandana Gupta, NHS IAPT; Idyli Kamaterou, Surrey and Borders NHS Trust; Vandana Gupta, Surrey and Borders NHS Trust; Soraya Aweys, Surrey and Borders NHS Trust.

According to 2011 UK Censuses (Office of National Statistics, 2012), people aged 65 years and above make up 16.6% of the UK population. The evidence suggests that approximately 25% of people 65 years and above living in the community have symptoms of depression but only a third of them discuss it with their GPs. Of those discussing with their GP’s only half get treatment which is primarily medication (Department of Health, 2009).

Long-term conditions (LTCs) are more prevalent in older people: 58% of people over 60 experience LTCs compared to 14% under 40 (Department of Health, 2012). Patients with chronic conditions suffer from related psychosocial factors, anxiety and depression, that have an impact on their quality of life.

In 2015, NHS National Intensive Support Team feedback to Surrey Commissioners demonstrated very poor uptake locally and nationally for Older People into IAPT services. Recommendations were made to Care Commissioning Groups (CCG’s) look at innovative ways to improve access.

North West Surrey CCG (NWS) board approved for an 18-month pilot delivered by Mind Matters Surrey to provide evidence based CBT treatments in an accessible setting for vulnerable older people. The pilot was carried out at the Bedser Hub (a facility providing a range of health, social care and community services to older people with co-morbid physical health diseases) to assess the effectiveness of individual and group CBT in reducing depression and anxiety and improving the management of LTC.

The Bedser Hub pilot started in March 2016 for a period of 18 months. It involved one CBT therapist from Mind Matters IAPT based at the Hub twice a week.

Mind Matters IAPT at the Bedser Hub offered either individual or group CBT sessions. Every person referred to the service was offered a face-to-face assessment before a treatment plan was developed. The group consisted of seven 1.5-hour sessions. The individual CBT was offered face-to-face but telephone sessions were available if necessary (e.g. if ill health or...
transport problems were getting in the way of people accessing the Hub for a particular session.
The psychometric tools used at the Hub to assess people’s mental health symptoms and to track their progress were the following:
‘Patient Health Questionnaire’ (PHQ-9) to assess symptoms of depression
‘Generalised Anxiety Disorder Assessment’ (GAD7) to assess anxiety symptoms
‘CORE-10’ to assess symptoms, wellbeing, functioning and risk
LTC question to assess people’s confidence in managing their chronic physical health conditions, ranging from 0 (low) to 5 (high confidence).
In order to collect patients’ feedback about their experience of the service following assessments and treatments, the ‘Patient Choice and Experience Questionnaire’ was administered.
In this pilot review, we compare patients’ scores on the above tools before and after treatment.
Demographic and psychometric data gathered during assessment was collated on an Excel spreadsheet and the following information was generated: service-users age, assessment outcome, the number of sessions, baseline and post treatment measurements of the above described tools (PHQ-9, GAD-7, CORE-10, LTC) and therapy outcome.
Due to the large data set, the first step of data analysis was extracting and cleaning data: if missing values were randomly distributed, the cases were deleted; excel analysis of patient’s means and average scores on the above tools before and after therapy were calculated.
Tables and graphs with relevant information and overall results were also created.
Overall for both individual and group interventions, participants’ symptoms improved following CBT therapy at the Hub.
PHQ-9 scores in both individual and group treatment dropped. The same applies to anxiety symptoms for which individual therapy was more effective. There was an improvement in CORE-10 for both individual and group treatments. People’s confidence in managing their long-term condition improved in both treatments types but marginally more in the group setting.
(Tables and diagrams can provide more information in this section)
Although a high number of people were referred to the pilot at the Hub, only 27 people completed individual and group therapy. Some people were not suitable for therapy with Mind Matters IAPT but most people declined therapy. The main reasons were: feeling able to cope/ not feeling they need support, being busy with appointments for their physical health/ not able to find time for therapy and ill health. This feedback was used to improve suitability of referrals via education to referrers, facilitating transport and having open door policy for people to re-refer themselves.
People who entered therapy (both individual and group) showed clinical recovery of both anxiety and depression symptoms. Participants who had individual therapy had higher symptoms for both anxiety and depression before treatment, compared to the ones who attended group treatment. Therefore, they made more progress and their symptoms improved more during therapy. However, group work was more effective in improving people’s confidence in managing their LTC. This is possibly because people tend to normalise their physical and mental health symptoms in the group and they do not feel isolated and alone in their difficulties, which is something that has a positive impact on their confidence levels.
There was only a slight increase in LTC confidence scores as it might be harder for this population to achieve “full confidence” over the management of their LTC conditions.
Qualitative feedback received by participants:
‘You have resolved a lot of problems for me: I had suicidal thoughts when I started therapy but not anymore, I now include my husband more in my care and I am more open with him. I also make more of an effort in life and I avoid less situations. Those sessions made me think about my relationships with people and clarify thoughts I did not identify before’.
‘I feel really grateful for your help. You have guided me in a very helpful way and I now feel that I am back to my normal self.’
‘I really looked forward to our sessions - it was something different. I feel I can speak to you - normally I do not feel comfortable with people I do not know. I do not feel that depressed anymore. I made the effort to do more things and I feel more confident now.’

CBT seems to be effective in treating anxiety and depression in older adults with long-term conditions.

However, it might be important to consider the treatment setting as, according to this pilot, the group setting was more effective in helping service-users feel more confident in managing their LTCs. Reducing their loneliness and isolation as well as normalising their symptoms were aspects of the group setting that the service-users found really helpful.

Is Group Cognitive Behavioural Therapy as effective at Individual Cognitive behaviour therapy in treating Generalised Anxiety Disorder in a routine IAPT Service?

Marianne Fanous, University of Bath; Jo Daniels, University of Bath

Group Cognitive Behavioural Therapy (gCBT) is increasingly used in Increasing Access to Psychological Therapies (IAPT) services and group formats offer a potentially more economical intervention, yet there is limited knowledge of its efficacy as a delivery format for Generalised Anxiety Disorder (GAD) in context of unimpressive effect sizes in standard interventions. Most evidence relies on RCTs which lack the ecological validity and clinical relevance to practitioners. Of existing RCTs for gCBT for GAD, studies do not directly compare treatment formats. To address gaps in literature, this naturalistic study provides insight into the efficacy and attrition between individual and group CBT interventions for GAD using real data from a routine IAPT service between April 2015 and April 2017. This study aimed to investigate whether gCBT could be as effective and acceptable as Individual CBT for GAD at Step 3 in IAPT.

Data was pooled from a search on IAPTus of those entered into receiving Step 3 CBT for GAD, comparing group versus individual treatment formats. Participants were screened to ensure that GAD was their primary concern and that all were treated using the IAPT endorsed Dugas’ model of uncertainty (1998). Outcomes were self-reported anxiety (measured by the Generalised Anxiety Disorder-7, GAD-7) and depression (measured by the Patient Health Questionnaire-9, PHQ-9) and attrition.

Analysis between groups indicated that anxiety \( F(97) = 67.302, p < .01, n=99 \) and depression scores \( F(97) = 5.035, p = .027, n=99 \) significantly reduced over time in both group and individual CBT formats. However, neither depression \( F(97) = .050, p =.824, n=99 \), nor anxiety scores \( F(97) =1.882, p =1.73, n=99 \) differed by treatment modality. Treatment format did not predict clinical recovery from GAD (Exp (B)=2.56, CI 0.95 = [2.1, 2.24], p=.06, n=99). Against predictions, patients were statistically \( \chi^2 (3) = .84, p =.84, n=99 \) no more likely to drop out if receiving gCBT (27%, n=44) than individual CBT (30%, n=55).

GCBT is as effective as individual therapy for patients with a primary diagnosis of GAD in a routine IAPT setting and offers an acceptable and potentially more economical alternative; though this warrants further research with more controlled conditions, this naturalistic design offers some credibility and insight into a pragmatic evaluative comparison.

As there is a lack of evidence on the effectiveness of the interventions used in IAPT and the gap between research trials and clinical practice is large (Scott, 2018). The study’s direct comparative nature and its use of natural clinical data and adds to current understandings of the impact of delivery format of CBT, bridging the gap between RCTs and clinical practice. Given the efficacy, applicability and efficiency of gCBT, this study supports the use of GAD groups, and their alignment with IAPT’s targets of improving access and recovery. This study provides support for the utilisation of group CBT for GAD in routine IAPT settings, and may prove to be a more economical alternative. This study increases evidence base related to the utility of gCBT’s transferability to practice.

Psychological formulation is a central process in many contemporary evidence-based psychological therapies and is heavily referenced throughout professional standards and guidelines. Despite the significance of formulation in clinical psychology and wider mental health professions, there is limited evidence to show that formulation benefits the client or improves outcomes in therapy, including the working alliance and measures of distress. The key aims of this study was to investigate whether (1) formulation impacts on working alliance and (2) there is a relationship between formulation, working alliance and psychosocial outcomes. The study used a repeated single-case A-B, mixed methods design. The design included a non-treatment baseline phase (A), measuring weekly symptoms of low mood and was followed by the intervention phase (B), which consisted of eight weeks of CBT focusing on low mood. The CBT intervention incorporated two ‘product’ formulations (in session 3 and 7) and ‘process’ formulations, which were delivered throughout.

Participants and the therapist completed weekly measures at the end of each session, which included measures of working alliance, depression and well-being. Change interviews were also undertaken at the end of therapy to triangulate results. Data analysis mainly included visual analysis, simulation modelling analysis and clinical/reliable change. Seven participants were recruited, with five participants completing the full eight week CBT intervention. The analysis showed a slight relationship between formulation and working alliance, although evidence was not robust enough to confirm whether formulation directly impacts working alliance. The results showed mixed findings in terms of the relationship between formulation, working alliance and psychosocial outcomes measured. Although over half of participants showed an improvement in depression and two improved in well-being, it was not possible to attribute these changes specifically to formulation.

This study contributes to a dearth in the literature surrounding the impact of formulation on outcomes in CBT. The findings discussed are mixed and although tentative conclusions can be made that formulation, particularly the product formulation may have contributed to elements of the working alliance, it is not possible to state that formulation directly impacted on the working alliance. The study also highlights the complexity of psychotherapeutic research and the challenges of disentangling processes to draw conclusions on what variables contribute to changes in outcomes. The utility of single-case designs enables researchers to study complex therapeutic processes using a scientific methodology, ultimately bridging the gap between research and clinical practice. This study provides a platform for future research into formulation and should further consider some of the limitations discussed, e.g., does the accuracy of process formulations mediate the working alliance, is it possible to separate the working alliance from the process of formulation.

This study encourages a critical discussion and reflections surrounding the utility of psychological formulation, specifically in CBT. It offers implications such as, considering the impact formulation has on the working alliance, for the client and also therapist. The study also opens up new ideas and opportunities for future research which will hopefully continue to develop our understanding of the mechanisms and impact of psychological formulation in practice.
The aim of this project was to develop, pilot and evaluate an online Cognitive Behavioural Therapy course that could be accessed from home, overcoming many of the barriers to attendance, whilst retaining the supportive nature of group therapy. The course content was developed by a Clinical Psychologist and delivered in collaboration with the Health Visiting Team. The course was delivered within an IAPT service that encompasses both rural and urban areas. In addition to the IAPT Minimum Data Set, the Edinburgh Postnatal Depression Scale and the Behavioural Activation Scale were completed by email. Patient Feedback was routinely collected. Higher rates attendance and lower drop out compared to face to face courses offered by the service Good recovery rates, as measured by the IAPT MDS Positive patient feedback Improved professional working relationships between the IAPT and Health Visiting teams. Implications for clinical practice and working with women in the perinatal period within IAPT are discussed, as well as future developments Webinar is a promising method of offering CBT, particularly in rural areas and where there are barriers to attending face to face Online courses can enable clients to engage who might otherwise not access the service.

A Mixed-Methods Investigation of Parent-Child Posttrauma Discussion and the Effects of Encouraging Engagement

**Rosie McGuire, University of Bath; Rachel Hiller, University of Bath; Vanessa Cobham, University of Queensland; Katharina Haag, University of Bath**

Recent developments in the child trauma field include preventative interventions that focus on augmenting parental support. However, we have limited knowledge of how parents experience trauma conversations with children. There were 127 families who completed a joint narrative task, in which they were supported in having a trauma-related discussion with their child. These families were asked to rate how distressed they felt during this task. A sub-group of 20 parents were then interviewed to find out more about their experiences of both spontaneous trauma-related conversations and the structured joint narrative task, following their child’s experience of an acute trauma. Parent and child ratings of distress during the structured task were low for all 127 families that took part; however, both parent and child were significantly more distressed if the child had PTSD. In the interviews, parents reported both facilitators (e.g. open and honest relationship with child) and barriers (e.g. parent/child avoidance of discussion) to spontaneous trauma-related conversations with their child. Additionally, they described the trauma-related discussion researchers asked them to have with their child as an opportunity to start the conversation, to understand their child’s feelings, and for the child to process the trauma. However, it was also uncomfortable or upsetting for some parents/children, and it made some parents become more overprotective. Most parents had discussed the trauma with their child before they were encouraged by researchers to engage in the joint trauma narrative task, and most parents considered this prescribed trauma-related discussion with their child as beneficial. Those who were unsure or upset during trauma-related discussion, identified how more information or support could help encourage them to engage in a conversation about their child’s trauma with them. Together, the current study helped us to recognise why parents may or may not feel comfortable talking about their child’s traumatic experiences with them, and how professionals could better support parents in having trauma-related discussions with their children. However, it is worth noting that only one participant interviewed was a father, therefore the views documented are predominantly maternal. Fathers also play an important role in providing support for their children following trauma, and their support strategies and experiences may be very different to mothers, so future research should strive to include more fathers in their sample to further investigate these differences. Results suggest a low-dose, parent-led intervention encouraging families to discuss trauma would be well-received. By providing parents with the skills needed to support their child’s
post-trauma adjustment, it could prevent the development of clinical post-traumatic stress symptoms and thus reduce the burden on clinicians.

Kind Mind: A Compassion Focussed Therapy group for adult mental health patients

Katie Pownell, Mersey Care NHS Foundation Trust; May Sarsam, Mersey Care NHS Foundation Trust; Donna Gardiner, Mersey Care NHS Foundation Trust; Corey Morgan-Forsyth, Mersey Care NHS Foundation Trust; Kate Hannah, Mersey Care NHS Foundation Trust

Low self esteem, shame and worthlessness often hamper engagement with acute mental health services. We therefore introduced the “Kind Mind Group” - a 6 session CFT group aiming to challenge ideas of worthlessness, self-blame, and low self esteem, through skills-based learning and reflective group-based discussion. The group had been piloted in Broadoak Unit, Mersey Care.

The Kind Mind group was introduced onto three acute inpatient wards at Clock View. Patients on the ward were invited to attend on a weekly basis. The group was open in format, meaning that people could attend at any point and attend as many or as few sessions as possible whilst an inpatient. Data were collected using feedback forms from participants in each session.

Quantitative feedback (graph):
How useful did you find today's session in building your self-esteem? Average score: 4.37
Did you find today's session easy to understand? Average score: 4.47
Did you find today's group supportive? Average score: 4.51

Qualitative feedback:
-“I find the session is supporting me to get an understanding of my emotions and is supporting me to stop piling my feelings onto myself”.
-“Brilliant group session. Very relaxing & supportive”.
-“It’s been good to understand a bit more about my self-esteem”.
-“Was anxious coming in as got a lot on, but am actually glad I did now as I feel more positive”.
-Feedback indicates service users found the group was supportive, safe, opened up discussion, and built self esteem.
-Open group format allowed for experience of compassion, care, and acceptance.
-Kind Mind group can be delivered by range of psychology gr

The results demonstrate that it is efficacious to run an open format compassion focused therapy group on acute inpatient wards.

Family Accommodation and Symptoms of Obsessive Compulsive Disorder: The Role of Distress Tolerance in a Significant Other: A Pilot Study

Lucy Hale, University of Surrey; Clara Strauss, Sussex Partnership NHS Foundation Trust; Blake Stobie, South London and Maudsley NHS Foundation Trust; Warren Leaver, University of Surrey

Family accommodation of OCD symptoms refers to actions taken by those close to individuals experiencing OCD to reduce symptom-related distress. Examples include enabling rituals, providing reassurance and modifying routines (e.g. Merlo et al., 2009). Family accommodation of symptoms related to obsessive compulsive disorder (OCD) is common and has been associated with greater OCD symptom severity (e.g. Lebowitz, Panza & Bloch, 2016), in addition to poorer treatment outcome (e.g. Merlo et al., 2009). Levels of accommodation also seem to be associated with family/carer distress (e.g. Flessner et al. 2011). However, not all families/carers accommodate the OCD symptoms to the same degree and it remains unclear as to why this variability in levels of accommodation exists. As distress seems to be associated with family accommodation, it seems that the role of distress tolerance in significant others living with individuals with OCD in their propensity
to accommodate the OCD symptoms could be a valuable line of enquiry. The majority of the literature investigating family accommodation in OCD is correlational and research into how some of these factors are related to levels of accommodation and indeed OCD symptom severity remains in its infancy.

This study examined a theoretical model that suggests family/carer accommodation mediates the relationship between family/carer distress tolerance (more specifically, intolerance of uncertainty (IU) and tolerance of negative emotions; TNE) and OCD symptom severity. Thirty two adults experiencing symptoms of OCD and someone who lived with them completed a survey comprising of screening questions, demographic information and self-report questionnaires (total N=64). The mediation analysis found that the 95% confidence intervals crossed zero, showing that levels of relational accommodation did not significantly mediate the relationship between carer IU or TNE and OCD symptom severity. Furthermore, carer IU and TNE did not significantly predict levels of accommodating the OCD symptoms. Levels of accommodation predicted OCD symptom severity (p<.05), but this did not remain significant when controlling for carer mental health.

This is the first study to examine whether accommodation of OCD symptoms mediate the relationship between distress tolerance in a significant other living with someone with symptoms of OCD and OCD symptoms. This study concluded that accommodation of the OCD symptoms is common amongst adults with OCD who live with someone. The proposed theoretical model was not supported empirically in this study and the hypothesised factors explained a limited amount of the variance in levels of accommodating behaviours. It was concluded that although the study was underpowered, there are likely to be other factors not accounted for in the proposed model that explain some of the variance in accommodating behaviours. Whilst the study replicated the finding that there is a significant correlation between levels of family accommodation and OCD symptom severity, it calls for the need to control for carer mental health in analysis. The authors continue to develop the study to investigate factors that predict levels of accommodation, in addition to developing the mediation model proposed.

This study supports the literature reporting that family accommodation is common. Accommodation is an important factor to consider as it directly contradicts the central aims of recommended cognitive-behavioural treatments for OCD. Behaviourally, accommodation of the symptoms could prevent exposure to feared situations and obstruct the individual’s opportunity to extinguish the fear response. Cognitively, accommodation could prevent individuals from stopping their safety seeking behaviour, which would impede the opportunity to test unhelpful threat appraisals and develop alternative ones. Not all families accommodate OCD symptoms and not all accommodate symptoms to the same degree. It is unclear as to why this variability in family accommodation exists. It is therefore important to gain a better understanding of factors that might predict levels of accommodation of the OCD symptoms. This could have implications for clinical practice in terms of including responses to the concerns as part of the formulation and addressing accommodation to the OCD in treatment.

CBT Supervision on the coalface – how closely does the reality mirror the recommendations? An exploration of supervisor and supervisee experiences

Jason Roscoe, University of Cumbria; Julie Taylor, University of Cumbria; Susan Wilbraham, University of CumbriaRuﬁus Harrington, University of Cumbria

Clinical supervision plays an important role in the training of new CBT Therapists and is considered to be essential for skills development, ongoing support and maintaining of standards in both new and qualiﬁed practitioners (Pretorius 2006). Regular supervision that involves a variety of methods is also a necessary component of gaining and maintaining BABCP accreditation which many require therapists require for gaining employment. Little was known from a phenomenological perspective about the 'lived experience' of supervisees and supervisors in terms of the factors that inﬂuence the choices they make.
about how to use clinical supervision. Similarly, it was also unknown as to how trainers and supervisors decide to structure their supervision sessions or whether they felt they had the appropriate knowledge and training to be effective in this role in the absence of a unified supervision model in the profession. Previous research by Townend et al (2002) using a postal questionnaire with a sample of 280 BABCP accredited CBT Therapists found sought to establish a national picture of how supervision was experienced. This study was undertaken pre-IAPT (Improving Access to Psychological Therapies) and given the significance of IAPT in how CBT is delivered it is important to gather knowledge about how perceptions might have changed following this. The current study is the first to have collated the views of both supervisees and supervisors and those who practice CBT both accredited and non-accredited or who are not BABCP members.

A qualitative research design was used involving a sample of six therapists with a broad range of clinical experience that were selected from the first author’s professional network for semi-structured interviews. The six participants were interviewed with some of them having dual roles or three roles as trainer, supervisor and supervisee. The questions looked to explore participants’ experience of providing and receiving supervision and whether these experiences met with their expectations of the supervisor or supervisee roles. Transcripts were thematically analysed following the approach recommended by Braun & Clarke (2006). The data is still being transcribed however themes from the responses will be analysed and available prior to the conference.

It is unclear what role the supervision component plays in the successful translation from research trials to everyday clinical practice. Unusually experienced clinical psychologists tend to provide or supervise therapists in research trials but this is not typically the case in IAPT services. It is important to establish if the supervision provided on the coalface closely resembles that which has been documented in the research trials which support the treatments being applied to patients. As there is no unified approach to supervision it is difficult to measure the impact of that which therapists are receiving currently. The study suggests that further research is required to help supervisees and supervisors with CBT identify ways of getting the most out of the supervision experience. Unlike the CTS-R there is no universally adopted comparable supervision measure to ensure that there is consistency in terms of format or delivery. There is also no mandatory requirement for Supervisors to have attended specific supervisor training or to be accredited as supervisors. This begs the question, if there is no unified framework in CBT Supervision then how do we ensure standards are consistent and how are we supposed to gauge good quality versus sub standard supervision practices in the current training and supervision culture?

Cognitive-behaviour Therapy in Treatment of Psychological Difficulties after Road Traffic Accident

Sirous Mobini, Aspire Clinical Psychological and Neuropsychological Services (ACPNS)

Road traffic accidents are very common in the UK and other countries. The Department for Transport estimates that in 2014 around 740,000 people had been road casualties in Great Britain. A high proportion of these people involved in RTA will suffer from physical and psychological injuries as a result of the accident. RTAs are known to have significant consequences for mental health and quality of life as a direct result of the traumatic experiences of the accident or indirect results largely unrelated to the nature of the injuries (Mayou & Bryant, 2002). Patients presented with a range of psychological and psychiatric symptoms including driving anxiety, passenger anxiety, generalised anxiety, phobia, anger, panic attack, somatisation, low mood and depression, and post-traumatic stress disorder symptoms characterised as hypervigilance, avoidance, intrusive thoughts and preoccupation with the trauma memories. Almost all patients displayed some adjustment
disorder symptoms due to long-term stress associated with dealing with litigation process and insurance. Patients were 14 females and 2 males involved in road traffic accident. The treatment was trauma-focused CBT for PTSD, CBT for phobic reactions and GAD and low mood and depression. A combination of CBT and Acceptance and Commitment Therapy (ACT) was used for treatment of adjustment disorder. The patients started their treatment around 22.5 months post-accident in average, ranging from 10 – 46 months post-injury. Two patients, one male and one female, also sustained mild head injury as a result of the accidents and presented with some mild cognitive impairments. In terms of number of sessions, the treatment sessions ranged from 10 – 24 hours, with an average of 14 sessions (hours).

Measures of anxiety and depression (GAD-7, PHQ-9, HADS,) and PTSD (IES-R) indicated significant reductions in anxiety and depressive symptoms and PTSD. All scores reduced from moderate and severe to normal range and none met criteria for clinical caseness after treatment. Patients also reported improvement in their psychological adjustment with the consequences of their injuries and litigation process.

Nine out of 16 patients (56%) recovered fully from the psychological and psychiatric consequences of the accident and the rest (44%) had good recovery after treatment. Only one patient was taking psychotropic medication at the time of the treatment. In terms of functional abilities, after the completion of treatment, all patients were able to drive on the roads again and reported their driving returned back to pre-injury state.

CBT is effective in the treatment of patients with anxiety, depression, and PSTD symptoms following a RTA. It is important to use CBT more flexibly with these group of patients due to complexity of physical and psychological symptoms and incorporate third wave CBT (ACT) into the treatment regime to address adjustment difficulties related to psychosocial stress (e.g., dealing with litigation process and insurance). Clinicians need to incorporate psychological CBT-based formulation in to the legal and social context of the injury.

Metacognition and Happiness

Lowri Dowthwaite, Unisity of Central Lancashire;

Happiness and subjective wellbeing have been associated with a number of benefits, including improved health, psychological resilience, work success and academic achievement (Lyubomirsky (2005); Miret et.al (2014)); Farhud, Malmir & Khanahmadi (2014). Deppe (2014); Marques, Pais-Ribeiro & Lopez (2011). Positive psychology is being explored more also in the realm of therapeutic practice and links well with some CBT approaches. The aim of this study is to explore determinants of happiness within a student population and to establish if there are areas that could be nurtured and cultivated that would further help students to be happy, engaged and successful at university. In particular, the study will examine the five factors of flourishing as researched by Seligman (2010; 2012). These factors are: Positive Emotions, Engagement, Relationships, Meaning and Accomplishment and also examine impact of personality types and metacognitive processes. A Cross-sectional design was employed with 241 participants completing six questionnaires.

The participants completed a battery of questionnaires. To elicit a measure of happiness, the Oxford happiness scale (Hills & Argyle, 2002) was utilised as the dependent outcome variable. The PERMA –Profiler (Butler & Kern, 2016) was used as an independent measure of contracts associated with happiness. The Metacognitions Questionaarire-30 (MCQ-30 Wells & Cartwright-Hatton 2004) was completed to examine positive and negative beliefs about worrying thoughts, attitudes & processes. In addition to the above, this study also examines the relationship between personality traits, happiness and flourishing, using the Goldberg personality scale. (Goldberg, 1993). For example, it was hypothesized that Extroversion will be mostly associated with hedonic happiness (Positive Emotion and Relationships) and
Conscientiousness and Openness more related to the eudemonic (Meaning and Accomplishment) experience of happiness, also known as the ‘good life’ (Ryan & Deci, 2011). Data has been analysed using zero order correlations to establish significant relationships between the variables, followed by hierarchical regression analysis to establish significant predictors, for example experiencing frequent positive emotions and having close relationships is a strong predictor of Happiness. The study has also found significant differences between male and females, the most significant being that females experience more frequent negative emotions and engage in more worry and rumination than males. The study has also discovered that although women score higher on neuroticism as a personality trait than men, they are also more likely to laugh more than men and they report higher levels of positive emotions than men. Males and females score equally for overall happiness and satisfaction with life. We are just completing our analysis therefore are unable to include significance values as of yet but our initial stats look very promising. We are confident that our data analysis will show some significant correlation between extraversion and happiness, a strong relationship between neuroticism and happiness, which will be mediated by metacognitive beliefs and processes, such as worry. We also predict many interesting differences between male and female metacognition and experiences of happiness.

There are many possible implications for CBT practice that the study hopes to explore further. In particular how we can integrate positive psychology interventions into therapeutic practice, particularly in IAPT services, for people experiencing mild-to-moderate anxiety and depression. Also how might our understanding of gender differences, particularly in relation to metacognitive beliefs shape our future practice.

Balancing distance and closeness: a dyadic qualitative exploration of assessment processes for talking therapies

Angela Sweeney, St George’s, University of London; Steve Gillard, St George’s, University of London

Large numbers of adults access psychological therapies in England every year, with a steady rise since 2000 (NHS Digital 2016). The Improving Access to Psychological Therapies (IAPT) programme alone aims to treat 1.5 million people annually by 2020 (NHS England 2016). This suggests that huge numbers of people in England are assessed for psychological therapies every year, with an upward trajectory. There is some experiential evidence to suggest that clients can find assessments for talking therapies very difficult. Furthermore, did not attend rates in IAPT can be very high, with some evidence that short, impersonal assessments are causal (Marshall et al 2016). Research has also found high rates of burnout amongst IAPT practitioners (Westwood et al 2017). Despite this, and a governmental emphasis on placing service users’ experiences at the heart of healthcare service development and provision, understanding of clients’ experiences of assessments is limited by a lack of research. Trauma-informed approaches aim to minimise harm and create safety for service users and practitioners, and may be relevant in understanding and improving IAPT and other talking therapy assessments.

Following extensive literature reviews, this survivor-led study used qualitative dyadic interviewing to understand the ways in which assessments are enacted and experienced by assessors and clients. Statutory and third sector therapy providers in a large metropolitan city participated. Separate, confidential interviews were conducted with seven clients and seven assessors who had been involved in the same assessments. Interviews explored issues such as the meaning and impact of assessments, experiences of waiting, discussing trauma and social identity. Responses were compared and contrasted through ‘versus’ and ‘consensus’ coding. This meant that the integrity of individual accounts was retained, with an analysis of convergence and divergence within and between dyads generating a third, etic perspective (Eisikovits and Koren 2010). This study was part of a larger programme of research, funded by NIHR, investigating talking therapy assessments.

The key interpretative theme that emerged was balancing distance and closeness. An understanding of aspects of dyad member’s identities was key to explaining how and why
Closeness and distance was enacted and balanced, these were: strangers, humans, experts, collaborators and survivors. Key sub-themes which contributed to understanding the nature and impacts of balancing closeness and distance within the context of identities were identified: experiencing connection, building trust, enacting safety, and opening up, holding back. Moving beyond the micro, we also identified systemic factors that mediated experiences of closeness and distance within assessments.

This study has implications for understanding how clients’ experiences of assessments can be improved. Along with extensive literature work, the findings of this study will help shape good practice guidelines for conducting talking therapy assessments. A greater understanding of the impact of assessments on clients, and how assessment processes might be improved.

Are safety-seeking behaviours relevant to physical health conditions? A systematic review of typology, function and impact

Samantha Lloyd, University of Bath; Jo Daniels, University of Bath

Cognitive behavioural therapy (CBT) has been increasingly applied to the understanding of physical health problems, and treatment of associated distress and reduced quality of life. However, outcomes for CBT for physical health conditions are moderate at best, with calls for further research into potential maintaining mechanisms of distress in these conditions. The concept of safety seeking behaviours (SSB) has made a significant contribution to cognitive behavioural interventions across anxiety disorders and is emerging within literature on physical health problems, with potential for improving outcomes. Objectives: The aim of this systematic review was to examine the current evidence for SSB across physical health conditions in adults and synthesise what is currently known of the typology, perceived function and impact of such behaviours, with a view to better operationalisation of SSB within physical health conditions.

Conceptual and empirical papers, of any study design, reporting on ‘safety seeking behaviours’ or ‘safety behaviours’ in adults with physical health conditions, published in English were eligible for inclusion. Electronic databases of Scopus, EMBASE, Medline and PubMed were searched between November 2017 and January 2019. Study quality and risk of bias of included studies were assessed.

29 eligible papers, including both conceptual (N = 9) and empirical studies - of a range of designs -(N=20) were identified and included in the review. Identified studies included a range of conditions: insomnia (N = 11), chronic pain (N = 4), comorbid pain and insomnia (N = 1), Irritable Bowel Syndrome (IBS, N = 2), persistent dizziness (N=3), incontinence (N = 1), sexual dysfunction, (N = 1), heart problems (N=2), non-cardiac chest pain (N = 1), tinnitus (N = 1), diabetes (N = 2). SSB were found to be relevant to a range of physical health conditions, where the perceived function of such strategies is to prevent a feared catastrophe, or the consequences of this. Whilst idiosyncratic strategies were found across health conditions, commonalities in typology were also found, in line with those identified in anxiety disorders. Across health conditions, SSB were theoretically implicated in the development and maintenance of both physical and psychological symptoms through maintenance of fear-related beliefs. However a lack of empirical testing of this was identified. This review provides evidence of the relevance of SSB to a range of health conditions. This has important potential treatment implications for reducing distress and improving quality of life in physical health through identifying and intervening with such strategies. However there is a need for a more consistent and validated approach in the conceptualisation and measurement of SSB across physical health conditions, with further empirical research warranted, particularly on the impact of SSB on cognitions.

This review has important implications for cognitive behavioural interventions in physical health conditions, with increased focus on SSB having potential to improve current treatment outcomes relating to distress and quality of life in physical health conditions.

Specificity of sensitivity to betrayal and betraying others in Obsessive Compulsive Disorder and Depression
Mental contamination (MC) was first introduced by Rachman (2006) to describe subjective feelings of ‘dirtiness’ which are experienced in the absence of direct physical contact/contaminants. These feelings of “internal/emotional dirtiness” are often linked to experiences of being humiliated, violated or deceived, and commonly involve a moral appraisal of the self as shameful or 'bad' (Herba & Rachman, 2007). Despite betrayal being a commonly encountered concept within society, culture, literature etc. little is known about betrayal as a psychological concept within applied psychological research. There is some evidence which indicates a link between MC Obsessive Compulsive Disorder (OCD) and the role of betrayal (Rachman, 2004; 2010; Warnock-Parkes, Salkovskis, & Rachman, 2012; Coughtry et al., 2013). A recent study in clinical samples (Pagdin, 2017) found that betrayal scores were a moderate predictor of the experience of mental contamination, though the role of perceived “perpetration” in terms of betrayal remains ambiguous. It has been posited whether rumination could also have a role in the experience/reporting of betrayal in MC OCD. The current study therefore aimed to determine whether people with MC in OCD are relatively more sensitive to the idea that they have betrayed others compared to those with OCD without a major component of MC. The study also aimed to determine if rumination moderates the impact of the perception of being betrayed and betraying others. Comparisons were made across three clinical groups (MC OCD, OCD, and depression) with a ‘non-clinical’ benchmark comparison group. This study was based on a cross-sectional, between-groups design. An anonymous online questionnaire was completed by participants; including betrayal specific measures. Participants were recruited through NHS sites and social media platforms. 204 participants took part in this study (N=43 in MC OCD group, N=64 in OCD group, N=43 in the depression group and 54 in the non-clinical control group).

**Please note that this research is being completed as a part of a Doctorate in Clinical Psychology which will be submitted in May 2019. Therefore the results and discussion are currently pending but will be available at the end of May 2019 **

The results of this paper will contribute to our clinical understanding of the role of betrayal in mental contamination OCD, which is known to be a ‘hard to treat’ form of OCD. It is hoped that a better understanding will lead to informed psychological treatment, the development of which is still in its infancy for this subtype of OCD. Current treatments emphasise working with the historical “betrayal” experience; if the sensitivity to the sense of being a “perpetrator” is also involved in the experience of MC, then this might also need to form part of the focus of treatment.

A CBT-Supported Very Low Calorie Diet IAPT Intervention for People with Type 2 Diabetes

Ellie Wilkinson, Lift Psychology, AWP NHS Trust; Abby Hookey, Oviva UK; Darragh O'Shea, Imperial College Healthcare NHS Trust; Jon Freeman, Lift Psychology; Deborah Collins, Great Western Hospital NHS Trust

Type 2 diabetes has reached elevated levels in the UK resulting in significant health and economic costs to the individual and the health service. Obesity is believed to account for 80-85% of the risk of developing type 2 diabetes, indicating weight loss interventions may be of value. Evidence suggests that losing 10% of original body weight may improve glycaemic control in people with type 2 diabetes, despite weight regain (Baker et al, 2009). Further, a growing body of evidence suggests that a Very Low Calorie Diet (VLCD) can improve body weight, glycaemic control and potentially result in diabetic remission in those diagnosed with type 2 diabetes (Lim et al., 2011).
An 8-week VLCD programme was developed and delivered by a primary care psychology (IAPT) service, with input from dietetics and support from local GPs. Participants were provided with support to adhere to the programme and to make the required lifestyle changes through group-based teaching of CBT-based skills. Such skills included managing unhelpful cognitions, relaxation, assertive, communication, mindfulness and problem-solving skills.

Pre, post and follow-up health measures were collected including blood glucose levels, HbA1c and weight. Qualitative feedback was also sought.

A statistically significant decrease in mean blood glucose levels from baseline to study end was found (t[10]=4.22, P<0.002 [two-tailed]). Overall mean decrease in blood glucose levels during the study period was 1.93 mmol/L (95% confidence interval [CI], 0.914–2.957). Statistically significant improvements in mean blood glucose levels did not extend into the follow-up period.

A statistically significant decrease in mean HbA1c from baseline (50.90 ± 6.93 mmol/mol [6.8%]) to study end (39.45 ± 2.94 mmol/mol [5.8%]) was also observed (t[10]=6.20, P<0.001 [two-tailed]). Overall mean decrease in HbA1c during the study period was 11.45 mmol/mol (95% CI, 7.34–15.56). Statistically significant improvements in mean HbA1c were maintained at 3-month follow-up.

There was a statistically significant decrease in mean body weight from baseline (112.84 ±20.54 kg) to study end (96.24 ±17.63 kg; t[10]=14.44, P<0.001 [two-tailed]). Mean overall decrease in body weight was 16.6 kg (95% CI, 14.04–19.15). Statistically significant improvements in body weight were observed at 3- and 12-month follow-up.

Qualitative feedback was overwhelmingly positive about the programme, especially regarding the CBT-based techniques acquired during the diet, as well as the social support provided by the group-based approach.

On completion of the 8-week VLCD programme, fasting blood glucose decreased significantly, and 10 of the 11 participants were within the non-diabetic range. These results support previous findings by Lim et al (2011) that a VLCD undertaken over an 8-week period by people with type 2 diabetes can reduce body weight and improve glycaemic control.

Although the improvements in glycaemic control were not maintained at 12-month follow-up in the present study, several participants’ medication had been reduced or stopped over this timeframe and no new medications were introduced or doses increased. Participants’ positive feedback indicates that the intervention is acceptable and can be provided within a primary care setting with support from GPs.

CBT can facilitate adherence to VLCD’s and support the implementation of long-term lifestyle changes. This, alongside dietary and medical support, has the potential to enhance the health of the population and reduce the significant economic costs associated with type 2 diabetes.

Does self-compassion play a role in eating pathology and body image? A systematic review and meta-analysis

Fidan Turk, University of Sheffield
Eating disorders and body image concerns are severe mental health conditions, with substantial consequences for health and quality of life, so it is important to consider treatments that might enhance our ability to treat such cases. Recently, there has been a growing body of research on self-compassion in relation to such problems. However, we are not yet clear about the extent of such effects, given the range of studies and methodologies used. This paper reports on the results of a systematic review and meta-analysis that considers the size of such an effect and the factors that might moderate its relationship with eating and body image psychopathology.

A systematic literature review was carried out using three key databases (Web of Science, Psychinfo, PubMed), and meta-analysis was used to reach firm conclusions about the size of the effects and moderators, across a range of correlational and experimental studies.
The effect of compassion in isolation was relatively small, though it showed some potential to add to the effects of other interventions. The value of compassion as an intervention or preventative factor for eating and body image issues might lie more in its ability to add to other therapies, rather than as an alternative to those other interventions.

Why do rapid improvements happen? Client and therapist processes in cognitive behavioural therapy and behavioural activation

Asha Ladwa, University of Exeter; Heather O'Mahen, University of Exeter; Kim Wright, University of Exeter; Adele Hayes, University of Delaware

Rapid, stable symptom improvements in therapy, known as sudden gains (Tang and DeRubeis, 1999), are a robust pattern of change found in psychological therapies for depression, including cognitive behavioural therapy (CBT) and behavioural activation (BA). Research has found that individuals who experience sudden gains earlier on in treatment enjoy better outcomes at post-treatment and some have found there are longer lasting clinical benefits. However, the client and therapist processes surrounding a sudden gain are poorly understood. Therefore, the current study examined both client and therapist processes to understand what precedes and accompanies the sudden gain, and whether these processes are associated with outcome in CBT and BA.

Data from the COBRA trial, which assessed cost and clinical effectiveness of CBT and BA for adult depression, were used for this secondary analysis. Depression symptoms were assessed using the Beck Depression Inventory at each session, which was used to identify sudden gains. 25 individuals from each therapy who experienced sudden gains were matched to individuals in a yoked control group. They were matched by treatment, Patient Health Questionnaire baseline score and session number. Three sessions over the sudden gain, which totalled to 274 therapy audio recordings, were coded using the Change and Growth Experiences (CHANGE) manual, a coding system designed to examine processes of change within psychotherapy.

We will present the findings of this ongoing research in relation to client processes such as hope, behaviour and avoidance, and therapist processes such as specificity, corrective information and therapeutic relationship. We will present the processes surrounding the sudden gain, as well as relationship to outcome and treatment differences.

This work has both theoretical and clinical implications for practice within CBT and BA. Despite CBT being widely used to treat a range of psychological disorders, our understanding of why CBT is efficacious and the current gold standard of psychotherapy is still limited. Exploring different patterns of change, such as sudden gains, and comparing them to other treatment modalities may help us understand what works in CBT and compare mechanisms of change to other treatments. This research can inform the practice of CBT, at the level of training therapists, to help bring around these positive sudden symptom improvements in treatment so they can enjoy the long lasting clinical benefits.

Combined group and time-intensive cognitive behavioural therapy for OCD: a proof of concept study

James Quah, Trinity College Dublin

Cognitive behavioural therapy has a strong evidence base for the treatment of OCD. However, around a third of people are non-responders and there are several barriers to treatment. These include long waiting times, scarcity of competent therapists, and non-adherence to treatment. Group CBT and time-intensive CBT have been used to improve response rates. However these formats each have their own advantages and disadvantages. One previous case study (Reeder and Taylor, 2015) has described a combination of these formats to maximise their advantages while minimising their disadvantages. For example the normalising and motivating effect of group CBT was coupled with the ability of individual CBT to focus on a participant’s idiosyncratic presentation. The purpose of this
study was to determine whether additional preliminary evidence could be found for the effectiveness and acceptability of combined group and time-intensive CBT (CGICBT) for OCD. A quasi-experimental one group pre-test – post-test design was used to evaluate the effect of CGICBT on 8 adult participants with OCD in a routine clinical environment in Ireland. A four week CGICBT programme was delivered in which participants attended one group session and two individual sessions of CBT per week. A range of self-report measures were conducted at pre-intervention, post-intervention, and at one and three-month follow-up. Completer and clinically significant change analyses were carried out. Significant treatment effects were found for OCD symptoms at the end of treatment and at the follow-up sessions. Significant improvements in depression, anxiety and functioning were also detected. Large effect sizes were found and compared favourably with those found in the literature. Analysis of clinically significant change showed that where improvements occurred, these changes were largely clinically meaningful. The intervention was rated as highly satisfactory.

This study provides preliminary evidence for the effectiveness and acceptability of CGICBT for OCD, alongside the previously described case study. Design limitations, such as the small sample size mean these results should be taken cautiously, however, they do provide justification for more rigorous evaluation of the format. Should further efficacy studies corroborate these findings, these results, together with the established evidence-base for the models of OCD used in the intervention, support the use of CGICBT in routine clinical practice in Ireland. This novel treatment approach fits within Irish Health policy aspirations to deliver evidence-based, recovery-focused treatments. The brevity of the treatment and that several service users can be treated concurrently, may go some way to addressing long waiting times and heavy caseloads for cognitive behavioural therapists. Although possibly not suited to all, the format offers an additional choice of treatment for those with OCD and could be a useful option in incrementally increasing both adherence to treatment and response rates. There is also potential for CGICBT to be used as part of a stepped care model. This aims to deliver the most effective treatments in the least intrusive way possible and is recommended by NICE (2005). In short, low cost options CBT can be tried before treatment is "stepped up" and higher cost, more intensive therapies are used. NICE (2005) recommends intensive CBT for severe or treatment resistant OCD. In a sense, CGICBT is both efficient, due to the number of service users who can be treated at a time and the short duration of treatment, and also costly, in that there is an increased demand on therapists’ time for this duration. However, it could be of use at this level of the stepped care model. NICE (2005) also recommends that service users should have access to specialist OCD services. Within the Irish public health service, this may not be feasible due to a general dearth of CBT therapists. There was the sense that collaborating on the delivery of this intervention, necessitating informal training for CBT for OCD and regular supervision, constituted a valuable learning experience for the therapists involved. This is speculative because this was not the focus of the study, however, Taylor and Reeder (2015) noted that their therapists valued the experience because of the opportunity to share information and to work alongside colleagues in delivering the intervention. Perhaps collaborations such as these can contribute to the continuing development and expertise of therapists.

Barriers to the Short Health Anxiety Inventory (SHAI) being completed in a specialist CFS/ME

*Jo Daniels, University of Bath; Kirsty Ryniks, University of Bath*

Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) is a debilitating condition which affects between 1-2% of the population and is characterised by unexplained, ongoing and excessive fatigue unalleviated by rest, sleep disturbances and muscular pain (NICE, 2007). Health anxiety (APA, 2013) has recently been reported as highly prevalent in CFS/ME, in the region of 42% (Daniels, Brigden, & Kacorova, 2017; Daniels, et al. in submission) with emerging evidence suggesting health anxiety is both associated with
symptom severity and also amenable to treatment (Daniels & Loades 2017; Daniels et al in submission). Due to protracted diagnosis, lack of validation and heterogeneous presentation in CFS/ME it is unsurprising that rates of health-focussed anxiety may be elevated to levels higher than in other medical populations. Concerns have been raised that the short health anxiety inventory measure is unacceptable to service-user due to wording, and that this could (a) impact clinicians’ ability to engage and develop a therapeutic relationship (b) potentially lead to neglect of a pressing clinical need. The aim of this study is to assess barriers to the SHAI being completed within a specialist CFS/ME clinic.

Methods:
This study used a multi-pronged mixed methods design, including a service focus group with MDT CFS/ME clinicians (N=15), online national survey of CFS/ME clinicians (N=57) and individual interviews with service-users (N=2).

Results:
1. Focus group
Several themes emerged from thematic qualitative analysis: timing of use, phrasing/language of the SHAI, clinician and patient bias, questionnaire fatigue and negative previous experiences.

2. Online survey
Thirty-one 31 were based in CFS/ME services, 26 were in other areas of clinical health. These clinicians worked in Oncology, IAPT, medicine and four national CFS/ME services. Of the three services who reported using the SHAI routinely, only the clinician working in the medical directorate did not report challenges in using it. Findings reflected themes associated with wording relating to ‘hypochondriasis’ the relevance to medical populations, lack of validation of realistic fears and general feelings of inappropriateness of the measure.

3. Patient consultation
There was agreement that it might be helpful to think about the timing and context of administering the SHAI. Issues were raised regarding the language of the SHAI being outdated or too technical (e.g. ‘hypochondriac’) and queried people’s understanding of what a number of words might mean, including ‘bodily sensations’, ‘ill’, ‘images’, ‘serious illness’, and ‘lastingly relieved’. They also struggled with item two of the SHAI, stating “How do I know what other people are experiencing...a six to me may be a two to you...I have no idea how much pain others may be going through!” and “How do I know how much others worry?”

Conclusions:
Clinicians and service-users agree on core difficulties with the utility of the SHAI in the CFS/ME population. These themes extend to other health areas, as indicated by responses from other clinical health psychologists.

The timing of the SHAI being administered pre-diagnosis, the language of the SHAI and lack of context around the questionnaire were identified as barriers that were likely to be contributing to the SHAI not being completed by a proportion of service-users. Survey fatigue was also highlighted. This suggests that adaptation of the SHAI is vital for use with CFS/ME, particularly given the high co-morbidity of health anxiety in this population. Future research should focus on engaging service-users in the development of a measure which is appropriate to need, acceptable while also retaining reliability and face validity.

How do adults, youths and caregivers experience receiving trauma-focused cognitive behavioural therapy? A systematic review of the literature

James Griffin, Coventry University; Magdalena Marczak, Coventry University
Despite Trauma-Focused Cognitive Behavioural Therapy being a recommended treatment for Post-Traumatic Stress Disorder, clinician surveys have indicated some concerns about the acceptability of this treatment (Frueh, Cusack, Grubaugh, Sauvageot & Wells, 2006). Exploring client’s experience of receiving NHS care is in line with government’s guidelines on involving service users in developing NHS services in the UK.
(Department of Health, 2014), yet this continues to be a neglected area in psychotherapy research.
A systematic electronic search was carried out on 19th November 2018 using Academic Search Complete, PsycINFO, PsycARTICLES, MEDLINE, AMED and PILOTS electronic database. Qualitative and mixed methods studies were eligible for inclusion. A total of 14 papers of mixed quality were identified. Analysis of the reviewed articles’ findings identified three main themes: clients’ ambivalence to undertake therapy, importance of the therapeutic relationship, and new perspectives gained through exposure. The review confirms that, for adults, youths and caregivers, receiving trauma-focused CBT has a positive impact on their lives in many ways. Individuals spoke about a reduction of distressing symptoms, such as nightmares and flashbacks and an improvement in social functioning. Future research investigating people who have dropped out of trauma-focused therapy, or who did not find it to be effective could provide insight into the factors which make TF-CBT therapy difficult for some clients to tolerate. Although exposure-based interventions have been found to be efficacious in the treatment of PTSD in several well-controlled studies, clinicians who treat PTSD rarely use them (Cahill, Foa, Hembree, Marshall & Nacash, 2006). Barriers to therapists’ use of exposure element in therapy include inadequate training and concern about the clients’ condition worsening as a consequence of treatment. The implications of this include people not gaining access to effective treatment for PTSD which is a major public health concern. The current review highlights the clinical paradox of talking about the trauma, where the process can be distressing but ultimately is considered as a beneficial experience. Findings suggest that clinicians working with PTSD should expect their clients to be ambivalent about starting therapy and engaging in exposure based interventions. However, ambivalence and increased distress should not be seen as an indicator of treatment non-response. Clinicians should aim to spend sufficient time at the beginning of the therapy developing a strong therapeutic alliance prior to starting an exposure based intervention. Alongside developing a good working alliance, clinicians should also ensure they provide sufficient psycho-education about the symptoms of PTSD and rationale for conducting reliving, which also reflects guidance from Ehlers and Clark (2000).

Evaluation of Collaborative Cognitive-Behavioural Case Formulations in a Clinical Psychology Program: A Client Perspective

Lee Kannis-Dymand, University of the Sunshine Coast (USC); Sunshine Coast Mind & Neuroscience – Thompson Institute; Aleisha Myers, USC, Australia; Geoff Lovell, USC, Australia; Berquin Human, Cooinda Mental Health Service, Buderim Private Hospital, Australia; 

Cognitive behavioural case formulations (CBCFs) have been widely used collaboratively within the Cognitive Behavioural Therapy (CBT) context, with regards to developing an individualised approach to therapy. However, there is little research examining how clients experience shared formulations, and their reactions to the process. The current study aimed to further explore the role of CBCFs in an outpatient, student-staffed community clinic, through investigating the clients’ reported experiences. A total of 30 adult participants aged between 18 and 67 (M = 37.50, SD = 11.20) with a range of mental health concerns, completed a CBCF session as a part of routine therapy with a provisional psychologist. Immediately following the session, participants completed a questionnaire that included five 5-point Likert scales measuring clients’ experience of the collaborative CBCF and two open questions capturing further information about the process. Results revealed high scores across all questions on the Likert scales. A total of nine themes were identified from qualitative data regarding the clients’ experience of the process. Six of the themes related to a broadly positive emotional response, two were associated with a broadly negative emotional response, and one was considered to be a neutral emotional response.
Findings suggest that the collaborative, visual process of CBCF is a constructive experience for clients, that facilitates clients to better understand their difficulties, elicits optimism and acceptance, and a sense of being understood by their treating therapist. Implications for clinical practice suggest that the utilisation of CBCFs is a key component of treatment. However, while these formulations are often experienced as beneficial by the client, therapists need to be mindful of the range of emotions clients may experience in response to this process.

Evaluation of a culture-free, CBT-based, third wave therapy manual

Lydia Baxter, Southern Health NHS Foundation Trust; Peter Phiri, Southern Health NHS Foundation Trust; Isabel Clarke, Southern Health NHS Foundation Trust; Shanaya Rathod, Southern Health NHS Foundation Trust; Farooq Naeem, Southern Health NHS Foundation Trust

Psychotherapies are now widely available for individuals with mental disorders and emotional health problems in the western world. Cognitive Behaviour Therapy (CBT) for example, is recommended as a treatment option in National Treatment Guidelines in the UK (APA, 1993; NICE, 2009). However, despite this, limited progress has been made in providing evidence based therapies for service users from ethnic minority groups. Despite the advances in providing culturally sensitive mental health services, disparities among racial and ethnic minorities still exist. Our group developed culturally adapted CBT (e.g.; Naeem et al., 2015; Rathod et al., 2015). This current project is a further development to investigate a culture free therapy founded on mindfulness.

Aims and objectives
To assess the feasibility and acceptability of the intervention using the third wave CBT approach with diverse cultures. To find out whether the intervention can reduce; (1) symptoms of emotional health problems, and (2) disability.

Method
This is a preliminary evaluation of a new intervention using a before and after evaluation design, to assess the effectiveness of culturally-adapted CBT based intervention for clients with common mental disorders and emotional problems attending Adult Mental Health Services. A description of a generic version of the intervention can be found in Clarke and Nicholls (2018).

Sample
We recruited (n=32) service users with mild to moderate mental health problems, who were identified through Adult Mental Health (AMH) services (e.g. IAPT and CMHT). Participants received weekly sessions of a culture free intervention with a trained therapist for 8-12 weeks, with a 2 month posts treatment follow-up. Outcome measures: HAD scale, CORE OM, BSI, WHO Disability Assessment Schedule 2.0 completed at baseline, end of therapy and at follow-up. PEQ will be completed at the end of therapy. Therapy sessions were audio recorded to ensure adherence to the therapy manual.

Results
Statistical analyses will be carried out using intention to treat analysis. An analysis of covariance (ANCOVA) model will be built as appropriate using the post-study questionnaire as the endpoint, adjusting for baseline questionnaire score, and length of time in study. Pearson’s correlation coefficients will be used to examine the relationships in the PEQ items with outcomes. This study is in progress and preliminary analysis of completed cases has shown significant improvement and a high level of satisfaction with the approach. This poster presentation will share the final, completed and collated analysis of all cases.

Discussion
The intervention being piloted here has shown that the following elements indicate acceptability as a culturally-adapted form of CBT: by acknowledging and centralizing the immediate experience of distress, the “felt sense” (Clarke & Nicholls, 2018, p.4), it side-steps westernized medicalising conceptualisations; in line with third-wave CBT, it uses mindfulness in a targeted and practical manner that does not require extensive practice or commitment to the wider mindfulness tradition, which may not be familiar or acceptable to
the individual, and it lends itself to the inclusion of family members and to the incorporation of religious and spiritual conceptualisations.

The completed cases have shown that the intervention helped to facilitate good engagement with both participants through validation of emotions, along with recognition of their strengths. Combined with a rigorous behavioural focus, this has led to real change in behaviour, which is expressed in their individual questionnaire data. The simplicity of this intervention, along with its sensitivity to religious factors and flexibility in involving relatives promises acceptability for non-Western cultures.

Potential implications for the everyday practice of CBT

The under-utilization of CMHTs by members of ethnic minority groups is widespread and can lead to delays in early presentation resulting in crisis. The development of a culturally sensitive CBT for this group is clinically relevant, and the current intervention shows a positive trajectory.

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**Barriers and solutions for North East IAPT services to engage with research: a scoping project**

**Lucy Dunbar, South Tyneside NHS Foundation Trust;** David Ekers, Tees Esk & Wear Valleys NHS Trust/University of York; Lisa Boyd, South Tyneside NHS Foundation Trust

The Clinical Research Network (CRN) identified recruitment of IAPT services in the North East region for involvement in research had been difficult and wanted to understand why, to improve future involvement. A scoping exercise was undertaken to explore what the main barriers were to being research active and the perceptions of potential solutions.

A scoping exercise was conducted where interviews took place with 24 people (clinical leads, service managers, practitioners) within local IAPT services, R&D roles within NHS commissioned IAPT services and Commissioners in the region to explore their views and themes were highlighted. Contact was made with the chair of an existing Northern IAPT Practice Research Network (PRN) to understand more regarding their model, with a view to consideration if this was replicable in the North East region.

A number of common barriers and themes across IAPT services were reported. These included time, staffing levels, targets, lack of research experience and knowledge, and poor links to R&D and other academic institutions. Themes that arose from what would make it easier to be involved in research included more time, money, staff, better links with R&D, access to research experience and knowledge and an organisational commitment to research.

It may be useful for consideration of improved links between services, R&D depts., academic institutions and the CRN to support IAPT services to be more engaged in research.

The clinical implications for improved involvement in research activity are that services may have increased focus on evidence based practice and delivery of such, and with greater collaboration between research focus and service delivery may improve patient outcomes longer term.

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**Presenting a model for an online intervention for carers of people with psychosis.**

**Amy Johnson, Northumbria University;** Markku Wood, Northumbria University

Carers and family members of people with schizophrenia or psychosis provide an invaluable role in supporting their ill relative. However, the caring role has been shown to negatively impact on carer health with carers showing high levels of distress and social isolation.

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, which is presented on this poster.
A mixed methods design consisting of both qualitative and quantitative elements was completed however this poster will only include some reference to the qualitative results which primarily aided model development. 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. Qualitative results were analysed via thematic analysis (Braun & Clarke, 2006) leading to the identification of five themes. Themes are ‘Empowerment through Knowledge’, ‘Connection, Understanding and Advice Online’, ‘Personal Preference: Considering the Accessibility of the Internet’, ‘The Landscape of Carer Support’ and ‘Experts by Experience’. Key mechanisms were identified within these themes are used to guide model development. Although not the primary aim of this project, this also includes suggested content following participant recommendations. Understanding carer online support use and views with regards to developing an online intervention could increase understanding of carer support needs. These results formed the basis of the development of a model for an online intervention for carers of people with schizophrenia or a psychosis-related disorder which could aid future research. Although this project does not specifically focus on Cognitive Behavioural Therapy (CBT), the results of this study could inform future online-related support (such as computerised CBT) as well as the acceptability of this medium for interventions. Finally, this may also offer efficacy of treatment and rapid access to meet commissioning services. Understanding the beliefs behind the possessions: an exploration of profiles of Hoarding Disorder using Q-methodology

Rowan Tinlin, Newcastle University; Claire Lomax, Newcastle University

The current CBT conceptualisation of Hoarding Disorder (HD) understands hoarding behaviour in the context of vulnerability factors and beliefs about the value and meaning of possessions interacting. Several beliefs in HD have been hypothesised, however, little is known about how these interact or whether they are universal within hoarding populations. Q methodology is able to explore lived experience; by not only gathering beliefs, but investigating how individuals perspectives are similar or different. Therefore, a concourse of beliefs about possessions was developed and 32 adults with clinically significantly levels of HD completed a Q-sort alongside measures of hoarding behaviours, mood, OCD, attachment style.

Q factor analysis produced four profiles of HD; consisting of groups of participants whom shared a particular perspective on beliefs, as well as shared characteristics; (1) ‘expression of identity’ in which individuals endorsed beliefs about possessions communicating past, present and future ideas of ‘self’, (2) ‘responsibility and morality’ in which beliefs about protecting possessions and caring about the wellbeing and correct and environmental use of objects were endorsed, (3) ‘stability and predictability’ in which beliefs about possessions being predictable and reliable were highly agreed with, alongside beliefs about human beings being unpredictable or the world being chaotic, and (4) ‘objects as emotional and meaningful beings’ in which anthropomorphic beliefs about objects having the potential to host emotions were endorsed frequently.

The identification of distinguishable profiles within HD has clinical implications regarding the assessment and treatment of the condition. The four profiles were characterised by different categories of beliefs about possessions, attachment styles, and levels of anxiety, depression and OCD symptoms; suggesting that assessment tools and different interventions would be necessary to treat individuals within each profile.

The current CBT model for HD (Frost and Hartl, 1996) includes beliefs about possessions which are incorporated in the many CBT protocols currently published and available for use with individuals with HD. However, this research highlights beliefs which are not yet included within the model, and moreover, suggests that different interventions might be
useful for targeting beliefs within different profiles of HD. This research will hopefully invite discussion around the current use of CBT for HD.

Anger Management and Emotional Control Programme: evaluating outcomes of group CBT in a novel adult group

Jane, Felix Basher, Higgins-Stockden, North East London NHS Foundation Trust (NELFT); Felix Higgins-Stockden, NELFT; Denitsa Batsova, NELFT; Sheila Ufot, NELFT; Ruimin Ma, NELFT

Despite the lack of recognition of anger in the diagnostic manuals, there has been an increase in CBT-based anger management programmes (Beck & Fernandez, 1998), which has been shown to improve Anger Control (AC) and Anger Expression (AX; Blacker et al., 2008). This study evaluates the efficacy of a skills-based group CBT Anger Management and Emotion Control (AMEC) programme within a naturalistic clinical sample with differing diagnoses.

A naturalistic repeated-measures design was used to assess anger before and after completing the 16-week AMEC programme using the State-Trait Anger Expression Inventory-2 (STAXI-2). Participants were excluded if currently involved in domestic violence. No exclusions were made on the basis of substance misuse. This study included 70 participants (16f, 54m; mean age=38.9, SD=12.2) who completed all 16 sessions. Shapiro-Wilk's and Levene's tests were carried to assure that all assumptions were met. Then STAXI-2 sub-scale scores were compared using a Wilcoxon Signed-Rank Test (WSRT) Paired Sample T-Tests to examine differences in state anger (SAng), trait anger (TAng), AX and AC. Data from the STAXI were tested for normality using a Shapiro-Wilk Test which found that pre- and post-group scores for SAng and TAng were not normally distributed (p<0.05). WSRT analysis indicated that the SAng post-group score of 20.9 was statistically significantly lower than the pre-group score of 26.4 (Z = -3.2, p < 0.05; d = .80), and the TAng post-group score of 23.3 was statistically significantly lower than pre-group score of 28.5 (Z = -5.05, p < 0.05; d = .69). The Shapiro-Wilk's Test found that pre- and post-group scores for AX and AC were normally distributed (p > 0.05), therefore a Paired Samples T-Test was carried out.

There was a significant decrease in AX scores from pre- (M=42.8, SD=8.45) to post-group (M=36.5, SD=10.4; t(69)= 4.5, p < 0.001; d = .71). There was a significant increase in AC scores from pre- (M=30.7, SD=7.1) to post-group (M=39.7, SD=11.2; t(69)= -6.52, p < 0.001; d = .87). When assessing difference in AC scores between gender, there was a significant increase in males (t(53) = -6.91, p < 0.001), but not females (t(15) = -1.31, p = 0.21).

Analysis showed the AMEC programme to have significant therapeutic effect across all subscales of the STAXI, most pertinently TAng, AX, and AC. Limitations - due to attrition, data from participants who did not complete the full programme were excluded, therefore change in STAXI-2 scores weren't analysed. There were fewer female participants, which limited power to statistically analyse gender difference. Future research - with a larger sample size, differences in gender and primary diagnosis can be analysed. Furthermore, future research will include a waiting-list control and an active control of 'low intensity telephone skills coaching'. Further examination of the efficacy of the AMEC programme could be done using 6-month follow-up and controlling for social desirability.

Conclusion - this research has shown CBT is efficacious in developing better anger management skills in a naturalistic clinical sample and has provided the grounding for carrying out further in-depth analysis of CBT treating anger.

Using CBT to manage feelings of anxiety in a transgender adolescent: a single case experimental design

Holly Panting, Tavistock and Portman NHS Foundation Trust; Tilly Langton, Gender Identity Development Service

Young people who present as gender diverse or who meet criteria for a diagnosis gender dysphoria have been found to have higher rates of anxiety than the general population.
The reasons for this are complex and likely to be multi-faceted, and it is likely to involve an interplay between gender-based distress levels, feelings about the body, internal thoughts and feelings, and how a young person is responded to in the world as they develop.

CBT has the largest evidence base for the treatment of anxiety in both adults and young people, and is recommended by NICE Guidelines. However, research examining the utility and efficacy of CBT interventions in transgender young people is scant. A recent review of evidence based treatment for young transgender people with social anxiety (Busa et al., 2018) indicates that CBT could be useful for this population, with appropriate adaptations. This review concluded that research is needed both to examine whether CBT is efficacious for transgender young people, and to outline appropriate adaptations that need to be made for this population in order to ensure the effectiveness of CBT.

The Gender Identity Development Service (GIDS) is the nationally designated NHS service for children and young people experiencing confusion and distress related to their gender development.

Though specific CBT interventions are not delivered routinely by GIDS, the intervention presented here is hoped to act as an example of the type of work that could be completed with young people under CAMHS services.

This study with a single case experimental design (n=1) examined the efficacy of a CBT intervention for anxiety for a 17 year old transgender adolescent. Standardised and idiosyncratic outcome measures were used throughout the baseline and intervention phases, and feedback on the therapeutic process was also sought.

Data collected during the baseline and intervention phases will be presented, and discussed in line with the hypotheses made.

The results will be discussed in light of existing research in this area. Considerations and adaptations that could be made to CBT interventions when working with gender diverse adolescents will be discussed.

Though specific CBT interventions are not delivered routinely by GIDS, the intervention presented here is hoped to act as an example of the type of CBT work that could be completed with young people under CAMHS services.

CBT for Foreign Accent Syndrome: A Single Case Study

Nicola Birdsey, University of Bath

‘Becky’ was referred to secondary care services for support with Foreign Accent Syndrome (FAS), following extensive medical investigations, which had failed to find a neurological explanation. Becky alternated between two European accents, and experienced aphonia, low mood, anxiety in social settings, poor sleep, low confidence and difficulties communicating with others. Becky’s life was severely impacted by these problems; she was not able to work and relied on others, resulting in strained relationships with friends and family. Becky’s FAS started the day she encountered a close family bereavement. However, Becky held firm beliefs about a neurological aetiology of her difficulties and initially saw no utility in psychological input.

In the absence of empirically-based cognitive behavioural models for FAS, a collaborative longitudinal formulation was developed to identify: core beliefs (‘I am a burden to others’), dysfunctional assumptions (‘to avoid hurting others I must not express my thoughts and feelings’ and ‘the cause of my FAS is neurological’), the activating event (family bereavement), and cognitions, feelings and behaviour (‘I don’t enjoy people; being around others makes me feel anxious…so I avoid people’). Attending to early experiences within the formulation (including early parental divorce) helped Becky to make sense of her difficulties. The intervention included: scaling beliefs, identifying evidence for/against a neurological cause (Theory A/Theory B), problem-solving, reframing, cognitive restructuring, stress management and activity scheduling. Homework was set to consolidate skill development. Written communication was used when aphonia was present.
Psychological distress was measured using CORE-OM, as distress is a common feature of FAS (Jones et al., 2011) and it is validated in secondary care settings (Lyne et al., 2006). Self-reported distress in the assessment phase reached moderate-severe clinical levels (M=14) and scores peaked mid-intervention (range=21-25), which coincided with stressful life events. By the end of therapy, Becky demonstrated significant improvements in functioning and wellbeing; distress reduced below clinical cut-off (<10) in the final three sessions (M=4), demonstrating statistically reliable change (CORE Partnership, 2007). Therapeutic alliance was measured using the Session Rating Scale (SRS) (Duncan et al., 2003). Becky's scores (M=10) indicated that a tailored CBT approach aligned with her goals, and fostered the development of a positive therapeutic alliance.

This case study suggests that a formulation-driven CBT approach was helpful in reducing distress from persistent ‘moderate-severe’ to sub-clinical levels for an individual with FAS. Although a range of CBT techniques were employed, the key mechanisms of change were cognitive restructuring, activity scheduling and stress management. In this case, accepting an alternative non-neurological cause was central in initiating change; this was the turning point for improved mood, decreased ‘stuckness’ and Becky reporting a ‘huge weight being lifted’. Interestingly, Becky's voiced returned for the three final treatment sessions, although it is not clear whether distress reduction contributed to speaking ability or vice versa. This case indicates that a tailored CBT approach in the context of a positive therapeutic relationship was helpful. However, in the absence of a clear treatment pathway for people with FAS, the development of a CBT for FAS treatment model is needed.

Many individuals with FAS present with symptoms that remain medically unexplained and these presentations represent a challenge to health care services, with patients considered to experience protracted difficulties, overuse services and derive limited benefit from traditional treatments (Woolfolk & Allen, 2012). The implications of not finding effective treatment options are costly to both services and the individuals in distress. Without clear guidance on how to treat non-organic FAS, some clinicians may lack confidence in identifying the best treatment pathway. It is hoped that this case will provide a provisional template for other clinicians to use when presented with clients with FAS. Moreover, this case supports the use of a longitudinal formulation informed CBT approach tailored to the needs of an individual with FAS. Although this is a single case study, it provides initial support for the utility of CBT for FAS.

Who gets offered CBT for psychosis in the 12 months following a psychiatric hospital admission? Follow-up data from an inpatient randomised controlled trial (RCT)

**Maria Stefanova, University of Bath; Maria Stefanova, University of Bath; Pamela Jacobsen, University of Bath**

Current NICE guidelines for psychosis and schizophrenia recommend that all patients be offered Cognitive Behavioural Therapy for psychosis (CBTp), and Family Interventions (FI). Large-scale audits of NHS Trusts have shown that provision of both CBTp and FI are very low, ranging from 5-13% over a 12-month period (Colling et al., 2017). Alongside concerns over the generally low rate of provision, there are also concerns about how biases in referral pathways may further compound inequalities in who is offered therapy. For example, there is evidence that people from black and minority ethnic backgrounds (BME) may be less likely to be referred for therapy compared to people from non-BME backgrounds (Lwembe, Green, Chigwende, Ojwang, & Dennis, 2017).

Data was collected as part of a randomised controlled trial of psychological therapy for psychosis on inpatient wards (ambITION trial; Jacobsen et al., 2019). Follow-up data from electronic health records was recorded on how many trial participants were offered, and received, NICE-compliant therapy in the 12 months after discharge. This afforded the opportunity to examine rates of therapy receipt in the 12 months after inpatient discharge, and also to describe the clinical and demographic characteristics of patients who were offered or received therapy.
The results will show if there were any significant demographic (e.g. ethnicity) or clinical predictors (e.g. length of illness) of who gets offered, and who receives, CBTp and FI in the 12 months following a hospital admission.

The findings will be discussed in the context of previous findings on the generally low rate of provision of NICE-compliant psychological therapy for service users with psychosis, and possible sources of inequalities in referral pathways, and how these may be addressed.

The under-provision of CBT for psychosis is major national concern, and it is important to have clearer data on who gets offered CBT for psychosis, particularly in a major transition in the care pathway, such as moving from inpatient to community care.

**Psychological processes in persistent pain: the role of attachment and intolerance of uncertainty (IU)**

**Zoe Gotts, Newcastle University; Lucy Robinson, Newcastle University; Morag Ritchie, Newcastle University**

Chronic Pain impacts social, emotional and physical functioning and research is moving towards exploration of psychological processes that contribute to persistent pain, including non-pharmacological interventions. Emerging evidence has shown indication of avoidance responses to intolerance of uncertainty (IU) in chronic pain and how pain-related fear impacts upon the development and continuation of pain. The study examines the role of attachment insecurity and the two constructs of IU (desire for predictability and uncertainty paralysis) on pain disability in Fibromyalgia.

364 participants, aged 18-84 years with a diagnosis of Fibromyalgia completed measures of Pain Disability, Intolerance of Uncertainty, Experiences in Close Relationships and anxiety and depression. A mediation analysis was conducted to determine the relationship between attachment and pain disability through intolerance of uncertainty. Avoidant attachment style was a significant predictor of inhibitory IU. Mediation analysis revealed a direct effect of avoidant attachment on pain disability and a direct effect of inhibitory IU (uncertainty paralysis) on pain disability. Anxious attachment was a significant predictor of prospective IU (desire for predictability). There was also a significant direct effect of anxious attachment style on pain disability. However, prospective IU was not a significant predictor of pain disability.

The findings indicate that in the context of avoidant attachment style, there is partial mediation for inhibitory IU on pain in Fibromyalgia. However, for those with an anxious attachment style, there appears to be no mediation effect of prospective IU on pain disability. Interestingly, the direct paths of anxious attachment on prospective IU and prospective IU on pain, remain significant.

Understanding these psychological processes involved in Fibromyalgia has implications in other disorders where persistent pain is a key symptom complaint. This helps in understanding the relationship between attachment style and the transdiagnostic construct intolerance of uncertainty, which in turn has clinical implications in targeting modes of early intervention, specifically attachment and IU.

Is cognitive behavioural therapy effective for treatment of low self-esteem, following intimate partner violence?

**Faith Brammer, University of Bath**

JB was a 25 year-old woman, who presented with low self-esteem and high levels of anxiety and depression. She had been in an abusive relationship for five years (suffering physical and psychological abuse), which ended four years prior to therapy. She was also bullied frequently throughout school and felt overlooked by her parents as a child, as her brother required additional care regarding disabilities.

During assessment, she described feeling worthless much of the time and held very negative views of herself regarding her personality and appearance. Alongside this, she described persistent low mood and feelings of isolation, as well as high levels of anxiety and occasional
panic attacks, which she believed were triggered by social situations where she worried her appearance was being judged. JB’s goals for therapy were to feel better about herself, to stop putting herself down so frequently and to understand the impact her previous relationship had on her current feelings about herself and her self-esteem.

A collaborative formulation of JB’s presenting difficulties was developed, in line with the CBT model of low self-esteem (Fennell, 1997). A focus on low self-esteem was chosen to fit with JB’s goals for therapy. The formulation hypothesised that JB’s early experiences had led her to form negative core beliefs about herself and her self-worth, which were highly exacerbated by her experience of intimate partner violence (IPV). Consequently Jane developed a number of negative beliefs about her self-worth and her appearance (e.g. “I am second best”; “I’m useless”; “I’m ugly”), some of which JB identified as being directly attributable to her experience of abuse. As a result of these beliefs, she developed dysfunctional assumptions about the world that she relied on to cope with daily life (e.g. “If I avoid doing things, I can’t get it wrong”). These beliefs were activated by situations in which the assumptions were threatened. This led to negative predictions, and she consequently experienced symptoms of anxiety and engaged in behaviours that maintained her beliefs. As a result, her beliefs were confirmed and she experienced self-critical thoughts, which resulted in low mood, which maintained the cycle.

The intervention included 11 individual sessions of CBT for low self-esteem, in line with suggestions of Fennell (1997). This intervention was tailored to reflect the impact of JB’s experiences of IPV.

Weekly measures were taken of JB’s self-esteem (measured by the Rosenberg Self-Esteem Scale, (Rosenberg, 1965)) and levels of depression and anxiety (measured by the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer & Williams, 2001) and Generalised Anxiety Disorder questionnaire (GAD-7; Löwe et al, 2008).

A gradual increase of self-esteem was found, increasing from an average of 2.6 during the baseline period to 10 following the intervention period. JB also reported feeling more positive about herself and more confident in her own views and abilities.

JB’s levels of anxiety reduced from the moderate range (average of 14.4) during the baseline period, to the mild range (9) following the intervention. Her levels of depressive symptoms remained in the moderate range (average of 13.4 at baseline, to 14 following the intervention).

This case suggests CBT for low self-esteem may be effective in improving self-esteem following experiences of intimate partner violence. This expands the known evidence base for CBT interventions for low self-esteem. JB had experienced trauma in her past relationship and appeared to have some unresolved symptoms related to this. This case tentatively suggests CBT may be effective in improving self-esteem in spite of this and without specific trauma work. This suggests that CBT for low-self esteem could be incorporated into the stabilisation phase of trauma work (Zayfert & Becker, 2009).

Potentially unresolved trauma symptoms may account the fluctuation in JB’s symptoms of depression and anxiety, which seemed inconsistent with her increase in self-esteem. Discussing her experiences in a therapeutic environment may have re-connected her previously avoided memories and provided validation for emotions she was shameful of or struggling to make sense of. This highlights that this type of intervention could be included as part of longer-term trauma work, as she may not have been ready to address the full impact of the trauma while experiencing very low self-esteem, which was also reflected by JB’s feedback after the intervention.

This case implies that tailored CBT for low self-esteem can be effective following experiences of trauma, specifically domestic violence. It also suggests that this approach could be included prior to CBT for trauma, in cases where the subject may not initially feel ready to begin trauma work.

The Effectiveness of Internet-Based Cognitive Behavioural Therapy in the Treatment of Postnatal Depression: A Systematic Review
Julie Vibholm, University of Dundee, NHS Greater Glasgow & Clyde; Alexandra Willis, University of Dundee

Pregnancy and the postpartum period are accompanied by psychological, social and biological changes, which for some women can precipitate Postnatal Depression (PND): a common complication following childbirth. Due to the debilitating nature of depression, demands of childcare and stigma associated with PND, some do not seek treatment, despite these being available and effective.

Cognitive Behavioural Therapy (CBT) has been found effective in the treatment of PND, and is recommended by national guidelines. Yet, when delivered as individual therapy, this does not address the critical barriers and concerns faced by new mothers including childcare responsibilities, concerns about stigma or fears of removed custody when disclosing their difficulties.

Internet-based CBT (iCBT) is an alternative mode of delivering CBT, which has proven efficacious for a range of disorders, including depression. Developed according to the principles of cognitive and behavioural principles, iCBT can be delivered as a therapist guided or unguided approach, which women can access at their leisure.

To date, few studies have examined the effectiveness and acceptability of iCBT in the treatment of PND and results are promising. The evidence-base of internet delivered interventions in the peri and postnatal period has recently been systematically and meta-analytically reviewed (Lee, Denison, Hor & Reynolds, 2016; Lau, Htun, Wong, Tam & Klinan-Yobas, 2017). Reviews included studies that focused on iCBT for PND as well as grief, stress and post-traumatic stress disorder. The heterogeneous nature of the clinical samples makes it difficult to draw a conclusion about iCBT for PND. The aim of this systematic review was therefore to assess the effectiveness and acceptability of iCBT in the treatment of PND.

Six randomized controlled trials were included in this review. Across all, iCBT was found to be acceptable and effective when compared to control groups, with effect sizes ranging from small to large. In terms of methodological quality, studies scored on the higher range. However, some limitations must be considered in interpretation of these findings.

The implications of findings suggest iCBT may be an effective and acceptable treatment for PND. However, there are some important limitations which must be considered. Variability in primary outcome measures of depression introduced a difficulty in comparing findings with some relying on screening and self-report measures to assess symptom severity. Only half offered details on how treatment protocols had been adapted to PND. This is important to understand, which elements are useful in the treatment of PND and for replication of research. Finally, within all studies therapist support was offered to iCBT treatment groups. This is an important confounding factor, which makes it difficult to gauge whether symptom improvements can be attributed to intervention, support or both. Thus, more methodologically sound research is needed to develop a sound evidence base for iCBT for PND.

Therapist-assisted iCBT may be good alternative option, with therapeutic effectiveness similar to individual CBT. This indeed appears to be an acceptable treatment option for mothers given that it is relatively more accessible, and as such they would be able to accommodate accessing treatment around their responsibilities and theoretically would alleviate the fear of stigma. Moreover, iCBT is an easily accessible evidence-based intervention, which may have an important function as a cost-effective treatment for PND within a stepped care model.
Zachary Parker, Manchester Metropolitan University; Hannah Watson, University of Northampton/Northampton NHS Trust; Zachary Parker, Manchester Metropolitan University

This presentation reports on the clinical utility of a novel scale; the Recoverability from Post-Traumatic Distress Disorder Scale (PTSD-PRS). This scale was developed and validated with clinical and research utility in mind.

The PTSD-PRS initial construction was completed through literature reviews around the concepts surrounding recovery and beliefs/biases around mental health recovery and PTSD. Participants from various backgrounds (those diagnosed with PTSD; those not diagnosed; those who worked with PTSD patients, and those that do not work with PTSD patients). Factor analysis was conducted to determine the structure of this scale.

The PTSD-PRS is a valid and reliable measure that can be used both clinically and in future research to further our understanding of recoverability perceptions for a diagnosis of PTSD. The factors identified by the analysis support the general ideas identified in the literature/clinical practice. Future directions for additional research will be considered.

The PTSD-PRS application in routine practice with clients diagnosed with PTSD may help develop the therapeutic alliance via transparency and aiding in collaborative care. In addition, the PTSD-PRS may help therapists and other professionals working with PTSD better understand the impact of their own biases and beliefs.

Which trauma-focused CBT approaches are most effective in reducing PTSD symptoms in adults who have experienced serious sexual assault or serious non-sexual assault?

Alastair Barrie, JSA Psychotherapy

According to the Diagnostic and Statistical Manual of mental disorders, Post-Traumatic Stress Disorder (PTSD) is a major mental health condition characterised by five main symptom clusters (DSM-5, 2013). Firstly, individuals have to be exposed to a traumatic event. Secondly, this traumatic event is persistently re-experienced, usually in the form of nightmares, flashbacks or emotional and physical distress. Thirdly, the individual avoids stimuli that remind them of the trauma. Fourthly, they experience negative thoughts or feelings that either started or worsened after experiencing the trauma. Finally, they experience trauma related arousal that either started or worsened after experiencing the trauma (DSM-5, 2013). Trauma is specifically described by Resick (2014) as ‘the actual or threatened death of someone or a threat to someone’s physical integrity.’ The DSM-5 (2013) provides a more comprehensive definition of trauma as being ‘exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence’. This systematized review focuses on the development of PTSD after experiencing ‘serious’ sexual assaults (SSA) and ‘serious’ non-sexual assaults (SNSA). We will highlight treatments which demonstrate benefits for PTSD clients and to elicit the most effective treatment for sub groups of clients- clients with PTSD following SSA and clients with PTSD following SNSA. We will elicit the similarities and differences between the most effective treatments for our clinical sub groups. Finally, we will produce recommendations for future practice and research by comparing our findings to Cognitive Processing Therapy (CPT), which is here taken as our TAU factor.

This study follows a systematised literature review format (Grant & Booth, 2009). The aim of this systematized review is to collect research data from different studies and critique it in order for us to be able to conclude the most effective method of care (Cochrane 1972 cited in Cluett, 2006). According to Grant and Booth’s (2009) description, this review searches a selection of databases then analyses all of the results in a systematic manner. The generic term used in searches was ‘Assault’. The specific terms used in searches were ‘PTSD’, ‘Sexual and Assault’, ‘Physical and Assault’, ‘CBT’ and ‘rape’ (following search strategy described by Cluett, 2006). These worlds were also searched in systematic combination, again following Cluett’s (2006) strategy. The databases searched were (in line with Cartwright-Hatton, 2004 & Piet, 2011); PubMed, PsychInfo, Web of Science, MEDLINE (EBSCO), Cochrane Library and Wiley Online Library. One of the most problematic limitations of a systemised review such as
this is that quality assessment may be less identifiable than in other study designs (Grant & Booth, 2009). To address this, our review used the Effective Public Health Practice Project Quality Assessment Tool for Quantitative Studies (EPHPP) to determine the quality of the included studies (Effective Public Health Practice Project, 1998).

We were unable to elicit differences in the most effective treatment approaches for SSA versus SNSA. We judged that PE and CPT are of roughly equal effectiveness for SSA with little difference in changes to threat-beliefs, PTSD symptoms (Suvak, 2012) or, as Rizvi (2009) demonstrated, treatment drop-out rates. This is especially the case when taken in tandem with Scher’s (2017) study which found that both CPT and PE were equally effective at reducing trauma-related threat beliefs. This seems to imply that clinicians could use either PE or CPT as they see fit, perhaps with a slight preference for PE since it seems to produce the same results as CPT in fewer sessions. We also discovered a difference in the effectiveness of different exposure methods. Resick (2008) and Resick (2014) found that CPT without the written exposure component is as effective as CPT with the written exposure for PTSD. Synthesising this result with that of Rizvi (2009) and Suvak (2012), suggests that PE’s exposure components, imaginal and in vivo exposure, are more effective than CPT’s exposure, that of written accounts. We argue that this demonstrates ‘written exposure’ as a ‘weak’ component of CPT. Finally, we found a potential conflict in approaches to trauma-belief changes and how best to achieve them. Zoellner’s (2011) study found that CPT and not PE produced effective changes in trauma-beliefs whilst Scher (2017) concludes that both treatments produced these effects. If, as previously argued, PE’s exposure techniques are more effective than CPT’s and if PE modifies trauma-beliefs then that would seem to argue for PE being the more effective and ‘well rounded’ treatment. This could especially be the case since PE requires nine sessions (Scher, 2017, Suvak, 2012 & Rizvi, 2009) whilst CPT is recommended for 8-12 sessions (NICE clinical guidelines for PTSD, 1.9.2.3). A programme which achieves the same results in less time should be strongly considered as the preferred treatment. However, there is also a considerable body of work demonstrating the efficacy of CPT at treating PTSD symptoms and especially for modifying trauma-beliefs (Zoellner, 2011, Schulz, 2006 & Chard, 2005). Recommendations will, therefore, take a ‘both/and’ instead of an ‘either/or’ approach.

When reviewing Scher (2017), Resick (2008) and (2014), Rizvi (2009) and Suvak’s (2012) results, we can suggest that the strengths of CPT, combined with the strengths of PE would produce a greater improvement of trauma-related threat beliefs than either individual treatment. Instead of choosing one treatment over the other, we propose replacing the written accounts of CPT with the in vivo and imaginal exposure of PE. Placing focus on strong cognitive restructuring and strong exposure techniques would lead to a cyclical interaction of therapeutic components. We suggest that this would lead to exposure being structured and carried out like a series of behavioural experiments. Under this model, the client is exposed to anxiety provoking situations with the aim of gaining new knowledge and evidence for or against certain predictions and beliefs (Rouf, 2004). After the exposure experiment, the results are reflected on and any evidence gained is used to either challenge or strengthen the target belief. For PTSD, this could be used once trauma-beliefs are discovered. These would be tested by exposure in two main ways. Firstly, the information gained through placing the trauma memory in its correct context (Ehlers & Clark, 2000) with the details filled in (Foa, 1995) will provide new information to counter some of these beliefs. Secondly, exposure activities produce experiences of mastery which bring about changes to the clients’ threat-beliefs. These in turn, under the new model, would enable them to engage in further exposure work with a new set of beliefs and assumptions which are then reinforced or fine tuned. This sequence would then be repeated in a cyclical fashion, taking the form of a series of behavioural experiments. The literature in our study suggests this as an effective way to combine the best parts of CPT and PE based treatments. Research is needed to discover whether these theoretical benefits would be realised. Our second recommendation is for practitioners. Since there is a large body of evidence clearly demonstrating the efficacy of CPT, this should still be considered TAU until the previously recommended research has been carried out. We are not aiming to replace an ineffective
treatment, merely seeking to improve an already effective one. The literature suggests that the way to do this is by changing the exposure methods used and ensuring that cognitive restructuring is interwoven with these other, effective components.

A multi-method evaluation of a compassionate cognitive behavioural psychotherapy group for people who self-harm

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In the UK one CBT based group intervention for people who self-harm (Wood & Trainor, 2011) has been offered with some success but has not been replicated yet. Based on the NICE guidelines for people who self-harm (2011), the authors have created a new 12 session group treatment approach integrating Compassion Focused Therapy (Gilbert 2010) and Cognitive Behavioural Therapy (Sutton, 2004). This was a pilot innovation funded project from the local clinical commissioning group and was provided and evaluated by staff and student psychotherapists at a University in the North of England. This presentation will outline the content of the group and the multimethod evaluation. The group content included: functional analysis and maintenance cycles of self-harm, recognition of the role of interpersonal processes, coping strategy enhancement, compassion focused interventions and the production of a personal compassionate soothe box. Rayner & Warne’s (2016) cycle of shame was also discussed in the group and consideration given to how other people’s reactions may exacerbate self-harm and become a maintenance cycle. The focus was initially a safe psycho-educational approach using research case studies from the first authors prior qualitative research, this encouraged participants to make sense of other peoples’ self-harm. This then progressed into a formulation and individual based therapy as the participants began trusting each other.

This is a multimethod quantitative and qualitative study. The first phase of the research was evaluated using four pre and post intervention questionnaires; GAD-7 (Spitzer et al, 2006), PHQ-9 (Kroenke et al, 2001), Self-compassion scale (Neff, 2003, 2016) and Self-injury cognitions scale (Siddaway et al, 2018). The second phase of the study was a thematic analysis of the self-harm diary (created for the group). The third phase of the study was a codesigned phenomenological focus group. This was thematically analysed.

The role of receiving compassion and self-compassion were deemed very important to participants. The therapist role of compassionate validation (without shock or rejection) was pivotal in helping the group increase self-compassion, understand more about their self-harm and cope in different ways. The compassionate soothe box and discussions about other people’s self-harm were deemed very effective by the participants. A new model integrating Compassion focused therapy and CBT for working with people who self-harm. This can either be used as an individual session guide or a in a group.

Predictors of Carer Burden at First-Episode Psychosis: A Multilevel Statistical Approach

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Carers play a vital role in reducing patient mortality and facilitating recovery and community integration after a first psychotic episode (Fridgen et al, 2012; Revier et al, 2015). However, caring for an individual with first-episode psychosis can be subjectively burdening. Indeed, many carers reporting clinically significant levels of depression, anxiety (Hamaie et al., 2016), and post-traumatic stress disorder (Barton & Jackson, 2008). Yet, our
knowledge of the factors that predict carer subjective burden at first-episode psychosis is limited. With this in mind, the current study sought to investigate predictors of carer burden after first-episode psychosis in the largest, most ethnically diverse, and comprehensively characterised sample to date.

This was a cross-sectional study that utilised data from routine National Health Service (NHS) measures in a London early intervention in psychosis service. Carers completed the following measures: The Illness Perception Questionnaire (Lobban et al., 2005) which assessed illness beliefs, the COPE Inventory (Carver et al., 1989) which assessed coping strategies, and the Experience of Caregiving Inventory (ECI; Szmukler et al., 1996), which assessed carer subjective burden. A range of carer and patient socio-demographic and clinical factors were also collected. Illness beliefs, coping strategies, and carer and patient demographic and clinical factors were examined in terms of their relationship to carer burden. Relationships were tested for each of the 8 ECI subscale scores and total negative burden (calculated by totalling scores from the 8 subscales).

Theoretically, significant predictors of carer burden can be usefully integrated into a cognitive model of caregiving, as no model currently exists specifically on carer burden at first-episode psychosis specifically. Clinically, the identified socio-demographic and clinical predictors offer some direction in identifying carers who are most at risk of experiencing burden. The psychological predictors also inform our understanding of specific cognitive-behavioural factors that may maintain carer burden, which can be modified as part of therapeutic intervention. Future research is required to establish the developmental trajectory of carer burden over time through the use of longitudinal studies. The identified socio-demographic and clinical predictors help clinicians to identify carers who are more at risk of experiencing subjective burden. Each of these characteristics can be considered as independent risk factors. Each risk factor may serve as a marker for clinicians prioritising assessments of such caring situations. As illness beliefs and coping strategies have been shown to be modifiable (Riley et al., 2010; Onwumere et al., 2017), they can be targeted as part of cognitive-behavioural therapy (CBT), in order to potentially lower carer burden. This may include learning more realistic negative illness beliefs, and encouraging carers to use more adaptive coping strategies, in individual or group CBT.

Improving access to evidence-based treatment by developing a brief identification tool for anxiety and depression in adolescents

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Anxiety and depressive disorders are the most common mental health disorders in adolescence. Cognitive Behavioural Therapy (CBT) is the most well-established treatment for anxiety and depression in young people, but only a minority access CBT. A failure to identify anxiety and depression when they first emerge presents a significant barrier to treatment access. Existing screening questionnaires are lengthy, making them impractical for routine use in community settings (e.g. schools, GP appointments). The purpose of this study is to develop and evaluate a short (10-15 item) self- and parent-report questionnaire to assess symptoms of DSM-5 anxiety and depressive disorders in adolescents.

The study combines two large (>200) samples of adolescents (age 11-17), and their parents: a community sample recruited through local secondary schools and a clinic-referred sample recruited through a University-based research clinic. Participants completed the Revised Child Anxiety and Depression Scale (RCADS) and the Mood and Feelings Questionnaire (MFQ); and the clinic-referred sample participated in a diagnostic interview. To develop the brief identification tool, we examine the functioning of RCADS and MFQ items. The short scale’s internal consistency, concurrent, convergent and divergent validity are evaluated, and ROC analyses are used to establish sensitivity, specificity and optimal cut-off scores.
This new brief questionnaire has the potential to improve early identification of anxiety and depression in adolescents. Its brevity and easy administration will make it feasible for use in school and primary care settings, and self- and parent-report versions will facilitate application in situations where only a single informant is available. Future research should evaluate the new questionnaire’s capacity to monitor change in symptoms over time and in response to treatment.

Access to evidence-based treatment is reliant on accurate identification of mental health problems when they first emerge. A brief identification tool for anxiety and depressive disorders in adolescents has the potential for widespread use in community settings to help ensure those who may benefit from CBT reach the appropriate services. Subject to further research, in the future the tool could also be used to assess client and therapy progress in CBT with adolescents.

Home practice rates during a Mindfulness for Psychosis group: A systematic review and a qualitative study of Service User Views

**Twinkle, Katherine Choksi, Sawyer, University of Bath; Pamela Jacobsen, University of Bath; Twinkle Choksi, University of Bath; Katherine Sawyer, University of Bath**

Mindfulness based treatments which encourage non-judgemental acceptance and awareness of psychotic symptoms, such as hearing voices or delusional thoughts, can be beneficial for people with psychosis (Louise et al., 2018). Mindfulness-Based Interventions include both within-session and home practice exercises. Higher rates of home practice completion have been shown to predict better treatment outcome in mindfulness-based cognitive therapy (MBCT) for depression trials (Lloyd et al., 2018; Parsons et al., 2017). However, we do not yet know whether a similar relationship between home practice completion and treatment outcome also applies to mindfulness for psychosis.

Due to differences in mindfulness treatment protocols and differences between clinical groups, it is reasonable to expect a difference in home practice in people with psychosis compared to depression. For example, in Chadwick’s adaptation of MBCT for people with psychosis, patients are encouraged to do short periods of home practice, but it is not emphasised as an essential part of the program like in mindfulness for depression (Chadwick, Taylor, & Abba, 2005). Furthermore, people with psychosis may face additional barriers to completion of home practice (e.g. cognitive difficulties, worries about practicing without therapist support when distressing psychotic symptoms are present).

This study has two parts. The first is a systematic review to investigate how much formal home practice people report doing during participation of a mindfulness for psychosis group compared to MBCT/MBSR groups for depression. The second part of the study is to conduct a qualitative study to find out more about people’s experiences of home practice during a mindfulness for psychosis group. Semi-structured individual interviews will be conducted with service users of a community mental health team who took part in a mindfulness for psychosis group as part of their routine care. The interviews will focus on exploring self-reported facilitators/barriers of doing home practice in between sessions of mindfulness for a psychosis group.

The findings will be discussed and compared with other reviews and qualitative studies. Gaps in the literature will be identified, such as whether mindfulness for psychosis trials routinely record and report home practice rates. Factors which are identified as facilitators or barriers to completing home practice will be discussed in relation to the particular clinical group, and the clinical setting of the mindfulness group. Identifying possible facilitators and barriers to people completing home practice when doing a mindfulness group can aid in adapting treatment protocols accordingly by implementing facilitators (e.g. access to guided practices online) into future mindfulness-based interventions for psychosis.
How well do voice-hearing assessment measures capture the positive experiences of individuals? A review of published assessment measures to date.

Lucy Armstrong, University of Bath; Lucy Armstrong, University of Bath; Pamela Jacobsen, University of Bath; Lorna Hogg, University of Oxford

Auditory hallucinations, especially hearing voices, are amongst the most commonly observed symptoms in schizophrenia. Much of the research and interventions around voice-hearing (VH) primarily focus on the idea that this phenomenon is distressing for people, however a handful of studies have demonstrated that beliefs and overall experiences of VH can also be positive (Jenner, Rutten, Beuckens, Boonstra and Sytema, 2008; Sanjuan et al., 2004). In exploring positive experiences of VH, we may extend our understanding of coping strategies that individuals use in response to voices and potential reluctance to engage with treatment, even when individuals report as unwell. One area, yet to be explored, is the way in which positive experiences are represented in VH assessment measures used in research and clinical settings. In the present systematic review, we aim to provide an updated review of VH measures since the last review (Ratcliff, Farhall, & Shawye, 2010) and to assess the degree to which positive experiences of VH are captured by these.

We will be approaching this project in three stages:

1) To provide an updated review of VH measures for psychosis or psychotic-like experiences that have been published in the last 9 years. PUBMED/MEDLINE, PsycINFO and PsycTESTS will be used to identify relevant papers with the following search terms: voice-hear* (hearers, hearing), auditory hallucinations, instrument, measure, scale, interview. Inclusion criteria: Any psychosis or psychotic-like experiences measures which include voice items, published between December 2009 and January 2019, can include measures for people of any age and gender. Papers from any country will be examined papers, provided that they are written in English. Exclusion criteria: Papers not written in English (there are not sufficient resources available for translation), if the full text of the scale is not available, if measures have been translated, but question content is unchanged.

2) The term “positive experiences” will be defined using a triangulated approach (drawing on ideas from professionals, experts by experience and the research literature) and a framework of positive categories will be produced from this. This will be incorporated into the Data Extraction Form, which also covers scale utility, construction and development.

3) All published measures will be evaluated using this framework/form and results will be written up.

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TBC. Results will be explored in terms of future research and assessment development within the HV domain.

Outcome measures are an integral part of assessment and treatment within the CBT approach. An updated review of available voice-hearing measures is needed for researchers and clinicians alike. Considering the positive aspects of voice-hearing may help clinicians to engage individuals who are reluctant to connect with services, and it is additionally important for our changing culture and understanding around psychotic experiences.

The association between parenting, self-compassion, friendship and depression in Chinese adolescents

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Self-compassion, i.e., being kind to oneself in difficult times (Neff, 2003), has proven beneficial for emotional well-being, e.g., decreasing depression, in adults (e.g., Raes, 2011) and adolescents (e.g., Bluth et al., 2016). Although there is some evidence for its beneficial role for interpersonal functioning in adults as indicated by better resolving of relationship conflicts (Yarnell & Neff, 2013), there is limited research about the association between self-compassion and social functioning, i.e., friendship, in adolescents. It is also not well
understood how an individual’s early family or care giver experience (Neff & McGehee, 2010) are associated with trait-level self-compassion. Based on previous research on attachment (e.g., Jiang et al., 2017), it can be hypothesized that parenting is important for the formation of self-compassion in adolescence, to date there is limited research exploring the association between parenting and self-compassion. The current study therefore aimed to explore the association between parenting, self-compassion, friendship and depression in a sample of Chinese adolescents. A cross-sectional survey study was conducted in 567 Chinese adolescents (M age = 13.41, SD age = 1.71; 43.9 % girls) using a revised brief version of Alabama Parenting Questionnaire (Shelton et al., 1996) to assess parenting, a short form of the Chinese version of Self-compassion Scale (Zhao et al., in preparation) to assess self-compassion, twelve items from the Network of Relationships Inventory (Furman & Buhrmester, 1985, 2009) to assess friendship and the short form of Mood and Feelings Questionnaire (Angold et al., 1995) to assess depression. Using structure equation modelling, we identified a model that significantly explained levels of depression.

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In the discussion, we discussed the associations between self-compassion and social functioning and the interesting finding related to the associations between friendship and depression in adolescents. Also, the current research implies the importance of self-compassion on mental well-being and social skill development in adolescence.

(1) providing evidence on the associations between self-compassion, friendship and well-being in adolescence, and highlighting the value of self-compassion in adolescence.

(2) This potentially showed that involving self-compassion in CBT (teaching adolescents to learn the concept of self-compassion) may be beneficial for depressive teenagers to change the way that they are treating themselves.

Exploring and Improving the Factors that Lead to Clinical Change within the Mindful Life Group: a Thematic Analysis approach

Lucy Armstrong, University of Bath; Lucy Armstrong, University of Bath; Elizabeth Marks, University of Bath; Helen Joannidi, Avon & Wiltshire Mental Health Partnership NHS Trust; Michael Houser,

The popularity of mindfulness-based interventions (MBI) such as MBCT (Mindfulness-Based Cognitive Therapy) in health settings has grown significantly, in addition to the incorporation of mindfulness practices within other approaches (e.g. DBT; Dialectic Behaviour Therapy). MBIs have been shown to be effective in reducing symptoms in various mental and physical health conditions, and in enhancing quality of life (see Gotink, Chu, Busschbach, Benson, Fricchione, & Hunink, 2015 for a recent review). Despite being underpinned by theoretically transdiagnostic mechanisms, most MBIs have been researched as applied to homogenous presentations / diagnostic categories in the form of clinical trials. A few studies have assessed how MBI may have general benefits in mixed groups, for example Fledderus, Bohlmeijer, Smit, and Westerhof (2010) demonstrated the efficacy of a combined ACT/MBI intervention for improving well-being in participants with mild-to-moderate distress. Similarly, researchers have explored the value of MBI across specific age groups, with older adult studies demonstrating reductions in blood pressure (Palta et al., 2012), back pain (Morone, Greco & Weiner, 2008), and loneliness (Creswell et al., 2012). Whilst research generally suggests that increased practice leads to increased benefits, evidence supports the use of even very brief mindfulness interventions for conditions like pain (e.g. Zeidan et al., 2011), suggesting that these are still effective in reducing affective reaction and behavioural impulsivity.

On the basis of this research, integrated groups that are conducted in a flexible way to suit the needs of individuals may be an effective way to provide treatment. This has the potential to improve treatment efficiency and cost-effectiveness, if mental health services can offer therapy that is accessible to more patients at any one time. UK services are already utilising MBI in this way, for example in inpatient settings where flexibility and heterogeneous groups have been found anecdotally to benefit a range of patients (Didonna, 2009). However, it is
important to rigorously explore whether such MBI groups are acceptable and effective as they currently stand. Such evidence could offer important information about the mechanisms and processes within group-based MBI that lead to benefit for patients. Informed by this research evidence, an "Introduction to MBCT" course in South-West England, the Mindful Life (ML) Group, has been developed for a mixed-age and mixed-presentation group of patients within secondary mental health care. Adaptions include extending the course duration to 12 sessions and making sessions briefer (1 ¼ hours). Each week is themed based on elements of practice that are in line with the MBCT framework (Segal, Williams, & Teasdale, 2012). The group has been running since 2015, with approximately 8-9 people attending each group. Group members are referred in by four different services and clinical difficulties have included bipolar disorder, MCI, physical health conditions, depression, anxiety and being a caregiver.

Aims of this project are to evaluate and provide recommendations to improve the delivery of the ML group, including the change in balance between discussion and practise. This will provide further information about the flexible way in which group MBI can be conducted within services.

The project was reviewed and approved by the University of Bath Psychology Ethics Committee and subsequently approved by the Research and Development department at the local NHS Trust. Participants provided written informed consent for interviews. Following consultation with the clinical psychologists and the supervisors, the following research questions were agreed:

1) Is the Mindful Life group facilitating change in its current format? How do participants feel this change occurred?
2) Have participants continued to practise and are they benefitting from the group once it has finished?
3) Which aspects of the intervention were most and least valued by participants?
4) How could the group be improved to encourage and enhance mindfulness practise for its members?

The above questions formed the basis for developing an interview schedule. This, along with the aims and proposed methodology was discussed with two service users (one of whom had previously attend the ML group) after which the final project design was agreed. ML group facilitators invited previous group participants to take part in interviews. A purposive sampling method was used, contacting patients from the most recent ML groups first, and continuing chronologically back in time. Individual semi-structured interviews lasting 20-30 minutes were conducted over the phone with eight participants, which allowed for reasonable coding opportunity and data saturation to be reached. Participants were thanked for their time and provided with debrief information in case of potential distress arising following interviews.

Interviews were audio recorded, transcribed verbatim and analysed by the project lead using Thematic Analysis (TA) (Braun & Clarke). Based on existing research around aspects of change within MI (Segal, Williams & Teasdale, 2002; Shapiro et al, 2006); and the researcher’s own professional background and personal interest in mindfulness, a combination of deductive and inductive analysis was used to code the data. Analysis was checked over by a supervisor to ensure reliability of coding.

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TBC (results will be available in May 2019)

Mindfulness-Based Interventions (MBI) are a popular and effective component of many third wave CBT approaches, including Dialectic Behaviour Therapy, Compassion Focused Therapy, Acceptance and Commitment Therapy, and Mindfulness-Based Cognitive Therapy. Evaluation of an "Introduction to MBCT" mixed group could provide useful information to clinicians about how to implement MBI in an accessible way to groups of service-users with a range of ages and difficulties.

Scoping project looking into the barriers of IAPT services engaging in research in the North East of England
Introduction:

Improving Access Psychological Therapies (IAPT) services deliver evidence-based talking therapies, for common mental health disorders, to people throughout England. In 2017-18 over 1.0M attended at least one appointment, and more than 0.5M people, from 197 Clinical Commissioning Group (CCG) areas, completed therapy. Publically available data show considerable variation in treatment effectiveness between CCG areas. In order to better understand factors contributing to such variability, we evaluated the relationship between demonstrated clinical effectiveness (recovery) and service- and client-related factors, within our own IAPT services.

Methods:

Data from a cohort of cases (n=1,315) from three CCG areas was collected as part of a routine service evaluation. Cross-tabulations and chi-square for significance, were performed to establish significant associations and differences between variables. A hierarchical logistic regression model was developed using the service-related and client-related variables to predict IAPT defined recovery.

Results:

A number of significant differences were found between client-related variables and recovery status. More specifically, increased recovery rates were found among those with a planned ending (62.1% recovered) in comparison to those deemed to have completed treatment (attended two or more appointments involving therapy) but who had an unplanned ending, i.e. dropped-out (23% recovered); those who were employed (63.6%) in contrast to the unemployed (30.5%); and among clients rated, at their first session, as having high motivation to change (66.3%), in comparison to those perceived to have low motivation (29.8%). The final predictive model accounted for 36.2% in recovery variance and correctly classified 70.8% of the cases. Six variables, three service-related and three client-related, contributed to the model. Time waited to enter treatment, number of previous IAPT referrals, unemployment and high number of presenting problems were negatively associated with recovery. Number of treatment sessions and high client motivation were positively associated with recovery.
Discussion: Although low recovery for those with an unplanned ending was not surprising, the unexpected low recovery rates amongst unemployed service-users raises questions about how best to help this cohort of clients. Findings on service-related variables, that jeopardise recovery, are compatible with previous research within IAPT and highlight the importance of the way that psychological therapy services are delivered. A central finding of this study is the strong relationship between early motivation to change and eventual clinical effectiveness. Further assessment of motivation, using validated questionnaires, and investigation of how best to influence motivation over the course of treatment, is indicated. Conclusion: A number of variables show clear relationships with recovery within IAPT services. The strength of these relationships, and the underlying variability in demonstrable benefit, warrants consideration of how best to adjust the process of therapy to better engage and enable all our clients to make the most of the opportunities available. Routine monitoring and evaluation of the needs of all service users, and how well they are being met, is important for delivery of high quality psychological therapy services.

Investigating a therapist-guided, parentassisted remote digital behavioural intervention for tics in children and adolescents—‘Online Remote Behavioural Intervention for Tics’ (ORBIT) trial: protocol of an internal pilot study and single-blind randomised

Charlotte Sanderson, UCL Institute of Child Health / Great Ormond Street Hospital; Charlotte Hall, Institute of Mental Health, University of Nottingham; Bethan Davies, Institute of Mental Health, University of Nottingham; Per Andren, Karolinska Institutet, Stockholm Health Care Services; Tara Murphy, UCL ICH Great Ormond Street Hospital; Tourette syndrome and chronic tic disorder are common, disabling childhood-onset conditions, and can be associated with significant distress, psychosocial impairment and reduced quality of life. According to NICE guidelines, Behavioural therapy should be offered as first-line treatment for children and young people with tics. Behavioural therapy is also seen as a preferred option by many families seeking support, over pharmacological treatments. However, there are very few clinicians who are trained in specialist interventions for tics, and many families are unable to access appropriate care. It is estimated that only 1 in 5 young people with tics currently access behavioural interventions, and those that do often receive far fewer sessions than recommended. This trial investigates whether an internet-delivered, behavioural intervention for tics, with remote therapist support, can reduce severity of symptoms.

This parallel-group, single-blind, randomised controlled superiority trial with an internal pilot is recruiting children and young people (aged 9–17 years) with a known or suspected tic disorder. Eligible participants are randomised to receive 10 weeks of either: 1) online, remotely delivered, therapist-supported exposure response prevention (ERP) behavioural therapy for tics, or 2) online, remotely delivered, therapist-supported education about tics and co-occurring conditions. Parents of young people taking part also complete a ten-week ‘supporter’ programme, with therapist-support. Participants are followed up mid-treatment, and 3, 6, 12 and 18 months post randomisation. A group of PPI members was created to shape and guide the study. The group comprises four parents and four children and young people with a diagnosis of TS, plus two PPI members with previous experience of large studies. 12:00:00 AM

An integrated process evaluation will analyse quantitative and qualitative data in order to fully explore the implementation of the intervention and identify barriers and facilitators to implementation.

The findings from the study will inform clinicians, healthcare providers and policy makers about the clinical and cost-effectiveness of an internet delivered treatment for children and young people with tics, and have the potential to support widening of access for specialist treatments of tics.