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Keynote Addresses

Learning how to build positive mood and wellbeing in depression: From basic science to clinical practice

Barney Dunn, University of Exeter
One of the cardinal symptoms of depression is anhedonia - a loss of interest and pleasure when engaging with pleasant activities. It is increasingly recognised that anhedonia is prognostically important and the failure to repair it is associated with poorer depression outcomes. Existing psychological therapies for depression have predominantly focused on reducing negative thinking and feeling and arguably have relatively neglected building positive thinking and feeling. This keynote will review basic science findings characterising the nature of anhedonia in depression, identifying which psychological mechanisms underpin it. Secondary analyses of randomised controlled trials evaluating how well CBT, Behavioural Activation and Anti-Depressant Medication repair anhedonia will also be presented. How this work has been translated into the development of a novel therapy approach targeting anhedonia will be outlined and preliminary findings of the feasibility, acceptability and efficacy of this therapy will be presented.

Brief, intensive, and concentrated CBT for anxiety disorders

Lars-Göran Öst, Stockholm University, Sweden
Anxiety disorders are among the most common mental disorders with a lifetime prevalence of 12.5%. Cognitive-behavior therapies (CBT) varying between 8-15 sessions in length, are evidence-based for the treatment of anxiety disorders in both adults and youth. During the last two decades treatments that are brief, intensive, or concentrated (BIC) have been developed and this meta-analysis includes 87 RCTs across the anxiety disorders. There are 36 brief, 44 intensive, and 7 concentrated treatments. BIC yielded a lower attrition (2.1%) than standard CBT (6.1%). The effect sizes (ES) for comparison of BIC with waiting-list (1.39 and 1.47) and placebo (0.87 and 0.82) were significant, whereas the comparison with standard CBT (0.03 and 0.07) for adult and youth studies, respectively, was not. In adult studies remission at post/recovery at follow-up was 73%/75% for BIC and 74%/73% for standard CBT. In youth studies the corresponding rates were 54%/64% for BIC and 57%/63% for standard CBT. Within-group ES at post and follow-up were 1.90 and 1.93 for BIC, and 1.96 and 1.87 for standard CBT, indicating maintenance of the effects up to 12 months after therapy. Advantages and disadvantages of BIC are discussed and it is suggested that BIC-interventions represent a paradigm shift in the delivery of services for patients with anxiety disorders.

Cultural Therapy for the Prevention of Self Harm: Turning the World Upside Down

Nusrat Hussain, University of Manchester
Suicide is a major global public health challenge, every 40 seconds a person die of suicide. Suicide is among 3rd leading cause of death in 15-35 years old group. According to the World Health Organization suicide rates have increased up to 60% in last 45 years and more than 70% of these suicide deaths are in low and middle income countries (LMICs). History of self harm increases the risk of suicide up to 100%.
To determine whether culturally adapted manual assisted problem-solving therapy (C-MAP) results in decreased suicidal ideation in patients with a history of self-harm. The study also explored the experience of self-harm in Pakistan and views about culturally adapted intervention.
A total of 221 participants recruited from public hospitals in Karachi were randomized into two study arms i.e., 12-week C-MAP intervention or treatment as usual (TAU) group (NCT01308151). Participants were assessed using Beck Depression Inventory, Beck Suicidal Ideation, Beck Hopelessness Inventory and EQ-5D. In order to explore the experience of self harm, semi-structured in-depth interviews were conducted with 19 participants. Patients in the C-MAP group showed statistically significant improvement on all outcome measures including health related quality of life. Framework analysis highlighted the role of difficulties in interpersonal relationships, domestic violence, isolation and poverty as factor associated with self harm. The brief psychological intervention was found to be feasible and acceptable in a low resource setting where self harm is an illegal act and is condemned socially and also religiously

The WHO’s Mental Health Gap Action Program (mhGAP) for LMICs advocates delivery of evidence-based interventions to manage a number of priority conditions including suicide and self-harm. The results of the study have implications for addressing the huge mental health treatment gap across the globe.

Chronic fatigue syndrome: Emotion processing and stress reactivity

**Katharine Rimes, King’s College London**

Chronic fatigue syndrome (CFS, also known as ‘ME’) is characterised by severe and disabling physical and mental fatigue that occurs for most of the day and has lasted at least six months. A range of other symptoms are typically present, such as muscle or joint pain, headaches, concentration difficulties and sleeping problems. It is often triggered by a virus or adverse life event. Multiple factors are likely to be involved in the maintenance of symptoms and these will vary across individuals. This talk will focus on two related areas that have been investigated in relation to chronic fatigue syndrome. Research investigating emotion processing and stress reactivity in people with CFS / ME will be described and treatment implications discussed.

**Anxiety-linked Attentional Bias and its Modification: Critical Reflections and New Directions**

**Colin MacLeod, The University of Western Australia**

It is well-established that both elevated dispositional anxiety and clinical anxiety dysfunction are characterised by an attentional bias that operates to favour the processing of threatening information. Compelling evidence that this attentional bias causally contributes both to heightened anxiety vulnerability and to clinical pathology has been provided by studies showing that the successful modification of the attentional bias serves to reduce anxiety reactivity to stressors, and to attenuate dysfunctional symptoms associated with anxiety disorders. Nevertheless, recent years have witnessed debate and disagreement over a number of important issues concerning anxiety-linked attentional bias and its modification, including the nature of the attentional mechanisms that underpin the observed patterns of processing selectivity, the adequacy of the assessment procedures most commonly used to measure this attentional bias, and the therapeutic value of directly modifying attentional bias to threat in enhancing emotional resilience and treating anxiety disorders. This presentation will reflect on these contentious issues to i. convey the nature of the debates that have arisen; ii. highlight some misconceptions that have the potential to drive ongoing misunderstanding; and iii. illustrate some of the new directions our own research into anxiety-linked attentional bias and its modification has recently taken, in response to these various issues.

**Imagery Rescripting: a method to process memories of traumatic and other negative experiences**
Arnoud Arntz, University of Amsterdam, the Netherlands

Imagery Rescripting (ImRs) is an experiential method to process memories of traumatic events and other negative experiences that lie at the root of patients’ problems. In Imagery Rescripting patients imagine the original experience but alter the sequence of events so that their needs are better met. With very complex cases and early trauma’s, the focus is on memories from childhood and it is usually the therapist leading the Rescripting and intervening in fantasy to stop abuse, bring safety, and correct misconceptions about the experience, whilst the patient imagines being the child. ImRs has found a wide range of applications, from PTSD, chronic depression and treatment-resistant anxiety and eating disorders to personality disorders. Moreover, it is the standard treatment of nightmares in the US. With patients suffering from visual intrusions the application is quite straightforward as the intrusions, or the memories that they are based on, can be directly addressed in Imagery Rescripting. However with other problems, like a negative self view or distrust in others, first memories of experiences that underlie such basic schemas need to be found. Usually the use of an ‘affect bridge’ between a recently experience of activation of the schema and a spontaneously early memory helps, and applications of this in a wide range of clinical problems have been found to be effective. Imagery Rescripting has a number of attractive elements, including its broad and flexible range of application, its focus on changing the meaning of the experience, and the fact that it is not necessary to relive the whole trauma in all its details (which increases acceptability and usefulness for very severe cases). In this keynote the clinical effectiveness of ImRs will be discussed, as well as laboratory studies into basic mechanisms that underlie ImRs, indicating that ImRs indeed works thru meaning change.

10 years of IAPT - an overview of clinical and organisational lessons learnt

Stephen Kellett, University of Sheffield and Sheffield Health and Social Care NHS Foundation Trust

As a provider of PWP and High Intensity training since 2008 and also part of the Yorkshire and Humber IAPT Practice Research Network (PRN), this talk will identify and reflect on the key challenges, achievements and continuing issues with the IAPT programme from clinician, educator and researcher perspectives. The talk will showcase the teaching and curriculum innovations developed by the teaching teams and highlight the key publications from the PRN to develop a narrative overview of the 10 years. The talk will also share some key insights into (a) the defining features of more and less competent CBT therapists, (b) how to develop and maintain effective collaborations between educators and clinical services and (c) how to put practitioners at the heart of evaluation efforts.

What is sleep … and why does it matter?

Colin Espie, University of Oxford

There is nothing that is more fundamental to behavioural, cognitive and emotional functioning than sleep. Like breathing, sleep is a largely involuntary behaviour that is essential to life, and it occurs unfailingly as part of an approximate 24-hour cycle across the lifespan. This presentation will summarise our current understanding of sleep and circadian processes, and how they relate to mental health. It will be argued that sleep is a primary function, rather than a secondary one, and that we should incorporate management of sleep and circadian processes into our treatment plans. Both scientific data and clinical illustration will be incorporated throughout the presentation.

CBT for depression: it’s time to integrate

Stephen Barton, Newcastle CBT Centre and Newcastle University
Psychotherapy integration is usually between therapy schools such as cognitive-behavioural, systemic, interpersonal or cognitive-analytic. This keynote argues for integration within the field of CBT. CBT for depression is heterogeneous with multiple theories, models, evidence-bases and therapeutic approaches. The past twenty years has seen a lot of diversification with the emergence of Behavioural Activation, Rumination-Focused CBT, Mindfulness-Based CT and other 3rd wave approaches, such as CFT and ACT. These developments are welcome because depression is a multi-factorial problem: clinical presentations are often wide-ranging, co-morbid and complex. Multiple approaches create more therapeutic possibilities. The field now has an embarrassment of riches but it lacks coherence. Competition is inevitable but it tends to magnify differences, not unify them, and this can be confusing for front-line therapists. For some years the Newcastle group has been developing an integrated model that harnesses the shared processes of cognitive and behavioural therapies. It offers integration at theoretical, evidence-based and practical levels. It’s not a new therapy; it’s a way of organizing current therapies to increase fidelity and respond to the needs of particular patients. The approach is technically eclectic and uses cognitive science models (self-regulation, dynamic systems) to specify maintenance processes. Empirical studies, practice-based evidence and a case illustration are used to introduce the approach.

The art of the possible: behavioural activation for adults with learning disabilities

Andrew Jahoda, University of Glasgow
No abstract given

Child trauma and posttraumatic stress disorder

Sarah Halligan, University of Bath
Following traumatic experiences (e.g., physical or sexual assault, serious accidental injuries, natural disasters), young people are at risk of developing posttraumatic stress disorder and other adverse outcomes. For many young people exposed to trauma, psychological services are not available and they must rely on informal sources of support. This talk will consider the factors that influence child psychological adjustment posttrauma, with a focus on the role that families may play in determining outcomes. In addition to studies of relatively low risk UK samples, preliminary work in a high risk international setting will be described.

The dirt road to psychopathology: Disgust-based mechanisms and their relevance for CBT

Peter J de Jong, University of Groningen
Disgust is a strong emotion that is characterized by negative appraisals, pervasive avoidance tendencies, and distinct autonomic defensive reflexes. Although disgust is typically conceptualized as an adaptive emotion, it can become highly dysfunctional when it is elicited by “the wrong” stimuli, when the threshold for experiencing disgust is (too) low, or when people experience feelings of disgust as being highly aversive. Until recently, disgust received only scant attention in clinical psychological science and has even been framed as “the forgotten emotion in psychopathology”. This situation is changing with a rapidly growing scientific interest in disgust as a relevant factor in mental disorders. This presentation will provide a concise review of this emerging research, illustrate how disgust-based mechanisms might contribute to the development of various disorders (e.g., phobias, OCD, PTSD, sexual dysfunctions), and address the potential implications for clinical interventions.
Working with parents to make a difference: from local to global and back again

Rachel Calam, University of Manchester

The quality of parenting children experience plays a key role in their development. There is strong evidence indicating that high-quality, evidence based, theoretically driven parenting and family skills programmes can lead to significant improvements in the quality of parenting and family life that children experience. These interventions have the potential to prevent a wide range of difficulties, including emotional, behavioural and social problems, and national and international organisations recognise the potential of such approaches to prevent progress into long-term difficulties including mental health problems, substance misuse, violence and crime. In this presentation, new applications and developments in parenting and family skills programmes will be described, including work with families with parents with mental health difficulties, and international work with parents and families in very low resource settings and contexts of displacement due to armed conflict. Lessons learned in these contexts have relevance for work in a wide range of settings.

Understanding and Enhancing Treatment and Prevention of Depression

Ed Watkins, University of Exeter

Depression is a major global health challenge and amongst the leading causes of disability. Moreover, there is a major treatment gap: our best treatments achieve remission rates less than 1/3 and limited sustained recovery, and traditional models of psychotherapy treatment cannot reach sufficient numbers to tackle the global burden. We thus need more scalable and efficacious interventions, including prevention of depression. I will review third interleaved approaches to enhance the treatment and prevention of depression. First, understanding and targeting key psychopathological mechanisms implicated in the onset and maintenance of depression a potential way to improve the effectiveness and efficacy of treatment and prevention, using the example of rumination. Ruminations contribute to the maintenance and onset of depression and anxiety, acts as a final common pathway for multiple vulnerabilities, and is identified as a transdiagnostic mechanism (Nolen-Hoeksema & Watkins, 2011). Basic research suggests that rumination can be usefully conceived as a mental habit (Watkins & Nolen-Hoeksema; 2014; Hertel, 2004) with an abstract decontextualized thinking style implicated in its negative consequences (Watkins, 2008). Adaptations of CBT targeting rumination are efficacious for difficult-to-treat residual depression (Watkins et al., 2010), outperforms standard CBT in treating major depression (Hvennegard et al., submitted) and prevents anxiety and depression in high risk young adults (Topper et al., 2017). Second, underpinning the efficacy gap is limited understanding of how complex psychological interventions for depression work (Holmes et al., 2014). To address this, a second approach is to conduct experimental research to better understand the active ingredients of therapy, which I illustrate through a large-scale factorial trial of internet CBT. A third approach is to utilise non-traditional approaches to tackle depression including through information technology and lifestyle change, including change in the nutrition (the MooDFOOD project).

Mental Imagery and Mental Health Science: From a Hospital to a Refugee Camp

Emily Holmes, Karolinska Institutet, Sweden

Mental imagery involves an experience like perception in the absence of a percept, such as “seeing in our mind’s eye”. Intrusive, affect-laden mental images cause distress across mental disorders - Intrusive memories that “flash backwards” to past trauma occur in post-traumatic stress disorder (PTSD) while images that “flash forwards” to the future can occur in bipolar disorder.
My clinical research group has an interest in understanding and treating maladaptive mental imagery via psychological therapies. To do this, we are curious about what we can learn from cognitive psychology and neuroscience to inform treatment development. I will discuss recent work concerning intrusive memory encoding (Clark et al, 2016, Psych Med); disrupting memory re-consolidation via dual task interference to reduce the frequency of intrusive memories (James et al, 2015, Psych Sci); and impact of imagery in depression (Holmes, Blackwell, et al, 2016, Ann Rev Clin Psych: *). A broader vision for science-informed psychological treatment innovation will also be explored from working hospitals (Iyadurai et al, in press) to further afield with refugees (Holmes, Ghaderi et al, in press).

Website and publications: http://ki.se/en/cns/emily-holmes-research-group

* please see to get an origami model about imagery in depression

CBT for Clinical Perfectionism: The good, the bad and the reality

Roz Shafран, UCL Great Ormond Street Institute of Child Health

Perfectionism can be dysfunctional in a number of ways. First it can be present a significant clinical problem in its own right that interferes with functioning. Second, it can interfere with successful treatment of Axis I disorders. Third, it is a risk factor for the development of psychopathology. The first part of the keynote will present an overview of the current cognitive-behavioural approach to the understanding and treatment of perfectionism including results from the first meta-analysis indicating that it can be successfully addressed. Findings from different modes of delivery will also be presented and lessons learned from mistakes will be embraced. The second part of the keynote will describe top tips for treatment. The presentation will conclude with suggestions for future directions for the development of research and therapy for perfectionism.

Paranoia: understanding and treating excessive mistrust

Daniel Freeman, University of Oxford & Oxford Health NHS Foundation Trust

Paranoia denotes the unfounded idea that others intend to cause you harm. Many people have a few paranoid thoughts, and a few have many. Persecutory delusions, seen in mental health services in the context of psychotic disorders, represent the severest form of paranoia. In this keynote talk, the development of a new translational treatment – the Feeling Safe Programme – will be described. The epidemiological research, theoretical framework, experimental studies, and clinical trials that underpin the Feeling Safe Programme will be outlined. The spirit, style, and content of this intervention will be explained. The overall ambition is for a step change in recovery rates for patients with severe paranoia.

Symposia

Treating complex trauma reactions in refugees: a series of case presentations

"The pain is gone! The pain is gone!" Using imagery re-scripting to facilitate a sense of personal resolution and healing.

Kerry Young, CNWL NHS Foundation Trust and University College London; Reem Shafiq, Kings College Hospital NHS Foundation Trust

The effectiveness of trauma-focused therapy in the reduction PTSD symptoms is well established. Further, evidence is emerging about its efficacy in the treatment of Complex PTSD (e.g. Cloitre et al., 2012). For refugees and asylum seekers, their traumatic experiences may include multiple levels of threat, injury, loss and displacement, as well as an inability to
hold perpetrators to account. In such circumstances, it can be challenging to facilitate a sense of personal resolution within short-term, trauma-focused therapy.

For some years now, Arnoud Arntz and colleagues have been using imagery re-scripting within trauma-focused therapy for PTSD, to provide a sense of empowerment or protection within memories of childhood abuse (Arntz, Sofi & van Breukelen, 2013; Arntz, 2012.) Indeed, a recent meta-analysis highlights the promising results gained through using imagery re-scripting across a number of disorders (Morina, Lancee and Arntz, 2017.) In this case study, we will show how we used imagery re-scripting as part of trauma-focused intervention with a refugee client who had experienced a forty-year history of trauma and abuse. We will discuss how the imagery re-scripting offered what seemed to be a powerful addition to her treatment. We hope that it will give other clinicians concrete ideas about how they might use the technique in their work with people with long and complex trauma histories.

Developing compassionate trauma narratives
Adele Stevens, Forced Migration Trauma Service, CNWL NHS Foundation Trust & Berkshire NHS Foundation Trust; Theresa Schwaiger, South London and Maudsley NHS Foundation Trust

It is well-established that trauma-focused therapies are the treatments of choice for PTSD. Currently, the weight of the available evidence points to Narrative Exposure Therapy (NET; Schauer, Neuner and Elbert, 2011 ) as the treatment of choice for PTSD within refugees who have experienced multiple traumatic events. However, it has also been widely acknowledged that the standard PTSD framework does not incorporate the full range of difficulties arising in individuals exposed to prolonged and repeated traumatic events (i.e. Type II trauma), such as political violence and torture. This has led to Complex PTSD (CPTSD) being proposed as a sibling diagnosis to PTSD in ICD-11. In addition to standard PTSD symptoms, individuals suffering from CPTSD also present with pervasive difficulties in emotional regulation and/or inter-personal functioning. From audit data at Woodfield Trauma Service, we know that a small but significant proportion of our client group meet the proposed diagnostic criteria for CPTSD. Furthermore, recent research has explored CPTSD in refugee populations and found this to be a valid and relevant construct for individuals exposed to persecution and displacement (e.g., Nickerson et al., 2016.)

At present, there is little published guidance about how to adapt standard trauma-focused treatment to take account of CPTSD symptoms in a refugee population. This presentation will describe how key ideas from Compassion Focused Therapy (CFT) were interwoven into individual NET treatment of a refugee who presented with CPTSD. This approach relies heavily on the work developed by Deborah Lee using CFT for CPTSD in non-refugees. It is acknowledged that this is a preliminary attempt at making such adaptations and we will discuss learning points for future cases. We hope that this case study will provide therapists with ideas about how they can treat clients with prolonged and repeated trauma histories, who present with symptoms of CPTSD.

'I feel powerful': treating PTSD in refugees using Imagery Rescripting
Sameena Akbar, Forced Migration Trauma Service, CNWL NHS Foundation Trust

It is well-established that trauma-focused therapies are the treatments of choice for PTSD. Currently, the weight of the available evidence points to Narrative Exposure Therapy (NET; Schauer, Neuner and Elbert, 2011 ) as the treatment of choice for PTSD within refugees who have experienced multiple traumatic events. However, audit data from the Woodfield Trauma Service suggest that a third of clients drop out before completion of therapy. Based on feedback from therapists, the most common reason for dropping out of treatment is the emotional distress associated with the retelling of traumatic events. Recently, there have been encouraging studies (Arntz, Sofi & van Breukelen, 2013; Arntz, 2012) which suggest Imagery Rescripting (ImRS) as an alternative treatment for PTSD to multiple traumatic events. Imagery rescripting does not require a repeated/detailed discussion of the distressing elements of a traumatic event. The intervention involves the patient being encouraged to imagine a rewritten version of the
trauma narrative in which they feel less distressed and more empowered. As such, ImRS might be worth considering when clients are at risk of dropping out of trauma-focused treatment.

This presentation will describe how ImRS was conducted with a refugee patient suffering with PTSD to a number of traumatic events. The techniques used and her 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 provide therapists with an alternative treatment pathway to explore when working with this client group.

Targeting Intolerance of Uncertainty in the treatment of anxiety: Rationale, description and preliminary outcomes

Appraisal of situational threat and situational intolerance of uncertainty in anxiety-provoking situations of personal concern: An evidenced-based rationale for targeting IU in treatment?

Sara Milne, Newcastle University & Northumberland Tyne and Wear NHS Foundation Trust, Claire Lomax, Newcastle University & Northumberland Tyne and Wear NHS Foundation Trust, Mark Freeston, Newcastle University & Northumberland Tyne and Wear NHS Foundation Trust

Background: Intolerance of uncertainty (IU), recently characterized as the fear of the unknown, and threat appraisal, usually understood as the overestimation of the probability and severity of a negative outcome, are related constructs which both contribute to anxiety. While research has long established the role of threat appraisal in anxiety responses in situations, research into IU has largely concentrated on the contributions of trait IU to anxiety symptoms, especially GAD. This has made it difficult to establish whether situational IU contributes significantly to anxiety in specific situations independent of threat appraisal. This study aimed to examine the constructs of threat appraisal and IU in personally relevant anxiety-provoking situations to investigate the potential unique contribution of IU to situational anxiety.

Method: This online study recruited a community sample of adults (N=297); 60.2% were in employment and 20.4% were studying. Participants completed standardized questionnaires, as well as a measure of situation-specific anxiety mapping onto major diagnostic categories, namely, social anxiety, (performance and interaction), panic-like symptoms, checking household appliances, body-image, worry (personal and professional lives), and illness concerns. Using a measure of trait anxiety, 29.6% were experiencing anxiety of potential clinical significance. 85.7% of the sample rated one or more scenario as highly relevant to them and 87.1% rated this scenario of at least moderate concern. They then their rated level of threat appraisal and situational IU in response to the specific situation that was the most relevant. Situational IU was operationalized by appraisals of how uncertain the situation is and the degree that people are bothered by it.

Results: Regression analyses found situational IU significantly predicted situation-specific anxiety even after controlling for the effects of gender and age (5.6%), frequency of concern (13.0%), imminence of threat (NS) and most importantly situational threat appraisal (16.3%). Situational IU accounted for an additional (21.7%). Further analyses showed that behaviours conceptualized as addressing the uncertainty in the situation were significantly predicted by situational threat appraisals (37.6%), and once again by situational IU when entered last (23.2%).

Discussion: These finding expands upon previous research by demonstrating that situational IU contributes to situational anxiety independently of or over and above threat appraisals. Cognitive models of anxiety are well established and have established ways of targeting threat appraisals, usually through behavioural experiments. Behavioural experiments involve making predictions (based on threat appraisals and alternatives, known as hypotheses A and B) and then finding out what happens. Typically finding out is either by doing something you have never done (usually overcoming avoidance), or by not
doing something you always do (dropping safety-seeking behaviours). The results of this study, along with other findings in the field of IU argue that something similar needs to be done with IU. We propose that this can be done in two ways, either by changing appraisals of uncertainty (which may only be possible in specific types of situations or to a limited degree) or especially by learning to tolerate the uncertainty inherent in many situations and indeed in everyday life.

Understanding and targeting intolerance of uncertainty for autistic adults: Development of the Adult Coping with Uncertainty in Everyday Situations (CUES-A)© Programme

Renske Herrema, Newcastle University; Jacqui Rodgers, Newcastle University; Emma Honey, Newcastle University; Mark Freeston, Newcastle University & Northumberland, Tyne and Wear NHS Foundation Trust

Background: Intolerance of Uncertainty (IU) has been found to be a key construct in the development and maintenance in a range of anxiety disorders and anxiety is a common co-occurring condition in adults on the autism spectrum. We recently developed a parent based group intervention (CUES: Coping with Uncertainty in Everyday Situations), aimed at providing parents of young people on the autism spectrum with effective strategies to reduce their child’s IU. This development project demonstrated that the intervention was acceptable and feasible to families. However, no such programme exists to address IU in autistic adults. The aim of this study was initially to understand the experience of uncertainty on a day-to-day basis and identify a suitable target situation in order to adapt and evaluate our intervention programme to make it suitable for use, on an individual basis with autistic adults experiencing IU.

Method: A multiple baseline single case experimental design (SCED) was used to identify and track personally salient uncertain situations with four autistic adults on a day-to-day basis, over a fourteen week period. Commensurate with SCED, participants completed measures over three time phases; baseline, intervention and follow-up. Participants were aged over 18 years, with a diagnosis of autism, with intellectual ability in the average range. The primary outcome measures were electronic daily diaries for individualised self-monitoring of personally relevant symptoms, behaviours and engagement in target uncertain situations. Participants completed daily diaries across all three time phases (baseline, intervention and follow-up) to provide individualised self-monitoring of personally relevant symptoms, target behaviours and engagement in target situations. Participants also completed outcome measures (PHQ-9, GAD-7, IUS-12, Stress scale from DASS-21 & RBQ-2A) at three time points; initial session, first session of intervention programme and follow-up. During the intervention phase participants received eight, one hour weekly IU treatment sessions with a qualified low intensity CBT therapist. The follow-up session allowed further monitoring of progress and a feasibility interview allowed participants to feedback their experiences of participating in the CUES-A programme.

Results: Engagement and retention for the intervention was excellent with all four completing treatment. All four participants were able to complete the daily self-monitoring and identified a target situation which they found difficult to manage. There was clear improvement on diary measures for two participants while one maintained levels during treatment which coincided with far more frequent contact with the target situation. Secondary outcome measures (PHQ-9, GAD-7, IUS-12, Stress scale from DASS-21 & RBQ-2A) showed reductions in scores for all four participants over the three time phases (baseline, intervention & follow-up). All participants reported that they were better able to manage uncertainty and their target situation following completion of the intervention. In addition to some encouraging evidence for improvement, there is a promising degree of acceptability and feasibility of the intervention programme. In the follow-up interviews participants reported they valued the experience of therapy, practical strategies to help them cope with uncertainty, the collaborative approach and individualisation of the intervention programme.

Discussion: Our study is the first to explore the impact of intolerance of uncertainty on daily functioning for autistic adults and demonstrates that therapeutic interventions can be
successfully adapted for use with this population. The single case experimental design provides evidence that autistic adults are able to identify target uncertain stations that have a significant impact on functioning in daily life and the that the intervention led to a decrease in anxiety in the target situation and increased confidence in their ability to cope with the situation. Furthermore, our data indicate that participants found daily self-monitoring of the symptoms and behaviours associated with these situations to be acceptable although there may be some issues with sensitivity of measures in at least one case. The results provide evidence of the feasibility of self-monitoring and the CUES-A programme; further developments targeting intolerance of uncertainty for autistic adults are planned.

**Developing a module to target intolerance of uncertainty in the transdiagnostic treatment of anxiety: Design, treatment, and preliminary outcomes**

Ashley Tiplady, Newcastle University & Northumberland Tyne and Wear NHS Foundation Trust; Sally Askey-Jones, Newcastle University & Northumberland Tyne and Wear NHS Foundation Trust; Kevin Meares, Northumberland Tyne and Wear NHS Foundation Trust; Richard Thwaites, Cumbria Partnership NHS Foundation Trust; Mark Freeston, Newcastle University & Northumberland Tyne and Wear NHS Foundation Trust

**Background:** Although IU has been a target in the treatment of IU it has rarely been specifically targeted in the treatment of different anxiety disorders. Given the increasing evidence for the role of IU in anxiety disorders alongside threat perception and threat appraisals, there is an increasingly strong rationale to directly target IU as well as threat. In fact the treatment developed and tested here had an initial focus on IU in everyday life before targeting IU in threatening situations. The aim of this study was to develop a transdiagnostic module IU and test it within a Multiple Baseline Single Case Experimental Design (SCED). This design is ideal for treatment development as it is “data rich and participant poor” and enables a small number of participants to be studied with a high level of detail in a rigorous design.

**Method:** Six participants with some combination of GAD, health anxiety, social anxiety, or panic disorder were recruited from two IAPT services; four completed treatment. The treatment package and the manual was developed by the authors. After a baseline phase, treatment consisted of a psycho-educational phase, a phase focusing specifically on IU in everyday life, followed by a phase linking IU to the main threat situations, depending on the participant. At the end of this phase there was a monitoring phase. At the end of this phase, if the participant had not responded sufficiently, an appropriate evidence based treatment was offered. The main outcome variables were daily diaries tracking IU, their appraisals and main target symptoms. Measures of anxiety, depression and specific symptoms were administered as per IAPT protocols. The two therapists were experienced and qualified practitioners, having worked in IAPT and other services before commencing training in clinical psychology. They were supervised by highly experienced cognitive therapists. The acceptability and tolerability of treatment was assessed by interviews following treatment.

**Results:** The daily diary data for each participant were plotted and subjected to systematic visual analysis of trend (slope), variability, level, and change between phases. These were supplemented by appropriate single-case statistics assessing non-overlap. The standardised measures were subject to analysis of reliable and clinically significant change. Outcomes are described at both the individual level and across the series of patients. There were some discrepancies between daily diaries and routine outcome measures, and although in some cases the daily diaries which allow stronger inference did not indicate significant effects, the routine outcome measures indicated successful outcomes using reliable and clinically significant change methodology.

**Discussion:** The treatment developed for this study initially targeted IU in everyday life in relatively non-threatening situations so the initial focus was on reductions in IU rather than anxiety or specific threat. The multiple baseline SCED with distinct phases and daily measures is an ideal design for tracking the key variables through the different phases. We will discuss the range of outcomes observed as a function of presenting problems and engagement in the IU phase.
Developing a module to target intolerance of uncertainty in the transdiagnostic treatment of anxiety: Conceptual, clinical, and practical challenges
Sally Askey-Jones, Newcastle University, Northumberland Tyne and Wear NHS Foundation Trust; Ashley Tiplady, Newcastle University, Northumberland Tyne and Wear NHS Foundation Trust; Richard Thwaites, Cumbria Partnership NHS Foundation Trust; Kevin Meares, Northumberland Tyne and Wear NHS Foundation Trust; Mark Freeston, Newcastle University, Northumberland Tyne and Wear NHS Foundation Trust
Background: Although there is increasing evidence that changing IU may be key to successful treatment of anxiety, there are a number of challenges in keeping the focus on IU rather than addressing uncertainty about threat. While we were developing the module we realized the necessity to develop our own ability to distinguish between uncertainty, people’s reactions to uncertainty, and the behaviours that people use to manage or reduce uncertainty. Part of this was from formulating cases from an IU perspective rather than a traditional perspective of appraisal of threat and safety seeking behaviours. This presentation addresses our experiences in first developing the conceptual underpinnings to the module, developing materials to be used during the treatment, and some of challenges in maintaining a consistent focus on IU during therapy.
Vignettes: We will present some vignettes that will illustrate how the treatment plan was developed and implemented for specific participants, including increasing awareness of IU, metaphors about IU, behavioural experiments targeting IU, and then linking IU to threat. We will also consider related changes observed in IU and threat appraisals during treatment. Further we will reflect on how our own understanding of IU and indeed of our own IU has developed over the development and testing of the treatment.
Discussion: One of our key reflections while developing and testing the treatment was the extent to which the cognitive model of anxiety based on perception and appraisals of threat and maintained by safety-seeking behaviours dominated our thinking. It took a considerable time and effort to consistently think about anxiety in a different way, but as we did it led to a different understanding of the contribution of IU to anxiety, but also how IU is pervasive in people’s lives far beyond the areas where they experience anxiety. This raises issues as to whether this broader IU is an ongoing vulnerability factor, even when IU about specific threats may have been reduced. The discussion will reflect where we are in developing an IU focused treatment and consider what the next steps may be.

Control and Awareness in Anxiety: What Might be the Factors Underlying Effective Exposure?

Exposure and reorganization: The what and how of effective psychotherapy
Tim Carey, Flinders University
The general effectiveness of exposure techniques is well documented. The underlying mechanism which exposure helps people to manage their emotional states, however, is less clear. By clarifying the important mechanism and principles of exposure it will be possible to use exposure in more flexible and responsive ways so that more people can benefit from it. Furthermore, when the underlying principles of exposure are considered, exposure can be regarded as a transdiagnostic component of successful psychotherapies. Perceptual Control Theory (PCT) provides a useful theoretical framework from which to understand exposure. PCT offers a functional, rather than a conceptual or statistical, mechanism of change. From a functional perspective, exposure promotes the resolution of psychological distress by activating an internal process of reorganization. In order for reorganization to be effective, it is important that sufficient time is available for people to generate different possibilities and to review these and modify them as required. It is also ideal if the individual is able to control the pacing and intensity of the exposure activities. Finally, drawing a person’s attention to higher level perspectives they briefly experience as they undergo exposure activities will enable the development of more resilient and robust attitudes. This paper will
discuss the importance of these factors and the way they can be combined in a transdiagnostic cognitive therapy.

**Avoidance is not a learned behaviour: Studies of distance control in spider phobia**  
Warren Mansell, University of Manchester; Andrew Willett, Vassar College; Kate Oliver, University of Manchester; Nicholas Beard, University of Manchester; Nicolle Brown, University of Manchester; Francesca Jackson, University of Manchester

The majority of psychology research seeks to understand, predict and change behaviour (the 'control of output' view). This implies that behaviour itself can be easily measured and categorised to be used as a dependent variable within research studies. A contrary view to the majority is that behaviour is a dynamic attempt by an organism to control its own perceptual input as part of a negative feedback control process (the ‘control of input’ view; Powers, 1973, 1978, 2008). This view proposes that it is the sensory goals of behaviour that can be reliably assessed, whereas the behaviour required to meet those goals is highly variable and dependent on the current environmental context.

The clinical consequence of the commonly assumed 'control of output' view is that behaviours can be identified and classified as dysfunctional. For example, it is seemingly well established that people with phobias avoid the source of their fear. Indeed, escape and avoidance are essential diagnostic criteria (APA, 2015). The majority of second and third wave cognitive behavioural models still regard the behaviour as at the end of a causal chain, as controlled output and as an important target of a psychological intervention.

On the other hand, the clinical consequence of the 'control of input' view is that individuals strive to control their perceptual experiences through whatever means necessary, and it is these perceptual goals that are primary, and they are the target of intervention (Alsawy, Mansell, Carey, Tai & McEvoy, 2015; Brady & Raines, 2008; Carey, 2011). Because any behaviour can serve to control input, depending on the circumstances, the behaviour itself is not the target of the intervention. So, a ‘control of input’ therapist working with a client with a phobia would be interested in how the participant controlled their perception of a phobic object, regardless of whether they achieved this through avoidance, escape, eye movement, mental control or even through doing nothing.

We pitched the ‘control of input’ view against the ‘control of output view’ in a series of three studies that each involved the participant controlling their virtual distance from phobic and neutral images on a computer screen. In each study we predicted that high spider fearful participants would maintain spider images, and not neutral images, at a further distance than low spider fearful participants regardless of the actions they would need to engage in to do so. We predicted and generally found this to be the case, regardless of the autonomous movement of the image (Study 1), the reversal of the relationship between joystick direction and distance from the image (Study 3), and regardless of whether an unpredictable, and therefore not previously learned, relationship between joystick direction and distance occurred for each trial of the task (Study 3). We also validated the task against a behavioural approach task in each study, and addressed a range of potential confounds.

**Stances towards emotion across diverse therapies: What have they all in common?**  
Sadie Hassall, University of Manchester; Warren Mansell, University of Manchester

Different theories and psychological interventions have varied views regarding the way that people should, or should not, relate to their emotions ('stance'). They also use a range of different terms to describe stances towards emotion and it is not clear the extent to which they might overlap. The aim of this study was to try to further understand the basic mechanisms involved during emotion regulation by looking at how much variance is shared across the various stances. Informed by Perceptual Control Theory (PCT; Powers, 1973, 2005) it was proposed that the desired intensity of the emotion and the effort one puts in to maintain that intensity is key. An Emotional Stance Questionnaire was formed from a total of 20 stances that are suggested by existing theories and therapies people take towards their emotions. In addition, a measure of desired intensity and effort was developed and administered to 150 students. The stances used were: Tolerate, Deny, Face, Eliminate, Suppress, Avoid, Manage, Ignore, Endure, Focus on, Notice, Allow, Accept, Express, Value,
Utilise, Embrace, Relish, Bring on, and Distract. The different emotions assessed were anxiety, uncertainty, and excitement, as well as a common positive and a common negative emotion that were self-identified by participants.

An exploratory factor analysis extracted five factors. Two overarching factors emerged: Emotion Disengagement and Emotion Enhancement. For negative emotions, these factors subdivided to include Emotion Utilisation, Emotion Expression and Emotion Control.

Emotion Enhancement and Emotion Disengagement demonstrated relationships with participant ratings of intensity and effort across emotions. Importantly, for negative emotions, Emotional Expression was closely correlated with self-reported symptoms of anxiety and depression, but Emotional Utilisation was not.

We found that there were commonalities amongst the different stances towards emotions. The desired intensity of an emotion and the effort that people put in to maintain this intensity may play a role in the basic mechanisms of emotion regulation. Also, it appears that when people report using a negative emotion for a functional purpose, this is less likely to be associated with mental health symptoms than when they report expressing a negative emotion per se. These results are discussed with relation to the role of awareness of higher level goals for emotion in PCT.

An Experimental Test of the Role of Control in Spider Fear
Andrew Healey, University of Manchester; Warren Mansell, University of Manchester; Sara Tai, University of Manchester

It is well established that uncontrollable adverse experiences lead to increased distress, but the role of client control during psychological interventions such as exposure is less clear. Earlier studies reported inconsistent findings, most likely owing to variations in the way control was manipulated, degree of exposure, the outcome variables chosen and the follow-up periods used. Importantly, studies to date had suggested to participants that approaching their fears was beneficial thereby biasing their choices and these studies had not measured change beyond the laboratory. A new experiment was designed that gave 96 spider-fearful participants full choice over their degree of exposure, and manipulated the degree of control as the extent to which their movement of a joystick influenced their virtual distance from a moving spider image. Those with high control were yoked with a low control counterpart to ensure equal amounts of exposure. Measures were elicited at baseline, post-exposure, and at follow-up. As predicted, compared to low control participants, those with high control over exposure approached closer toward a spider post-exposure and reported less spider avoidance after an average of 17 days. No group differences were found in physiological or subjective distress during the task, nor in distress and dysfunction.

The role perceived control in treatment of anxiety: does a network analysis approach have something to add?
Oliver Schauman, Royal Holloway University of London; Gary Brown, Royal Holloway University of London

Perception of control has been highlighted as an important process in the maintenance of emotional distress (e.g., Barlow, 2002). Perceptual control theory also places disrupted control as the key process underlying psychological problems (Powers, 1973; 2008). It is however unclear how clients’ perceptions of control relate to other constructs that conventionally have been linked to maintenance of anxiety and thus have been identified as targets for treatment. An online cross-sectional survey of UK general population (N=252) exploring the structure of relationships between anxiety and anxiety relevant constructs was conducted. Included were indicators of targets of treatment (e.g., worry, intolerance of uncertainty, and specific fears/beliefs) in traditional CBT for anxiety. In addition to this, the study also included measures of perception of control. The analyses presented explored whether a relatively new analytic approach, network analysis (McNally, 2016) can complement traditional psychometric methods to offer novel insights into the importance of sense of control in the treatment of anxiety. Network analysis is a novel approach to understanding covariation among conceptually related variables without reference to putative underlying latent constructs. In contrast the latent variable approaches in which
importance of a construct is inferred from its strength of association with an unmeasured factor, network analysis affords more direct indicators of centrality in terms of strength (how strongly a variable is associated with other variables), closeness (how directly/indirectly a variable is related to all the other variables) and betweenness (how often a variable lies on a pathway between two other variables). This approach was employed to evaluate the centrality of perceptions of control compared to other anxiety-relevant constructs, affording a sense of how perceptions of control as a focus of treatment might relate to levels of anxiety in comparison to other more conventional constructs.

Chronic fatigue syndrome: co-morbid fatigue and distress, predictors of outcome, mechanisms of change during CBT

**Depression and anxiety in adolescents with CFS/ME**
Maria Loades, University of Bath; Kate Rimes, King’s College London; Trudie Chalder, King’s College London

Approximately 1 to 2% of children and young people will be affected by Chronic Fatigue Syndrome (CFS)/myalgic encephalomyelitis (ME). CFS/ME has a significant impact on daily functioning: children and young people with CFS/ME miss an average of one year of school (Crawley et al., 2011). Published data, based predominantly on self-report questionnaires, has indicated that about 1 in 3 children and young people with CFS/ME also have probable depression (Bould et al., 2013), and at least 1 in 3 have probable anxiety (Crawley, 2009), particularly separation anxiety and social anxiety. However, due to overlapping symptomatology, it is not clear whether these individuals would meet full diagnostic criteria for anxiety and depression on a diagnostic interview.

This study will examine the prevalence of anxiety and depression in children and adolescents (N=122) age 8 to 18 (mean 15.02, S.D. 1.83) attending a specialist CFS/ME service, presenting both self-report and parent report data (N = 102 mothers and 65 fathers). It will also examine whether self-report measures are correlated with diagnoses using diagnostic interviews (MINI) in 52 children and adolescents. Clinical considerations will be discussed.

**Fatigue, disability and the experience of severe CFS/ME in young people**
Sheila Ali, South London and Maudsley NHS Foundation Trust; Lucy Adamczyk, King’s College London; Mary-Jane Willows, Association of Young People with ME; Sheila Carruthers, Association of Young People with ME; Sue Webb, Association of Young People with ME; Mary Burgess, South London and Maudsley NHS Foundation Trust; Trudie Chalder, King’s College London

CFS/ME can be severely debilitating for adolescents and young people, impacting upon social life, home and education. There is a lack of research about young people who are severely affected by CFS/ME. The aim of this study was to gain a better understanding of any difficulties faced by young people who are severely affected by CFS/ME, and to investigate which factors are associated with fatigue, disability and school attendance. Participants were recruited from a charity for young people with CFS/ME. Participants were eligible to take part if they were aged between 11 and 26, had a diagnosis of CFS/ME, and had severe CFS/ME as defined by the AYME Functional Ability Scale (Moss, 2005).

Participants completed paper questionnaires at baseline (T1) and four months post-baseline (T2). Questionnaires included measures of fatigue severity, social adjustment, mood, and illness beliefs, as well as an open-ended question for comments about participants’ experiences of CFS/ME and their involvement with AYME.

51 young people were included in the study. At T1, participants reported high levels of fatigue severity and impaired social adjustment. Ten people (19.6%) were bed-bound and 33 (64.7%) reported using a wheelchair.

A multiple regression model containing age, gender and fear avoidance beliefs at T1 significantly predicted poorer social adjustment at T2.

Qualitative comments from participants indicated that CFS/ME impacted on all aspects of their lives. Some participants reported difficulties with accessing treatment and education.
and reported that there is a general lack of awareness and understanding of CFS/ME. However, young people were hopeful about the future and felt that recovery was possible. Fearful beliefs about activity are associated with poorer social adjustment. These beliefs could be addressed during treatments such as CBT. The young people reported that recovery from severe CFS/ME was possible, and we hope that these findings will help this to happen by informing future research about treatments for this condition.

Understanding the Mechanisms of Change in Cognitive-Behavioural Therapy for Chronic Fatigue Syndrome: A Structural Equation Modelling Approach
Trudie Chalder, King’s College London; Peihan Yu, King’s College London
Chronic fatigue syndrome (CFS) is a debilitating condition that is characterized by chronic or prolonged fatigue. Previous research has concluded that cognitive-behavioural therapy (CBT) is an effective treatment in managing the symptoms of CFS. However, the mechanisms of change of CBT for CFS is not well understood. The current study aimed to investigate the mechanisms of change of CBT for CFS, by assessing the hypothesized mediation model suggesting that changes in patients’ CFS-related fear avoidance beliefs mediate the relationship between the changes in their CFS-related avoidance behaviour and CFS illness outcomes, fatigue and physical functioning. Data from 487 patients who were diagnosed with CFS and received CBT treatment at a national specialist service were collected at pre-treatment, treatment sessions 4 and 7, and at discharge from treatment. Structural equation modelling was used to assess the mediating effects in the hypothesized mediation model and its competing mediation models. Results of structural equation modelling agreed with the hypothesized model – changes in participants’ fear avoidance beliefs at treatment session 7 fully mediated the relationship between the changes in their avoidance behaviour at treatment session 4 and CFS illness outcomes at discharge from treatment. This suggests that CFS patients’ avoidance behaviour should be addressed early on in the CBT treatment before their fear avoidance beliefs, as this is likely to significantly improve patients’ CFS illness outcomes over the course of CBT treatment.

Immediate and Early Gains in Cognitive Behavioural Therapy for Chronic Fatigue Syndrome
Elyse Couch, King’s College London; Sabine Landau, King’s College London; Trudie Chalder, King’s College London
Chronic Fatigue Syndrome (CFS) is a chronic condition resulting in disabling mental and physical fatigue. Cognitive behavioural therapy (CBT) has found to be an effective treatment for CFS. However, CFS is a heterogeneous condition where each patient’s experience of the disease varies greatly, which can affect their response to CBT treatment. It is not understood how change occurs during CBT for CFS. Research for other psychological conditions, such as depression, has suggested that change during CBT treatment occurs as a substantial improvement between two treatment time points rather than a gradual change over time. These substantial improvements can be defined as a ‘gain’. Currently, gains have not been defined for CFS, nor it is known how gains made in the early stages of treatment related to outcomes at the end of treatment.
This paper will describe the adaptation of criteria for gains in CBT treatment for CFS and its application to data from 530 patients with CFS receiving routine CBT treatment. Gains were described as either ‘immediate gains’, occurring between sessions 1 and 4 or ‘early gains’ occurring between sessions 4 and 7’. Predictors of early responses to treatment and effect on outcomes at the end of treatment will be discussed as well as how the treatment effect can be maximised during the initial stages of treatment.

Negative self-concept as a transdiagnostic process in disorders of adolescence and young adulthood

Possible selves and the importance of hope in psychosis and youth mental health
The self has long been implicated in the development and maintenance of psychosis and psychotic like experiences. It has been suggested that disturbance of the basic or minimal self, known as "ipseity", may underlie positive psychotic symptoms, via difficulties in distinguishing experiences as one's own (Sass & Parnas, 2003). In addition, the extended self – or identity – is also likely to be affected in psychosis (Estroff, 1989). Indeed, psychosis often occurs in adolescence and early adulthood – an important time for identity development. Moreover, an episode of psychosis is a significant – and sometimes traumatic – life event and thus may alter an individual’s beliefs about themselves and their place in the world. This talk will describe data on "possible selves" – selves one hopes or fears they may become in the future – in a cohort of young people following a first episode of psychosis. Links between possible selves, symptoms and functioning are discussed before outlining the potential for psychological interventions to foster more positive possible selves and instil hope for the future. Data from the Improving Social Recovery in Early Psychosis (ISREP; Fowler et al., 2009; Hodgekins & Fowler, 2010) study are presented, highlighting hope and positivity as important mediators of outcome in a trial of Social Recovery oriented Cognitive Behaviour Therapy (SRCBT; Fowler et al., 2013). Finally, this talk will discuss themes relating to the self which may be common across mental health difficulties in adolescence and early adulthood and consider opportunities for transdiagnostic research and intervention.

**The Specificity of Positive and Negative Self Evaluation in Healthy and Depressed Adolescents**

**Faith Orchard, University of Reading; Laura Pass, University of Reading; Shirley Reynolds, University of Reading**

Depression is prevalent among adolescents and can have long-term impacts. Cognitive theory states that individuals with depression view themselves negatively. Depressed adolescents typically use more negative and fewer positive words to describe themselves than healthy adolescents. However, the specificity of which negative and positive words are used is not known. In order to challenge increased negative self evaluations and decreased positive evaluations, it is critical to understand the content of these thoughts. Adolescents aged 12-18 years were recruited from both the community (N = 204) and from local child and adolescent mental health services (N = 54). All participants completed self-report measures of depression symptoms (Mood and Feelings Questionnaire), and clinic adolescents also took part in a diagnostic interview (Kiddie-Schedule for Affective Disorders and Schizophrenia). All young people then completed the Self-Description Questionnaire (Kelvin et al., 1999), on which they rated themselves on a 3-point likert scale in relation to positive, neutral and negative self-descriptive adjectives (e.g. lovable, friendly, stupid). Analyses have been conducted to explore which adjectives are most commonly used by adolescents in the community, which words best distinguish between healthy and depressed adolescents (grouped according to diagnostic and self-report measures), and finally which words cluster together and are best associated with symptoms of depression. It was found that negative words are broadly better predictors of depression, with highly distinguishing words supporting with the cognitive theory of depression e.g. worthless, failure. There were more subtle differences in positive self-evaluation – those with 'normal' mood rated themselves more positively, but depressed young people still endorsed pro-social positive adjectives (i.e. kind, friendly). Thus even during periods of depression, positive interpersonal elements of the self were preserved. Although we know that adolescents with depression will rate themselves as broadly more negative and less positive than healthy adolescents, this data suggests that there are a specific set of positive attributes that remain positive even when a young person develops depression. Findings will be discussed in the context of theory and practice. Specifically the authors believe that there may be implications for the assessment of depression diagnoses and how self-evaluation is targeted in therapy.
Adolescent depression: Facets of identity as protective factors.

Emily Green, Reading University; Emily Green, Reading University; Jennifer Fisk, Reading University; Judi Ellis, Reading University; Shirley Reynolds, Reading University

Negative self-concept is a core symptom of depression and is reported by the majority of adolescents referred for depression (Orchard et al., 2016). Self-concept develops and consolidates during adolescence and influences core autobiographical beliefs and memories in later life. In addition to evaluation of the self (positive to negative), self-concept has different elements or ‘facets’ e.g. physical, social, occupational, inter-personal etc. (Addis & Tippett, 2004). Multiple facets of self-concept may confer protection against depression (Linville, 1985; 1987) and therefore better understanding of self-concept during adolescence may help identify a key mechanism related to well-being.

This research examines facets of self-concept in non-clinical adolescents aged 13-18 years. The aims of this research were two fold i) to establish the psychometrics of a measure of self-concept when used with adolescents – The Twenty Statements Test (TST) and ii) to examine associations between self-concept and symptoms of depression in adolescents. The Twenty Statement Test, (TST) consists of 20 incomplete sentence stems “I am……” which participants are invited to complete. Two samples of young people were recruited from the community. In study 1, 207 YP aged 13 to 18 completed the TST and MFQ. Using a newly developed coding scheme, 3 categories of self-concept’ accounted for over 71% of all items elicited from the TST – adjectives (characteristics), family relationships and demographics. There was no significant correlation between symptoms of depression and the frequency of self-concept statements. There were gender differences, females gave significantly more statements than males. Age differences were also found; adolescents aged 14 gave significantly more statements than adolescents aged 16, 17 or 18. In study 2 we recruited 245 YP aged 13 to 18. The aim of this study is to replicate and evaluate the use of the self-concept coding scheme, to examine associations between self-concept and depression symptoms, and to explore more closely the relationship between current self-concept and young people’s ‘future self’. 

Exploring the self-concepts of young adults recovering from first-episode psychosis with and without persistent negative symptoms

Brioney Gee, University of East Anglia; Norfolk and Suffolk NHS Foundation Trust; Brioney Gee, University of East Anglia; Norfolk and Suffolk NHS Foundation Trust; Jo Hodgkins, University of East Anglia; Anna Lavis, University of Birmingham; David Fowler, University of Sussex

Background: Identity disruption and the emergence of a new, often more negative, self-concept is a widely recognised consequence of the experience of psychosis. It has been hypothesised (Lysaker & Lysaker, 2004) that this identity disruption might be implicated in the development and maintenance of negative symptoms (reductions in expression, motivation and social interest). The current study explored the self-concepts of young adults recovering from a first episode of psychosis accompanied by persistent negative symptoms, and compared them to those of individuals who experienced first-episode psychosis without persistent negative symptoms.

Methods: Thematic analysis of transcripts of in-depth interviews with 24 young adults recovering from first-episode psychosis recruited from UK Early Intervention in Psychosis (EIP) services. Participants were questioned about their beliefs about themselves and whether they felt their identity had changed during the course of their psychosis. The responses of those with and without persistent negative symptoms (measured using the Positive and Negative Syndrome Scale; Kay et al. 1987) during their first 12 months of EIP treatment were compared.

Results: Individuals who presented with persistent negative symptoms gave brief descriptions of themselves focused primarily on their personality traits. They often chose adjectives such as ‘quiet’, ‘shy’ and ‘serious’ to describe themselves. Most felt psychosis had not impacted their identity but some felt their experience of psychosis had changed them for the better. Those who did not present with persistent negative symptoms often described...
themselves using social roles, relationships and group memberships in addition to personality traits. Several such participants expressed that the experience of psychosis had damaged their sense of self.

Discussion: The study’s findings suggest that schizoid personality traits may be central to the self-concept of young adults who experience persistent negative symptoms during their first episode of psychosis. The relative paucity of social roles, relationships and group memberships within the self-descriptions of this group might be interpreted as evidence that the experience of negative symptoms has a detrimental impact on the self-concepts of young adults who experience these symptoms. However, unlike those without negative symptoms, most participants who presented with persistent negative symptom did not feel that their experience of psychosis had adversely impacted their identity. The possible implications of these findings for understanding negative symptoms in first-episode psychosis will be discussed.

Psychotherapeutic Provision in Iraq: Clinical Intervention and Training Development for Mental Health Practitioners

Implementing a CBT training model in a conflict zone - Iraq experience
Saleh Dhumad, Central and North West London NHS Foundation Trust
The Iraqi people have been exposed to on-going extreme forms of violence and tremendous stress due to political unsettle on-going violence, unemployment, and lack of public services. The Iraq Mental Health Survey report 2006/7 has identified the need to develop comprehensive psychosocial measures for vulnerable populations, and this cannot be achieved without developing psychotherapy services to deliver psychological interventions and provide training and research in the field.

A pilot project for psychotherapy training and service delivery
The project’s aim is to develop capacity for psychotherapy training and effective service deliver in Iraq through the implementation of training programmes for mental health professionals; making psychotherapy training as an essential requirement of post graduate psychiatry curriculum and setting up psychotherapy services and research centres.

The project was discussed with Iraqi psychiatrists and an email survey of psychotherapy training was completed to evaluate the level of knowledge and skills of Iraqi psychiatrist in the field of all forms of psychotherapeutic interventions.
In 2008, an email survey of psychotherapy training and delivery in Iraq was circulated to Iraq Mental health network, 50 psychiatrists (60 %) have responded to the survey. The results showed that 85 % of them had no training in any form of Psychotherapy. Only 15 % have had short courses without supervision. Almost all psychiatrists agreed that they need training and psychotherapy would be helpful for their patients.

After consultation with Iraqi psychiatrists about the form of psychotherapy they thought would be helpful at the current stage, the consensus was that they would like to be trained in Cognitive Behavioural Therapy.

Therefor the initial phase of the project was to train trainees at the Iraq Board of psychiatry. The Iraq Sub Committee at the Royal College of Psychiatrist working with the Iraq Board of Psychiatry introduced a new psychiatry curriculum, this included psychotherapy as a core component of the training.

The Iraq board of medical specialties / Iraq Board of Psychiatry appointed Dr Saleh Dhumad, consultant psychiatrist and CBT therapist in the UK, as a visiting consultant to lead the project and insure on-going training and supervision.

The training programme model:
1. Agree needs locally through field visits and survey
2. Establish communication; via email group
3. Deliver short courses, and material; 3-4 times a year
4. Supervise on line and via Emails, and short visits
5. Deliver therapy
6. Monitor progress
We established an email group for Iraqi Mental Health Professionals mainly psychiatry trainees: CBT-IRAQ@yahoogroups.co.uk. Trainees joined an online CBT course PRAXIS CBT, Northumberland, Tyne and Wear NHS Trust: www.praxiscbtonline.co.uk, 20 trainees were enrolled; to ensure access to training materials. Brief CBT courses, 4 day training courses twice a year, this has been taken place every year since 2009. Supervision; online supervision, group discussion, This is also on-going

Services development:
The first psychotherapy service has been established at Mental Health department at Baghdad teaching Hospital. The department focus at the initial stage on Cognitive Behavioural Therapy training, and service delivery, currently for adults but in the future to expand to all age groups, including child psychotherapy at later stages. This is mainly supported by trainee psychiatrist, Board students, from 2nd and 3rd year of training, and supervised online by external trainer, consultant psychiatrist and CBT therapist (UK based).

The Progress:
Since the start of the project more than 50 psychiatry trainees have completed the CBT training programme as part of their core training. We have frequently evaluated patients’ views and trainees’ views, over all both found CBT as a effective in helping patients with anxiety and depression.

Improving distance learning in conflict zones
Hasanen Al-Taiar, Oxford Health NHS Foundation Trust
It is well known that unstable geopolitical environments present barriers to medical education and healthcare systems development. Iraq is a rich Middle Eastern country which suffered with the consequences of three and a half decades of military conflicts and invasions since 1980. Certain parts of Iraq are occupied by ISIS which is being defeated at the time of writing.
However, movement restrictions, checkpoints, and political volatility have exacerbated psychiatric disease in many parts of Iraq. Cultural attitudes towards mental illness, difficulties in postgraduate education, and limited resources result in poor provision of psychiatric care. There are a few psychiatric hospitals in Iraq, the main one being Al-Rashad Hospital in Baghdad which was built in the traditional asylum design in 1950. It has the capacity of 1200 beds distributed across 4 male wards and 2 female wards.
OxPIQ (Oxford Psychiatry in Iraq) project provides online learning to Psychiatry Trainees (Residents) in Iraq. It has been developed by the Oxford University Medical Education Fellows in association with the Board of Psychiatry and Medical Education Unit in Baghdad, and Medicine Africa, King's College, London. The programme was launched in March 2016 and covers topics from all psychiatric specialties e.g. adult, child and adolescent, forensic, old age, psychotherapy and intellectual disability. The programme consists of interactive sessions on specific topics with invited consultants from the UK followed up two weeks later by a case based discussion presented by one of the Trainees in Iraq. OxPIQs is a synchronous web-based, distance-learning partnership aiming to address these identified deficits in medical education in Iraq. Using an online virtual classroom [Figure 1], participants attend tutorials with clinicians in the UK (mostly psychiatrists but also physicians).
Tutor- and student-provided cases act as the focus for developing postgraduate skills in clinical reasoning, differential diagnoses, and management plans.
Our Goals:
Augmenting intrinsic motivation amongst learners: intrinsic motivation can be augmented by using an assessment system that further encourages conceptual understanding e.g. Problem Based Learning (PBL), and case studies.
We aim at motivating learners to look at studying as a means to enhance personal development rather than a means to an end.
Results:
In the last 12 months, OxPIQ has delivered around 34 postgraduate tutorials to psychiatry residents at various stages of training and career.

As a result of increasing interest and to continue sustainability, a scientific committee comprised of three senior psychiatrists and a project manager has been set up. Feedback has been consistently positive and trainees thought that this experience improved their intrinsic deep learning via a transformative way:

“I can say that there has been an improvement in my way of tackling some critical issues with patients like suicide for example. This improvement surely had a reflection on the way patients cooperate and commit to their appointments. For me those sessions were very helpful.” (3rd year Board trainee).

Conclusions:
The programme demonstrates that long-distance collaboration at postgraduate level is increasingly feasible using online platforms. It provides an effective low-cost approach to overcoming geopolitical barriers in medical education. OxPIQ is improving learners’ intrinsic motivation and is helping them to utilise adult models of learning.

Future Pathways:
OxPIQ will continue delivering seminars in requested topics to trainees. We are also looking to extend teaching in mental health to parties in which links were made at the mental health conference.

Implications:
We would like to see a sustainable improvement amongst Iraqi psychiatrists’ in domains like the clinical knowledge and academic skills. This is “work in progress” and could be measured by reflective practices and utilisation of learnt skills. It could also be measured via gathering patients’ feedback.

Adaptation of CBT for religious/spiritual inclusivity: An experience of CBT training in Iraq
Sarfraz Jeraj, SLAM NHS Foundation Trust and University of Surrey
The Faculty of Medicine at the University of Kufa in Iraq has been proactive in organising academic conferences for a number of years within the constraints of a war torn country. In 2016 they planned to host a mental health conference to address this challenging area of Iraqi health which is dominated by psychiatric input. The conference organisers were keen to explore a range of mental health treatment approaches that would be relevant to Iraqi citizens. A number of mental health practitioners in the UK who have links with the Iraqi community and some experience of working with Muslims, including Iraqi clients, were invited to contribute to this conference which took place in February 2017.

One of the four key objectives of the Faculty of Medicine at the University of Kufa is “Enhancing the ability to understand the psychological and social behaviour of the patient that helps in their diagnosis and treatment”. In line with this objective the University of Kufa provided a forum for sharing mental health research, enhancing awareness of different approaches to treatment and workforce planning and to stimulate conversation around different models of mental health care. The conference was aimed at a wide audience from medical students and psychiatrists to a wide range of mental health practitioners from across Iraq.

The University of Kufa undertook a survey among faculty members and local clinicians of the areas of mental health they would like to hear more about at a conference. In response to this, the subject of alternatives to medical treatments for depression that Iraqi people could engage with was identified. I facilitated a workshop on the CBT treatment for depression based on the classical “Cognitive Therapy for Depression” protocol outlined by Beck (1979). Some adaptations incorporated strong behavioural focus with local practices and constraints in mind, as well as some of the Islamic beliefs relevant to many Iraqi people. Another workshop included working with systemic family therapy where live role play was used to familiarise delegates to the approach.

Common Religious Understanding
Goal of overcoming depression by working to achieve peace (Salaam in Arabic) which relates to a meta goal familiar to many

Balance in relation to activity scheduling and within the constraints of people's lives. This included the value religion places on earning an honest living being nine tenths of worship

Working with the religious concept of forgiveness – cognitive restructuring

Working with the religious concept of servitude – meaningful behavioural activation

Working with the religious concept of striving and coping based on blessing – motivation

Response

Feedback was obtained from:
- delegates in situ (as much to check understanding as how relevant the material and discussion was)
- a brief focus group of volunteer delegates after the workshop
- email feedback after the workshop
- fellow facilitators who were observers in the workshop
- additional feedback was offered by the organisers in response to comments shared by delegates

Key themes to emerge from the feedback included:
- parsimonious concept delivery leading to retention of concepts
- learning enhanced by practical demonstration
- resonant application of concepts using local and personal examples
- lack of training and supervision resources/infrastructure to put concepts into practice

Implications

Based on the feedback there are four strands of implications to consider:

Enhancing future workshops in Iraq

Enhancing my teaching and practice in the UK

Research focus on efficacy/effectiveness of CBT and culturally/religiously adapted CBT in Iraq

Support for provision of CBT training and supervision in Iraq

**Incorporating Iraqi Islamic religious understanding of grief into CBT based intervention**

Yasmin al Asady, Central and North West London NHS Foundation Trust

Bereavement and grief, despite being one of the most universal of life experiences, are perhaps the least universal in one’s personal experience of them. Perhaps by virtue of the very roots of bereavement being in set firmly in a relational context, grief can be heavily influenced by various factors; culture, religion, personal narrative and individual thinking styles to name but a few.

In an increasingly multicultural society, with increasing demands on services, and increasing calls for standardisation and manualised interventions the challenge therefore is to incorporate an understanding of the aforementioned individual differences into personalised treatment approaches.

Using first hand experiences of Iraqi Shia-muslim bereavement practices, both in Iraq and within the Iraqi Diaspora community in London, I hope to explore the social, cultural and religious connotations of grief practices and how this may influence access to and progress through CBT-based grief therapy for patients of Iraqi Shia-muslim heritage within the UK.

Several culturally rooted core beliefs that appear to be central to the collective Iraqi Shia-muslim community can pose barriers to successful therapeutic interventions. This can be at the very beginning of the journey, pertaining to beliefs about the line between normal and
complicated grief, how this may be conceptualised as a manifestation of mental ill health, and what implications such a conceptualisation may have. At the other end of the process, with regards to the practicalities of delivering therapy, one must consider the effect of language barrier on the development of a therapeutic relationship and how this can impact the level of cultural appreciation on the part of the therapist. Furthermore, on a more abstract level, it will influence the very vocabulary with which a person may conceptualise their experience.

From a religious viewpoint one can consider the heavy social pressure of religious group expectations and the fine line between protective religious practices and the added burden and guilt of falling short of religious expectations, in addition to the further loss of potential coping mechanisms should religious allegiance be challenged by bereavement. In a society where religious hierarchy often dominates local power structures, one must also be cognisant of the wider political agenda that may have usurped an individual's personal experience.

No discussion of grief within the context of a community of Iraqi heritage can be considered complete without a efforts to appreciate of the collective trauma the nation has endured over decades of dictatorship and multiple wars, and thus the indescribable amounts of loss, both processed and unprocessed in nature, that contribute to the interpretation and meaning making process when working through loss with this patient group. Of particular importance is the collective ritualised mourning behaviours as part of the annual 'Ashura' commemorations is often viewed as protective against the grief of the nation.

Impact on training and practice:
In addition to the clear potential impact of therapies that are not attuned to the culture of the patient in question, and the importance of developing cultural competence, one must also consider the impact of neglecting such factors in the ongoing training and development of therapeutic approaches. In a bid to improve access to psychological therapies both within minority communities within the UK and through collaborative projects with centres in Iraq, it is essential that local knowledge is not colonised by 'evidence-based' truths that undermines the complex fabric of cultural and religious identities that underpins this community.

Use of brief intervention CBT in makeshift medical camps in Karbala and Najaf, Iraq
Annie Shamsi, Central and North West London NHS Foundation Trust
The first systematic survey to investigate the public perception of mental health in Iraq was carried out by Sadik, Bradley, Al-Hasoon and Jenkins (2010). Results showed that Iraqi people often understand mental illness to be caused by traumatic events. Findings included the belief that individuals suffering with a mental health disorder are to blame for their condition. Although respondents significantly believed that they will be able to maintain a friendship with someone with mental health problems, a similarly large number believed that people should avoid all contact with them. Medecins Sans Frontieres (MSF, 2012-13) has found a similar range of responses: shame, fear of discovery, and fear of being abandoned or ostracised are all frequently mentioned by patients on the MSF programme which is run jointly with the Iraqi Ministry of Health (IMoH, 2012-13).
It has become an accepted part of the cultural norm to live with mental health difficulties without seeking treatment. Development of resilience has become part of the accepted reality, and this is in equal parts due to i) limited availability of services, ii) little knowledge of or belief in the efficacy of intervention, and iii) stigma and shame. Affected individuals are therefore continuing to function at a suboptimal level with little knowledge or choice. This was confirmed in the author's experience of working with individuals on the ground, for whom it was a novel and self indulgent experience to be able to speak in depth about themselves and the development of their difficulties.
MSF and IMoH have jointly developed a model of counselling care with the following two primary goals:

1. To establish and replicate a model of mental health counselling in health centres throughout Iraq, including the training and supervision necessary for sustainability
To increase public awareness about psychological problems in order to encourage assistance seeking, thereby reducing the stigma associated with mental ill-health.

As a first step our UK based mental health team of volunteers is focusing on the former aim. While the slow progress continues in government backed initiatives to develop mental health counselling, the key role of volunteering in the reconstruction of post conflict society has been highlighted for Iraq (Al Uzri, 2013).

This paper will present the author’s experience of providing psychological assessment and brief therapy in the holy cities of Najaf and Karbala, Iraq during the peak pilgrimage period. During the arba’een period the tragic martyrdom of the grandson of the Prophet of Islam is commemorated across the Muslim world, and particularly amongst Shia Muslims. The largest gathering on record takes place annually in the city of Karbala to mark this historic event with rituals and ceremonies demonstrating outpourings of grief. Estimates of numbers vary from 20 to 25 million.

Within this context, a voluntary international group of medical and allied health practitioners establish annual medical camps for both emergency and longer term treatments. This paper provides an account of the first year that psychological therapy was introduced to the camps. Due to the nature of the camps the CBT based intervention was brief. Discussion of the content, style and format of the intervention will include adaptation of the CBT model to include the religious sensitivities of the patients, in particular during this heightened period of mourning. Patients responded well to the encompassing of Islamic, moral and ethical concepts to which they could relate, such as the concepts of gratitude, contentment, humility and patience.

Time for change: Where does change matter in the course of CBT for eating disorders

**CBT for eating disorders: The impact of early changes in eating pathology on later changes in personality pathology, anxiety and depression**

Hannah Turner, Southern Health NHS Trust; Emily Marshall, Southern Health NHS Trust; Francesca Wood, Southern Health NHS Trust; Lusia Stopa, University of Southampton; Glenn Waller, University of Sheffield

Whilst studies have consistently identified early symptom reduction as an important predictor of treatment outcome in the eating disorders, the impact of early change on common comorbid features has not been investigated. This study of CBT for eating disorders explored patterns of early change in eating pathology and longer-term change in personality pathology, anxiety and depression. It also explored the impact of early change in eating pathology on overall change in personality pathology, anxiety and depression. Participants were 179 adults diagnosed with eating disorders who were offered a course of CBT in an out-patient community eating disorders service in the UK. Patients completed a measure of eating disorder psychopathology (Eating Disorders Examination-Questionnaire, EDE-Q) at the start of treatment and following the 6th session. They also completed measures of personality disorder cognitions (Personality Belief Questionnaire – Short Form, PBQ-SF), anxiety and depression (Hospital Anxiety and Depression Scale, HADS) at the start and end of treatment. There were significant changes in eating pathology over the first six sessions of treatment. Significant improvements were also seen in personality disorder pathology, anxiety and depression by the end of therapy. Effect sizes were medium to large for both completer and intention to treat analyses. Early changes in eating pathology were associated with later changes in common comorbid features, with early reduction in restraint being a key predictor. These findings demonstrate that early symptom change can be achieved in CBT for eating disorders when delivered in routine clinical practice. Such change has long-term benefits that go beyond the domain of eating pathology, enhancing change in personality pathology, anxiety and depression.

The role of sudden change in brief CBT for non-underweight eating disorders
Aim: To explore the role of sudden gains in eating disorders therapy; particularly the impact on treatment outcome.

Method: Participants were 43 adults diagnosed with eating disorders who completed a course of brief Cognitive Behavioural Therapy. Patients completed start of treatment measures on eating psychopathology, personality disorder beliefs, anxiety, depression and therapeutic alliance and weekly measures of eating disorder psychopathology. Sudden gains were measured as a 50% drop in behavioural symptoms between session 4-8, maintained for at least 2 weeks with symptoms not returning above 25%.

Results: Initial eating disorder severity, anxiety, depression and personality pathology did not significantly differ between those who did and did not have a sudden gain during therapy. However, a positive therapeutic alliance at the end of session 1 was associated with later sudden gains. It was found that sudden gains were significantly associated with remission (abstinence of eating disorder behaviours and a score <2.77 on the EDEQ-Global) at end of treatment.

Discussion: Findings suggest the importance of the first session in eating disorders therapy and the collaborative nature of goal setting in whether patients experience a sudden gain in therapy. Secondly, sudden gains appear to be linked to better treatment outcomes, suggesting the importance for clinicians to not give up and to stick with therapy.

Evidence-based CBT for eating disorders in primary care settings: Effectiveness with non-underweight cases

Charlotte Cooper, Avon and Wiltshire Mental Health Partnership NHS Trust

This study aimed to determine whether Cognitive Behavioural Therapy (CBT) for eating disorders can be effective in a routine, primary care clinical setting, and to assess dose response. No effectiveness studies of CBT delivered in such settings have previously been published. There is developing evidence supporting the importance of change early in CBT. The study consisted of 47 patients who commenced treatment with a publically funded primary care eating disorder service in Bristol, UK. Participants attended 7-33 individual sessions with CBT therapists. 74.5% completed treatment. Treatment completers had a remission rate of 69%, as measured by EDE-Q. These results are comparable to effectiveness previously demonstrated by more specialist services. For those who attended more than 12 sessions, length of any additional therapy was not associated with any further change in eating or depressive psychopathology. Overall, the findings support effectiveness of CBT in primary care settings. The non-linear association between number of sessions and recovery highlights the importance of early change.

The importance of (very) early change in brief CBT for eating disorders

Glenn Waller, University of Sheffield; Hannah Turner, Southern Health NHS Trust; Madeleine Tatham, Norfolk Community Eating Disorders Service

Objective: To determine whether early change is as relevant to outcomes in brief CBT as it has been shown to be in conventional CBT for eating disorders.

Methods: A case series of 106 non-underweight eating disordered cases received a 10-session individual CBT. The change in eating and mood characteristics over the first four sessions were used to determine whether any predicted the outcome by the end of therapy, using intention-to-treat and completer analyses.

Results: The therapy was effective overall. However, initial characteristics did not predict outcomes, early symptom change in two domains predicted a better outcome in multiple regression analyses. The first was reduction in levels of restraint, and the second was a reduction in depression levels.

Discussion: These findings indicate the importance of getting patients to eat early in their CBT. It is likely that such a change in eating patterns is also responsible for the apparent role of change in depression, given the link between dietary intake and mood.

Dissociation in Psychosis: mechanisms and intervention
Dissociation mediates the relationship between childhood maltreatment and subclinical psychosis
Charles Cole, University College London
Numerous studies have found that dissociation mediates the relationship between childhood adversity and auditory hallucinations in adult clinical populations. This has supported the theoretical proposition of Moskowitz et al. (2009) that psychotic symptoms are "traumatic in origin and dissociative in kind". The results of our study (Cole, Newman-Taylor & Kennedy, 2016) suggest that dissociation also mediates this relationship in a subclinical population and for the first time, dissociation mediated the relationship between childhood maltreatment and delusional ideation. Depersonalisation, dissociative amnesia and absorption (three specific dissociative processes) might be particularly relevant as mediators, although the mechanism through which they exert their mediating effect remains unclear.

Working with psychosis and dissociation in clinical practice – where do we start?
Katherine Newman-Taylor, University of Southampton
We know that people with psychosis are more likely than others to have experienced trauma in early life. We also know that dissociation has a key role in the relationship between trauma and mental ill-health. So why do we not routinely consider dissociation when working with people with psychosis?
This presentation describes two examples of CBT with people struggling with psychosis and dissociation. CBT formulation was used to map the psychosis and dissociative processes maintaining distress and impeding recovery. This enabled joint decision making about what might be useful therapeutically to manage these experiences and live more fully in line with the individuals' goals and aspirations.
Consistent with the literature, clinical experience suggests that dissociation may be one of a number of pathways contributing to distressing psychosis. As psychologists and CBT therapists, we need to understand and work with the interplay between early experience, dissociation and psychosis, if we are to support people with complex trauma in their recovery.

The link between dissociation and hallucinatory experiences: From basic research to therapy
Filippo Varese, University of Manchester
In recent years, a growing number of empirical studies has linked the predisposition to experience hallucinations to increased levels of dissociation. Evidence suggests that dissociation might represent an important psychological mediator of the well-established relationship between trauma exposure and the core symptoms of psychosis (Varese et al 2012). This presentation will build on the findings of a recent meta-analysis on the link between hallucinations (and in particular auditory verbal hallucinations or "hearing voices") and dissociative experiences (Pilton et al. 2015), as well as the findings of recent clinical studies by our research group on the psychological mediators of the trauma-psychosis link (Pearce et al., under review). Through a critical analysis of the available evidence, we will aim to clarify whether dissociation could be seen as process that increases vulnerability to specific psychotic symptoms or specific types of hallucinatory experiences. Furthermore, the added value of considering dissociation in the context of psychological interventions with clients with distressing psychosis will be evaluated further through the preliminary findings of a case series of a CBTp intervention for distressing auditory verbal hallucinations modified to target dissociation at early stages of therapy.

Findings from a feasibility trial of brief CBT for Depersonalisation Disorder in Psychosis
Simone Farrelly, Institute of Psychiatry, Psychology and Neuroscience, King’s College London; Emmanuelle Peters, Institute of Psychiatry, Psychology and Neuroscience, King’s College London; Matilda Azis, Institute of Psychiatry, Psychology and Neuroscience, King’s College London; Anthony S. David, Institute of Psychiatry, Psychology and Neuroscience, King’s
Background: Recent research suggests that depersonalisation symptoms may be prevalent in those with current psychotic symptoms, and, when present, these symptoms are associated with increased impairment. Aim: We aimed to establish if a brief, six session treatment protocol adapted from a Cognitive-Behavioural model of Depersonalisation Disorder was feasible to deliver as well as acceptable to participants who also had current psychotic symptoms. Method: A single-blind, randomised controlled trial with a treatment as usual control condition was used to examine our research aims. Feasibility and acceptability estimates examined included rates of referral, acceptance, eligibility, consent, satisfaction and improved skills/knowledge to manage depersonalisation. Results: Over a 10 month period, 21 individuals were recruited to the trial. Data suggest that the intervention was feasible to deliver and highly acceptable to participants. Preliminary clinical data suggest decrease in mean scores of depersonalisation, auditory hallucinations, anxiety and depression though further, appropriately powered analyses are required before any definitive statement can be made. Conclusions: Overall the data suggest that a larger-scale trial is warranted.

Measurement and enhancement of recovery in bipolar disorder

**Service Users experiences of recovery - a mixed method study**

Barbara Mezes, Lancaster University; Steven Jones, Lancaster University; Fiona Lobban, Lancaster University; Damien Longson, Manchester Mental Health and Social Care Trust; Deborah Costain, Lancaster University

This talk will present the results of a qualitative investigation into personal recovery experiences of service users with bipolar disorder. The interviews were conducted as part of a mixed methods study and followed two quantitative phases - a prospective questionnaire study to explore psychological processes associated with personal recovery in bipolar disorder and an experience sampling study to explore the day-to-day personal recovery experiences of service users. Personal recovery was measured in the quantitative phases using the Bipolar Recovery Questionnaire (Jones et al., 2013) and purposive sampling was applied to identify and invite participants from the quantitative phases, who demonstrated diminished, average or more advanced personal recovery. The semi-structured interviews aimed to deepen our understanding of factors influencing recovery experiences in individuals with different recovery scores and the interplay of long term and momentary personal recovery experiences. More specifically, the thematic analysis contrasted the recovery experiences of participants (N=21) and their views on the definition and process of recovery in bipolar disorder (including both day-to-day and longer term experiences) and focused on factors that may impact on personal recovery of service users and contributed to different experiences, including mood fluctuation, important life events, activities, interpersonal relationships and helpful (or less helpful) thinking processes and behavioural strategies.

**Psychological processes underlying personal recovery in bipolar disorder**

Alyson Dodd, Northumbria University; Steven Jones, Lancaster University; Fiona Lobban, Lancaster University

Recovery is an important outcome among people with bipolar disorder – and highly variable over time and between people. To maximise recovery through psychological therapies, we need a better understanding of what factors determines this variation. As with psychological therapies aiming to delay relapse and improve symptoms, research on the psychological mechanisms underlying recovery is crucial to inform effective recovery-focused therapy. This talk presents findings from two studies on the psychological processes associated with personal recovery in bipolar disorder. Study 1 was a cross-sectional investigation of whether negative beliefs about mood swings and self-referent appraisals of mood-related experiences were negatively associated with personal recovery in people with bipolar
disorder (n = 122). Normalising appraisals of mood changes were positively associated with personal recovery, while depressive symptoms, negative self-appraisals of depression-relevant experiences, extreme positive and negative appraisals of activated states, and negative beliefs about mood swings had negative relationships with recovery. Study 2 was a longitudinal investigation of whether negative beliefs about mood swings and early warning signs monitoring predicted change in personal recovery over time (48 week follow up) in bipolar disorder (n = 96). Both studies found that more negative illness models (relating to how controllable, long-term, concerning, and treatable mood swings are) are associated with diminished personal recovery in bipolar disorder, over and above mood symptoms. These types of cognitive representations of mood swings are potential mechanisms of change in psychological interventions. Psychological interventions aiming to empower people to feel better able to manage mood and catastrophise less about mood swings, and therefore develop less negative illness models, could facilitate personal recovery in people with BD, which might be achieved in recovery-focused therapy.

Recovery focused CBT for older adults with bipolar disorder
Elizabeth Tyler, Lancaster University; Steven Jones, Lancaster University; Fiona Lobban, Lancaster University; Chris Sutton, University of Central Lancashire; Sheri Johnson, University of California, Berkeley; Colin Depp, University of San Diego; Kenneth Laidlaw, University of East Anglia

There is very little research or service development for individuals over the age of 60 with bipolar disorder. As the population ages, there will be significant demands on healthcare services, especially if the current lack of evidence based treatments continues. Recovery focused CBT for older adults with bipolar disorder (RfCBT-OA) is a 14 session individual intervention, tailored to meet the specific needs of this client group. It has been developed through a review of current literature in the area and consultation with service users. The intervention is currently being tested out using a parallel two- arm randomised controlled treatment design to determine the feasibility and acceptability of RfCBT-OA plus treatment as usual (TAU) compared with TAU. Participants (N=50) are being recruited in the North-West of England via primary and secondary mental health services and through self-referral. Participants in both arms complete assessments at baseline and then every three months, over the 12 month follow-up period. RfCBT-OA has the potential to improve outcomes for service users, helping them to develop a range of coping strategies and putting them more in control of managing their mental health problems. The presentation will focus of the development of the intervention and preliminary findings from the research trial.

Adapting Behavioural Activation (BA) for different populations

Adapting Brief Behavioural Activation for adolescents with depression: pilot and plans for the future
Laura Pass, University of Reading; Shirley Reynolds, University of Reading

Depression in young people is a common and debilitating disorder, associated with numerous adverse impacts including educational underachievement, increased risk of comorbid mental health difficulties, substance misuse and suicidal behaviour. Current evidence based treatments for adolescent depression can be lengthy and difficult to access, and are also limited by the number of trained therapists available. Behavioural Activation (BA) is an evidence-based treatment for depression in adults and has been shown to be effective when delivered by non-specialist clinicians. This may be a promising treatment for young people due to the relative simplicity of the approach, which does not require cognitive work. Cognitive development is still ongoing in adolescence and cognitive difficulties can also occur as a symptom of depression, so a non-cognitive approach may be particularly appealing for this client group.

This presentation outlines the adaptations made to the adult protocol for Behavioural Activation for the Treatment of Depression (BATD-R, Lejuez, et al., 2011), to make it suitable for adolescents in the UK. The rationale for adapting this particular protocol will be discussed, including the structured, brief nature of the intervention and consideration of
values. Brief BA (Pass & Reynolds, 2014) is a brief (6-8 session), structured intervention designed to be delivered by a range of professionals who do not require specialist qualifications or extensive training. This presentation will outline the developmental adaptations made, as well as discuss how a low-intensity treatment for adolescent depression can be designed to be delivered by a variety of professionals. Pilot data from CAMHs and school based delivery of Brief BA will be discussed, along with lessons learned and directions for future research.

Adapting Behavioural Activation for people with Intellectual Disabilities: A randomised control trial
Andrew Jahoda, University of Glasgow

Aims: Behavioural Activation is a psychological therapy that has been shown to be as effective as CBT in tackling depression. The advantage for adults with intellectual disabilities is that Behavioural Activation (BA) is less dependent on verbal communication. The question was whether it would be possible to successfully adapt BA for people with intellectual disabilities and recruit participants to a large-scale, multi-site trial of an individual psychological therapy for people with a learning disability.

Methods: The manuals were developed and participants were randomised to Behavioural Activation and Guided Self-Help, an ethical alternative therapy. Participants were followed-up at four months, eight months and twelve months post randomisation. Participants were recruited from sites in Scotland, England and Wales using a multipoint recruitment strategy.

Results: The target recruitment was for 166 participants and final total achieved was 162 participants. The key challenges to achieving recruitment were not only with identifying individuals who have learning disabilities and depression but also in recruiting and training sufficient numbers of therapists to deliver the interventions.

Conclusions: Successfully adapting BA and recruiting to this trial offers hope for developing the evidence base for using psychological therapies with people who have learning disabilities. Lessons were also learned about the considerable challenges to be overcome.

Therapist and service factors in delivering CBT

The competencies required to assess and treat using low intensity CBT by Psychological Wellbeing Practitioners
Stephen Kellett, University of Sheffield and Sheffield Health and Social Care NHS Trust; Lucy Hughes, Uni of Sheffield; Mel Simmonds-Buckley, Uni of Sheffield; Stephen Kellett, Uni of Sheffield

Despite the PWP role now being firmly established within IAPT (and indeed demand for PWPs being on the increase), the competencies required to work in such a ‘low input, high throughput’ clinical environment have not been previously clearly defined. Previous methods of assessment of such clinical skills have been based on measuring adherence. The research team wanted to develop skillfulness measures in order to assess the degree of expertise evident in PWP delivery (i.e. competency), not simply whether an activity took place (i.e. adherence). This talk will focus on the development and validation of two PWP competency measures; (1) for assessment sessions and (2) for treatment sessions.

Measures were developed and went through initial face and content validity checks with an expert panel (N=8). A sample of N=80 novice PWPs, N=55 qualified PWPs and N=24 expert trainer PWPs then viewed and rated a recording of a PWP assessment session and also a treatment session. PWPs (n=80) also had assessment and treatment sessions rated (counterbalanced for anxiety and depression presentations) in terms of competency (with measures of helpfulness, the alliance and the friends and family test completed by actor patients) in order to assess construct validity. Tests were repeated to assess stability over time and a coaching intervention applied to assess sensitivity.

The assessment and treatment competency scales both display good content validity, internal reliability, test-retest reliability, inter-rater reliability and construct validity. There is an associated between assessment competency and the willingness of the patient to be seen again and during treatment there is a relationship between competency and the alliance.
The scales developed appear useful in the training and ongoing supervision of novice and qualified PWPs. The scales have been designed for easy use in services and need to be regularly used in clinical supervision accordingly.

1. PWPs being able to self-assess their competency with both anxious and depressed patients
2. Supervisors being able to integrate competency assessment into clinical supervision.

The misappraisal of the role of the therapist in therapy: An update to psychotherapist self-assessment bias.

Zachary Parker, University of Northampton

It has been well established that over appraisal of skills, or self-assessment bias, exists in numerous fields. It has only recently been empirically established that this occurs within both US and UK psychotherapists. While self-assessment bias is not a new concept, the effects this bias may have on the work conducted by psychotherapists needs to be explored. Therefore, this presentation will examine the magnitude of self-assessment bias among UK psychotherapists, explore the effects that this bias may have in clinical practice, and address steps that can be taken to reduce potential harm that may come from self-assessment bias.

This study focused on psychotherapists who treated anxiety disorders. A total of 220 responses were collected from psychotherapists who were actively involved in treating anxiety disorders. These psychotherapists completed self-report surveys that asked for their self-rating of skills, their perceptions of clients' responses to therapy, assessed which therapy paradigms they employed (e.g., CBT, humanistic), which specific therapy techniques they employed, their own levels of anxiety and self-esteem, and their attitudes towards CBT. These surveys were completed either online or at previous BABCP workshops. The data were analysed using comparative and correlational methods.

This study supports previous findings from the UK and the US in that psychotherapists engage in self-assessment bias and held unrealistic beliefs regarding their clients' responses to therapy. Their overall self-assessment bias is influenced by internal factors (e.g., self-esteem), age/years if experience, accreditation status, and their use of non-CBT techniques. Considering their impressions of clients' responses to therapy, therapists saw themselves and not the therapy or the therapeutic tools as being the driving factor for recovery or improvement of the client.

Having supported previous research on self-assessment bias among psychotherapists, the new finding here is that psychotherapists see themselves as being the only factor that influences a client's recover. This inaccurate belief is in direct conflict with previous research and its implications also conflict with the research around telehealth and distance therapy. This belief may be part of a confirmatory bias loop that is maintained by the need to reduce cognitive dissonance and maintain a positive self-image.

There are three major implications for the psychotherapists themselves. First, these inaccurate beliefs and biases may increase the chance of therapist drift. Second, it could lead to lack of appropriate professional development. Third, it may create a blindness to the need for change in practice or of poor skills training in general. Considering, the client there are several implications for client well-being. First, this bias and false belief can create a culture of client blame, when therapy does not go well. Second, it can foster the development of learned helplessness amongst clients. Third, it can potentially prolong or intensify the suffering of the client. Considering the public view of psychology and CBT, this can also harm the overall perception of the field of psychology and harm the public's faith in CBT psychotherapists.

Eating As Treatment (EAT): A Health Behaviour Change Intervention to Improve Treatment Outcomes for Head and Neck Cancer Patients Undergoing Radiotherapy

Amanda Baker, University of Newcastle, Australia; Ben Britton, University of Newcastle; Kristen McCarter, University of Newcastle; Luke Wolfenden, University of Newcastle; Chris Wratten, Calvary Mater Newcastle Hospital; Judy Bauer, The University of Queensland; Gregory Carter, University of Newcastle
Malnutrition is a significant problem in the head and neck cancer (HNC) population and is associated with an increase in complications due to side effects of treatment as well as increased morbidity. Despite these concerns, HNC patients are often noncompliant with dietary advice and have to overcome significant barriers to eat.

The aim of this study was to test the effectiveness of the Eating as Treatment (EAT) intervention. EAT is a dietitian delivered health behaviour change intervention to prevent malnutrition in patients with HNC undergoing radiotherapy.

A stepped wedge cluster randomised design was used. All recruitment hospitals began in the control condition providing treatment as usual and then switched to the intervention condition. Dietitians were trained in the EAT intervention including both intervention specific skills and Behaviour Change Counselling (BCC) skills. Practice change strategies were also implemented to improve intervention adherence and care according to evidence based dietetic guidelines.

HNC patients aged 10+ undergoing radiotherapy with curative intent were recruited from radiotherapy departments in four Australian sites. The primary outcome of nutritional status, as measured by the Patient Generated Subjective Global Assessment (PG-SGA) was analysed using generalised linear mixed models. Dietitian adherence to BCC and study specific techniques were assessed using a 20% random sample of audio recorded and coded dietetic sessions. Frequencies of the implementation of evidence based guidelines to patients were assessed via audiotape and medical record audits. The change in the odds of implementation of care according to best practice guidelines was assessed via logistic regression.

Between July 2013 and January 2016, 307 participants were recruited with the final follow-up assessment conducted in May 2016. Nutritional status as measured by the PG-SGA found that participants in the intervention group had significantly lower (better) scores than those in the control group at the end of radiotherapy ($\beta = -1.48(\text{SE} \pm 0.72) p<0.05$). Thus, the intervention was effective in significantly reducing malnutrition.

Relative to pre-training, application of both study specific skills and BCC was significantly greater. The clinical practice change strategies significantly improved the odds of implementation of four of six guideline recommendations ($p<0.05$). The greatest improvements were found for patient screening for depression ($\text{OR}=349; 95\% \text{ CI}: 69, 1756; p<0.0001$).

This trial is the first and largest multi-centre trial of psychological strategies to attempt to prevent malnutrition in HNC patients. The EAT intervention demonstrated an improvement in nutritional status as measured by the PG-SGA at the critical time point at the end of radiotherapy. The effectiveness of the clinical practice change strategies in increasing the provision of care according to evidence based clinical guidelines could serve as a model for improving the implementation of guidelines in other outpatient clinics in Australia and internationally.

The EAT intervention is based on established behaviour change counselling methods, including cognitive behaviour therapy. It has the potential to be inexpensively integrated into all cancer centres, become part of dietetic tertiary training and further demonstrate the importance of cognitive behavioural interventions in an oncology setting.

**Identifying and overcoming barriers older people face in accessing CBT for severe mental health problems**

**Katherine Berry, University of Manchester; Laura Brown, University of Manchester; Gillian Haddock, University of Manchester**

Older people with severe mental health problems, such as schizophrenia are a large and growing patient group who experience significant distress and disability, resulting in substantial health and social care costs. CBT for older people has the potential to reduce distressing symptoms and improve quality of life and community functioning, thus preventing unnecessary hospitalisations and care home placements. However, older people with severe mental health problems are not routinely offered CBT. Furthermore, according to the Department of Health, older adults have unique needs requiring specifically tailored interventions, meaning that CBT developed for younger adults may need to be adapted. This
The project aims to identify barriers to carrying out CBT with older people with severe mental health problems, develop recommendations about how existing CBT interventions for severe mental health problems need to be adapted and devise an implementation plan for how these problems can be overcome using a case study approach within one Mental Health Trust.

We have interviewed 10 therapists, 11 potential referrers, 21 service users over 50 years of age and 8 carers about their views on barriers to accessing CBT and how these might be overcome, including how CBT needs to be adapted. All interviews were transcribed and analysed using thematic analysis.

Key themes identified related to attitudinal barriers within staff teams (e.g. people are too set in their ways to change or won’t want to talk about personal problems) and service users/carers’ negative experiences of care in the past which resulted in negative expectations about future treatments and lack of trust in staff. There was also evidence of physical barriers, including poor physical health and mobility problems which adversely impacted on access. Participants highlighted the need for more groundwork within staff teams and in service user groups to breakdown attitudinal barriers, as well as increasing the physical accessibility of intervention through flexible service provision.

We will draw on the results of the analysis and our knowledge of the implementation literature to devise and deliver an implementation strategy for increasing access to CBT specifically for people with severe mental problems in later life. We will present this plan as part of the paper as well as our plans to assess the impact of the strategy via data routinely collated by the Trust on the offer of, referrals for and uptake to CBT.

CBT is an evidence-based approach for working-aged adults with severe mental health problems. Currently the majority of older people with severe mental health problems do not receive talking therapies. They are only offered medication which can have more harmful side-effects in older people due to age-related changes in metabolism and the increased likelihood of interactions with medications for physical health problems. A key output from this project will be an implementation strategy for improving older people’s access to CBT for severe mental health problems. Ultimately, this will reduce age discrimination and increase the range of treatments that are available to the patient group. A further research output will be recommendations about how CBTs for severe mental health problems primarily developed on the basis of research with younger adults needs to be adapted for older people. If we increase access to CBT it is important that clinicians take into account the unique needs of older people. It is widely accepted that therapies for older people need to be adapted, for example, to account for physical and cognitive decline, to more closely target specific beliefs such as ‘I am too old to change’ and to address problem areas, such as loss of social role typically associated with later life.

This study has been funded by the BABCP research funding scheme.

Compassionate Mind Training enhances Cognitive Behavioural Psychotherapy training for students.

Gillian Rayner, University of Salford; Elaine Beaumont, University of Salford; Lisa Bluff, University of Salford; Gosia Bowling, University of Salford; Emma Walker, University of Salford

Students undergoing Cognitive Behavioural Psychotherapy (CBP) training may be vulnerable to symptoms of stress and burnout because they may work in settings that are emotionally and physically draining, with clients that experience high levels of distress (De Stefano et al., 2012, Beaumont, 2016). Psychotherapy students also experience high levels of anxiety when they commence their first placement and engage in psychotherapy supervision rating practice competence (Rønnestad and Skovholt, 2003). On observing these stressors in the students, the programme leader and team designed a compassionate self-practice and reflection intervention based on Compassionate Mind Training (CMT) (Gilbert, 2009). This was added to the CBP curriculum.

This two-phased multimethod research study examined the effects of adding Compassionate Mind Training (CMT) to the MSc CBP training programme. In Phase 1, The Self-Compassion Scale (Neff, 2003), Compassion-for-Others Scale (Pommier, 2011) and the Interpersonal Reactivity Index (Davis, 1980) were used with 35 students to examine, self-compassion,
compassion for others, dispositional empathy and self-critical judgement. Questionnaires were completed pre-and post the training. In Phase 2 of the study, a qualitative focus group was facilitated with 6 participants. Questionnaire Statistical analyses used SPSS 20 for Windows. Changes between pre-and post-scores were assessed using repeated measures paired sample t-tests. The focus group was analysed using Thematic Analysis.

It was found in Phase 1 that CMT had favourable effects. Self-compassion increased and self-critical judgement reduced post training. A statistically significant increase was observed pre to post training for self-compassion (M= 3.26, SD = 0.7 versus M = 3.61, SD = 0.8, t(20) = -2.473, p =0.022). A statistically significant reduction was observed in self-critical judgement pre to post training (M= 3.34, SD = 0.9 versus M = 2.96, SD = 1, t(20) = -2.782, p =0.012).

Compassion for others increased post training although scores did not reach statistical significance in this area. The discussion in the focus group complemented the findings of the qualitative questionnaire. This supported the idea that participants in the intervention were able to re-engage with their compassionate self and consider the importance of compassion in psychotherapy. The focus group provided detailed feedback on exactly what was useful and how this had enhanced their personal, educational and therapeutic provision with clients.

In conclusion, the addition of the compassionate mind training increased compassion to self and others, reduced self-criticism and had a positive impact on the learning experience, personal practice and compassionate work with clients.

The programme team considered this a useful addition to CBP training to improve the learning experience for students, personal compassion and compassion towards clients when using CBP. This work also supports the use of self-reflection and self-practice in CBT.

Bipolar disorder: enriching theory, developing treatment

**Post-Traumatic Stress Disorder, Appraisals and Bipolar Disorder Symptoms**

Laura Frost, The University of Manchester; Warren Mansell, The University of Manchester; Filippo Varese, The University of Manchester; Sara Tai, The University of Manchester

In order to inform both the prevention and treatment of bipolar disorder, it is important to understand the factors that lead to more severe symptoms. The prevalence of trauma within bipolar disorder samples is high and for unknown reasons is related to a more severe clinical course of illness. Yet it is unclear what mediates between past trauma and current symptoms. The Integrative Cognitive Model of Bipolar Disorder (Mansell et al., 2007) proposes that extreme multiple conflicting appraisals of changes to internal states are central to the development of symptoms.

The current study aimed to investigate if Post-Traumatic Stress Disorder (PTSD) is related to current depressive and manic bipolar symptoms. If confirmed, it will be tested if positive, negative and conflicting appraisals of internal states can mediate the relationship.

The sample consisted of 82 participants from the baseline data of the ‘Think Effectively about Mood Swings’ trial (Mansell et al., 2014). Participants were assessed using The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) before completing a battery of questionnaires. Measures included the Beck Depression Inventory (BDI), the Hamilton Depression Rating Scale (HAM-D), the Perceived Conflict subscale of the Internal States Scale (ISS), the Bech–Rafaelsen Mania Rating Scale (BMRS), the Generalised Anxiety Disorder 7 (GAD) and the Hypomanic Attitudes and Positive Predictions Inventory (HAPPI).

Subscales of positive appraisals, negative appraisals and conflicting appraisals were calculated from the HAPPI items. Twenty-seven participants met the diagnostic criteria for PTSD, this equated to in 32.9% of the sample. The majority of the variables did not meet the assumption of normality, therefore a non-parametric approach to analysis was taken. Spearman’s correlations demonstrated significant positive associations between PTSD and depressive symptoms, GAD, positive appraisals, negative appraisals and conflicting appraisals. A series of hierarchical regressions found that PTSD could significantly positively predict depressive symptoms but manic symptoms could not be predicted. Consequently manic symptoms could not be included in the mediation analysis. To investigate whether
appraisals of mood states mediated the relationship between PTSD status and depressive symptoms, a series of mediation analyses were carried out using the mediation macro PROCESS for SPSS (Hayes, 2013). The effects of PTSD on depressive symptoms were found to be significant, however mediation by appraisals did not occur. These findings will be discussed in relation to previous research and their potential implications for clinical practice and future research.

**Exploring extreme positive and negative beliefs about sleep: A Delphi study with professionals**

Lydia Pearson, University of Manchester; Warren Mansell, University of Manchester; Sophie Parker, University of Manchester

Disrupted sleep (including insomnia, hypersomnia, and the reduced need for sleep) is known to be significantly interconnected with the mood fluctuations experienced in bipolar disorder (BD). Understanding the cognitive processes that are common to the development and maintenance of these sleep disruptions could aid intervention for both sleep and mood. Research has investigated these cognitive processes in insomnia and results are promising for cognitive behaviour therapy intervention and outcome, including in the BD population. In order to expand upon the understanding of sleep across the mood spectrum, the role of sleep beliefs should be explored in the context of both depressed and elevated mood states. This can inform appropriate assessment for use in both a clinical and research setting. This study used the Delphi method to enable professional experts in the field of BD to share, review, and provide consensus on sleep beliefs in the context of their clinical and research experience. Sleep belief statements had initially been generated via both a literature review and service user statements. The experts were invited to take part in 3 rounds of producing and rating statements that represented positive and negative sleep beliefs for both sleeping more or less than usual. 19 statements were endorsed as important or essential for inclusion in assessment by >80% of the panel. The feedback and statements generated by these experts will help to inform the assessment of cognitive processes regarding sleep and mood in a BD population. This in turn can aid the development of effective cognitive behaviour therapy interventions. In order to best achieve this, further work needs to be done in learning more about the service user perspective and consensus of these beliefs, testing these beliefs in the BD population, and developing an appropriate measure for use in a clinical and research setting.

**What are people’s experiences of a novel cognitive behavioural therapy for bipolar disorders? A qualitative investigation with participants on the TEAMS trial.**

Emmeline Joyce, Greater Manchester Mental Health NHS Foundation Trust & The University of Manchester; Sara Tai, The University of Manchester; Piersanti Gebbia, The University of Manchester; Warren Mansell, The University of Manchester

Effectively treating bipolar disorders is considered challenging for clinicians. Existing psychological interventions have often produced mixed outcomes and modest effects on symptomology and outcome. To address the need for a more effective intervention, a new cognitive behavioural therapy has been developed, based on an integrative cognitive model (“Think Effectively About Mood Swings” or “TEAMS” therapy). TEAMS is a client-led therapy which includes unique components compared to previous psychotherapies for bipolar disorders; including addressing current symptoms and comorbid difficulties, and helping clients achieve long-term goals. A pilot randomised controlled trial of TEAMS Therapy vs Treatment As Usual has recently concluded. The current qualitative study explored trial participants’ experiences of TEAMS therapy; their recommendations for its improvement; and experiences of beneficial post-therapy changes. Individual semi-structured interviews were completed with 14 TEAMS therapy participants. Transcripts were thematically analysed, taking an interpretative and iterative approach. Two researchers independently coded the dataset. Four participants conducted member checks of the preliminary themes. Twelve subthemes emerged from analysis, encompassed within two overarching themes; “useful elements of therapy” and “changes from therapy”. Participants reported appreciating opportunities to talk freely; the therapists’ skill, kindness and approachability; and the
therapy’s person-centred nature. Some participants recommended there be more sessions than the 16 provided. Some described specific helpful therapeutic techniques: normalisation about moods; metaphors; methods to increase understanding of moods; relapse-prevention techniques; and reappraisal techniques. However, some participants did not report finding these techniques helpful. Post-therapy, participants reported changes in managing mood swings more effectively, and changed thinking. Some participants reported changes in neither, however. Participants also discussed being more accepting of themselves and of having bipolar disorder post-therapy; increased productivity; and less anxiety in social situations. The present study provides a detailed evaluation of participants’ therapy experiences. It reveals a number of beneficial changes attributed to TEAMS therapy; such as learning to manage moods, and problem-solve and reappraise situations. The study also highlights TEAMS techniques viewed as helpful, such as building healthy self-states and exploring advantages and disadvantages of moods.

The Button Question in Bipolar Disorder
Siri Folstad, University of Manchester; Warren Mansell, University of Manchester

In Stephen Fry’s BBC documentary “the Secret Life of the Manic Depressive” he interviewed different people diagnosed with bipolar disorder (Wilson, 2006). One question that he asked them all was - if they were to have the opportunity to get rid of their bipolar disorder permanently with a simple button press, would they? Surprisingly, most people said that they would not. One may question why someone would like to keep their disorder rather than become ‘normal’ when the majority of research suggests that having bipolar disorder impairs to an individual’s life.

Emerging evidence suggests that people with bipolar disorder do indeed associate it with positive qualities, such as amplification of experiences and increased empathy (Lobban, Taylor, Murray, and Jones, 2012; Parker, Paterson, Fletcher, Blanch and Graham, 2012). In addition, people with bipolar disorder report having positive beliefs about mental illness, which are associated with positive clinical outcomes Forgeraud, et al., 2016). Although studies have identified positive experiences, such as Parker and colleagues study named ‘The magic button question for those with a mood disorder’, none have explicitly asked whether people with bipolar disorder would wish to turn it off if possible.

Perceived benefits of bipolar disorder is a critical issue for treatment, and the desire to keep those benefits might be related to the modest effect of psychological treatments to date (Jauhar, McKenna, and Laws, 2016). Specifically, if patients believe they will lose positive qualities, it might have a negative influence on their treatment progress. However, if they believe that they can regain these qualities through treatment, under their own control, they may be more motivated to address their mood difficulties. Emerging research suggests that issues of control are critical to bipolar disorder (Crowe et al., 2012; Michalak, et al., 2006).

We recruited 132 people with bipolar disorder online through support groups cross-culturally. 29 responses were omitted as they failed to meet the inclusion criteria, resulting in 103 full responses. Our participants are from the United Kingdom (N=28), America (N = 57), Africa (N=6), Asia (N = 3), Central and Northern Europe (N = 7), and Australia (N=1). Our study revealed that 75 people with bipolar disorder would like to turn it off permanently, whilst 28 said they would not want to turn it off permanently. In contrast, 48 of the participants reported that if they could turn it off temporarily they would, whilst 55 said they would not.

We will use a chi-squared analysis to contrast the difference between the permanent and non-permanent condition. We will conduct a binary logistic regression analysis to test the predictors of the likelihood of pressing the button when it is permanent (the dependent variable). The independent variables will be established by conducting independent samples t-tests or chi-squared tests to see which demographic factors and therapy attitude ratings are significantly associated with pressing the button. Those significant at less than 1 will be entered into the regression. Content analysis of open text responses. Means and standard deviation of responses to each rating scale.
Delivering cognitive behavioural interventions for suicide prevention in acute settings: key issues and complexities

A qualitative exploration of suicidal psychiatric inpatients’ views, perceptions and expectations of psychological therapy in an acute ward setting
Yvonne Awenat, University of Manchester
Despite a growing evidence base for the effectiveness of psychological interventions to reduce suicidal thoughts and behaviours, treatment of hospitalized suicidal inpatients continues to prioritize ‘containment’ and physical treatment modalities such as electroconvulsive and psychiatric treatment. Stakeholder views are a known determinant of the ultimate successful implementation of novel interventions into usual practice (MRC, 2008). We therefore used qualitative methods to investigate suicidal inpatient’s hypothetical views and expectations about a psychological treatment targeting suicidality (CBSP). This paper describes the processes and results of our investigations.

Staff and patients’ views of acute mental health wards and their relationship with inpatient adverse events
Kamelia Harris, University of Manchester
Frequent incidents of adverse behaviours, such as suicidal acts including self-harm, occur on mental health hospital inpatient wards. Adverse behaviours on mental health wards can have a psychological and physiological impact on both inpatients and staff (Renwick et al., 2016). It is important to consider factors which precipitate adverse behavior and involve inpatient and staff views in doing so. An important gap in the literature concerns the ways in which staff and inpatient attitudes to the mental health ward environment affects the occurrence of adverse behaviours. Therefore, self-report questionnaires were used to ascertain staff and inpatient views of the mental health ward environment and adverse behavior data were extracted from NHS incident reports. This paper discusses the results and implications of such investigations.

The therapeutic alliance in providing Cognitive Behavioural Suicide Prevention Therapy (CBSP) on inpatient wards
Daniel Pratt, University of Manchester
Cognitive behaviour therapies have been found to be effective at reducing suicidal behaviour, especially when designed, tailored, and implemented to focus on suicidality (Tarrier et al, 2008). We have developed and manualised a new talking therapy intervention for suicidal behaviour; Cognitive Behavioural Suicide Prevention (CBSP). Our individualised treatment offers a structured, theoretically-based, psychological intervention designed to address and amend the specific psychological architecture responsible for suicidal behaviour, using established cognitive-behavioural techniques. This paper will present a summary of key learning points arising from the delivery of CBSP within an inpatient setting. A practical focus will be placed upon both contextual and individual factors affecting the delivery of the therapy with inpatients. These issues will also be brought to life in a case study from the INSITE trial. This case description will comprise of a review of the assessment material initially presented by the client, followed by the case conceptualisation developed by the therapist and client. A description of the intervention and change techniques implemented by the therapist will then follow, before concluding with reflections and implications.

A pilot study to investigate the feasibility and acceptability of a cognitive behavioural suicide prevention therapy for people in acute psychiatric wards
Gillian Haddock, University of Manchester
Suicide is a major cause of preventable death, and suicidal behaviour is prevalent in acute psychiatric wards. People admitted to acute psychiatric wards often experience repeated episodes of suicidal behaviour, causing great distress and heavy use of NHS services. There
is little research investigating effective psychological treatments for suicidal patients in inpatient settings although previous research has shown that psychological therapies which specifically target suicidal behaviour can be effective at reducing suicidality. This paper describes a pilot RCT of cognitive-behavioural suicide prevention (CBSP) versus treatment as usual for people of any diagnosis in acute, inpatient psychiatric wards. The primary objective was to explore whether CBSP was feasible and acceptable for patients and staff. Secondary objectives were to assess the impact of the intervention on suicide behaviour and ideation and functioning. Participants allocated to CBSP were offered up to 20 sessions delivered whilst on the ward and continued into the community if the participant was discharged. Blind assessments of outcome were carried out at 6 weeks and 6 months following consent to participate. The intervention was highly acceptable to staff and patients with good therapeutic alliance achieved. Data relating to acceptance, attendance, attrition will be presented. Secondary outcomes in relation to suicidal ideation, affect, psychological variables thought to relate to suicide and functioning will be presented with some preliminary data on cost effectiveness.

Broadening perspectives on Intolerance of Uncertainty

Worry, intolerance of uncertainty and culture among Saudi men and women: Initial findings

Khulood Almansoor, King Saud University, Saudi Arabia; Ahmad AlHadi, King Saud University, Saudi Arabia; Patrick Rosenkranz, Newcastle University; Mark Freeston, Newcastle University and Northumberland Tyne and Wear NHS Foundation Trust

Background: Although worry and GAD have been extensively studied in Western societies over the last 25 years, there are still relatively few studies from non-Western societies. As worry content is thought to reflect the concerns of individuals at their developmental stage and as a function of their context, then culture would be expected to be a major influence. The Saudi culture is inspired by the Islamic and Arab traditions and history of the region. Over the last two generations there have been rapid changes in education, health care, life-style and technology. The concept of temporal acculturation is relevant, reflecting the idea of modern versus traditional perspectives of Saudi society and the degree to which people identify with either or both. This study is part of a research programme that attempts to develop a culturally-informed model of worry and GAD that can be used to adapt existing treatments.

Method: The sample consists of 200 men and 171 women who were recruited through the workplace and through social networks. They represent a young (mean age = 31), mostly urban and educated sample (>60% have university education); about half were married.

Well established questionnaires were subjected to rigorous translation, back-translation and checking procedures. Internal consistency and test-retest reliability were checked; all were in the acceptable to excellent range. The questionnaires reported on here are the Penn State Worry Questionnaire, GAD-7, PHQ-9, Intolerance of Uncertainty Scale-12, the Worry and Anxiety Questionnaire, and the Worry Domains Questionnaire (adapted for the Saudi context).

Results: Overall, women reported significantly higher levels of worry, anxiety, depression, and intolerance of uncertainty. In particular the difference between men and women was large (d>1) for worry. By free recall, the most frequently reported worry themes were family, the future, finances, everyday concerns, and work. Women reported more worry than men about family, loss or sickness of a loved one, and marital problems, while men worried more about political matters and religious matters. Given the large gender differences separate analyses were run for men and women predicting PSWQ scores from first the content subscales from the WDQ and then from interfering behaviors from the modified WAQ. After controlling for age and employment, interfering behaviors accounted for 42% of men’s PSWQ scores, with avoidance, procrastination and reassurance each making individual contributions. For women, the behaviors accounted for less variance (20%), with avoidance, over preparation, and procrastination each making significant contributions. After controlling for age and employment, the six worry domains accounted for 41% of
men’s PSWQ scores, with the future and "envy and the evil eye" both making individual contributions. For women, 27% of PSWQ scores were accounted for by worry domains, with lack of confidence, the future, and "envy and the evil eye" all making significant individual contributions.

Discussion. As far as we know this is the first in depth study of worry among Saudi men and women. Clear differences between men and women were found. Although women reported more worry (and other symptoms), the regression models for both worry content and worry-related behaviours were stronger for men. Further, worry themes reported through free recall and as predictors of the tendency to worry also reflected culturally specific themes, namely, the political and religious matters as worry themes for men, and worries about "envy and the evil" as a predictor of PSWQ for both men and women. While the greater tendency of women to worry (and report anxiety and depression) as well as the strong relationship between IU and worry replicates findings from other cultures, these data suggest that gender and culture need to be carefully considered. Although the sample was comprised mostly of young, educated, urban and largely professional Saudi men and women, we cannot assume that Western models of worry and GAD can simply be transposed. Indeed, the next study on larger samples has extended the concept of temporal acculturation to reflect the rapid societal change, considered the role of religiosity and spirituality within an Islamic society, and extended measures of positive beliefs about worry and cognitive avoidance to reflect traditional and contemporary aspects of current-day Saudi culture.

Worry and intolerance of uncertainty among older adults: Potential impact on healthy ageing.

Anna Hodgson, Newcastle University and Northumberland Tyne and Wear NHS Foundation Trust; Danielle Payne, Newcastle University; Holly Bemrose, Newcastle University; Daniel Collerton, Newcastle University and Northumberland Tyne and Wear NHS Foundation Trust; Mark Freeston, Newcastle University and Northumberland Tyne and Wear NHS Foundation Trust

Background. Worry has been extensively researched in relation to working age adults, however relatively little is known in comparison about worry in older adults. Although there have been a number of studies conducted since the mid-eighties, relatively few studies have been conducted in the UK and relatively few have addressed worry in the context of increased life-expectancy, better health and medical care while ageing, longer periods of active participation through the third age, increased expectations of life after 60 or 65 years, and an increased awareness of dementia and other problems associated with ageing. There is also relatively little known about the underlying psychological processes that are related to the tendency to worry in later life. Understanding the impact of health and mental health among older adults can help develop understanding of healthy ageing where a key dimension is the continuing engagement in personally meaningful activities even when changes occur in health status, mobility, etc. The present study therefore examined the relationships between worry, intolerance of uncertainty (IU), physical health functioning and engagement in personally meaningful activities in adults over the age of 60 via self-report questionnaires.

Method. A total of 271 participants (age range 60-93 years; M=70.17; SD=6.41) completed the study. Most data was collected online while other data was collected through face-to-face or pen-and-paper administration in a variety of contexts. The questionnaires administered were the Penn State Worry Questionnaire (PSWQ, short form, validated with older adults), the Intolerance of Uncertainty Scale-12, a revised version of the Worry Scale for Older Adults (WSOA), the RAND 36-item Short Form Health Survey, the Meaningful Activity Participation Assessment (MAPA) and the Engagement in Meaningful Activities Survey (EMAS). The WSOA was reviewed, updated to reflect ageing in the UK in 2016 (based on consultation with experts), and piloted along with the other questionnaires.

Results. Analyses replicated earlier findings with a strong positive correlation between the Penn State Worry Questionnaire and Intolerance of Uncertainty Scale, and between the Worry Scale for Older Adults and Intolerance of Uncertainty Scale, both between .60 and .70. These results are also consistent with previous findings in younger populations indicating
that the association between worry and IU continues in later life, both for the tendency to worry (PSWQ) and for the age-relevant worry themes assessed in the WSOA. We also examined a number of models considering the potential mediation and moderation effects linking age, IU, worry, health and mobility status, and continuing participation in personally meaningful activities as a proxy for positive ageing.

Discussion. This study has updated, replicated and extended what we know about the relationships between IU, worry content and the tendency to worry within a UK sample of older adults. It adds to an evidence base for a full life-span account of IU and worry where a developmental perspective is required to understand and formulate why people worry and what they worry about. This study also starts to address the impact of IU and worry on positive ageing and raises important questions about any reductions in participation with increasing age and decreasing health status and mobility. It suggests that mental health, in this case worry, contributes to positive aging and better health and argues for the provision of psychological therapies (with necessary adaptation) across the lifespan.

The association between intolerance of uncertainty, emotion regulation, impulsivity, and general distress in patients with Borderline Personality Disorder: Preliminary evidence

Gioia Bottesi, University of Padova, Italy; Veronica Tesini, University of Padova, Italy; Silvia Cerea, University of Padova, Italy; Marta Ghisi, University of Padova, Italy

Background. Current models of impulsivity identify negative urgency (NU), positive urgency, lack of premeditation, lack of perseverance, and sensation seeking as the main dimensions. Interestingly, some recent research on analogue samples on the association between intolerance of uncertainty (IU) and impulsivity found that IU and NU, which refers to the tendency to engage in rash behaviour when experiencing negative affect, are moderately related. This finding suggests that IU can trigger impulsive behaviours and that, possibly, the subsequent reduction of a sense of uncertainty and its associated discomfort might negatively reinforce the behaviour.

There has been relatively little investigation of the relationship between IU and impulsivity among patients suffering from disorders characterized by difficulties with emotion regulation (ER), such as Borderline Personality Disorder (BPD). Nonetheless, individuals reporting maladaptive ER strategies usually employ ineffective coping behaviours (i.e., impulsive) to reduce the distress associated with the activation of uncomfortable emotions (which can be triggered by uncertainty). The main objective of the current study was to examine the association between IU, ER, impulsivity, and general distress in a sample of Italian patients with BPD. As data collection is still in progress, only preliminary correlational findings are reported here.

Method. Forty-eight patients (21 males and 27 females) aged 18-64 (M=42.49; SD=11.97) with BPD entered the study to date. 86.9% of them were medicated and the mean duration of the ongoing psychological treatment ranged between 4 and 48 months (M=17.64; SD=12.82). All participants completed the following questionnaires: the Intolerance of Uncertainty Scale-12 (IUS-12), the Difficulties in Emotion Regulation Strategies (DERS), the S-UPPS-P Impulsivity Scale (S-UPPS-P), and the Depression Anxiety Stress Scales-21 (DASS-21).

Results. Correlational analyses highlighted strong positive correlations between the IUS-12 and the DASS-21 total score, as well as between all the DERS subscales and the DASS-21 total score. However, none of the S-UPPS-P subscales were associated with the DASS-21 total score. There were positive correlations (medium-high range) between the IUS-12 and all the DERS subscales but none between the IUS-12 and any of the S-UPPS-P subscales. Lastly, some moderate correlations among some of the DERS subscales and some of the S-UPPS-P subscales emerged; in particular, the DERS Difficulties engaging in goal-directed behaviour subscale positively correlated with the S-UPPS-P Lack of perseverance subscale; the DERS Impulse control difficulties, Lack of emotional clarity and Lack of emotional awareness subscales positively correlated with the S-UPPS-P Lack of premeditation subscale; the DERS Lack of emotional awareness subscale negatively correlated with the S-UPPS-P Sensation seeking subscale.
Discussion and conclusions. The correlational findings to date suggest that IU is related with ER and general distress, but not with impulsivity in this sample. The lack of association contrasts with previous results obtained on large analogue samples. On the other hand, difficulties in ER were associated with both general distress and some of the impulsivity dimensions, and in particular with the lack of premeditation. The preliminary nature of the current data prevents drawing any generalizable conclusions about the association between IU, ER, impulsivity, and general distress in patients with BPD. Conducting further analyses on a larger sample of patients with BPD, particularly mediational models, comparisons with healthy control group, and expanding investigation to other “high-impulsivity” clinical samples (such as patients with substance use and addictive disorders) are the next steps. A better understanding of the relationship between IU, facets of ER and impulsivity, and general distress in these clinical populations has important treatment implications and may lead to conceptualizing, developing, and finally testing the effectiveness of trans-diagnostic, IU-based psychological interventions as a component in the treatment of emotional dysregulation among “high-impulsivity” individuals.

What do CBT therapists know about their own reactions to uncertainty in everyday life?

Thomas Campbell, Newcastle University; Coltan Thompson, Newcastle University; Mark Freeston, Newcastle University and Northumberland, Tyne and Wear NHS Foundation Trust; Ashley Tiplady, Newcastle University and 2Northumberland, Tyne and Wear NHS Foundation Trust

Background: This presentation is grounded in two distinct areas. The first, Self-Practice/Self-Reflection (SP/SR) and other experiential methods are important approaches used in training CBT and other therapists. This type of approach increases knowledge “from the inside out”, increases understanding and skills, and is believed to make therapists more empathic. The second, the role of Intolerance of Uncertainty (IU) across disorders, is a programme of transdiagnostic clinical research that seeks to develop an understanding, an empirical base, and a treatment for the difficulties people encounter with “not knowing” or the “unknown-ness” of what will happen in their lives. There is now strong evidence that IU is implicated in a wide range of mental health problems, stress reactions, adjustment to physical health, as well as decision making in everyday life. Therapists are increasingly aware of IU in a range of presentations and are curious about how to identify and target IU in therapy. However, despite the interest in IU there is still relatively little written about its treatment outside of a few sources mainly in the worry/GAD literature. As part of advanced training on IU for CBT therapists, we have been collecting data from experiential exercises during the workshops. The exercises address three issues:

1) Do I know how intolerant of uncertainty I am?

2) Can I detect feelings/sensations of uncertainty as distinct to feelings of anxiety?

3) Do I engage in any behaviours that may linked to intolerance of uncertainty?

Method: The study received ethical approval from Newcastle University. Therapists were informed at the start of the workshop about the research aims. They were informed that their participation in experiential exercises was optional. They were invited to contribute to the research element by submitting their exercise worksheets but were under no obligation to do so – they could decide later whether they wished to contribute them or not. The exercises would be run anyway and spare copies of the materials were available to take away. Most participants consented and most of those contributed worksheets. The data presented here concerns an exercise where they used silhouettes of people to locate and describe or illustrate their feelings/sensations associated with positive anticipation, negative anticipation and uncertainty, or simply not-knowing. In addition to the physical location, the data included pictures, words, metaphors, etc. This was coded using a multidimensional coding scheme developed from the GRID system of coding emotion based
on emotion terms, cognitive appraisals, bodily reactions, expressions, feelings and action tendencies (see Fontaine, Scherer & Soriano, 2013).

Results: Forty-five workshop attendees participated. Initial inspection showed that the proportion of words in uncertain situations were between the positive and negative situations on high arousal and low pleasure and relatively higher on novelty. Likewise, the uncertain situations were between the other two on body symptoms and subjective feelings and relatively higher on cognitive appraisals. Coding of the body location indicated few differences between the situations with majority in the chest or stomach area. There was clear evidence of a strong somatic signal for uncertainty that overlapped with both positive and negative anticipation.

Discussion. Although IU is of increasing interest as a construct and a potential target for treatment, most of what we know about it is from studies using dispositional measures such as the IUS or IUS-12. We still know relatively little about its phenomenology. Our own experiences in developing awareness and treatment indicate that the cognitive model of anxiety based on appraisal of threat, safety-seeking behaviours and underestimation of coping resources is so well-established that it is difficult to put it to one side and so identify the specific contribution of IU although as a construct it resonates with therapists and patients alike. This is a first attempt to raise awareness of the phenomenology of IU, identify key features of IU and has implications for new lines of investigation into IU, the development of treatment strategies, and dissemination.

Improving Access, Engagement and Outcomes for British South Asian Communities

Addressing Muslim clients’ beliefs in djinn, magic and the supernatural in therapy
Ghazala Mir, University of Leeds
How should therapists respond to client beliefs in the supernatural, especially when this has implications for mental health? Professional training rarely equips practitioners to engage with such beliefs and there is considerable inconsistency in practice responses. This presentation will present best practice approaches drawing on findings from a study to culturally adapt Behavioural Activation therapy for Muslim clients. Ghazala’s research focuses on addressing and preventing social exclusion in health and social care settings. She is currently leading an interdisciplinary Inequalities Research Network of academics, practitioners, voluntary organisations and policymakers to support joint work towards a fairer society: http://www.lssi.leeds.ac.uk/inequalities-network/

How do we develop services that British South Asians want to engage with?
Saiqa Naz, Sheffield IAPT and Andrew Beck, University of Manchester
There is a considerable unmet need for psychological therapies amongst British South Asian communities. Services may need to proactively work to overcome barriers to access by creatively engaging communities in discussions about mental health and adapting the ways that services are delivered to take community preferences into account. This presentation includes clips from an award winning play about mental health and stigma developed by Rochdale CAMHS which was developed to raise awareness of mental health in the Pakistani community.
Saiqa Naz is a cognitive behaviour therapist and BABCP Equality and Culture SIG committee member She currently works for Sheffield IAPT.

‘There is nothing physically wrong with you’ Me: ‘Yes there is doctor, I am sure something has been missed’: The Assessment and Treatment of Medically Unexplained Symptoms in British South Asians
Nadeem Gire, University of Central Lancashire
Medically Unexplained Symptoms (MUS) are highly prevalent globally and are routinely encountered by healthcare providers. MUS has an adverse effect on a patient’s quality of life and carries a significant economic burden to healthcare systems globally. Evidence suggests that non-pharmacological interventions such as Cognitive Behaviour Therapy (CBT) can lead to improvement in patients’ functioning and quality of life. In some South Asian cultures distress and mental health problems are more likely to be expressed and understood through physical pain and medically unexplained symptoms rather than psychological distress. Nadeem Gire presents research in the cultural adaptation of CBT for MUS and highlights factors which need to be considered when working with British South Asian populations, to ensure the integration of service users’ concerns about MUS into CBT, in a way that enhances engagement and supports better outcomes in therapy. Nadeem Gire is a PhD Student funded by the UK National Institute of Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care North West Coast (CLAHRC-NWC) at the University of Central Lancashire. As part of his PhD work he is currently testing a Cognitive Behavioural Therapy based Mobile App intervention for the real-time treatment of psychosis, called Techcare. He also works alongside Prof. Nusrat Husain as a clinical researcher at Lancashire Care NHS Foundation Trust, is a Visiting Research Fellow at the Pakistan Institute of Learning and Living and is a member of the Global Mental Health Research Group at the University of Manchester.

Co-Production: Culturally Adapted CBT Group for Tamil refugees and asylum seekers in South West London
Meera Bahu, iCOPE Islington Psychological Therapies & Well-being Service, Camden & Islington NHS Foundation Trust
Many South Asians arrive in the UK as refugees following trauma related to civil wars, terrorism, crime and civil unrest. Shikainah Champion has developed award winning Cognitive Behaviour Therapy services in South London to meet the needs of this population of service users and reports on ways that services and therapists can adapt to ensure best possible outcomes.

Parental Experiences, Perceptions and Well-being

Barriers and facilitators to seeking and accessing professional help for anxiety disorders in children: What do parents think?
Tessa Reardon, University of Reading
Anxiety disorders are among the most common childhood mental health disorders, and are associated with significant negative outcomes. Effective treatments for child anxiety exist, but only a minority of affected children access such treatment. The reasons for these low rates of treatment access are not well understood, thus limiting any targeted approach to improving access. As the key ‘gatekeeper’ to treatment access, this study aims to establish parents’ perceptions of barriers/facilitators to seeking and accessing professional help for childhood anxiety disorders. The study adopts a mixed-methods approach, and includes i) qualitative interviews with parents of children (aged 7-11) with an anxiety disorder; and ii) a questionnaire study with a large national sample of parents of children (aged 7-11) with an anxiety disorder identified in the community. Findings highlight the range of barriers parents experience throughout the help seeking process, and indicate areas for potential intervention in relation to service provision and raising public awareness and understanding of child anxiety and the help seeking process.

Mothers’ experiences of having an adolescent child with depression: An interpretative phenomenological analysis
Monika Parkinson, University of Reading
Adolescence represents a significant period of vulnerability for the development of depression. Whilst research has begun to explore factors associated with the development, maintenance and outcomes of adolescent depression, there is little research investigating
this experience from a parental viewpoint. The aim of this study was to explore mothers’ experiences of having an adolescent child with depression. Eight mothers of depressed adolescents were recruited following their child’s clinical assessment at a Child and Adolescent Mental Health Service and participated in semi-structured interviews. The transcripts of the interviews were analysed using interpretative phenomenological analysis. Five interlinked super-ordinate themes were identified: ‘finding a reason, something to blame’; living with uncertainty; feelings of helplessness and frustration’; ‘depression changes them’; and ‘hiding own emotions and needs’. A key finding across the themes was the emotional turmoil and sense of uncertainty experienced by mothers. Implications for clinical practice and future research are discussed.

How CFS/ME is experienced and perceived by parents and families
Maria Loades, University of Bath & University of Bristol
Between 1 to 2% of children and young people will be affected by Chronic Fatigue Syndrome (CFS)/myalgic encephalomyelitis (ME). Published work has demonstrated the significant emotional and financial impact of having a child with CFS/ME on mothers (Missen et al, 2012), and also on the psychological wellbeing and quality of life of siblings (Velleman et al, 2015). We know that young people’s representations of their CFS/ME play an important role in coping and outcome (Gray & Rutter, 2007). However, little is known about parental illness perceptions. This study will present descriptive data on parental illness perceptions in a cohort of adolescent CFS/ME patients presenting to specialist CFS/ME services using the Brief Illness Perceptions Questionnaire (BIPQ). Parental illness perceptions will be compared to the adolescents’ own illness perceptions. Parental illness perceptions will be compared between those young people with CFS/ME who have co-morbid depression, and those who do not have depression. Data about the perceived impact on the family will be presented from a qualitative study of young people with CFS/ME who were depressed (N=9).

What about anxiety? Examining how trajectories of maternal anxiety influence offspring internalising and externalising outcomes
Asha Ladwa, University of Exeter
Background and aims: Maternal anxiety and depression are associated with an increased risk of adverse, long-term child outcomes. Most of this research has looked at maternal anxiety at one moment in time. Some researchers suggest that there are critical periods of child development when maternal mental health problems will have a particularly harmful impact on the child. The aim of this study was to examine how different patterns of maternal anxiety influence child internalising and externalising outcomes.
Method: Data was utilised from Avon Longitudinal Study of Parents and Children (ALSPAC), a large longitudinal birth cohort study, where maternal anxiety was assessed repeatedly from 18 weeks gestation to 61 months (5 years) after birth (n=8,379). Latent class growth analysis was used to identify maternal anxiety classes. Logistic regression was used to examine the association between differing anxiety patterns and offspring internalising and externalising outcomes at age 9 and 12 years. Results were adjusted for confounding variables including sociodemographic predictors and maternal depression.
Results: Four distinct classes of maternal anxiety were identified (low-stable, increasing, decreasing, chronic-severe). Analyses revealed that the increasing, decreasing and chronic-severe classes anxiety, compared to the low-stable anxiety class, were associated with more child externalising than internalising outcomes. Additionally, when controlling for depression, maternal anxiety still influenced these long-term child behavioural outcomes.
Conclusions: Key periods of risk for maternal anxiety occur during pregnancy and a gain when the child is 3-4 years old. Both episodic and chronic patterns of maternal anxiety have a negative impact on child behavioural outcomes. These data do not suggest there is a “critical developmental period” when maternal anxiety has a particularly negative effect on the child. Screening for maternal anxiety, separately from maternal depression, at multiple times throughout the perinatal period and early childhood may help enhance long-term child outcomes.
Father-child interactions at 3-months and 2 years: contributions to children’s cognitive development at 2 years
Vaheshta Sethna, Institute of Psychiatry, Psychology and Neuroscience, King’s College London

The quality of father-child interactions has become a focus of increasing research in the field of child development. We examined the potential contribution of father-child interactions at 3-months and 24-months to children’s cognitive development at 24-months. Observational measures of father-child interactions at 3-months and at 24-months were used to assess the quality of fathers’ parenting (n=192). At 24 months, the Mental Developmental Index (MDI) of the Bayley’s Scales of Infant Development measured cognitive functioning. The association between interactions and cognitive development was examined using multiple linear regression analyses, adjusting for paternal age, education and depression, infant age, and maternal sensitivity. Children whose fathers displayed more withdrawn and depressive behaviours in father-infant interactions at 3-months, scored lower on the MDI at 24 months. At 24-months, children whose fathers were more engaged and sensitive, and those whose fathers were less controlling in their interactions, scored higher on the MDI. These findings were independent of the effects of maternal sensitivity. Results indicate that father-child interactions, even from a very young age (i.e. 3-months) may influence children’s cognitive development. They highlight the potential significance of interventions to promote positive parenting by fathers, and policies that encourage fathers to spend more time with their young children.

Underlying Mechanisms of Adolescent Anxiety and Depression

Biases of self-evaluation, interpretation and memory
Faith Orchard, University of Reading

Background: Depression is highly prevalent during adolescence (Thapar, Collishaw, Pine & Thapar, 2012), and can have long-term negative impacts on a diverse range of social and health outcomes (e.g. Bridge, Goldstein, & Brent, 2006; Fergusson, Boden, & Horwood, 2007; Halperin, Rucklidge, Powers, Miller, & Newcorn, 2011; Rudolph & Klein, 2009). There are many theories that attempt to explain why depression emerges and why it is maintained. The cognitive theory of depression (Beck, date) suggests that depression is caused and maintained by pervasive negative biases in how individuals process and make sense of information about the world, the self and the future (Beck & Alford, 2009). These biases are observed in relation to different cognitive processes including attention, interpretation of ambiguous information, memory, and decision making. There is consistent evidence that cognitive processes are negatively biased and Hirsch et al. (2006) proposed that biased cognitions interact and influence each other to amplify their impact on depressed mood. The current study explores biases in interpretation, evaluation of the self, and memory biases in adolescents recruited from clinical and community settings. The aim was to examine which cognitive biases are best able to predict depression and if depression is best predicted by a combination of cognitive biases as proposed by Hirsch et al. (2006).

Methods: Adolescents were recruited from the community (N = 212) and from a clinical service (N = 82), they completed self-report measures of depression symptoms (Mood and Feelings Questionnaire; MFQ) and the clinic group also took part in a diagnostic interview (Kiddie-Schedule for Affective Disorders and Schizophrenia; K-SADS). Cognitive tasks tested self-evaluation, recall memory and interpretation bias. Analyses were conducted to explore (1) how well the measures of cognitive bias were associated with each other and (2) how well the measures of cognitive bias predicted depression both individually and using a combined score.

Results: A correlation analysis identified that depression severity (MFQ score) was significantly associated with all cognitive biases except for negative recall, and there were significant associations between scores of self-evaluation and interpretation. Furthermore, in a forced entry multiple regression model, only interpretation bias and negative self-evaluation was found to predict depression severity. In order to create a composite cognitive
score, a principal component analysis was conducted on the cognitive variables. A factor was identified including positive and negative self-evaluation, pleasantness ratings and interpretation bias. The composite score was found to predict depression better than any score independently, and was found to be a significant predictor of depression diagnosis. Discussion: This is the first study to directly test the combined cognitive hypothesis in adolescent depression. Cognitions of self-evaluation, recall memory and interpretation were explored in relation to their ability to predict depressive symptoms and diagnoses both independently and together. In support of the prediction, the composite cognitive score was a better predictor of depression severity than any individual score, furthermore, the composite score was found to be a significant predictor of depression diagnosis. These findings have implications for the measurement of depression, specifically where it may be beneficial to indirectly measure depression. For example, in some cases, young people may not want to admit to having mental health problems, or may find it hard to express their difficulties. Furthermore, some measures of cognitive biases may be as quick, if not quicker, to administer than self-report measures, and especially quicker than diagnostic interviews.

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

Jennifer Fisk, University of Reading

Depression in young people is a serious mental health problem and is associated with increased risk of suicide, substance abuse and depression in adulthood (Thapar et al., 2012). Overgeneral autobiographical memory (OGM) is a well-documented cognitive phenomenon in depression. OGM occurs due to a disruption in cognitive processing that leads to difficulty retrieving specific detailed memories from the past (Brittlebank, Scott, Williams & Ferrier 1993). Importantly, it predicts vulnerability to and the onset and persistence of depression (Werner-Seidler & Moulds 2012; Kuyken & Dalgleish 2011; Sumner, Griffith & Mineka, 2010; Hitchcock et al., 2014). The main theoretical model, the CARFAX model (Williams et al., 2007), posits that three cognitive processes underlie OGM; rumination, functional avoidance and reduced executive control. This study focuses on the executive control mechanism. Reduced executive control is likely to interfere with the ability to successfully hold a retrieval model in working memory and/or reduce capability to inhibit irrelevant information. Alongside its associations with disruptions in autobiographical memory processing, impaired executive control is suggested to be an overarching mechanism for other biases at various levels of information processing e.g. interpretation bias (Everat, Koster and Derakshan 2012). There is an abundance of literature supporting impaired executive functioning in adults (Dalgleish et al., 2007) but work is limited in young people and outcomes provide mixed results (Vilgis, Silk and Vance, 2015). Considering the significant period of cognitive development in the brain that occurs during adolescence, it cannot be assumed that outcomes from adult research will be the same for young people.

To investigate OGM and executive control in young people, 58 adolescents from a secondary school were assigned into two groups (community healthy (n=29) vs. community elevated (n=29)) based on depression scores. Depression scores were measured via The Mood and Feelings Questionnaire (MFQ; Costello & Angold, 1988). A cut off of 27 and above was used to identify those in the elevated group, and 12 and below for those in the control group. All participants completed the Autobiographical Memory Test (Williams and Broadbent, 1986) and three Executive Function tasks. These included a Verbal Fluency test as a broad executive function measure, The Keep track task as a measure of working memory and The Hayling Sentence Completion to measure inhibitory control.

Analyses have been performed on the data to identify group differences in overgeneral memory, rumination, verbal fluency and working memory scores. A Mann-Whitney U test revealed a significant difference in OGM bias between the healthy community (Md = 1.6, n=29) and elevated community (Md=3.4, n=29) groups, U=185, z=-3.7, p <0.001). This supports the existence of a relationship between OGM and depressive symptoms in young people. To test for group differences in executive function, whilst controlling for IQ, a multivariate analysis of covariance reported a significant differences between groups in Verbal Fluency (F(1,55) = 7.3, p<0.05) and working memory (F(1,55=11.9, p<0.05). The
elevated community group performed worse on both verbal fluency ($M=24.9$, $SD=8.1$) compared to the healthy community group ($M=31.8$, $SD=10.9$) and working memory ($M=18.4$, $SD=3.9$) comparative to the healthy community group ($M=22.2$, $SD=4.2$).

The results of this study contribute to our understanding of low mood in young people by confirming the relationship between depression symptoms and OGM, and highlighting that impaired executive is associated with young people with depression symptoms. The outcomes suggest impaired executive control may contribute to difficulties associated with depression, including OGM, however this does not appear to involve difficulties with inhibitory control. Results could lead to the development of new prevention and treatment strategies, or as a way of identifying who might be appropriate for certain treatments. For example, if working memory is a particular difficulty for someone, a working memory training intervention schedule may be helpful before engaging the young person in cognitive heavy therapies such as CBT.

**Biases in attention and interpretation in adolescents with varying levels of anxiety and depression**

*Anke Klein, University of Amsterdam*

Cognitive theories of anxiety and depression emphasize the importance of cognitive processes in the onset and maintenance of anxiety and depression disorders. There are indeed numerous studies that support the existence of biases in attention and interpretation in adolescent anxiety and depression. However, there are far fewer studies that address multiple biases simultaneously. This study investigated multiple cognitive biases in adolescence simultaneously, to investigate whether adolescents varying in their levels of anxiety and depression display an attention bias and an interpretation bias, and whether these biases are able to predict unique variance in self-reported levels of anxiety and depression.

**Method:** A total of 681 adolescents filled in the SCARED-41 and the CDI, and they performed a Dot Probe Task (DPT), and an Emotional Visual Search Task (EVST) to assess attention bias, and a Recognition Task (RECT-T) to assess interpretation bias.

**Results:** As expected, attention and interpretation biases related to anxiety were found. Mixed results were found with regard to depression: evidence was found for an interpretation bias, and for an attention bias as measured with the EVST but not with the DPT. Furthermore, attention and interpretation predicted unique variance in self-reported anxiety as well as in self-reported depression. Discussion: These results indicate that attention and interpretation biases are unique processes in anxiety and depression. Furthermore, these findings also suggest that anxiety and depression are based on similar underlying cognitive mechanisms. These results could be used to further conceptualize theoretical models of adolescent anxiety and depression and to inform interventions targeting cognitive biases.

**Two sites of one coin: Intolerance of uncertainty and relationships with adolescence-related anxiety and risk taking**

*Laura Dekkers, University of Amsterdam*

**Introduction:** Intolerance of Uncertainty (IU) may be defined as a dispositional characteristic, resulting from negative beliefs about uncertainty and its implications, wherein the possibility of a negative event occurring is considered threatening, irrespective of the probability of its occurrence. It is proposed that variability in IU is central in explaining adolescence-related increases in both anxiety and risk taking, rendering the study of IU of importance. We here present a paper in which we aimed to study the psychometric properties of the Intolerance of Uncertainty Scale–Short version (IUS-12), including its associations with trait anxiety and risk taking among adolescents.

**Method / Techniques:** A community sample of 879 Dutch adolescents, from diverse educational levels, and with an equal distribution of boys and girls, was classically tested. To obtain indices of IU, and self-reported trait anxiety and need for risk taking, questionnaires
were administrated; to obtain an index of risk taking behavior, adolescents performed on a paper-and-pencil version of a risk taking task.

Results / Outcomes: Results support the psychometric properties of the IUS-12 as a measure of IU among adolescents, in that the IUS-12 consists of a Prospective and an Inhibitory IU subscale (1a), which are partially measurement invariant across gender (1b), and that the IUS-12 and its subscales have reasonable-to-good internal consistency (2). Moreover, higher IUS-12 scores were related to, respectively, higher and lower levels of self-reported trait anxiety (3a) and need for risk taking (3b), while no relationship between IUS-12 scores and risk taking behavior (3c)—operationalized by performance on the risk taking task—were found. Finally, gender differences in IU were found (4), which may relate to higher levels of anxiety and risk taking, respectively, adolescent boys and girls.

Discussion / Conclusion: We conclude that the IUS-12 has good psychometric properties for usage among adolescent boys and girls, and may be central in explaining the adolescence-related increase in both anxiety and risk taking.

Potential implications for the everyday clinical practice of CBT: Exploring underlying mechanisms that are not typically direct targets of CBT, but are known to play important roles in the maintenance and perhaps the development of psychiatric disorders, is of importance. IU is one such candidate underlying mechanism. As such, studying IU may help to develop clear adolescent- and disorder-specific treatment programs.

Roundtable: Treating eating disorders across the lifespan: The impact and implementation of the NHS and NICE guidelines

Hannah Turner, Southern Counties Health NHS Trust; Rachel Bryant-Waugh, Great Ormond Street Hospital; Glenn Waller, University of Sheffield

This round table presentation will address recent NHS and NICE guidelines regarding the treatment of eating disorders across the lifespan. This includes the 2016 NHS Access and Waiting Times Guidelines for younger cases, and the 2017 revised NICE guideline for adults and younger cases. Those guidelines include the place of CBT and other evidence-based therapies, but also make substantial recommendations regarding the configuration of services. The three presenters will address:
• the background to the development of each of these guidelines
• the process of their development
• the intended (and unforeseen) consequences of the guidelines
• service access and the balance of high- and low-intensive care settings
• the importance of appropriate training in and implementation of the therapies
• the gaps in our clinical and research knowledge that have been highlighted by this process

Each presenter will address these topics in a set of brief introductory talks, followed by a discussion with the audience about ways of working effectively within these new guidelines (and how to ensure that the next set of guidelines is closer still to the best imaginable practice with eating disorders).

Mindfulness-Based Cognitive Therapy for depressed treatment non-responders

Neural effects of mindfulness training in chronically depressed patients

Thorsten Barnhofer, University of Exeter; Emilia Winnebeck, Freie Universität Berlin; Matti Gärtner, Charité University Medicine Berlin

Patients with chronic or recurrent courses of depression show changes in the dynamics and connectivity of central brain networks with such changes likely to serve as latent vulnerabilities. Mental training approaches such as mindfulness training might have particular advantages in addressing these latent vulnerabilities. This talk will present findings from a study that compared the effects of a brief mindfulness training to a resting control in patients with chronic depression. Resting state EEG and fMRI were assessed before and after the treatment. Analyses showed changes in a number parameters
suggesting that effects of the training translate into resting state characteristics and thus change predispositions towards particular forms of processing. We will discuss these findings in light of their implications for the treatment of chronic depression.

**MBCT for acute depression: a review**

Barney Dunn, University of Exeter; Emily Widnall, University of Exeter; Thorsten Barnhofer, University of Exeter

MBCT was originally designed for the prevention of relapse in patients with highly recurrent depression. However, recent trials have indicated that the treatment seems to be particularly efficacious in participants with residual symptoms and there is now a considerable body of work that has investigated use of the intervention in patients with current symptoms, particularly in patients with chronic or treatment-resistant depression. This talk will present findings from a systematic review of existing randomized controlled trials of MBCT for acute depression. Findings will be compared to data from routine clinical practices offering MBCT for patients with acute symptoms on a regular basis.

**A feasibility study of MBCT for depressed treatment non-responders**

Emily Windall, University of Exeter; Barney Dunn, University of Exeter; Thorsten Barnhofer, University of Exeter

A considerable number of depressed patients who receive high intensity-therapy within the IAPT pathway do not reach full recovery. MBCT might represent an effective treatment for this group. This talk will present data from a feasibility study of MBCT for IAPT non-responders. Participants were recruited from local services and received the standard eight-week treatment with minor adaptations taking into account the presence of acute symptoms. The talk will present data on feasibility, acceptability and usefulness of the intervention, and provide clinical insights into the adaptations and changes that might be required to address acute symptoms.

**Using mindfulness with young people suffering from symptoms of depression: a systemic approach**

Jerry Fox, University of Exeter; Tamsin Ford, University of Exeter; Patrick Smith, King’s College London; Jessica Richardson, King’s College London

The peak onset of depression is in the mid-teens, and those who become depressed in adolescence have a raised risk of recurrence and chronicity. This talk will describe the development of a systemic mindfulness approach for young people who have not responded or only partially responded to first line treatments for depression and anxiety in CAMHS. Based on the standard MBCT approach and using materials from the Mindfulness in Schools programs, the intervention offers eight weekly sessions to young people in parallel with sessions for their parents / carers in order to help them support and understand the treatment the young people are receiving. Different versions of these treatment have now been tested for their feasibility in a number of cohorts Clinical insights and data from these studies will be presented and discussed.

**Trauma and intrusive memories: emerging approaches to prevention and early intervention**

**Intrusive memories following an analogue trauma: insights from experimental psychopathology**

Ella James, MRC Cognition and Brain Sciences Unit, Cambridge

Intrusive memories of a trauma event is the hallmark symptom of post-traumatic stress disorder (PTSD). An experimental psychopathology approach allows us to examine the impact of exposure to (analogue) trauma in controlled conditions. We are interested in emotional mental imagery in the form of intrusive memories which can intrude to mind unbidden following a traumatic event. We use the laboratory-based trauma film paradigm to study intrusive memories in healthy volunteers. Participants view film-footage with traumatic content, and the frequency of intrusive memories is monitored in daily life over
one week. This allows us to study potential methods of reducing subsequent intrusions. Newly acquired memories for an event are transiently labile before becoming increasingly resistant to interference over time, a process termed 'memory consolidation'. Our research shows that intervening during this time period can reduce the frequency of subsequent intrusive memories; for example by completing specific visuospatial cognitive tasks (e.g. the computer game Tetris) which compete for the resources necessary for intrusions to develop [1]. More recently, studies of human memory have found that stabilised, older memories that have become relatively 'fixed' in mind (they have consolidated) can be 'reactivated' - rendering that memory labile and vulnerable to change as it undergoes memory reconsolidation. We have shown that we can reduce the frequency of intrusive memories for established (24h old) memories of experimental trauma. We will discuss experimental work which has shown that a procedure involving memory reactivation plus Tetris game-play led to fewer intrusions of an experimental trauma compared to memory reactivation or Tetris game-play in isolation [2]. Findings suggest brief cognitive task computer games may offer a non-invasive method to ameliorate intrusive memories after trauma exposure.


**A cognitive-task therapeutic to mitigate the occurrence of intrusive (but not deliberate) memories of trauma event(s): What are the mechanisms of action?**

Alex Lau-Zhu, King’s College London

Mitigating the occurrence of intrusive memories, while preserving deliberate memory for trauma, is clinically and ethically desirable: for example, a trauma victim may wish to have fewer intrusive memories but still able to wilfully testify in court. Research in experimental psychopathology suggests this may be possible, particularly in the context of a cognitive-task procedure (reminder cue + Tetris game play), which has shown to selectively reduce the frequency of intrusions while sparing deliberate (e.g. recognition) memory performance. Such a pattern of intrusive/deliberate memory dissociation is not predicted from standard theories of memory (consolidation), underscoring the need to investigate its mechanisms of action. We devised novel measures of memory to dissect changes for a trauma film following the cognitive-task procedure. We found a consistent reduction in intrusion frequency both outside and within the laboratory, but not in other (deliberate) memory aspects. Together, these experiments highlight that the modulation of memory ‘intrusiveness’ can be achieved without compromising the ability to deliberately remember the traumatic event.

**Sleep and intrusive memories after psychological trauma**

Kate Porcheret, University of Oxford

After experiencing or witnessing psychological trauma, highly distressing and debilitating involuntary emotional memories (intrusive memories) can occur. Sleep is known to enhance the consolidation of emotional memories, but this may not be the best thing following a highly distressing traumatic event. Clinically, disrupted sleep in the weeks and months after a trauma are associated with an increased risk for the development of post-traumatic stress disorder as well as other psychological conditions. But since the enhancing effect of sleep on memory consolidation is likely to occur in the first few days following a trauma, it is critical to investigate the role of sleep immediately after a trauma on post-traumatic symptomatology: the importance of which is enhanced given the common clinical assumptions of the benefits of sleep post trauma. Using the trauma film paradigm we have begun to unravel this situation. In a laboratory setting we have demonstrated that total sleep deprivation immediately after an experimental trauma (trauma film) resulted in fewer
Intrusive memories being reported, compared to a control group who slept as usual. Extending this into more ecologically valid conditions (sleep deprivation at home rather than in the lab) we have replicated this finding. Together these studies support the hypothesis that sleep deprivation could weaken the initial consolidation of traumatic memories, providing a therapeutic opportunity for the amelioration of post-traumatic symptomatology.

**Proof-of-concept randomised controlled trial of a simple cognitive task intervention posttrauma in a hospital emergency department**

Lalitha Iyadurai, University of Oxford

There is a lack of preventive interventions for post-traumatic stress symptoms that could be delivered in the immediate aftermath of psychological trauma. Laboratory studies with healthy volunteers have found that a simple cognitive task intervention, delivered within a few hours of watching a film with traumatic footage, can reduce the frequency of intrusive memories of the film over the following week. This randomised controlled trial (N = 71) investigated whether a simple cognitive task intervention (a reminder cue followed by playing the computer game “Tetris”), compared to an attention-placebo control condition (a simple written activity log), could reduce the number of intrusive memories of trauma in the week after a traumatic road traffic accident. Post-traumatic stress symptoms, anxiety and depression at one week and one month were also assessed, as well as participant feedback at one month. Participants in the intervention condition reported fewer intrusive memories in the week after the accident, and lower intrusion symptom scores at one week, than those in the control condition. Time-series analyses showed a greater decline in the number of intrusive memories over the week in the intervention compared to control condition. Participant feedback indicated that playing Tetris was easy, helpful and minimally distressing. A simple cognitive task intervention involving computer-game play, delivered within 6 hours of a traumatic event, offers a promising low-intensity, low-cost preventive intervention against intrusive trauma memories.

**Development of an early intervention to prevent posttraumatic stress symptoms after traumatic childbirth**

Antje Horsch, University Hospital Lausanne, Lausanne, Switzerland

Emergency cesarean section (ECS) is indicated in cases of risk to maternal and/or fetal life, therefore qualifying as a traumatic stressor for the mother linked with a risk of posttraumatic stress disorder (PTSD). Maternal PTSD following traumatic childbirth negatively impacts on the attachment relationship with and the development of the infant. Evidence-based early interventions to prevent the development of postnatal PTSD are lacking. The aim of this proof-of-principle randomised controlled study was to investigate whether the number of intrusive traumatic memories of mothers could be reduced by a brief cognitive task procedure carried out shortly after ECS. Women after ECS were randomized to one of two parallel groups in a 1:1 ratio: intervention (usual care plus cognitive task procedure) or control (usual care). The intervention group engaged in a visuospatial task (computer-game “Tetris”) for 15 minutes in the hours following their ECS. The primary outcome was the number of intrusive traumatic memories related to the ECS recorded in a diary for the week post-ECS. Results of intention-to-treat analyses showed that, compared with controls, the intervention group reported fewer intrusive traumatic memories and had a trend towards reduced acute stress re-experiencing symptoms after 1 week. The intervention was rated as acceptable by the majority of women. This study is a first step in the development of an early intervention to prevent postnatal posttraumatic stress symptoms.

Cognitive-behavioural interventions for psychosis within acute inpatient settings
Mindfulness-Based Crisis Interventions for patients with psychotic symptoms on acute psychiatric wards (amBITION study): A feasibility randomised controlled trial

Pamela Jacobsen, King's College London; Emmanuelle Peters, King's College London; Paul Chadwick, King's College London

Inpatient psychiatric care is a scarce and expensive resource in the National Health Service (NHS), with chronic bed shortages being partly driven by high re-admission rates. People often need to go into hospital when they have a mental health crisis due to overwhelming distressing psychotic symptoms, such as hearing voices (hallucinations) or experiencing unusual beliefs (delusions). Brief talking therapies may be helpful for people during an acute inpatient admission as an adjunct to medication in reducing re-admission rates, and despite promising findings from trials in the USA, there have not yet been any clinical trials on this kind of intervention within NHS settings. The amBITION study is a feasibility randomised controlled trial (RCT) of a manualised brief talking therapy (Mindfulness-Based Crisis Intervention; MBCI). Inpatients on acute psychiatric wards were eligible to take part in the study if they reported at least one positive psychotic symptom, and were willing and able to engage in a talking therapy. In addition to treatment as usual (TAU), participants were randomly allocated to receive either MBCI or a control intervention (Social Activity Therapy; SAT) which involved doing activities on the ward with the therapist. The primary objective of the study was to find out whether it is possible to carry out this kind of trial successfully within UK inpatient settings. The secondary objective was to collect pilot data on primary and secondary outcome measures, including re-admission rates at 6 month follow-up. Results will be presented on key feasibility data, including recruitment and retention in the trial, and qualitative feedback from participants and staff on the acceptability of the intervention. The results of the feasibility trial will indicate whether a subsequent efficacy pilot trial is warranted.

Stabilising sleep for patients admitted at acute crisis to a psychiatric hospital (OWLS): an assessor-blind, pilot randomised controlled trial

Bryony Sheaves, University of Oxford; Daniel Freeman, University of Oxford; Louise Isham, University of Oxford; Josephine McSherry, University of Oxford; Alecia Nickless, University of Oxford; Ly-Mee Yu, University of Oxford; Stephanie Rek, University of Oxford

When patients are admitted onto psychiatric wards, sleep problems are highly prevalent. We carried out the first trial testing a psychological sleep treatment at acute admission (Oxford Ward’s Sleep Solution). This assessor-blind parallel group trial randomised recently admitted inpatients to receive sleep treatment (plus standard care), or standard care alone (1:1). The treatment comprised of CBT plus light exposure, delivered intensively over a two week therapy window. Sleep monitoring watches were used to guide assessment and boost patient motivation. Assessments took place at 0, 2 (post-treatment), 4 and 12 weeks. Primary outcomes were insomnia (Insomnia Severity Index) and psychological wellbeing (Warwick Edinburgh Mental Wellbeing Scale) at week 2. This treatment is highly popular with patients and targets a process which is very commonly disrupted, irrespective of psychiatric diagnosis. Recent key findings will be presented alongside the sleep therapy techniques.

Systematic Review of Psychological Therapies for Psychosis in Acute Psychiatric Inpatient Settings

Kathleen Hodkinson, Webster University Vienna, Austria; Pamela Jacobsen, King’s College London, UK; Paul Chadwick, King’s College London, UK; Emmanuelle Peters, King’s College London, UK

The aim of the current study was to examine the state of the current evidence base for psychological therapies for psychosis in acute psychiatric inpatient settings. We included any study in English of an intervention (ranging from RCTs to conference abstracts to book chapters referencing single case studies) initiated in an acute inpatient psychiatric setting which was aimed at alleviating distress/impairment to functioning arising from psychotic symptoms or aimed at emotional difficulties commonly associated with psychotic symptoms. CRT and arts therapies were excluded. Electronic databases including PubMed, PsychInfo,
professional body publications, trial registries and various other sources were searched and the corresponding authors from all relevant papers from the last ten years were consulted. Records were initially screened for eligibility based on title/abstract by the primary reviewer, and then the primary and secondary reviewers both independently screened full text articles for inclusion. A standard data extraction template, including the Mixed Methods Appraisal Tool (MMAT) was used to record relevant data from each study and assess study quality. A narrative approach to synthesis was taken. The current presentation will report the results of this systematic review, in particular relating to the nature of the current evidence base for psychological therapies for psychosis in acute psychiatric inpatient settings, quality of the study designs, key outcome measures used, and details of the therapy type and mode of delivery, and any adaptations made for the population.

**Formulating complex presentations of psychosis within acute inpatient settings**  
*Catherine Donaldson, Belfast Health and Social Care Trust*

The positive symptoms of psychosis have previously been thought of as meaningless and irrational. This case series will describe different ways of developing an understanding of these experiences that is psychologically meaningful to clients and useful to teams and carers. All refer to complex cases with a trauma history. In some instances, it is apparent that psychotic symptoms are trauma-related as they comprise tactile hallucinations which are clearly decontextualized trauma fragments. In others, psychotic symptoms and alternate realities seem to be more of an escape from difficult life experiences without bearing direct relation to them although at times can become imbued with the threat and suspicion of the person’s general world view. And, in other examples, the person’s psychotic symptoms may be best understood as a symbolic language, representing and capturing a sense of themselves as unacceptable and an outsider. The early iterations of these formulations are outlined as are their revisions according to the changing goals and needs of the client. Differences in affect and perplexity across presentation and formulation are also described. The value of formulations in acute inpatient settings is explored in terms of helping to reduce the client’s distress, contain the crisis and direct decisions about aftercare.

**New randomised controlled trials in CBT**

**Internet-delivered Cognitive Behavior Therapy for OCD: A randomized controlled trial**  
*Reham Aly, Egyptian Association of Cognitive Behavior Therapy; Hisham Ramy, Egyptian Association of Cognitive Behavior Therapy*

During the last 45 years, cognitive behavior therapy (CBT) has gone from being a promising new treatment to the most well-established psychological treatment for obsessive compulsive disorder. In several hundreds of randomized controlled trials (RCTs), CBT has been shown to be effective in treating these disorders and is a first-line treatment for this condition. This is due to superior treatment effects in combination with high safety. In general, long-term follow-up studies indicate that improvements gained after CBT endure over several years. In combination with relatively low intervention costs, CBT is thus a highly promising treatment from a societal cost-effectiveness perspective.

Several forms of remote CBT have been developed, the general idea is that CBT delivered through the Internet or using telephone communication reflects the content of conventional CBT, but is administered as a form of therapist-guided treatment protocol using remote communication methods e.g. the Internet. Remote CBT consists of modules for therapy, each corresponding to a session in conventional CBT, which the patients practice as they progress through the treatment.

Aims: Estimation of applicability & efficacy of remote cognitive behavior therapy for treating patients suffering from obsessive compulsive disorder in Egypt. A group of patients suffering from Obsessive compulsive disorder was randomized into two groups; one received CBT as usual & the intervention group received CBT using telephone &/or the Internet. Both groups were assessed pre- & post treatment using the Yale Brown Scale for OCD symptom severity.
& Beck Depression Inventory for symptoms of associated depression. The Quality of Life scale was also applied to all patients participating in the study.
Both groups of patients were committed to the treatment program & no differences in drop-out rates were detected between the two groups. Pre- & post study measures indicated a statistical & clinically relevant changes in patients of two groups.
Delivering CBT for patients suffering from OCD in Egypt using remote communication methods (e.g. telephone &/or the Internet) appears to be effective in alleviating symptoms & improving the Quality of Life. Yet some adaptations to the standardized treatment protocol are mandated to render the protocol applicable through remote communication & enhancing cultural reception.
Delivering effective therapy for demanding patients is mandated to find new resolutions for reaching every patient even in remote area.

Online CBT, Delivered Via Synchronous Written Communication within IAPT. A Randomised Control Trial
Sarah Bateup, Anglia Ruskin University;
The Internet is increasingly being used to deliver CBT. Most studies to date have explored self-help (cCBT) and guided self-help (iCBT) but few have explored therapist delivered CBT via written communication. (IECBT) Over 13,000 patients have completed treatment using IECBT within IAPT.
The over arching aim of this study is investigate the differences between IECBT and face-to-face CBT and in particular whether there are differences between the two arms in relation to what patients recall about their treatment plan 3 months after therapy has been completed. Patients who are currently on a waiting list for step 3 CBT, at a South London IAPT service, are invited to participate in this study. Eligible patients will be randomised to either treatment as usual (face-to-face CBT) or IECBT. The same therapist will provide treatment. The primary outcome is 3 months post intervention when outcome rates between the two arms will be compared. Secondary outcomes will include the Working Alliance Inventory (at session 2 and session 6). In addition patients in both arms will be asked to recall the primary change mechanisms that their therapist used. The results will be analysed to understand if high levels of recall correlate with clinical outcome.
This trial is currently ongoing. The first findings will be presented.
This is the first randomised control trial that has compared IECBT with face-to-face CBT. The findings from this study will verify whether there are significant differences between the two methods.
IECBT is currently offered as a choice (at step 2 and step 3) in many IAPT services across the UK. As IAPT services are tasked with increasing access to 25% of prevalence more services are beginning to look at digital solutions. IECBT is currently the only digital method that is delivered idiosyncratically by therapists using standard disorder specific protocols. It is possible that there are significant difference between face to face CBT and IECBT and therefore that one method is more appropriate than the other in relation to specific disorders. In addition it is possible that a patients learning style will inform a decision about which method will lead to greater clinical gains.
The findings from this trial will enable clinicians and patients to make an informed choice.

Cognitive Behavioural Therapy vs Meta-Cognitive Therapy for Depression
Pia Callesen, University of Manchester; Adrian Wells, University of Manchester
Major Depressive Disorder (MDD) is one of the largest health problems worldwide.
Psychological treatments show variable efficacy rates with approximately 50% recovery rates in 'gold standard' cognitive behaviour therapies (CBT's). More effective treatments for depression are needed. Metacognitive therapy (MCT) is a new treatment for MDD that has produced promising results in preliminary studies. Hagen et al (submitted) showed very large effect sizes in a randomised trial comparing wait-list with MCT. In their study 70-80% were classified as recovered. The next step is to compare MCT with CBT in a definitive trial. In this study a large parallel randomised single-blind trial was conducted comparing metacognitive therapy (MCT) and Cognitive Behavioural Therapy (CBT). 155 patients
diagnosed with major depressive disorder (MDD) were assigned to up to 24 sessions of either CBT or MCT and treatment terminated when remission was reached defined as two consecutives scores of ≤8 on Becks Depression Inventory II (BDI-II). A last observation carried forward (LOCF) – analysis was conducted using Cohen's d, ANOVAs and reliable clinical significant change analysis done at post-treatment and at 6-months follow-up. Both CBT and MCT were associated with significant improvement in symptoms. MCT was significantly more effective than CBT on one of the primary outcome variables: Becks Depression Inventory (BDI-II) and the majority of secondary measures. Patients in both groups could be classified as recovered using objective Jacobson and Truax-criteria. Especially patients in the MCT condition recovered, Both treatments remained effective at 6 months follow-up with patients showing stable gains over time. Effect size and recovery rates in MCT were significantly larger than CBT at post-treatment and at 6-months follow-up. However, these findings need to be replicated with longer follow-up periods and methodological enhancements. Suggestions for future research will be discussed.

A Metacognitive focus in therapy seems to improve outcome significantly in the treatment of depression.

**Results from a randomised controlled trial of Memory Flexibility training in major depressive disorder**

Caitlin Hitchcock, MRC Cognition and Brain Sciences Unit; Emily Hammond, University of Exeter; Peter Watson, MRC Cognition and Brain Sciences Unit; Aliza Werner-Seidler, The Black Dog Institute, Australia; Tim Dalgleish, MRC Cognition and Brain Sciences Unit; .

Major depressive disorder (MDD) is associated with chronic biases in the allocation of attention and recollection of personal memories. Impaired flexibility in attention and autobiographical memory retrieval is seen to both maintain current symptoms and predict future depression. Development of innovative interventions to reduce maladaptive cognitive patterns and improve cognitive flexibility in the domain of memory may therefore advance current treatment approaches for depression. This early-phase trial sought to determine the feasibility of a novel autobiographical-memory based training programme, Memory Flexibility Training (MemFlex), and provide a point-estimate of effects on autobiographical memory flexibility and depressive outcomes to guide later-phase trial work.

We completed a single-blind, randomised, controlled, patient-level trial in which 60 individuals with MDD were randomly allocated to receive either psychoeducation (n = 28) or MemFlex (n = 32). After completing pre-treatment measures and an orientation session, participants completed eight workbook-based sessions at home. Participants were then assessed at post-treatment and at 3 month follow-up. At each assessment, participants completed measures of diagnostic status, depressive symptoms, and an autobiographical memory test. Other process outcomes, including rumination and cognitive avoidance, were also explored.

Results indicated that the MemFlex condition experienced a significantly greater improvement (d = 0.5) in memory bias, relative to the psychoeducation condition. At 3 month follow-up, 64% of participants in the MemFlex condition had remitted from major depression, compared to 48% in the psychoeducation condition. MemFlex also had a moderate effect on the experience of depression free days (d = 0.4).

This early-phase trial has demonstrated that MemFlex is able to improve memory flexibility, and may positively influence depressive outcomes. The low-intensity and workbook-based format of the programme may improve access to psychological therapies, and the results of this study have provided a platform for a later-phase trial.

Impaired cognitive flexibility, particularly in the processing of personal, autobiographical memories, is a strong predictor of depressive relapse. The results from this trial demonstrate preliminary evidence for the efficacy of a low cost, low-intensity programme that may be offered as an adjunct to CBT, to reduce risk of relapse.
Treating Procrastination using Cognitive Behavior Therapy: A Pragmatic Randomized Controlled Trial Comparing Treatment Delivered via the Internet or in Groups

Alexander Rozental, Stockholm University; David Forsström, Stockholm University; Philip Lindner, Karolinska Institutet; Simon Nilsson, Karolinska Institutet; Lina Mårtensson, Stockholm University; Gerhard Andersson, Linköping University; Per Carlbring, Stockholm University

Procrastination is a common problem among university students, with at least half of the population reporting great difficulties initiating or completing certain tasks and assignments. Procrastination can have a negative impact on course grades and the ability to achieve a university degree, but can also lead to psychological distress, such as, stress and anxiety. Cognitive Behavior Therapy (CBT) is often considered treatment of choice, but few studies have investigated its effectiveness in regular clinical settings.

The current study explored its treatment effects using a pragmatic randomized controlled trial comparing treatment delivered during eight weeks as unguided self-help via the Internet (ICBT) or as group CBT. In total, 92 university students with severe procrastination were included in the study (registered as a clinical trial on Clinicaltrials.gov: NCT02112383).

Outcome measures included self-reported procrastination, depression, anxiety, and physical and psychological well-being, which were distributed at pre- and posttreatment, as well as six-month follow-up. An outcome measure of procrastination was also administered weekly.

Linear mixed and fixed effects models were calculated, along with improvement and deterioration rates.

The results showed that both unguided ICBT and group CBT yielded large within-group effect sizes on procrastination, Cohen's $d = 1.24-1.29$, 95% Confidence Interval (CI) [0.76-1.74], and small to moderate benefits for depression, anxiety, and well-being, $d = 0.37-0.68$, 95% CI [-0.06-1.12]. In total, 32.6% were improved at post-treatment and 45.6% at follow-up.

No differences between conditions were observed directly after the treatment period, however, participants in group CBT continued or maintained their improvement at follow-up, while participants in unguided ICBT showed signs of deterioration.

The findings from the current study suggest that CBT might be an effective treatment for students with problems of procrastination, but that a group format may be better for some in order to sustain their benefits over time.

Procrastination is a common problem among university students, but few clinical trials have investigated the efficacy of different treatment interventions for this condition. The current study compared the results of CBT delivered as an unguided Internet-based treatment and CBT distributed in groups. The findings suggest that both formats is beneficial for many individuals with difficulties of procrastination, but that group CBT could be better for some, at least in the long-run. Together with a previous randomised controlled trial of CBT for procrastination evidence now looks promising with regard to providing effective treatments for this condition, but more research is warranted in terms of improving the results and to evaluate the benefits using also behavioural measures.

A pilot controlled trial of a cross-diagnostic, CBT-based, psychological model of care for acute mental health inpatients.

Charlotte Paterson, Edinburgh Napier University; Sean Harper, NHS Lothian; Thanos Karatzias, Edinburgh Napier University; Paul Hutton, Edinburgh Napier University; Adele Dickson, Glasgow Caledonian University; Nadine Dougall, Edinburgh Napier University

There is increasing demand for access to psychological intervention in acute mental health inpatient settings, however much of the psychotherapy research evidencing the effectiveness of psychological therapies for severe mental illness has been carried out in outpatient settings. Such evidence cannot be generalised to acute inpatient settings due to illness severity and unpredictable length of stays. Recent meta-analysis has summarised the existing acute inpatient evidence base and has provided promising results to suggest brief psychological therapy is beneficial for acute inpatients in reducing emotional distress and risk of readmission (Paterson, et al., in submission). Due to a redesign at the Royal
Edinburgh Hospital (REH) in NHS Lothian a cross diagnostic, psychological model of care, based on the work of Clarke and colleagues (Clarke & Wilson, 2009), has been applied in one acute mental health inpatient ward (intervention ward). The aim of the study was to evaluate the effectiveness of the applied psychological model with regards to self-reported psychological distress, self-efficacy in relation to mental health and number of readmissions. Participants were recruited from the intervention ward and a control ward (receiving TAU) and comparisons made. Outcome measures were collected at baseline, post-treatment and at 6 month follow-up. Outcome measures included the Clinical Outcome Routine Evaluation - 10 (CORE-10), Brief Symptom Inventory (BSI) and the Mental Health Confidence Scale (MHCS). Readmission data was also collected at 6-month follow-up.

Results will be presented at the conference in July. Implications and conclusions will be presented at the conference in July. If findings suggest the model is more effective than TAU there are clear implications for practice. Acute inpatient mental healthcare services should consider making psychological therapy available to patients who wish to receive it.

Evaluating unusual interventions for adult anxiety and depression using single case methodology

**Cognitive Behavioural Therapy for Paruresis (“Shy Bladder Syndrome”): A Case Study**
*David Hambrook, South London and Maudsley NHS Trust*

Paruresis, sometimes termed Shy Bladder Syndrome, refers to the inability to initiate or sustain urination in situations where there is a perception of real or potential scrutiny from others, accompanied by significant fear and anxiety, avoidance of feared situations, and subsequent negative impact on psychosocial functioning (Boschen, 2008). The exact positioning of Paruresis within the psychiatric nomenclature remains open to debate. Research suggests that Paruresis is not uncommon, and is associated with significant distress and impairment, yet little is known about the causes of, and effective treatments for this often very secretive and disabling condition. This presentation will describe the background to and course of formulation-driven CBT for a man presenting with primary Paruresis. The course of therapy aimed to address the idiosyncratic processes that were maintaining his anxiety and avoidance of urinating in public and help the patient work towards achieving goals that he had set for himself. Key outcomes including symptoms of depression, anxiety, functional impairment, and Paruresis-specific distress were tracked session by session and will be presented here. The outcome of this course of therapy with this patient will be discussed in the context of the existing evidence base for Paruresis and the implications for further research and practice.

**Cognitive Behaviour Therapy for Olfactory Reference Disorder (ORD): a case study**
*Rhani Allen-Crooks, King’s College London*

Olfactory Reference Disorder (ORD) is preoccupation with the belief that one is emitting a foul odour. It can be a distressing and substantially impairing problem. However, very little is known about its successful treatment. This study describes the treatment of a 38-year-old female with longstanding ORD using Cognitive Behavioural Therapy (CBT). Case conceptualisation focused on identifying unhelpful beliefs and maintaining factors including safety-seeking behaviours, self-focus and avoidance. These were then targeted using a variety of techniques including discussion and behavioural experiments to facilitate belief and behaviour change. Following a 12-week treatment, measures of anxiety and depression reduced to below clinical thresholds. In addition, there were reductions on a specific measure of symptoms of ORD. Issues regarding the use of CBT to treat this particular disorder are considered.

**Time Intensive Cognitive Behavioural Therapy for Specific Phobia of Vomiting using a Single Case Experimental Design**
*Alexandra Keyes, King’s College London*
Specific Phobia of Vomiting (SPOV) is considered difficult to treat, and to date there is limited research on treatment effectiveness. Research suggests that specific phobias can be successfully treated using time intensive sessions. Furthermore, evidence suggests that a proportion of people with SPOV experience intrusive imagery from aversive early memories of vomiting. This study therefore aims to evaluate the effectiveness of time intensive CBT and Imagery Rescripting (ImRs) at reducing symptoms in individuals with SPOV. A multiple baseline ABACAD single case experimental design (SCED) was used to monitor symptoms across time in six participants. Standardised outcome measures (Specific Phobia of Vomiting Inventory [SPOVI] and Emetophobia Questionnaire [EmetQ]) were administered to measure SPOV symptoms at each clinical session. Visual analysis of graphed data and Tau effect sizes were used to compare data across treatment phases. Reliable and clinically significant change was also calculated. Findings suggest that both ImRs and time intensive CBT are associated with improvements across symptoms of SPOV. At the end of treatment, five out of six participants (83.3%) achieved reliable improvement and three (50%) achieved clinically significant change on the SPOVI, which was maintained at 3 month follow up. Time intensive treatment was associated with high client satisfaction ratings. Time intensive CBT appears to be comparable to weekly CBT in reducing SPOV symptoms in the majority of cases. Further research is needed to replicate findings in studies using larger sample sizes, and to compare effectiveness with weekly CBT and other treatment approaches by randomised controlled trial.

An investigation of Time intensive behavioural activation for depression using single case design
Sarah Miles, Royal Holloway, University of London
Depression is now the second biggest cause of disability, worldwide. Given depressions wide-spread cost, yet existing barriers and limitations to its treatments, increasing access to its effective/preferred treatment requires more attention. Behavioural activation shows particular promise as an accessible and disseminable treatment for depression. Provision of time-intensive psychological interventions also shows promise for increasing access to treatments and they have proven efficacy in the treatment of anxiety disorders. However, there is limited exploration of the combination of the two: time-intensive behavioural activation for depression, especially in outpatient settings, where depression is most often treated. Therefore, this study aimed to investigate the efficacy of time-intensive behavioural activation for depression, using multiple baseline design. Eight participants meeting criteria for major depressive disorder, were recruited from three Improving Access to Psychological Therapies (IAPT) services in London, and received time-intensive behavioural activation. Treatment consisted of seven bi-weekly sessions and three optional booster sessions. Daily idiographic symptom measures were collected across baseline, intervention and follow-up periods. Standardised depression and IAPT measures were collected weekly. Data were analysed using both visual and statistical analysis. The findings, as well as therapist’s and participant’s perceptions of the acceptability and feasibility of the intervention, will be discussed.

Developments in treating anxiety

A complex interplay: Cognitive Behavioural Therapy for severe health anxiety in Addison’s Disease to reduce Emergency Department admissions
Jo Daniels, University of Bath; Elizabeth Sheils, University of Bath
Addison’s Disease (AD) is a rare endocrinological autoimmune disease occurring as a result of adrenal insufficiency, which can be life-threatening (Weiss, Dyrud, House & Beresford, 2005). Recommended self-management strategies are vague (Knapen, Puts & van Schalk-Goodfellow, 1993) which leaves the patient sensitive to bodily change, lacking in certainty and anxious about the management of a potentially life-threatening condition. Anxiety is common in AD, with a 17.5% prevalence rate of health anxiety in endocrinological disorders (Tyrer et al. 2011). For AD and co-morbid anxiety, the picture is
complex: early detection of infection and illness is vital for the successful management of AD; however, strategies such as symptom hypervigilance (commonly seen in health anxiety) are counterproductive and can elevate and intensify symptomatic experiences of potentially innocuous bodily variations, which can be misinterpreted as confirmation of an AD crises. Due to the life threatening nature of AD, the Emergency Department (ED) may be considered an appropriate place to present during an adrenal crisis; however, where severe health anxiety and AD present in combination, attendances may be precipitated by peaks in health anxiety, rather than a true adrenal crisis. The dilemma for the patient is that the two may feel indistinguishable.

The aim of the present study was to establish whether a standard CBT treatment for health anxiety can lead to a reduction in psychological distress and ED admissions in a patient with AD; the secondary aim was to facilitate the development of specific self-management strategies in the context of actual or perceived illness.

An AB case study design was utilised with pre and post therapy measures of anxiety and depression, and primary outcome measure of health anxiety repeated weekly throughout treatment. Data on ED attendances were taken for the 12 months preceding therapy and 12 months following completion of therapy. Treatment consisted of 12 sessions of standard CBT for health anxiety, as per Salkovskis Warwick and Deale (2003) with minimal adaptation.

Reliable Change Index analysis indicated reliable and clinically significant reductions, from severe to sub-clinical levels scores across all measures. There was a complete amelioration of Emergency Department attendances: from 30 days/6 admissions in 12 months preceding treatment to zero in the 12 months following treatment.

This approach was found to be effective for an N=1 study of the application of the health anxiety model to AD. In addition to reductions in clinical measures, the patient reported increased confidence in managing her condition, particularly due to the development and successfully tested self-management strategy developed within therapy. There is a paucity of research into the value of psychological therapy in the field of Addisons despite other endocrinological conditions receiving more attention. Further research is warranted. Limitations include the lack of extended baseline of anxiety and mood, however retrospective admission give some indication of a stable presentation prior to treatment. Findings support the clinical utility of the cognitive behavioural therapy model for complex presentations of AD, offering a potential adjuvant treatment option where elevated anxiety is interfering with self-management.

**Group CBT for Older Adults with Generalised Anxiety Disorder**

**Shonagh Scott, Sheffield Health & Social Care Trust; Manreesh Bains, Sheffield Health & Social Care Trust; Jo Hall, Sheffield University; Stephen Kellett, Sheffield University; Raul Berrios, Sheffield University**

Prevalence rates of GAD in older adults are estimated to be between 3.4%-6.3%. However, GAD is ‘frequently missed’ as a disorder by services due to factors such as comorbidity & medication use. Chronicity is an issue as around 90% of older GAD sufferers are diagnosed before the age of 60 years.

In the treatment of GAD, older adults prefer psychological therapy to medication. To date, trials of group CBT for older adults with GAD have reported conservative findings. However, much of this research does not reflect recent innovations in treatment approach based on trial evidence in younger adult samples. Therefore, the current study evaluated group delivery of the Dugas & Robichaud (2007) treatment protocol to older adults with GAD. A case series with an A-B design with follow-up was used to assess feasibility, acceptability, effectiveness and potential change mechanisms across three study phases: baseline, intervention and follow-up. Mixed methods enabled triangulation of findings for convergence and complementarity purposes.

Eligible participants (N=23) were required to have a diagnosis of GAD, and were recruited through primary care and community mental health services. The adapted GAD protocol was delivered over 12 weeks. Participant outcomes were measured using the PSWQ, GAD-7, PHQ-9, IUS, and a daily worry diary. At the end of treatment, completer change interviews
and facilitator focus groups were conducted. Mixed outcomes were merged using a triangulation method.

Opt-in & dropout rates, alongside feedback (participant and facilitator), indicated that group delivery of the Dugas & Robichaud protocol was acceptable and feasible. Large PSWQ treatment effect sizes were found at the end of treatment and follow up. A medium treatment effect size for depression was found at follow up. Change mechanism findings suggested that addressing intolerance of uncertainty may have contributed to treatment gains.

The adapted GAD treatment protocol was found to be a feasible, acceptable, and effective treatment option for older adults with GAD. The protocol shows real promise as a treatment for GAD in older age and further controlled studies against other treatments are warranted. Group CBT appears to be an acceptable and effective treatment option for older adults with GAD.

Older adults with co-morbid depression can still benefit from CBT for their GAD. GAD treatment protocols should consider session pacing, inclusion of more recaps, and regular behavioural experiments as specific modifications with older adults.

**Metacognition and Social Anxiety: A Prospective Study**

Styliani Gkika, The University of Manchester; Adrian Wells, The University of Manchester/Greater Manchester Mental Health NHS Foundation Trust

Contemporary cognitive-behavioural models (Clark & Wells, 1995; Rapee & Heimberg, 1997) implicate social cognitions (i.e., conditional and unconditional self-beliefs and negative automatic thoughts) and cognitive processes (i.e., worry, self-focused attention, and post-mortem processing) in the maintenance of social anxiety. However, the metacognitive model (Wells, 2009; Wells & Matthews, 1994) suggests that metacognitive beliefs should play a role in regulating these processes. Preliminary evidence suggests that metacognitive beliefs are associated with social anxiety (McEvoy, Mahoney, Perini, & Kingsep, 2009; Nordahl, Nordahl, & Wells, 2016; Vassilopoulos, Brouzos, & Moberly, 2015), but the extent and nature of their contribution remains to be tested.

The current study tested if metacognitive beliefs can prospectively predict social anxiety. 156 university students and staff completed a battery of questionnaires measuring social anxiety, social cognitions, cognitive processes, and metacognitive beliefs at two time-points two months apart. Correlations, linear regression analyses and structural equation modelling were employed to explore whether metacognitive beliefs explain variance in social anxiety over and above social cognitions and whether their potential contribution is mediated by the cognitive processes.

The results showed that metacognitive beliefs about the uncontrollability of thoughts at time 1 explained additional variance in social anxiety two months later while controlling for social anxiety, worry, self-focused attention, and the post-mortem at time 1 and social cognitions at time 2. When controlling for worry, self-focused attention, and the post-mortem at time 2, only self-focused attention was a significant predictor. This suggested a mediating effect of self-focus, the post-mortem, and worry that was tested using structural equation modelling. There was an indirect effect of time 1 metacognitive beliefs about the uncontrollability of thoughts and about the need to control thoughts on social anxiety at time 2 through self-focused attention, worry, and the post-mortem. The mediation model fitted the data well.

The results support the metacognitive model and suggest that a formulation of metacognitive beliefs might enrich our understanding of social anxiety and improve its treatment.

**Treatment of co-occurring depression and anxiety in routine clinical practice**

Roz Shafran, UCL Great Ormond Street Institute of Child Health; Abigail Wroe, Royal Holloway University and Berkshire NHS Foundation Trust; Sasha Nagra, Royal Holloway University and Berkshire NHS Foundation Trust; Eleni Pissaridou, UCL Great Ormond Street Institute of Child Health; Anna Cougtrey, UCL Great Ormond Street Institute of Child Health
Between 40% and 60% of patients with a common mental health disorder meet criteria for both anxiety and depression yet clinical guidelines and psychological treatments have traditionally focused either on the treatment of depression or a specific anxiety disorder. The purpose of the study was to establish how best to treat co-occurring anxiety and depression within an IAPT service. Specifically, it aimed to compare cognitive behaviour therapy (CBT) focusing only on depression to a broader CBT focusing on both depression and anxiety.

Case notes of 69 patients with clinical levels of depression and anxiety of equal severity seen in a routine clinical service were selected at random to review from a possible pool of 991 patients. The mean age was 44.61 years (SD = 12.97). Forty-five of the sample (65%) were female and 88% reported their ethnicity white. Electronic records including weekly scores on a measure of depression (PHQ-9) and anxiety (GAD-7) were reviewed to establish whether therapy focused only on depression (CBT-D) or if it was broader and addressed both depression and anxiety (CBT-DA).

Results indicated significant overall improvement with CBT with 70% and 77% of the sample meeting criteria for reliable improvement on the PHQ-9 and GAD-7 respectively. Fewer patients who received CBT-DA met criteria for recovery on the GAD-7 at the end of treatment than those who received CBT-D. There was no evidence to suggest that CBT-DA was superior to CBT-D. There was a trend towards higher symptoms on both indices for the CBT-DA group.

In patients with clinical levels of depression and anxiety of equal severity, there is no advantage of a broader treatment addressing both anxiety and depression compared to a treatment focused on depression, and there may be a disadvantage in terms of recovery from anxiety.

This study has important limitations, in particular its retrospective nature. However, it is consistent with the small literature addressing a big clinical question of how to address comorbidity and suggests that it may be better for clinicians to focus on providing a simple, focused intervention for depression in cases of co-occurring anxiety and depression rather than trying to provide both interventions simultaneously within one course of treatment.

Cognitive bias modification reduces social anxiety symptoms in socially anxious adolescents with mild intellectual disabilities

Anke Klein, University of Amsterdam; Elske Salemink, University of Amsterdam; Eva de Hullu, Open University; Esther Houtkamp, VU University; Marlissa Papa, VU University; Mariët van der Molen, VU University;

Over the last years, Cognitive Bias Modification (CBM-I) techniques have been employed with the goal to decrease biased cognitions and anxiety symptoms. Recently, a critical meta-analysis has been published that made serious doubts for the clinical relevance of CBM techniques; Overall, they found effects on cognitive biases, but no effects on mental health measures. However, it should be noted that they found positive effects for interventions in school settings. Furthermore, the meta-analysis did not include targeted anxiety as moderator. This might be particularly relevant as cognitive theories state that biased cognitions are content-specific; meaning that individuals should only display cognitive biases for the content of their own anxiety, and not for others anxieties. Clearly more research is needed before firm conclusions can be drawn. Therefore, the present study was designed to examine the effects of an CBM-I training in positive interpretations in socially anxious adolescents within the school setting.

A total of 69 socially anxious adolescents between 12 and 18 years of age were randomly assigned to either a positive cognitive bias modification training for interpretation (CMB-I) or a neutral training. Training included 5 sessions in a two-week period, and each session consisted of 40 trainings items. Adolescents all visited special education schools for their intellectual disabilities. Primary outcomes were change in interpretation bias as measured with an Interpretation Recognition Task and a Scenarios Paradigm, and change in anxiety symptoms as measures with the Social Anxiety Scale for Children. Adolescents in the positive training group showed a significant reduction in interpretation bias on the two interpretation bias tasks after training, but not adolescents in the neutral
training group. Furthermore, adolescents in the positive training reported lower social anxiety than adolescents in the neutral training group. This study demonstrated that socially anxious adolescents can be trained away from negative social interpretation biases and there is some evidence that this corresponds to reductions in social anxiety. Furthermore, this is the first study that shows that CBM techniques might also be suitable for adolescents with intellectual disabilities. This study shows that CBM procedures could also work for socially anxious adolescents with mild intellectual disabilities.

Cognitive Processes in repetitive thought across mood disorders

The content-specificity of transdiagnostic deficits in attentional disengagement that are implicated in repetitive thought
Ann Martin, University of New South Wales; Michelle Moulds, University of New South Wales

Although it is well-established that attentional biases play a role in mood disorders such as anxiety and depression, the mechanisms that mediate this effect are poorly understood. The impaired disengagement hypothesis (Koster, De Lissnyder, Derakshan, & De Raedt, 2011) partially explains this relationship by acknowledging the core role played by repetitive negative thought in the aetiology and maintenance of symptoms across depression and anxiety disorders. Specifically, this hypothesis posits that deficits in attentional disengagement contribute to repetitive thought processes such as rumination and worry, which are understood to contribute to symptomatology in turn. Recent research supporting this hypothesis has implicated impaired disengagement in both rumination and worry, prompting the consideration that impaired disengagement may represent a transdiagnostic factor across both depressive and anxiety disorders. However, both the methods and stimuli used to study these attentional biases have varied across studies, resulting in mixed findings. As a result, the specificity of disengagement deficits and the extent to which they represent a transdiagnostic construct remains unclear. The present study aimed to address this issue by examining the specificity of disengagement deficits across a number of repetitive thought subtypes, including depressive rumination, generalized worry, and social post-event-processing. To assess attentional disengagement, all participants completed multiple versions of the Internal Shift Task (Lo & Allen, 2011). To examine the specificity of deficits, across these versions the stimuli varied in valence, thematic content, and idiosyncratic self-relevance. Preliminary findings suggest that attentional disengagement biases do not represent a generalized deficit; rather, that disengagement deficits apply only to specific content related to an individual’s repetitive thought. The implications of these findings for deficient attentional disengagement as a transdiagnostic contributor to repetitive thought will be discussed, as well as implications for the targeting of interventions aimed to treat repetitive negative thought.

Cognitive training to modify maladaptive schemas
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Cognitive models propose that maladaptive schemas – interconnected cognitive structures – play an important role to the onset and maintenance of anxiety and mood disorders as they guide the selection and processing of (emotional) information. Maladaptive schemas develop based on negative life experiences and are activated under conditions relevant to that specific schema. Accordingly, maladaptive schemas are linked to biased processing of emotional information. Ample research aimed to modify maladaptive schemas by altering these information processing biases. In order to test the malleability of maladaptive schemas, a cognitive training version of the Affective Simon Task (AST; De Houwer & Eelen, 1998) was developed. In Experiment 1, an unselected student sample (N= 132) had to identify whether the words were correctly or incorrectly spelled, while ignoring the affective
meaning of the word. The selected words were from a domain relevant to the general sample (i.e. academic related words) and a neutral domain (i.e. household related words). The positive training aimed to induce positive associations with academic words and negative associations with household-related word, for the negative training this was the opposite. To this end, the contingency of correctly/incorrectly spelled words was manipulated. Both the positive and negative training induced affective associations in the intended direction, as demonstrated by faster reaction times. An essential next step was replicating these findings in a sample with more maladaptive schemas. For Experiment 2, a sample of high-worriers was included (N = 102). The procedure was identical to Experiment 1, except that for each participant self-relevant words were selected for their most prominent worry domain based on the Worry Domain Questionnaire (WDQ; Tallis, Eysenck, & Mathews, 1992) Data collection recently finished, results and clinical implications will be discussed. The findings support contemporary cognitive models and suggest that cognitive training could potentially be useful in the modification of schemas and thereby affect schema-driven behavior. It offers a promising strategy for clinical practice that endorses new questions and hypotheses that need further elucidation.

Effects of an Eye-Tracking Based Attention Bias Modification Training in Dysphoric Individuals

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Background: To address shortcomings (e.g., poor reliability) of purely reaction-time based attention bias modification (ABM) paradigms, we developed an Eye-Tracking based ABM training (ET-ABM). This training aims at targeting the late disengagement from negative stimuli and the lack of attention for positive information, which is characteristic for depression. In half of the trials, participants are trained to disengage their attention from positive pictures and, in the other half, to maintain attention on positive pictures. Training trials only continue if participants show the required viewing patterns. In a first proof-of-principle study in healthy students, this positive training induced a positive attentional bias (longer fixations on positive compared to on negative pictures) and, specifically, faster disengagement from negative pictures. No changes were found in a negative training group, where the opposite viewing patterns were trained. The present study aims to replicate these findings in a dysphoric sample, with a sham-training as control condition and to test whether the training also affects stress-responses and state rumination. Methods: 80 dysphoric students (BDI > 9) are randomly allocated to either the positive training (PT), or a sham-training (ST), where attention is only measured (both picture types have to be disengaged from and attended to equally often). Changes in attentional processes are assessed with the eye-tracker. Moreover, stress-levels in response to a subsequent laboratory stressor are investigated as well as transference effects to state rumination. Results: Preliminary data-analyses on a subsample (N= 54; BDI: M = 16.98, SD = 6.12) suggest, that the PT induces a positive attentional bias (t(29)= 9.06, p<.001) and, specifically, faster disengagement from negative pictures (t(29)= 3.36, p=.002). The ST does not induce such changes (both p > .05). Data of the entire sample, as well as data on stress-responses and state rumination will be analysed upon data-completion (January, 2017). Conclusion: Results indicate that the ET-ABM successfully modifies attentional processes, and specifically late disengagement from negative stimuli in dysphoric students and hence, might be a promising alternative to existing ABM paradigms. Analyses on the complete data set will show, whether it may also have the potential to affect stress-responses and thus be of therapeutic value.

The Cognitive Mechanisms that Underpin Individual Differences in Retrospective Cognition about Past Bad Events
Rumination is a subjectively unpleasant experience that involves mental preoccupation with the factors that influenced the occurrence of past negative events, and the undesirable implications of these events. For some people, rumination can severely compromise emotional well-being, while for others rumination yields significant benefits, by adaptively guiding current decision making in ways that protect against the occurrence of potential future misfortune. The critical distinction between the tendency to engage in the former unproductive rumination, often referred to as ruminative brooding, and the tendency to engage in the latter productive rumination, often referred to as ruminative reflection, concerns whether or not the probability of occurrence of the past negative event that forms the focus of the rumination could have been attenuated through personal action. However, while cognitive-experimental research has, to date, revealed the information processing biases favouring negative information that contribute to individual differences in the general tendency to ruminate, it has not yet served to delineate the patterns of information processing that underpin the distinction between the tendency to engage in ruminative brooding vs. ruminative reflection. In the present research, we tested the novel hypothesis that individuals who engage in ruminative reflection are those people for whom the operation of processing biases favouring negative information are tightly aligned with negative events in which personal action could have influenced the probability of the event occurring, whereas people who commonly experience ruminative brooding lack this alignment, and so exhibit such processing biases regardless of whether or not personal action could have influenced the probability of negative events occurring. The implications of the present findings in terms of advancing understanding of the cognitive basis of rumination will be discussed.

The Role of Goal Structure in Personal and Occupational Wellbeing: Mechanisms and Research Directions

The emergence of goal conflict during mental simulation of personal goals and its association with perceptions of goal progress and life stress

A substantial number of studies have demonstrated that increased levels of personal goal conflict is associated with heightened anxiety, depression, lower wellbeing and related adverse outcomes. However, the mechanism of what underpins this relationship requires further explanation. One possible understanding emerges from the hierarchical formulation of goal structure put forward by Perceptual Control Theory. This postulates a goal organisation where higher levels aspect of the self (e.g. a fundamental value of compassion) are realised by lower sub-goals that are more concrete (e.g. regularly giving to a charity). Existing methodologies for assessing goal conflict have focused on the content of either lower or higher level conflicts but rarely their interaction. Examining their interaction may demonstrate that conflict disrupts how higher level goals are achieved by lower levels. If so, this would leave the higher levels chronically unresolved, resulting in psychological distress. The current presentation will describe a novel means of capturing the structure of goals that utilises mental simulation of a focal personal goal. The study was conducted in a student population (n = 71) and the central task involved a mental simulation protocol where the realisation of a focal goal (occurring within a 5 year horizon) was imagined. In doing so, a range of key sub-goals or events were coded and placed into a goal conflict matrix. Several dimensions of goal strivings, such as satisfaction with progress and achievability were measured, as well as indicators of stress and resilience. Measures of the vividness, plausibility and affective aspects of the simulation were gathered. Pre-simulation goal characteristics were not associated with conflict. However, significant associations did emerge after the simulation exercise, supporting the notion that interaction between higher and lower level goals brings conflicts into awareness. The extent of conflict was also associated with the ratings of simulation affect. These findings highlight how conflict may
destabilise evaluation of anticipated events, which may promote pessimistic expectations of
goal progress. These findings may inform therapies that directly address goal conflict and
ambivalence, such as motivational interviewing, acceptance and commitment therapy and
method of levels.

**The structure of therapist goals and its relationship to perceptions of goal attainment
and occupational stress**

**Sam Russ, University College London; Vyv Huddy, University College London**

Research has provided substantial evidence of the associations between goal conflicts and
reduced psychological and physical well-being, perception of goal progress and likelihood of
goal success (Kelly, Mansell & Wood, 2015). There are also specific associations between
patient goal conflict and motivation to engage in therapy. Judith Beck (2011) highlighted the
general relevance of client goals as central to most therapeutic interventions (particularly
CBT) but it is surprising that little attention has been given to therapists' goals. Therapist
goals are likely to emerge from competencies mandated by assurance bodies for the provision
of quality therapy and also the personal values and interests that exist outside of the formal
frameworks. It is possible that therapists perceive conflicts between these personal goals
(e.g. placing great value on listening to clients may conflict with the importance of
scheduling homework). This type of goal conflict could play a role in therapist wellbeing and
goal progression. Reduced affective well-being is a feature of the phenomenon 'burnout', a
form of work-related stress. If goal conflict is a factor negatively influencing therapist's well-
being, it could also impede their ability to provide high quality care. Fifty clinical
psychologists in training participated in a study of goal conflict, perceptions of attainment
and occupational stress. A semi structured interview format was employed to identify
therapists' goals followed by a goal conflict matrix used in other research on conflict. The
Maslach Burnout Inventory was used as a measure of occupational stress. In addition to the
quantitative analyses of goal characteristics and conflict, further thematic analysis of the
content of therapist goals was conducted. The findings of the study will be discussed in
relation to the implications for understanding the factors underlying occupational stress in
therapists.

**Goal conflict, ambivalence, and psychological distress: Elaboration of the nomological
net**

**Nick Moberly, University of Exeter, UK; Joanne Dickson, Edith Cowan University, Perth,
Australia**

Motivational conflict has long been considered to be responsible for psychological distress.
Such conflict may manifest itself as interference among personal goal pursuits (inter-goal
conflict) as well as ambivalence about the desirability of attaining particular goals. Previous
research has generally found that both inter-goal conflict and ambivalence are associated
with increased levels of anxiety and depression, and reduced levels of well-being. However,
new studies have examined whether these characteristics of goal conflict have additive
and/or interactive relationships with psychological distress, and whether these forms of
motivational conflict predict deterioration of symptoms. In this longitudinal study, 194
undergraduates listed ten important goal strivings, rated each on inter-goal conflict, goal
ambivalence, internalized motivation and expectancy of attainment. They then completed
measures of depressive and anxious symptoms, both at the baseline assessment and one
month later. Results indicated that ambivalence and inter-goal conflict made independent
but non-interactive contributions to anxious and depressive symptoms that were measured
concurrently, but did not contribute to deterioration in anxious or depressive symptoms
over the next month. The characteristics of conflicting and ambivalent goals were elucidated
in terms of internalized motivation and pessimism, such that the unique contribution of
motivational conflict to distress could be elucidated. Theoretical and clinical implications of
these findings will be considered, including the role of goal conflict in therapeutic
interventions.

**Approach/avoidance goal framing and rumination**
The distinction between approach and avoidance motivation is theoretically important and is known to be consequential for mood and psychological symptoms. However, the contribution of approach/avoidance motives to the cognitive mechanisms that have been implicated in psychological disorder has been less well investigated. Negative ruminative thinking is a key transdiagnostic process in clinical psychology and is believed to be instigated by problems making progress on personal goals. Avoidance motivation may increase rumination because it focuses attention on negative outcomes in a self-perpetuating manner, while fostering vigilance about the to-be-avoided outcome. An experiment in a non-clinical population investigated whether the manipulation of an approach/avoidance focus on blocked goals affects mood and rumination during a subsequent sustained attention to response task. Undergraduates completed baseline measures of mood, indicated an important problem that was currently unresolved and identified the relevant personal goal that was thereby thwarted. They were then randomly allocated to one of two conditions, both of which involved spending several minutes focusing on the consequences of failing to resolve the problem. In the approach condition, participants were asked to focus on the positive consequences that would not occur if they failed to resolve the problem. In the avoidance condition, participants were asked to focus on the negative consequences that would occur if they failed to resolve the problem. After completing another mood measure, participants undertook a sustained attention task in which the content of their thought was periodically probed while their mood was monitored. Results describing the effect of approach/avoidance focus on mood and subsequent ruminative thought will be presented, and theoretical and practical consequences noted. The implications of these data will be considered in terms of interactions between motivation, cognition and affect.

Goal self-discrepancies and perseverative thinking in anxiety and depression

Joanne Dickson, Edith Cowan University; Joanne M. Dickson, Edith Cowan University; Nicholas J. Moberly, University of Exeter; Gemma Williams, University of Liverpool; Christopher D. Huntley, University of Liverpool

Numerous studies have found that personal goal striving is associated with subjective well-being and positive adaptations in life. Emerging research however suggests that dysregulated goal pursuit is implicated in the maintenance of affective disorders. Regulatory Focus Theory (RFT) posits that affective states result from discrepancies between actual and desired self-states. In this study, we aimed to investigate whether promotion goal discrepancy (focused on actual and ideal-self discrepancy) and prevention goal discrepancy (focused on actual and ought-self discrepancy) were related to anxious and depressive symptoms. Anxiety and depression were studied concurrently to investigate possible shared and unique goal discrepancy profiles. The study also investigated whether relationships between goal discrepancy and anxiety and depression were mediated via perseverative thinking. The sample comprised 138 students from a university in the United Kingdom. Participants listed their ideal and ought goal selves and then completed self-report measures to rate ideal-self and ought-self goal discrepancies, and to assess perseverative thinking, depressive and anxious symptoms. Results showed a relationship between ideal-self goal discrepancy and depression, and this relationship was partially mediated by perseverative thinking. In contrast, the relationship between ideal-self goal discrepancy and anxiety was fully mediated via perseverative thinking. In the case of ought-self goal discrepancy the results showed that perseverative thinking partially mediated relationships with anxiety and depression. The study identified common and distinct patterns of results in relation to goal discrepancy, perseverative thinking, and emotional symptoms. The results further evidence that difficulties in perceived goal progress and effectively regulating goal pursuits are associated with emotional symptoms. Our findings highlight the importance of examining variables that may mediate the relationship between goal discrepancies and emotional symptoms and also highlight the importance of tackling goal discrepancy and perseverative thinking in relation to goal pursuit. The presentation will consider theoretical and clinical implications.
Extending Cognitive-Behavioural Theory and Therapy to medically unexplained symptoms and long-term physical conditions: an overview
Paul Salkovskis, University of Bath

“Medically Unexplained Symptoms” (MUS) are common, distressing, and typically poorly managed in general medical settings. Those suffering from these problems tend to incur significantly higher health costs than the general population. There are many effective treatments for different MUS; these are almost entirely based on Cognitive-behavioural approaches. However, the wide range of treatment protocols tend to be “syndrome specific”. As such, they do not generalise well in terms of training and application, making them expensive and difficult to disseminate, suggesting the desirability of developing a transdiagnostic approach. The general basis of such a CBT grounded transdiagnostic approach is considered, and the particular need to incorporate cognitive elements of both anxiety/health anxiety (threat) and depression (loss) is highlighted. Key empirically grounded and evidence based processes (both specific and general) previously identified as underpinning the maintenance of MUS are delineated. The way in which these can be combined in a transdiagnostic model which accounts for most MUS presentations is presented and linked to a formulation driven transdiagnostic treatment strategy, which is described. However, the need to take more syndrome-specific issues into account in treatment is identified, suggesting that the optimum treatment may be a hybrid transdiagnostic/specific approach with formulation, shared understanding, belief change strategies and behavioural experiments at its heart. The generalisation of such approaches to psychological problems occurring in the context of “Long Term Conditions” is identified as a further important development which is now within reach. The use of the term “Persistent Physical Symptoms” is considered.

Understanding and treating “Medically Unexplained Symptoms” in the context of work rehabilitation
Sigrun Olafsdottir and Jon Fridrik Sigurdssson, University of Reykjavik, Iceland

Medically unexplained symptoms (MUS), are common in all health care settings and are found in most medical specialties (Budtz-Lilly et.al., 2015; Kirmayer et al, 2004; Nimnuan et.al., 2001; Reid et.al., 2001; Streinbrecher et.al., 2011;). They have been associated with distress, disability and diminished quality of life and come with massive societal costs. For example, MUS have been associated with increased health care cost (Gerger et.al., 2015), work disability, sick leave and increased risk of permanent disability pension (denBoeft et.al., 2016; Hoedeman et.al., 2010; Rask et.al., 2015). Conventional medical therapy is largely ineffective for MUS and the effects of psychotherapy have been modest, although there is evidence for a range of Cognitive-Behavioural treatments (CBT) based on models that are highly specific to particular types of MUS. The limitations of these specific models are that they require training of several therapists with special training in CBT for the various subgroups of MUS. To address these limitation Salkovskis et al. (2017) have proposed a trans diagnostic cognitive behavioural model for MUS and have developed a novel hybrid trans-diagnostic CBT to treat MUS. This paper reports on a) the early stages of a study of the prevalence of MUS among Icelanders seeking work rehabilitation, including evaluation of social adjustment, work disability and psychological functioning. b) The development of an adjusted version of the above mentioned therapy that will be specially aimed at work disability and delivered in a group format.

Screening for medically unexplained symptoms in general practice
Emily Neal and James Gregory, University of Bath

Screening for medically unexplained symptoms in general practice is likely to be an important precursor of delivering treatment, both in terms of identifying unmet need and assessing the extent of distress and willingness to engage with therapy. The development and deployment of such screening is described in the context of six general practices in the
Gloucester area. Ways of integrating this screening with referral are considered. Preliminary data from the screening will be presented, showing that these symptoms are common, are strongly associated with psychological distress and that a substantial proportion of those identified would accept treatment were it to be offered. Implications of the development of treatment for such problems in general and IAPT services in particular are considered.

**Practicalities of delivering CBT for MUS**
*Alison Sedgwick-Taylor, Lets Talk (2gether NHS Trust), Gloucester*

The diverse range of Persistent Physical Symptoms which come under the heading of Medically Unexplained Symptoms mean that distinct treatment approaches for each category is not possible. Instead, a hybrid transdiagnostic-specific CBT approach is advocated. The development and first stages of deployment of this approach is described. Central to the treatment strategy is formulation and shared understanding; examples of more specific strategies in terms of discussion and behavioural experiments will be outlined.

**Using the school setting for early intervention for mental health disorders in adolescence**

**Brief Behavioural Activation (Brief BA) in secondary schools delivered by an Educational Psychologist: A pilot study**
*Laura Pass, University of Reading; Shirley Reynolds, University of Reading*

Depression in adolescence is a common and serious mental health problem. In the UK, access to evidence based psychological treatments is limited and training and employing therapists to deliver these is expensive. Brief Behavioural Activation (Brief BA, Pass & Reynolds 2014) was developed as a brief, structured behavioural intervention for depressive symptoms in adolescents, designed to be delivered by a range of healthcare professionals. Pilot results in CAMHS have been promising, but so far this has only involved therapists from the research team who adapted BA for adolescents. This study was designed to pilot the intervention within the school setting, with delivery by an Educational Psychologist who had not been involved in previous Brief BA work.

Adolescents in two local secondary schools were invited to take part in Brief BA if school staff felt they might benefit from the intervention. Following assessment, eight adolescents with symptoms of depression were offered Brief BA (6-8 sessions, followed by a review around one month later). Self-reported Routine Outcome Measures (ROMs) were collected at every session. All school liaison regarding cases, and delivery of assessment and treatment sessions was completed by an Educational Psychologist with existing links at both schools.

The results of the pilot study (outcomes on questionnaire measures, verbal report on progress, and school report of change) will be reported, along with consideration of acceptability and feasibility of the approach within this setting and delivery by a therapist from an Educational Psychology background. The study has important implications for further research on developing evidence based interventions within the secondary school setting for depression symptoms. Following this pilot, Brief BA requires further evaluation on a wider scale, to determine effectiveness in other school settings and delivered by a range of professionals.

**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*

Teachers are reported to be at increased risk of common mental health disorders compared to other occupations. Failure to support teachers adequately may lead to serious long-term mental disorders, poor performance at work (presenteeism), and sickness absence. It also jeopardises student mental health, as distressed staff struggle to develop supportive relationships with students, and such relationships are protective against student depression. Teachers report a lack of training in how to support students, which exacerbates
their work related stress. The prime minister has recently announced the introduction of mental health first aid (MHFA) training into all secondary schools, despite a current lack of evidence regarding the impact of MHFA on mental health outcomes. This paper outlines an intervention and evaluation, in which secondary school teachers receive training in MHFA, and have access to a confidential peer support service.

A cluster randomised controlled trial (RCT) with secondary schools as the unit of randomisation. Intervention schools will receive: i) Mental Health First Aid (MHFA) training for a group of staff nominated by their colleagues, after which they will 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 will continue with usual practice. The primary outcome is teacher wellbeing measured using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). Secondary outcomes are teacher depression, absence and presenteeism, and student wellbeing, mental health difficulties, attendance and attainment. Baseline measures were collected in the summer of 2016, and follow up data will be collected in summer 2017 and summer 2018. The intervention and evaluation was piloted in 6 schools (3 intervention and 3 control).

The results of the pilot study showed that MHFA training was considered relevant by schools, and trainees gained in knowledge, confidence in helping others, and awareness regarding their own mental health. A peer support service was established in all intervention schools and was perceived to be helpful in supporting individuals in difficulty – for example through listening, and signposting to other services - and raising the profile of mental health at a whole school level. Barriers to use included lack of knowledge about the service, concerns about confidentiality and a preference for accessing support from pre-existing networks.

The WISE intervention is feasible and acceptable to secondary schools. The full cluster RCT will establish the effectiveness of the intervention at improving secondary school teachers’ wellbeing and mental health, and developing their skills in supporting students. It will also contribute to the evidence gap regarding the effectiveness of MHFA training on the mental health outcomes of those who receive assistance from trainees.

**What do school-teachers need to support and educate about mental health effectively?**

*Lucas Shelemy, University of Reading*

School teachers are under pressure to respond to the emotions and behaviours of their pupils within the classroom, with a greater expectation than ever for teachers to be at the front-line for identifying, approaching and referring pupils with mental health difficulties (Department of Health; MHFA, 2015). Despite this, teachers are not obligated to learn about and understand mental health disorders as part of their training (Shepherd et al., 2013) and have limited access to support and supervision from professionals with expertise around mental health (Sharpe et al., 2016).

Teachers are vital in ensuring the sustainability for mental health interventions in schools, due to the low cost and high potential dissemination of resources (Atkins et al., 2010). There are many interventions and research programs that aim to equip teachers with the right tools to deal with such situations (e.g. Barrett et al., 2001; Stallard et al., 2014). However, there is not a consensus about which interventions are most effective (Fisak et al., 2011). This talk presents findings from two studies. The first study is a systematic review of the effectiveness of teacher-led mental health interventions. From this review, it was found that teachers are effective in delivering a mental health intervention to adolescents resulting in improved outcomes for students. The most effective teacher-led interventions are those that focus on cognitive-behavioural skills and have high program manual adherence.

The second study involved 7 interviews and 10 focus groups with teachers across the UK. For teacher-led interventions to be effective, it is critical that we fully understand teachers’ experiences, viewpoints and needs (Kidger et al., 2010). This study aimed to uncover exactly what mental health resources teachers want, would use, and find effective. Focus groups are an effective qualitative approach that can generate a wide range of views on such an issue.
(Underhill & Olmsted, 2003). These groups showed that teachers need a) clear guidance on how to have a conversation about mental health, b) evidence-based and professional training, c) good referral routes and communication with CAMHS services. Poor sustainability of teacher-led interventions may be due to low levels of acceptability from teachers (Han & Weiss, 2005). Teacher interest in the intervention needs to be met to ensure high levels of effectiveness.

**CBT for people with intellectual disabilities: National guidance, controlled studies and selfharming Behaviour**

*NICE guidance and quality standards for people with intellectual disabilities and mental health problems and challenging behaviours: Implications for practice*

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

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

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

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

**Conclusions:** The NICE approach to identifying and rating research evidence is rigorous but quite rigid and can lead to what some might consider somewhat narrow recommendations. A broader approach to reviewing evidence leads to more nuanced conclusions about the effectiveness of behavioural and cognitive interventions for people with ID.

**Who said it wasn’t possible? Delivering psychological therapies for a large scale randomised control trial (BEAT-IT) involving people with intellectual disabilities**

**Andrew Jahoda, University of Glasgow**

**Aims:** With notable exceptions, there has been scepticism about the ability to carry out trials of individual psychological therapies with people who have learning disabilities. This talk is about the challenges of delivering a large scale single blind randomised control trial of behavioural activation for people with learning disabilities and depression, compared to an attention control intervention of guided self-help.

**Methods:** A multi-point recruitment strategy was used in sites across Scotland, England and Wales. The participants recruited into the trial were randomised to a twelve session manualised behavioural activation intervention or to an eight session manualised guided self-help intervention.

**Results:** Participants were recruited from specialist learning disability health and social care services in Scotland, England and Wales, and Improving Access to Psychological Therapies services (IAPT) in England. Achieving the target recruitment (161 participants randomised), required sustained effort to engage services and help them identify potential participants.
More than four times the anticipated number of therapists had to be trained (95) to deliver the interventions. The therapists were members of community learning disability teams with experience of working with people who have learning disabilities and mental health problems. A smaller number of IAPT workers were also recruited as therapists.

Conclusions: It is possible to successfully recruit to and deliver a largescale trial of individual psychological interventions for people with learning disabilities. The possibility of building an evidence base will help to overcome the significant health inequalities faced by people with learning disabilities, who require help for mental health problems.

A comprehensive approach to fidelity in research on psychological therapies for people with intellectual disabilities: Examples from the BEAT-IT study

Dave Dagnan, Cumbria Partnership NHS Foundation Trust & Lancaster University

Aims: The paper will present an overview of the fidelity approach in the BEAT-IT study. The paper will describe fidelity to therapist and supervision characteristics, fidelity to manual and therapy quality and fidelity to therapy receipt through description of activities engaged in and other features of participant engagement.

Methods: Therapist demographic and supervision data were analysed. Both a measure of adherence to manual and a non-specific therapy process measure were developed based on previously available fidelity measures. Therapists in both arms recorded two therapy sessions that were rated by independent research associates (144 fidelity recordings were available for analysis), 45 recordings were also rated by a further research associate to determine inter-rater reliability. Data were available on activities engaged in and barriers to engagement.

Results: The data indicated that the therapists were predominantly nurses, had no accredited therapy training and received a mean of one supervision for every 1.8 therapy sessions. Therapist in both arms provided a high quality of therapy and closely followed the manuals. The scale had good internal reliability (alpha = 0.76). The most common barriers and activities engaged in for homework will be described and discussed.

Conclusions: The fidelity data shows that the core protocol for the recruitment of therapists and implementation of supervision was followed and therapists provided high quality of therapy that was consistent with the manuals. The ability of the study to deliver an intervention with a high level of fidelity through therapists with little specific therapy experience will be noted and discussed.

Self-harm and related behaviour: The involvement of anger and emotional instability among male forensic patients with intellectual disabilities

Ray Novaco, University of California, Irvine, USA

Background: The association of anger with harm-doing behaviour among psychiatric patients has been well-established with regard to violence toward others in numerous studies involving persons in hospital and in the community, including those with intellectual disabilities. Far less research attention has been given to anger and self-directed aggression or self-harm, particularly among people with intellectual disabilities.

Method and Results: Multiple measures of anger and self-harming behaviour were obtained regarding 129 male forensic patients with intellectual disabilities, 45% of whom had a history of self-injury. Patients' history of self-injury, controlling for WAIS Full Scale IQ, was significantly related to self-reported anger as assessed by NAS Total score (primarily its Arousal subscale) and by STAXI Anger Expression (primarily its Anger Out subscale), as well as to staff-rated anger (WARS) and to staff-rated emotionally unstable personality disorder (PDCC). A similar pattern of findings was obtained for patients' history of suicidality. Staff ratings (PDCC) of self-harm attempts were significantly related to Trait Anger and to patients' history of having been sexually abused, which in turn was related to patient self-reported anger (STAXI Trait Anger and Anger In, and NAS Arousal), controlling for IQ.

Conclusions: As large sample epidemiological research has found self-injury to be prevalent among people with intellectual disability and there is evidence for anger being associated
with self-harm in various non-ID populations, such as prisoners and soldiers, our findings with this sample of forensic patients call for anger treatment interventions to give attention to self-directed aggression, as well as to other-directed aggression. Further, the interrelationship between anger and shame comes into play in this domain.

Predictors of patient outcomes in IAPT: Outputs from the North West London Data Collaboration

Predictors of patient outcomes in IAPT: Outputs from the North West London Data Collaboration
John Green, Central and North West London NHS Foundation Trust
CNWL NHS FT, Eleanor Cowen, CNWL NHS FT, Sophie Jones, UEL
We analysed a very large anonymised IAPT dataset from our services looking at ways of improving outcomes. In this presentation we take an overview. The outcome metrics in use in IAPT, Recovery and Reliable Improvement, have different dynamics. Recovery is particularly sensitive to starting scores, Reliable Improvement less so. Change on the key IAPT scales, GAD, PHQ, WSAS is related to baseline score. Social deprivation is related to average Recovery at the service level but less strongly at patient level. A range of demographic factors affect outcome as do treatment variables such as number of sessions. Source of referral is only very weakly related to any outcome in our data. Outcomes for patients with LTCs vary by condition with some identical to those with no LTC down to particularly poor outcomes for those with chronic pain conditions. Comparisons between services need to take into account differences in patient population served. However national targets are potentially achievable in all services providing appropriate resources are available. We identify modifiable factors which can help to improve outcomes.

Ethnicity and IAPT
Federica Amati, Imperial College and CLAHRC NW London; Geva Greenfield, Imperial College London and CLAHRC North West London, Hilary Watt, Imperial College London, Anupama Rammohan, CNWL NHS Trust, Ruth Dennis West London Mental Health, Ross O’Brien, CNWL NHS Trust
Equality is an important consideration for services across the NHS. Ethnic group is related to a constellation of other factors such as language, morbidity and socioeconomic status. There are two key issues for IAPT. The first is access. One would not expect a straightforward match of IAPT access against crude OPCS figures because different ethnic groups within the population vary in age structure and other important demographics. Moreover the prevalence of common mental health problems would not be expected to be the same in different ethnic groups. These factors need to be considered while trying to model access. The second issue is outcomes. For some BMER populations outcomes are similar to those for non-BMER, whereas for others they are worse. We explore the ways in which these factors may influence outcomes.

Employment
Sophie Jones, University of East London; Zahra Khaki, CNWL NHS Trust, Renuka Jena, CNWL NHS Trust, Ruth Dennis, West London NHS Trust, Ryan Kemp, CNWL NHS FT, Alastair Bailey, CNWL NHS Trust
There are complex relationships between morbidity, outcomes and employment. Employment is associated with lower morbidity at baseline but it is also associated with better outcomes. Not only are the employed better in these respects but other individuals who have some form of occupation such as homemakers and volunteers are also better on average. Moving from lack of occupation to occupation is associated with better outcomes. The impact of moving into employment/occupation may be underestimated since it takes time for people to find employment or occupation. However the data is unable to tell us which way the arrow of causation points. It is possible that the relationship may be
bidirectional with improvement in mental health leading to improved occupational functioning and improved occupational functioning leading to better outcomes.

**Predictors**

**Joseph Landsberg, West London Mental Health NHS Trust;** Dominic Glover, West London Mental Health NHS Trust, Clair Pollard, CNWL NHS Trust, Aisling Daly-Eichenhardt, CNWL NHS Trust, John Green, CNWL

A wide range of different variables are associated with outcome in the individual patient. These include demographic factors such as language and social deprivation, treatment factors such as waiting times and number of sessions and morbidity factors such as entry scores and presenting problem. We examine some of the key predictors of outcome, and some of the factors which do not predict outcome or are weak predictors such as referral source.

**Do complex cases need complex treatment?**

**CBT for Adult Survivors of Complex Developmental Trauma**

Helen Kennerley, Oxford Cognitive Therapy Centre

The term "Complex Trauma" (Courtois, 2004) refers to a particular experience of prolonged or extreme single-event trauma, occurring in adulthood or childhood. However, the sequelae of childhood trauma [and neglect] are often complex, whether or not the experience was in itself “complex”. By the time people reach adulthood, childhood problems linked to trauma and neglect have often compounded neurologically, psychologically and socially. Herein lies the first of many challenges for the therapist – how do we capture these complexities in a way that is accessible to our patients, many of who are not ‘psychologically’ minded and are quickly overwhelmed by information. A simple framework to encapsulate the impact of an emotionally traumatic event is described, called the “Ripple Effect of Trauma”. It illustrated that we don’t work with “trauma” per se but with the neuro-psychosocial consequences (ripples) - a change at one level reverberating into a stress at another level and so on. The initial neuro-psychological impact of trauma (see De Bellis & Zisk, 2014 for a review) frequently leads to shifts in self and interpersonal perspectives and if this is maintained for years it can result in chronic unhelpful patterns of being, thus explaining the high correlation of developmental trauma with adult mental health problems (Mullen et al, 1993; Fergusson et al, 2013). Ways in which therapists should gain an understanding of the interacting complexity of current difficulties and risk issues will be discussed, and how these complexities can be described in a way that is accessible to patients, many of who are not ‘psychologically’ minded and are quickly overwhelmed by information. In essence – do not underestimate your skills and abilities as a therapist, but never underestimate the needs of your patients. Survivors of complex developmental trauma require specific therapeutic considerations: the neuro-social-psychological impact of early trauma, the interacting complexity of current difficulties and risk issues. However, a therapist’s basic skills in developing a constructive therapeutic alliance and formulating problems sets the scene for a productive intervention, and a good conceptualisation will direct a therapist to a “toolkit” of strategies.

**Complexity in Obsessive Compulsive- and Body Dysmorphic Disorder**

Oliver Sundermann, King’s College London; David Veale, King’s College London

The term ‘complex’ is widely and often inconsistently used in the treatment of Obsessive-Compulsive Disorder (OCD) and related disorders such as Body Dysmorphic Disorder (BDD). Practitioners may refer to complex OCD or BDD when patients present with severe comorbid problems, often in the context of trauma, personality difficulties, and dissociation; or when the illness is chronic and debilitating with previous multiple treatment failures. Current best-evidence treatment protocols for both disorders focus heavily on Exposure and Response Prevention (E/RP) and Cognitive Behavioural Therapy (CBT), however with moderate success, particularly in patients who are deemed ‘complex’, and often in those
with relevant shame or disgust-based past experiences. This talk describes factors that contribute to complexity in OCD and BDD, and link these with theory and practice. We emphasise the importance of understanding both the function of OCD and BDD-related behaviours (rather than the content of obsessions or compulsion), and the context in which they occur such as the family. We illustrate complexity in OCD and BDD using real case material, and formulate the clients’ difficulties using a functional and contextual approach, and demonstrate how E/RP and CBT can be enhanced successfully with imagery rescripting, family work, and compassion-focused therapy.

Complexity is in the eye of the beholder: using compulsive hoarding disorder as a case example
James Gregory, University of Bath
There are many factors that contribute to the perception of what is deemed a ‘complex’ case, from individual factors such as beliefs shaped by, for example, training (or absence of) and previous clinical experience to more systemic factors such as the views of colleagues, the involvement of multiple agencies and then more simply, what is known or not known about a person’s presenting problem and their treatment history. Although not exclusively, all of these issues—and more—are relevant to compulsive hoarding disorder (CHD). CHD is now recognised as a mental health disorder (DSM V, 2013) but it is rarely compared to other mental health presentations—encountered in mental health practice, but it is often deemed to be a ‘challenging’ and ‘complex’ presentation when it is. Drawing on case examples and research, the ‘complexity’ obstacles outlined above will be discussed in the context of CHD and suggestions for overcoming these will be made.

Complexity in eating disorders: A case for simplicity of CBT?
Glenn Waller, University of Sheffield
Complexity is probably the norm in the presentation of individuals with eating disorders, with substantial levels of physical complications and psychological comorbidity. There are many recommended therapeutic responses to such complex cases, ranging from reducing demands to using an uneviedenced alternative therapy. However, once one has ensured that physical and psychiatric risks are minimised, there is little evidence that such complexity has any impact on the outcome of CBT. This presentation will make the case that CBT clinicians should aim to use simple formulations and stick to the evidence base when working with eating disorders, especially where there is complexity, so as not to reduce the patient’s chances of benefitting. This need to stay on track is particularly true of so-called 'severe and enduring eating disorders', where the danger is that the label is used to allow therapists to abandon hope of recovery.

Patient-led Appointment Scheduling: An efficient way of optimising resources to improve patient access to services
Tim Carey, Flinders University
An ongoing challenge for mental health services is the ability to meet the increasing demand for psychological treatments in the context of constrained budgets and shrinking financial resources. Compounding this situation is the need to address the occurrence of missed and cancelled appointments which further strain health service resources. Patient-led appointment scheduling has emerged as an effective and efficient way of increasing service capacity and reducing waiting times for services. This approach to structuring treatment delivery is consistent with policy imperatives to increase patient choice and control over their own health care and it is also consistent with professional and ethical guidelines which stipulate that clients should be able to withdraw from the receipt of treatment. Patient-led appointment scheduling is supported by the theoretical framework of Perceptual Control Theory which emphasises the importance of self-regulation. Furthermore, patient-led appointment scheduling requires no additional resources for its implementation. This paper will discuss the theoretical, policy, and professional and ethical considerations associated
with patient-led appointment scheduling and will also provide empirical evidence to support this approach.

**Innovations in Practice: A new Consultation, Assessment and Reflection Model (CARM) used in Child and Adolescence Mental Health Services (CAMHS)**

Louise Mansell, Healthy Young Minds (CAMHS), Rochdale; Kirsty Hughes, Healthy Young Minds (CAMHS), Rochdale; Jane Ward Heyes, Healthy Young Minds (CAMHS), Rochdale; Adrian Brownlee, Healthy Young Minds (CAMHS), Rochdale; Sarah Collinge, CAMHS, Burnley; Daniel Blake, University of Manchester; Clare Charman, Healthy Young Minds (CAMHS), Rochdale

**Background:** National Guidelines stress the importance of waiting times, speedy assessments and interventions for children seeking mental health support. Theses guidelines also stress the importance of early help, multidisciplinary working to learn from each other, and collaboration with families regarding treatment plans (NICE 2005, National CAMHS Review 2008). In the current service waiting times had increased to +24 weeks and DNA rates were higher than national average. A brief survey with staff revealed that staff satisfaction was generally low, and that families were waiting prolonged periods of time for them to complete an assessment / care plan due to workload. Research indicates that waiting is one of the biggest predictors of patient satisfaction (Bjorngaard, Wessel, Osborg, & Hanssen-Bauer, 2008) and timeliness has been identified by children, young people and families as a key element to effective service (National Service Framework, NSF). In light of this, this pilot investigated the feasibility of a new model of assessing children and young people designed using evidence based models and theory.

The aims of this were to: reduce DNA rates and subsequently waiting times, increase staff and patient satisfaction, and it was also hoped that this would also produce more timely, formulation driven and collaborative care plans.

**Method:** The pilot was carried out between April - July 2015. Patients from the waiting list were invited to book an appointment based on the month they had been waiting since, and all new patients were invited to book an appointment based on month of us having received their referral. DNA rates were monitored by administration staff. Twelve CAMHS practitioners of different disciplines were identified to make up the ‘CARM Team’.

Practitioners developed a feedback questionnaire for all patients and undertook staff surveys at the end of each week to gather feedback about CARM, which was fed back and recorded at a weekly meeting.

**Results:** DNA rates dramatically reduced within the first month of CARM. On average over the course of the pilot, DNA averaged at 7% compared to an estimated 33% prior to CARM being introduced. A sample of patient satisfaction questionnaires were analyzed to reveal 75%-87% rated every satisfaction item as 10/10. Qualitative feedback regarding satisfaction revealed the most common theme was feeling listen to, or patients found it ‘helpful to listen to staff reflection’. Staff satisfaction was increased, with themes of ‘feeling more supported’, ‘safer in their decision making’, and having ’enjoyed’ their day. All assessments were completed in the one appointment with a formulation-driven care plan having been developed and discussed with the family, with the exception of children who required a referral to the more neuro-developmental team.

**Conclusion:** This approach has the potential to make the service a more effective and efficient place to see children and families. The early findings indicate that using this model enhances staff well-being and satisfaction, and increased patient satisfaction.

**Using patient-led scheduling to improve access to psychological interventions for people using Early Intervention in Psychosis services**

Robert Griffiths, Greater Manchester Mental Health NHS Foundation TRust

Robert Griffiths is a psychological therapist and Chief Investigator for the Next Level study (ISRCTN: 13359355). This is a NIHR funded study investigating a transdiagnostic psychological therapy called Method of Levels (MOL) for first episode psychosis. Robert’s background is in Early Intervention (EI) in psychosis services. He will provide feedback on an audit of a psychological assessment and formulation clinic that was available for users of an EI team and operated using the principles of patient-led scheduling. The aim
Facilitating control and choice through patient-led appointment scheduling on inpatient units
Sara Tai, University of Manchester
“Central to the Care Act 2014 is the principle of wellbeing. At the heart of the principle of wellbeing is ‘control by the individual over day-to-day life, including over care and support and the way it is provided’ (Care Act 2014, S1 (2)). However, people using mental health services often do not experience the same opportunities to take control and make decisions regarding their own treatment compared to people accessing services for physical health problems. This is particularly the case for people admitted to in-patient mental health facilities. This presentation considers the importance of control and choice, particularly when people are experiencing a mental health crisis. The use of patient-led appointment scheduling on in-patient wards; specifically an acute general adult psychiatric unit and a psychiatric intensive care unit, will be described. The aim of patient-led appointments aimed to both increase patient choice and maximise efficient use of limited psychology resources. The presentation will describe how patient-led scheduling was organised and focus on some of the challenges of implementing such an approach across two challenging in-patient settings. Specific challenges, including staff perceptions and practical organisational barriers will be discussed. Case studies will be used to illustrate this work and highlight the way in which appointment scheduling might reflect some of the interpersonal struggles with control that people can often experience.

Avatar therapy for distressing voices - lessons from the AVATAR trial for how we think about and work with voices

The AVATAR clinical trial: introduction, methodology and therapy set-up
Mar Rus-Calafell, Institute of Psychiatry, King’s College London
AVATAR therapy is a novel digital intervention which aims to reduce the frequency and severity of distressing voices. The approach is based on computer technology which enables each voice-hearer to create an avatar of the entity (human or non-human) that they experience talking to them. Using real-time voice conversion delivery software, the therapist can target the relationship between the person and their voice. The aim is to facilitate a dialogue in which the avatar progressively comes under the person’s control. The current study is an attempt to replicate the findings of the pilot study conducted by Leff et al (2013) in a much larger randomized clinical trial (n=150) comparing AVATAR therapy to an augmented Supportive Counselling approach in participants who have suffered from distressing voices for at least 12 months, despite treatment with adequate doses of medication. The primary outcome was total voice severity as assessed by the Psychotic Symptoms Rating Scale (PSYRATS-AH; Haddock et al., 1999) at 12-week follow-up. The talk
will present the research methods, data on recruitment, retention and safety, and therapy set up. Preliminary results of the trial will be reported along with additional analyses within the AVATAR therapy arm, exploring variables such as subjective perceptions of the avatar’s intentions and hostility, sense of presence and anxiety levels during the interaction.

**AVATAR therapy for distressing voices: Identifying mechanisms of change**

Miriam Fornells-Ambrojo, University College London

**Background:** AVATAR therapy is a novel intervention aiming to reduce persistent distressing voices by changing the relationship between the voice-hearer and a computerised representation of the persecutory voice. This interpersonal approach aims to support the voice-hearer to gain control over their distressing voice (Craig et al., 2015; Leff et al., 2013, 2014) in line with current understanding of auditory verbal hallucinations, in which beliefs about power, control and social inferiority influence relational responding, including reduced assertiveness towards a persecutor (Birchwood et al., 1993, 2004; Chadwick and Birchwood, 1994; Hayward, 2009; Paulik, 2012).

The current talk focusses on our investigation of the explanatory mechanisms of action. This trial will investigate three possible mediators of change in AVATAR therapy, namely, a reduction in beliefs about voice omnipotence and malevolence, an increased sense of power and assertiveness in the relationship with the voice, and a reduction of anxiety. SC benefits on total severity of auditory hallucinations were instead hypothesised to be mediated by therapeutic alliance. Modern causal inference methods will be used to analyse the above putative mediational factors (Emsley & Dunn, 2010). Parametric regression models will adjust for baseline measures of mediators, outcomes, and possible measured confounders.

This talk will discuss preliminary findings from the mediational analysis and discuss these in relation to existing interventions for verbal auditory hallucinations and current theoretical models.

**Characterising voices: a phenomenological investigation with implications for relational therapies**

Rachel Lister, Institute of Psychiatry, King’s College London

**Background:** Many voice hearers develop “coherent relationships with their voices” (Benjamin, 1989) with voice content often containing “the same dialogical structures one finds in ordinary speech” (Leudar, 1997). Previous research suggests a link between the personification or characterisation of the voice and the way in which hearers engage with this experienced social agent (Hayward, 2003; Woods et al., 2015; Deamer and Wilkinson, 2015).

**Method:** We conducted a phenomenological analysis of a comprehensive baseline assessment of the voice (n=60: AVATAR therapy arm only), using a coding frame developed for the current study. We then explored potential relationships between voice phenomenology, the ways in which the person related to the voices, and affect. We were particularly interested in understanding the possible impact of characterisation on engagement with the voice, both in daily life and during direct dialogue with the avatar.

**Results:** Participants experiencing commands to harm themselves were significantly more anxious, but not more depressed than individuals not experiencing this content. Voice content involving negative evaluations was associated with lower self-esteem. Participants with highly characterised voices reported greater engagement with voices in daily life. Importantly there was also evidence that these individuals showed higher levels of engagement with the avatar during therapy.

**Conclusion:** The study replicates earlier work on voice-phenomenology and suggests associations between phenomenological aspects of the voice-hearing experience, the way in which voice hearers relate with their voices, and affect. The novel findings related to voice characterisation and engagement may have important clinical implications for a new wave of relational therapies.

**An analysis of the key relational and interpersonal processes observed during AVATAR**
**therapy dialogue**

**Conan O’Brien, University College London**

AVATAR therapy involves a three way dialogue involving the therapist, the voice-hearer and the avatar, with the therapist supporting the hearer to relate to the avatar from a position of increased power and control. The present study aims to investigate key interpersonal behaviours observed over the course of AVATAR therapy. Twenty-five participants who completed AVATAR therapy were randomly selected and therapy sessions 1, 4 and last (typically session 6) were transcribed. A coding framework was developed drawing on relevant theory and literature, as well as clinical expertise from AVATAR therapists. The coding unit was defined as each vocal interchange between participant and/or AVATAR and/or therapist. Single factor repeated measures ANOVA were conducted to assess change over the sessions. Data will be presented, illustrating how interpersonal behaviours of the voice-hearer, therapist and avatar develop over the course of therapy. The study provides an insight into how AVATAR therapy may help voice hearers find more helpful ways of relating to distressing voices. Exploratory analyses investigating the associations between participant relating behaviours and subtypes of trauma, beliefs about voices and current social support will also be discussed.

**AVATAR therapy in action**

**Thomas Ward, Institute of Psychiatry, King’s College London**

AVATAR therapy is part of a new and exciting wave of therapies which adopt an explicitly relational approach to working with distressing voices. At the start of therapy, the voice-hearer creates an avatar, ‘embodying’ the voice with a digital face and voice. The person then dialogues directly with the avatar, voiced by the therapist (in a separate room) talking through a modified voice filter. The therapy offers the person the opportunity to stand up to their voice and develop a sense of power and control over these experiences. During this talk I will show-case the delivery of AVATAR therapy in the current randomised trial. The talk will include audio clips of live therapy providing an insight into avatar dialogue and highlighting therapeutic strategies. Key treatment targets include cognitive, affective and relational processes and I will discuss how work on self-esteem and compassion can be integrated alongside the focus on power, control and assertiveness. The AVATAR approach will be discussed in the context of clinical and theoretical developments in the treatment of distressing voices.

**Engaging with the communicative aspect of voice hearing (a linguistics perspective)**

**Felicity Deamer, Durham University**

There has been a recent shift in explanatory focus away from the auditory properties of voice hearing and onto the agentive aspect of the experience (that voices are often experienced as coming from an agent). Wilkinson and Bell (2014) draw attention to the fact that the tracking of specific agents plays a fundamental role in human cognition, which goes some way towards explaining why so many auditory verbal hallucinations are experienced as coming from particular re-identifiable agents. Although this promising approach brings to the fore the overlooked agentive aspect of voice hearing, it fails to explain why agency is often only sparsely represented, and why when agency is represented, it typically only manifests itself in a specific and narrow sense, as a malevolent “speaker behind the voice”. I want to go a step further in suggesting that the explanatory focus should in fact be on the communicative aspect of voice hearing; namely, the experience of (in the case of distressing voices) being harassed, abused, or generally berated by a communicative agent who “has it in for you”. By focusing on the communicative aspect of voice hearing, it becomes clear (a) how the auditory and agentive properties are necessary parts of the experience (a voice can’t mean anything or have any impact on the recipient unless it is the voice of an agent with communicative intentions), (b) what makes many voice hearing experiences so distressing (it is not the auditory properties or the agentive properties by themselves, it is the malevolent intentions of the represented agent that the voice conveys), and (c) why relational therapies, such as Avatar Therapy, are potentially so effective. Avatar Therapy
encourages voice hearers to view their voices as coming from intentional agents whose behavior is (to a certain extent) dependent on how the voice hearer perceives and carries themselves. The therapy makes the malevolent intentions of the voice the primary focus by facilitating and encouraging a communicative exchange between the voice hearer and their voice (voiced by the therapist). The aim of the dialogue is to change the participant's interpretation of and relationship to their voice, in the hope of lessening the negative impact that the voice has on them. The therapy encourages the participant to be more assertive and to have higher self-esteem, which positively impacts on the dynamic between the participant and their voice, thereby significantly lowering levels of distress.

Understanding psychosis and related phenomena

What makes Black groups in the UK 'hard-to-reach'? Examining potential predictors of engagement with mental health services in Black African and Caribbean people with psychosis

Amy Degnan, The University of Manchester; Katherine Berry, The University of Manchester; Dawn Edge, The University of Manchester; Kathryn Abel, The University of Manchester; Nick Crossley, The University of Manchester; Lucy Shattock, The University of Manchester

Black African and Caribbean people experience higher rates of psychosis and the greatest inequalities in mental healthcare when compared to all other ethnic groups in the UK. Often referred to as 'hard-to-reach', their engagement with services is disproportionately poor and characterised by fear, mistrust and avoidance; contributing to delayed access and worse outcomes. Ethnic variations in response to mental health problems are thought to be a result of interacting social and cultural factors located within particular social contexts or networks of social ties; including self-stigma, racial/ethnic discrimination, explanatory models and perceptions of illness and treatment. This is first and largest empirical study to examine relationships between social networks, illness beliefs, stigma and discrimination and their association with service engagement in Black people with psychosis.

Using a cross-sectional design, 51 Black African and Caribbean service users with psychosis were recruited from three NHS Trusts in Manchester. Participants completed a range of measures at one time point: social network mapping interviews, standardised interviews on psychosis symptoms, and validated questionnaires on illness beliefs, internalised stigma and ethnic/racial discrimination.

Correlational analyses of associations between variables will be presented followed by regression analyses to develop a model of predictors of service engagement in this group. Findings and implications will be discussed in relation to clinical practice and interventions to improve engagement with mental health services among Black minority groups. Potential components include addressing discrimination and culturally shaped beliefs/explanatory models in assessment and formulation, enhancing personal control and highlighting the benefits of treatment.

Training in 'cultural competency/awareness' and addressing cultural issues in clinical practice is essential given the changing political and cultural context in the UK. There are ethnic inequalities in engagement with services and access to psychological therapies but limited research examining how to address these disparities and cultural issues in everyday clinical practice. This study is therefore both novel and timely.

Cognitive Attachment model of Voices (CAV): how attachment theory and dissociation can develop understanding of distressing voices

Sandra Bucci, University of Manchester; Katherine Berry, University of Manchester

Recent meta-analyses have established robust associations between hearing voices and exposure to interpersonal trauma. The identification of mediating psychological mechanisms for this robust relationship is fundamental to the theoretical understanding of voice-hearing, and the development of treatments for distressing voices. Both dissociative and attachment processes have been identified as promising mechanisms that may help to explain vulnerability to voices; trauma has been shown to play a causal role in the development of
distressing psychotic experiences. This paper provides a theoretical model of the relationship between trauma, attachment, dissociation and voice-hearing: the Cognitive Attachment model of Voices (CAV).

The presentation will focus on presenting the CAV model and reviewing evidence from empirical studies including those by our own research group supporting relationships between different factors within the model.

Disorganised attachment patterns may influence vulnerability to voices, but adult attachment styles may also influence beliefs and relationships that voice-hearers can develop with voices. Dissociation appears to play a key role in explaining the relationship between trauma and distressing voice-hearing.

Findings will be discussed in the context of the proposed theoretical model of the relationship between trauma, attachment (in particular disorganised attachment), dissociation and vulnerability to voices. The future research and clinical implications of the model will be highlighted.

Trauma should be routinely assessed in the context of psychosis. Voice-hearing may be conceptualised as dissociated aspects of self in the context of childhood interpersonal trauma. Psychological formulations should include attachment processes, which, in turn, might shape intervention strategies in CBT for psychosis.

**Barriers and facilitators to ’moving on’ from Early Intervention in Psychosis Services**

Sarah Woodward, University of Manchester; Sandra Bucci, University of Manchester; Dawn Edge, University of Manchester; Katherine Berry, University of Manchester

Early intervention in psychosis teams (EITs) offer support to people experiencing a first episode of psychosis. The National Institute for Clinical Excellence (NICE, 2015) state that all people experiencing a first episode of psychosis should be offered a minimum of 16 sessions of manualised CBT for psychosis. Following treatment by an EIT a service user will either be transferred back to the care of their general practitioner, or be referred for ongoing support in secondary care services (usually a Community Mental Health Team, CMHT).

Research in other areas of service transitions have found that this can often be a difficult and challenging time for service users, and significant barriers appear to exist in achieving an optimal transition between care services (e.g. Singh et al, 2010, While et al, 2004). Barriers to transition from EIT to other services could have a significant impact on the wider service structure, including the ability of EITs to offer NICE concordant care. However, little research exists which examines the discharge process from EITs. Our study aimed to examine EIT staff members’ views of the discharge process, with particular emphasis on the barriers and facilitators they encountered.

Eighteen EIT staff members, representing management, social work, mental health nursing and psychiatry, took part in a semi-structured interview about their experiences. Interviews were transcribed and subject to Thematic Analysis following the guidelines laid out by Braun and Clarke (2006).

Four themes were identified: 1) ‘nowhere to go’: illustrated how service users remained in EIPS because other teams lacked capacity to take them; 2) ‘collaboration between agencies’ highlights the challenges of working across boundaries; 3) ‘therapeutic relationships’: reflects the loss service users and staff experienced at discharge; 4) ‘advanced planning’ relates to the necessity for advanced planning and service user empowerment to facilitate the discharge process.

Staff members described significant barriers to the discharge process. The theme ‘Nowhere to go’ described how service users would wait, in some cases for several years, for the opportunity to move on from the EIT. This increased the caseloads of those working in EIT, thereby reducing their ability to offer NICE concordant care and reducing the availability of service resources such as access to a CBT therapist. Greater collaboration between services led to an easier discharge process. Staff described how their therapeutic relationship was essential to good care, but led to feelings of loss at discharge. This is consistent with previous research regarding service transitions, which suggested the therapeutic relationship has an important impact on the experiences of transition (e.g. Catty et al, 2012).
This is the first in-depth exploration of EIT staff views on discharge processes. To ensure seamless transitions throughout care pathways, services need better inter-agency collaboration and more adequate preparation for transition. Increasing caseloads within EIT, caused by delays to the discharge process, mean that resources for CBT for Psychosis are limited. This means that service users may not be able to access therapy in line with the NICE guidance. Service users and staff experience a sense of loss at the ending of the therapeutic relationship. Therapists have a potential role in preparing both staff and service users for this ending, and providing training and supervision to other staff members regarding managing transitions.

Can cognitive-affective mechanisms explain the link between sleep quality and paranoia?

Jack Barton, University of Manchester; Filippo Varese, University of Manchester; Steven Jones, University of Lancaster; Simon Kyle, University of Oxford; Gillian Haddock, University of Manchester

Background: The current correlational and experimental data suggest that poor sleep, insomnia, and parasomnias are associated with experiences such as paranoia, hallucinations, and delusional experiences (Sheaves et al., 2016). However, it is uncertain how sleep disturbances increase the risk for psychotic-like experiences. Previous studies have identified negative affect as a partial explanation for the link but it rarely explains all of the variance between sleep disturbance and paranoia (Freeman et al., 2011; Mulligan et al., 2016). This suggests that poor sleep may predispose or exacerbate psychotic-like experiences through other mechanisms alongside negative affect. One hypothesis is that sleep disturbances influence proposed cognitive-affective mechanisms of psychosis and psychotic-like experiences (Freeman et al., 2003; 2007). In current cognitive models of psychosis (Freeman et al., 2007; Freeman, 2016), sleep is identified as an environmental stressor, and cognitive mechanisms such as jumping to conclusions (JTC) and emotion dysfunction lead to the threat belief. JTC is a data-gathering style characterised by reduced data gathering before making a decision and is argued to be characteristic of delusions and delusion proneness. However, despite a link between sleep disturbance and paranoia, no previous studies have explored whether the association between sleep and paranoia is mediated by these cognitive-affective mechanisms. Furthermore, the paucity of longitudinal studies (Freeman et al., 2011; Sheaves et al., 2016b) within non-clinical populations makes it hard to address issues of causal ordering. Therefore, the present study aimed to examine whether threat anticipation, emotion regulation and jumping to conclusions were significant mediators of an association between sleep and paranoid ideation. This study also examined whether sleep at baseline was predictive of paranoid ideation, and each of the purported cognitive-affect mechanisms highlighted, at a three-month follow-up.

Methods: An online study via SelectSurvey.NET asked participants questions on sleep quality (sleep condition indicator; Espie et al., 2014), paranoia (Green Paranoid Thought Scale; Green et al., 2008), hallucinations (Launay-Slade Hallucinations Scale-revised; Bentall & Slade, 1985a), negative affect (Depression Anxiety Stress Scales-21; Anthony et al., 1998), emotion regulation (Difficulties in Emotion Regulation Scales; Gratz & Roemer, 2004), threat anticipation (Bentall et al., 2009) and chronotype (Morning-Eveningness Questionnaire; Horne, 1976). Participants were also asked to complete an online 40:60 version of the JTC task whereby the aim was to draw beads randomly from one of two jars. The participants’ job was to determine which jar the beads were drawn out of. The order of the beads was set and participants had to decide between a ‘mostly red’ (60 red: 40 blue) or ‘mostly blue’ (60 blue: 40 red) jar. Participants were then followed up after three months and asked to complete the same questions and 40:60 JTC task online. Analysis was carried out using multiple mediation analysis through bootstrapping with bias-correct confidence intervals (Preacher and Hayes, 2008).

Results: The preliminary results of the cross-sectional and longitudinal component of this study shall be presented.
These can be discussed and considered in line of current cognitive-affective models of psychotic-like experiences.

Implications for CBT for insomnia and early intervention for psychosis.

**Two-Session Cognitive Bias Modification Training; Exercise Interpretation Bias**  
**Charlotte Clarke, University of Essex; Bundy Mackintosh, University of Essex; Nicholas Cooper, University of Essex**

Cognitive Bias Modification is the direct manipulation of a target bias by extended exposure to task contingencies that advocate predetermined patterns of processing selectivity (MacLeod and Mathews 2012). There has recently been a surge in interest in research methodologies employing these cognitive bias modification techniques. Such research has been mostly focused on two key areas of cognitive bias; interpretation bias modification (CBM-I), and attention bias modification (ABM) (MacLeod and Mathews 2012). There are fundamental biases that affect anxiety and depression, specifically negative cognitive interpretation biases; this is a tendency to evaluate an ambiguous situation in an aversive manner making it negative with anxiety (Butler & Mathews, 1983; Gortner, Rude, & Pennebaker, 2006; Rude, Wenzlaff, Gibbs, Vane, & Whitney, 2002). There is vast interest in the current literature to modify these cognitive biases to minimize the symptoms of depression and anxiety which could be applied to a clinical setting to improve mental health of the population respectively (Hertel & Mathews, 2011; Colin MacLeod & Mathews, 2012; H. L. Smith, Summers, Dillon, Macatee, & Cougle, 2016).

Cognitive theories suggest that negative cognitive biases; the tendency to preferentially encode negatively oriented information, are key to the onset and maintenance of anxiety and depression (Aaron T. Beck, 2008; A T Beck & Rector, 2005; Clark & Beck, 2010; Mathews & MacLeod, 2005; Rapee & Heimberg, 1997). Such theories suggest that these cognitive biases increase the variety, frequency, and intensity of these negative thoughts and processes, which in turn negatively impacts emotion and relative anxiety and depressive symptoms (Clark & Beck, 2010; Everaert, Koster, & Derakshan, 2012; Hallion & Ruscio, 2011).

Previous research has also found that increased perceived psychological stress correlates with depression (Hammen, 2005; Mazure, 1998; Salmon, 2001).

In a study by Kajtna, Stukovnik and Groselj (2011) investigated the effect of mood states on experienced levels of stress. They found no significant correlation between high experienced levels of stress and negative mood-states. This suggests that the physiological effect of stress has no effect on negative emotions and perhaps no effect on cognitive biases. This suggests support for the concept that mood enhancement; of which elicited form exercise will not improve emotions or furthermore cognitive biases, however it has not yet been investigate the role of cognitive bias modification that is focused on exercise. Previous research supports the role of social anxiety focused CBM-I training for reducing symptoms of social anxiety. Therefore as exercise is frequently named as reducing negative cognitive bias (Barnes et al., 2010; Tian & Smith, 2011) and ameliorating stress (Salmon, 2001; Yeung, 1996), one can propose that CBM-I training that is focused on reducing exercise anxiety, will effectively ameliorate anxiety and depression by reducing negative cognitive bias.

**Hypothesis One:** Participants in the CBM-I positive training program will show a decrease on anxiety, stress and depression measures after session one of training and then again following the second training. Participants in the control neutral CBM training will not show a decline, or not show as great a decrease as the CBM-I.

**Hypothesis Two:** Participants in the CBM-I positive training will show a decrease in negative cognitive interpretation biases (SST) when cognitively loaded, and in the non-cognitively loaded task. Participants in the PG will show no difference between sessions, or a difference between cognitively non-loaded SST tasks but not the loaded, before and after the training. Forty-eight participants were recruited from a general population over a period of four weeks, to participate in a two-part study. Participants had a mean age of 27.5 years, Forty-eight participants; 60% female, 40% male. Participants were required to attend two sessions. Participants completed the State-Trait Anxiety Inventory (STAI); (Speilberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983)), revised Beck Depression Inventory (BDI-II; (A. T. Beck, Steer, & Brown, 1996), and the Perceived Stress Scale (PSS; (Cohen, Kamarck, &
Mermelstein, 1983), the scrambled sentences test (SST; (Rude et al., 2002; Wenzlaff, 1993)) before and after the CBM-I positive and Neutral CBM training programme in both session one and session two.

Independent measures design; the independent variable is experimental group; CBM-I Training and PG (control group). The Dependent variables for the questionnaires are Time, session 1, (baseline, 1.0 and post-training, 1.5) and session 2 (pre-, 2.0, and post-training, 2.5). The Dependent variables for the SST were Time (baseline session 1, and after CBM-I/PG Training session 2), cognitively Loaded, and SST Non Loaded.

This study aimed to investigate the effect of two-session CBM-I training in comparison to neutral PG on cognitive interpretation biases, anxiety, perceived stress and depression. The results suggest that CBM-I training significantly decreases trait anxiety. Cognitive load during the SST had an interesting effect on interpretation biases. It was found that participants in the CBM-I training group, presented a greater decrease in negative interpretation biases when the SST was cognitively loaded than non-loaded, relative to the reverse effect when they had PG. There was a depression and state anxiety measures by Time, although the Group effect was not significant. There was no significant decrease of perceived stress either by Time, and Group effect was nearly significant.

One would expect CBM-I training to decrease depressive symptoms as depression in particular is characterized by a sense of hopelessness and an inability to generate positive images, whilst CBM-I forces a positive visualization, which aids the individual into interpreting ambiguous scenarios in a positive manner (MacLeod & Mathews, 2012). There is growing support for the effectiveness of CBM-I; but research is adamant that visualization of positive imagery is important for its effectiveness in adapting individuals cognitive interpretation biases (Mackintosh et al, 2013), however no Group effect support for the role of interpretation biases in depression was found in this study.

From the results found, one can suggest that CBM-I Training effectively trains individuals to interpret scenarios in a more positive manner and this positively influences mental state; in turn decreasing trait anxiety. Future research would benefit from the development of CBM paradigms that incorporate both attentional and interpretational cognitive biases; that investigate positive, neutral and negative biases; no research as of yet has investigated all of these. This would be most efficiently conducted using visual/pictorial stimuli for the attentional bias task, because attentional biases primarily focus on an immediate stimuli, that are universal in all cultures. Whilst interpretational cognitive biases should be measured with comprehension tasks, because they are more complex and require cognitive effort, yet must still be a fairly automatic response to still be a genuine instantaneous cognitive bias.

Furthermore, the results provide support for the specificity effect of CBM-I training (Mackintosh et al., 2013). That being, the results suggest that exercise focused CBM-I training, effects individuals interpretation biases in a similar way to physical exercise, therefore reducing negative bias and improving mood state. This is turn reduced trait anxiety. Following on from this one can suggest that future research focuses appreciates the effectiveness of exercise focused CBM-I training within the CBM framework.

Anxiety disorders are reported to be the most common mental health issue in the developing world (Merom, Phongsavan et al. 2008), furthermore being of higher risk to also developing co-morbid conditions such as, depression, substance use issues, and cardiovascular issues (Bartley, Hay et al. 2013), leading to more frequent healthcare visits, which is arguably putting additional pressures on our National Health Service (Vogelzangs, Seldenrijk et al. 2010). Therefore if we can find more effective or easily implemented and accessible therapeutic treatments this is advantageous.

Motivation and Affect Regulation in Mental Health

Understanding subclinical anxiety, depression and hypomania from a transdiagnostic motivational perspective
Joanne Dickson, Edith Cowan University; Sheri Johnson, University of California, Berkeley; Christopher Huntley, University of Liverpool; Andrew Peckham, University of California, Berkeley; Peter Taylor, University of Manchester

Dysregulated motivational processes have been implicated in the maintenance of affective disorders. This research investigates key facets of motivation and goal regulation concurrently in relation to affective symptoms. The presentation is based on a study using a university student sample recruited from the US (n= 280) and the UK (n = 231). Participants completed self-report measures of motivation, conditional goal setting (CGS), urgency, depression, anxiety and mania risk.

Behaviour activation, behaviour inhibition, CGS, and urgency results revealed shared and distinct patterns of relationships with depression, anxiety and mania risk. Notably, the findings indicate unique and common risk vulnerabilities in depressive, anxious and manic syndromes and extend an understanding of these syndromes from a transdiagnostic motivational perspective. Potential clinical implications are discussed.

Impulsivity and self-harm: It doesn’t do what it says on the tin
Peter Taylor, University of Manchester; Jody Rawlings, University of Exeter; Shannon Dandy, University of Liverpool; Joanne M. Dickson, Edith Cowan University; Richard Morriss, University of Nottingham; Mark Shevlin, University of Ulster

Trait impulsivity, especially urgency (the tendency to respond to emotions with rash behaviour) appears to be an important predictor of self-harm risk. It has been suggested that impulsivity increases the likelihood of unplanned or “impulsive” acts of self-harm, and that it may explain the transition from ideation about self-harm to behaviour. I present data from two online cross-sectional studies that tests these hypotheses (n = 219 and n = 1350). These data suggest that whilst trait impulsivity and urgency in particular is associated with self-harm it does not distinguish planned and unplanned acts of self-harm, and does not explain the transition from self-harm Ideation to behaviour. Urgency may increase exposure to distressing life events and so increase the likelihood that someone thinks about self-harm, rather than driving the behaviour directly.

Assessing emotional reactivity and its association with emotion regulation
Rodrigo Becerra, Edith Cowan University; Rodrigo Becerra, Edith Cowan University; David Preece, Edith Cowan University

Based on findings from the field of affective neuroscience, we suggest emotional reactivity (ER) includes a number of related, but separable, stages, i.e., activation, intensity, and duration. Given the lack of assessment tools measuring ER using this specific model and assessing both ER to positive and negative stimuli, we created the Perth Emotional Reactivity Scale (PERS). We present findings from a study examining the psychometric properties of the PERS in an adult community sample (N = 183). Confirmatory and exploratory factor analyses supported the capacity of the PERS to measure ER in the three dimensions as well as distinguishing between positive and negative ER. We also report the findings from a different study (N=300) that explored the relationship between ER (as assessed by the PERS) and emotions regulation abilities (as assessed by the Difficulties in Emotion Regulation Scale).

Beliefs about automatic mood regulation: Links to psychopathology
Alyson Dodd, University of Northumbria; Alyson Dodd, University of Northumbria; June Gruber, University of Boulder, Colorado; Kirsten Gilbert, Washington University, St Louis

Dual-process approaches have recognised that emotion regulation (ER) can be effortful or automatic. Psychopathology research has typically focused on the negative ER. However, ineffective regulation of positive emotion is detrimental for well-being and evident in psychopathology, particularly mania. This study developed a measure of beliefs about the automation regulation of positive emotions. In university students (n = 232), beliefs about the automaticity and transience of positive and negative mood states were positively associated with one another. Beliefs about the automaticity of positive and negative mood regulation were both negatively associated with engagement in effortful ER strategies.
(dampening positive affect; rumination and risk-taking in response to depression), depression, anxiety, and mania risk. Beliefs about automatic mood regulation for positive emotions appeared to be more relevant for ineffective positive affect regulation and hypomania. Overall, findings suggest that believing moods will come and go on their own with little effort required are adaptive processes, regardless of emotion valence.

**Imagery and metaphors**

**Functional Imagery Training: RCT of a new motivational intervention for weight loss**  
**Linda Solbrig, University of Plymouth;** David Kavanagh, Centre for Children's Health Research; Jon May, School of Psychology, University of Plymouth; Tracey Parkin, School of Health Professions, University of Plymouth; Ray Jones, School of Nursing and Midwifery, University of Plymouth; Jackie Andrade, School of Psychology, University of Plymouth  

**Functional Imagery Training (FIT)** is a new intervention for behaviour change in which motivational interviewing (MI) is delivered as a series of mental imagery exercises. Based on the Elaborated Intrusion theory of desire (Kavanagh, Andrade & May, 2005), FIT builds motivation and confidence by training clients to create and rehearse emotionally-charged mental images about their personal goal and how they will achieve it. To make healthy goals more vivid, realistic and concrete, participants are repeatedly encouraged to imagine the benefits of working towards, focusing most on those benefits that will happen right away. We report the results of an RCT comparing FIT and MI for weight management.

Advertisements for adults with a BMI ≥ 25 were placed in local media. Pregnancy was the only exclusion criterion. Weight (kg) and waist circumference (cm) were measured at baseline, 6m and 12m. Data on diet, physical activity, and quality of life were collected at baseline and 6m using the International Physical Activity Questionnaire (IPAQ), the Food Frequency Questionnaire (FFQ), and Global Quality of Life Scale (GQoLS). After baseline assessment, participants were randomised to receive FIT or MI, matched for contact time. Both interventions were delivered via an individual, face-to-face interview lasting 1h, followed by a 30-45 min phone call in week 1. Participants received a 10-15 min booster call every 2 weeks for 4 months, and then one call each month for the next 2 months. They also had the option of support via a dedicated Goal in Mind app. No support was provided between the 6m and 12m assessments.

A total of 121 were randomised, of whom 115 completed the 6m assessment. Intention to treat analysis assumed no weight change for the 6 non-completers. Mean baseline weight was similar at baseline (MI mean = 89.1kg, SD = 14.8; FIT mean = 90.4kg, SD = 15.9) and was lower in both groups at 6m (MI mean = 87.9kg, SD = 15.5; FIT mean = 85.7kg, SD = 14.8). Weight loss was higher for the FIT group than the MI group, F(1,119) = 33.71, p < 001, d = 0.95). Waist circumference showed similar results, with the FIT group losing a mean of 7.2cm in 6m compared with a mean loss of 3.1cm for the MI group (d = 0.83). In the FIT group, 33 of 63 (52.4%) participants lost a clinically significant 5% of body weight, compared with only 1 of 58 (1.7%) in the MI group. Complete FFQ, IPAQ and GQoLS data, and 12m weight and waist data, will be available by July. Initial qualitative data show that FIT participants liked the focus on positive imagery, the audio guided imagery exercises on the app, and that they felt empowered to choose their own lifestyle changes rather than follow a fixed diet.

These results strongly support the promise of FIT for supporting sustained behaviour change in the context of weight loss. FIT, but not MI, produced clinically significant weight loss in half the sample with a maximum of only 6.5 hours of treatment over 6m. FIT was well accepted by participants.

FIT could be easily and effectively integrated into CBT for a range of disorders where motivational support can help engage clients in treatment and help them develop and maintain functional behaviours.

**Virtuoso CBT: Attending to client metaphors to enhance conceptualisation**
Metaphoric language is a rich source of meaning. Attention to client metaphoric language has been asserted as a way of becoming a ‘virtuoso’ CBT therapist (Newman, 2015). Other CBT experts advocate the bringing of client metaphors into case conceptualisations (Butler, Fennell and Hackmann, 2008; Kuyken, Padesky and Dudley, 2009), but with little empirical basis. This study examined the effect of training experienced therapists to consciously attend to client metaphoric language and bring them into shared conceptualisations. We also examined whether working metaphorically suits some clients and therapists more than others.

Twelve experienced CBT therapists attended two half-day workshops in which they were trained to enhance CBT conceptualisations through attending to and developing central client metaphors for their experience and incorporate these into shared conceptualisations. The effect of the training was assessed by video recorded pre and post training roleplays. These were assessed by roleplay ‘clients’ on the Session Rating Scale (an alliance measure) (Duncan et al, 2003) and the Working Alliance Inventory- short form (another alliance measure) (Tracey and Kokotovic, 1989). Recordings of the sessions were assessed by an external rater (who was blind as to whether recordings were pre or post training) on the Collaborative Case Conceptualisation Rating Scale (Padesky, Kuyken and Dudley, 2011) and the revised Cognitive Therapy Scale (Blackburn et al, 2001). Therapists and clients all completed the Language Preference Report, a measure of preference for metaphoric language (Yarbrough, 1991).

There were significant improvements in both client and external ratings of alliance post-training. Therapist and client Language Preference Report scores were compared to alliance ratings, providing some pointers regarding therapist and client suitability for working in this way. An example will be provided of a therapist and client developing a shared metaphor during conceptualisation.

This study provides preliminary empirical support for the use of client metaphoric language in case conceptualisations as a way of enhancing alliance. While further research is needed, metaphoric language may prove to be an important process variable in CBT. Masterful use of metaphor has potential to enhance engagement of therapists and clients alike. If therapists are attuned to client metaphors and bring them into case conceptualisations, this may have benefits for the therapeutic alliance.

Does the internal "anorexic voice" play a role in anorexia nervosa?
Matthew Pugh, Central and North West London NHS Foundation Trust

An internal "anorexic voice" is often described by individuals with anorexia nervosa (Higbed & Fox, 2010). This voice is typically experienced as a second or third person commentary related to the individuals shape, weight and eating, and its implications for self-worth. Whilst research suggests that the voice may play a role in the maintenance eating pathology (Pugh & Waller, 2016; Tierney & Fox, 2010), the nature of this association remains unclear. This quantitative study aimed to determine which features of the anorexic voice are related to key aspects of anorexia nervosa and whether individuals fall into natural groups associated with particular voice-related experiences.

Participants were 49 individuals with a diagnosis of anorexia nervosa. Each completed validated measures of eating pathology, appraisals of the anorexic voice (its nature and perceived power), and intrapersonal styles of responding to voice. Body mass index and self-reported duration of illness was also recorded.

Features of anorexia nervosa (unhealthy eating attitudes, low body mass index and longer durations of illness) were found to be related to appraisals of the anorexic voice and particular ways of responding to it. Participants also fell into two subgroups: those describing a ‘weaker’ anorexic voice and those with a ‘stronger’ anorexic voice. Those experiencing a stronger anorexic voice tended to suffer from more severe and enduring forms of illness.
The anorexic voice appears to play an important role in the psychopathology of anorexia nervosa, including negative attitudes towards food, the use of compensatory behaviours and lowered body mass index. Working with the anorexic voice may therefore be beneficial, particularly for those individuals with severe and enduring forms of anorexia nervosa. Future research in this area is warranted. Experiences of an internal anorexic voice are common in anorexia nervosa. Echoing the qualitative research to date, this study suggests that voice may contribute to the perpetuation of disordered eating. Clinicians are encouraged to consider the role of the anorexic voice in the formulation and treatment of severe and enduring anorexia nervosa.

An adapted imaginal exposure approach to traditional methods used within trauma-focused cognitive behavioural therapy trialled with a veteran population

Manveer Kaur, Combat Stress - The Veterans’ Mental Health Charity; Dominic Murphy, Combat Stress; King’s Centre for Military Health Research; Kirsten Smith, Oxford Centre for Anxiety Disorders and Trauma

Evidence-based treatments of post-traumatic stress disorder (PTSD) include trauma-focused cognitive behavioural therapy (TF-CBT; NICE, 2005). A central component of this approach is the imaginal reliving of intrusive memories (Ehlers & Clark, 2000; Grey et al. 2001). Associated distressing cognitions that emerge can then be modified (Ehlers & Clark, 2000), all of which aims to result in a more contextualized, organized and coherent memory of the trauma that is less prone to involuntary retrieval. Clinicians working within a TF-CBT framework may also draw upon Foa’s (2011) model of repeated exposure to stimuli to reduce emotional responding, through imaginal reliving. A recent study has suggested that it may be possible to facilitate reliving by encouraging allocentric (viewpoint-independent) processing (Smith et al. 2015). This is achieved by purposefully manipulating the viewpoint of the trauma memory in imagery (Brewin et al. 2010), a process by which the systems in the brain responsible for contextualizing a trauma memory and reducing emotionally salient intrusions are activated (King et al. 2002). This process aims to connect fragmented traumatic images with trauma cognitions and emotions in a spatially rich and temporally fluid memory. In this paper we discuss an adapted approach to support clients with fragmented trauma memories that has been designed to support allocentric spatial processing.

Recent data has suggested that TF-CBT can be beneficial for veterans (Murphy et al. 2015); however, as a client group research also suggests they have poorer outcomes than non-veterans (Bradley et al. 2005; Bisson et al. 2007). A recent study of the factors that predict treatment response in veterans reported that high levels of pre-treatment dissociation were associated with poorer post-treatment outcomes (D.Murphy & W. Bussutil, unpublished data). Therefore techniques that allow dissociation to be managed and help contextualize memories would be helpful.

The aim of this paper is to highlight useful adaptations to the imaginal reliving and prolonged exposure elements of interventions from cognitive and neurobiological models of trauma-focused therapy (Ehlers & Clark, 2000; Foa, 2011), to support greater toleration of dissociation and processing of the trauma memories. This approach can be a helpful adjunct to facilitate cognitive reappraisal strategies such as imagery rescripting (Hackmann, 2011) and compassion-focused approaches (Gilbert, 2010) which are currently well used within specialist traumatic stress services. This approach aims to be useful where clients have struggled with traditional methods of accessing cognitions, imaginal reliving and grounding techniques in the therapy room alone, and for those who find contextualization of a fragmented image challenging.

This paper seeks to extend the evidence base by describing two cases in which clients
were encouraged to describe their traumatic experiences outdoors to manage dissociation levels, and to gradually build up a spatially dynamic cognitive map of the traumatic event that contained more allocentric frames of reference. Utility of this approach, theoretical underpinnings and further research will be discussed.

Two case studies are illustrated using the adapted treatment approach. In both cases Mr C and Mr P were veterans who had symptoms of PTSD stemming from traumatic events experienced during their military service. Both clients experienced difficulties in engaging with traditional methods of imaginal reliving and prolonged exposure, due to high levels of avoidance and low thresholds for dissociation, and subsequently had difficulties accessing their cognitions for updating. For both clients the prior use of multiple grounding methods in the therapy room were unsuccessful. They experienced their traumatic memories as fragmented images with a sense of ‘nowness’ (Birrer et al. 2007), which indicated a distinct lack of contextualization. Both clients were attending a 6-week residential programme for the treatment of PTSD, which involved attending psychoeducation and skill-based groups, alongside 15–18 sessions of individual TF-CBT.

An adaptive approach was then trialled to address these hindering factors. This involved three stages: (1) walking the client through the imaginal scene outdoors to address dissociation, (2) viewing the imaginal scene from multiple perspectives to facilitate contextualization of the memory and (3) identifying and reappraising the cognitions with frequently used approaches in trauma-focused therapy.

1) ‘Walking through the narrative’:
By reliving the imagined scene outdoors, this initial stage aimed to provide additional sensory grounding elements that were lacking in the clinic rooms. In doing so, we hoped to address the problem of clients easily dissociating while trying to discuss their trauma memories, and allow for access to their peri-traumatic cognitions. Second, we encouraged the clients to construct a 3D cognitive map of the spatial scene of the trauma, within which they could move around freely and focus on different elements. Conducting this outdoors as opposed to the clinic room allowed for multiple, sensory grounding elements, freedom of movement and space to create a rich construction of the scene.

2) ‘Manipulating the perspectives’:
The aim of this stage was to encourage the client to utilize the imaginal trauma scene, and begin to view it from different visual perspectives and angles, to facilitate allocentric processing. Through this kinetic exploration, we aimed for the scene to move on from a frozen image to a fluid 3D memory with more allocentric frames of reference, and increase the possibility of alternative cognitions to develop. Both clients continued to utilize the benefits of the sensory grounding elements outdoors while doing so.

3) ‘Restructuring the narrative’:
The latter stage of therapy involved utilizing the imagined 3D scene, visualized now from multiple perspectives, to more freely facilitate the use of memory updating (Ehlers & Clark, 2000), via imagery rescripting techniques (Hackmann, 2011), to contextualize and process the fragmented memory. Following the spatial perspective shifts in the imaginal traumatic scenes, both clients began to access alternative cognitions that they used to restructure the narrative, e.g. for Mr C by utilizing compassion-focused methods. As with the previous stages, they continued to do this outdoors and rescripted the imaginal scenes with newly developed verbalizations or actions.

Both Mr C and Mr P indicated positive outcomes post-treatment. They reported less anxiety and greater ability to focus on narrating their traumatic experiences while walking outdoors. Mr C attributed this to the benefits of the movement and the cool air temperature, while Mr
P similarly benefited from the increased sensory grounding opportunities by focusing on the noise of road traffic. Both were therefore able to overcome their dissociation symptoms and engage in prolonged exposure, with increased habituation over time.

In terms of their intrusive imagery, both clients reported benefits from manipulating the perspectives of the traumatic scene. Mr P was able to see traumatic images as moved on in time. Mr C continued to re-experience his traumatic image, but through readjusting the spatial properties and viewing the image from the past perspective, he was able to acknowledge and feel greater compassion towards his younger self, and in doing so his association with the traumatic image was improved.

From a clinician’s perspective, both clients were able to overcome the barriers of dissociation, the fragmented nature of their intrusive memories and to access the associated cognitions and update them with greater ease. This was achieved within the usual number of treatment sessions offered. Mr C and Mr P completed a number of outcome measures at the start and end of treatment. These included the PTSD Symptom Scale – Interview (PSS-I) for PTSD-specific symptoms. The maximum score on this measure is 51, with a cut-off score of 20 suggested as clinically significant for PTSD. We have found a 10-point reduction to be clinically significant (Murphy et al. 2015). The Work and Social Adjustment Scale (WSAS) was also used as a measure of wellbeing and quality of life, and the Dissociative Experiences Scale (DES) was included as a measure of dissociation.

In this paper we discussed an adapted approach to imaginal reliving and prolonged exposure, as utilized in TF-CBT, with two main aims. First, to address high levels of dissociation that can prevent clients with PTSD from engaging in exposure work. Second, to address fragmented intrusive imagery, by shifting from a static spatial image to a richer spatial representation that includes allocentric frames of reference. In addition, cognitive restructuring focused on ‘moving’ the fragmented image around in time to support the transition to a more processed spatially and temporally dynamic memory. The key differences between this approach and traditional approaches to TF-CBT appear to be (1) a greater focus on multiple sensory grounding while engaging in prolonged exposure outdoors, (2) development of an imaginal 3D image of the trauma, and (3) including information about the spatial relationships between objects from multiple viewpoints.

A contemporary neurobiological model of intrusive memories [Revised Dual Representation Theory; DRT-R (Brewin et al. 2010)] suggests that under conditions of extreme stress due to trauma, allocentric processing is impaired and PTSD arises from disrupted encoding of the context of the event, relative to spared affective/sensory representations of the traumatic content. In this view, hippocampally mediated allocentric spatial representations form an important part of the contextual representations that are disrupted in PTSD (Brewin et al. 2010). Brewin and colleagues (2010) suggest that the formation of vivid sensation based representations (S-Reps) without strong association to the corresponding contextual representations (C-Reps) allows S-Reps to intrude into the conscious in response to reminders.

This gives rise to re-experiencing PTSD symptoms such as nightmares and flashbacks in which the emotions that were present at the time of the trauma appear to be re-created with their original intensity.

Therefore, in the current study, by asking the clients to imagine the scene of the trauma from different viewpoints, with a particular focus on the changes in spatial relationships of objects within the scene, this allowed us to encourage allocentric processing and facilitation of contextualization. We hypothesize that this adapted approach may also have helped clients to better manage their dissociation by allowing them to focus on less emotionally laden aspects of the scene, while also maintaining
their presence within the imaginal reliving, and in doing so to be able to better tolerate their anxiety levels. However, to date we are not aware of any empirical data that supports this hypothesis.

Further systematic research is needed to determine the utility of this approach. A component analysis would elucidate which of the amendments to TF-CBT were effective or if it was a combination of both. Further investigation in populations with high levels of dissociation (e.g. survivors of torture and childhood trauma) would also be useful to determine the applicability of these amendments across client groups.

This paper can support clinicians in adapting traditional TF-CBT methods for veterans and potentially other client groups with PTSD who struggle with high levels of avoidance and dissociation. The key learning points are as follows:

1. Some clients with PTSD can face a number of difficulties when engaging with traditional approaches to imaginal reliving and prolonged exposure, utilized within the framework of TF-CBT. These include high levels of avoidance, dissociation and fixed 'viewpoint dependent' intrusive images.

2. In this paper we have found that adapting imaginal exposure methods to have a stronger emphasis on grounding and allocentric processing may be helpful for a subset of patients with PTSD that present with high levels of dissociation and are highly avoidant.

3. We acknowledge the limitations of a case study paper and suggest that further research is needed to compare this adapted approach with traditional approaches to TF-CBT.

Naturally occurring mental imagery and state emotional experience in dysphoria

Julie Lin Ji, MRC Cognition & Brain Sciences Unit, University of Cambridge; Fionnuala Murphy, MRC Cognition & Brain Sciences Unit, University of Cambridge; Colin MacLeod, University of Western Australia; Emily Holmes, Karolinska Institute, Stockholm

Mental imagery representations of emotional information can evoke powerful emotional responses, at times more so than verbal-linguistic processing of the same information (cf. Ji, Burnett Heyes, MacLeod, & Holmes, 2016). Biases in mental imagery-based cognition is postulated to play a role in the maintenance of emotional disturbance in depression (Holmes & Mathews, 2010; Holmes, Blackwell, Burnett Heyes, Renner, & Raes, 2016). However, it is currently unclear: a) whether dysphoria (mild to moderate depression) is associated with an elevated negative bias and/or reduced positive bias in naturally occurring emotional mental imagery generation; and if so, b) whether such biases contribute to dysphoria-linked differences in state emotional experience.

Two studies were conducted to investigate these questions. Dysphoric and non-dysphoric participants reported the occurrence of task unrelated mental imagery-based (and purely verbal-linguistic) cognition in real time during a novel mindwandering task. Participants also reported concurrent state emotion throughout the task. Mental imagery-based cognition (and verbal-linguistic cognition) occurred without instructions to generate mental representations of any kind during exposure to auditory verbal cues that were emotional (negative and positive) and unemotional (neutral).

Results indicate that dysphoria is associated with reduced positive bias in mental imagery generation under specific task environments. Importantly, evidence suggests the natural occurrence of positive mental imagery may be uniquely and positively associated with state positive mood elevation.

The present results for the first time provides evidence of a dysphoria-linked bias in the tendency to generate naturally occurring mental imagery-based cognition, and demonstrates a unique link between naturally occurring mental imagery-based cognition (relative to verbal-linguistic cognition) and mood elevation. The results provide support for the potential of positive mental imagery-based cognition to repair mood in dysphoria, and implications for future translational research in depression are discussed.

Promotion of positive, mental imagery-based cognition may facilitate boosting of positive emotional disposition in low mood individuals.
Mindfulness training increases increases hedonic processing in chronically depressed patients
Thorsten Barnhofer, Freie Universität Berlin, Germany; Maria Fisher, Freie Universität Berlin, Germany; Emilia Wimpebeck, Freie Universität Berlin, Germany; Matti Gärtner, Freie Universität Berlin, Germany

Reduced responsiveness to reward and appetitive stimuli is one of the hallmark features of depression. While mindfulness training has been introduced to the treatment of depression with a view to helping patients disengage from repetitive negative thinking, it has recently been suggested that it might also have significant effects on hedonic processing. Through broadening non-judgmental awareness, mindfulness may facilitate upward spirals of mood and processing. This talk will present data from a study in which we investigated effects of mindfulness training on attention to positively valenced stimuli. Chronically depressed patients were allocated to take part either in a brief mindfulness training or a resting control and performed a delayed response task in which they were presented with positive and negative words. EEG recordings during the task were used to assess P100, an early event-related potential that indexes attention to visual stimuli and has been found to be generally larger for unpleasant stimuli than pleasant stimuli. Analyses of changes from before to after treatment showed a significant time by treatment by valence interaction. Patients who had received mindfulness training showed significantly increased P1 to positive stimuli while there was no such change in the control group. There were no group differences in changes in P1 to negative stimuli. The findings indicate that mindfulness increases attention to appetitive stimuli and are in line with current theories suggesting that the training can have significant effects on hedonic processing.

Mindfulness-based cognitive therapy helps recurrent depressed individuals to access and activate the positive affiliative affect system when invited to direct compassion towards the self
Hans Kirschner, University of Exeter; Willem Kuyken, University of Oxford; Anke Karl, University of Exeter

The cultivation of self-compassion is increasingly recognised as being beneficial in improving mental health, positive emotions and wellbeing. Recent findings from our research group suggested that in healthy individuals the cultivation of self-compassion activates the positive affiliative affect system, a system characterised by a content and calm state of mind with a disposition for kindness, care, social connectedness and the ability to self-soothe when stressed. This was reflected in increased parasympathetic activity (indexed by increased heart rate variability) and decreased physiological arousal (indexed by decreased heart rate and skin conductance levels) as well as increased self-reported positive affiliative affect and self-compassion in response to the self-compassion induction. However, the activation of this positive affiliative affect system via the cultivation of self-compassion may rely on important individual differences in levels of self-criticism, insecure attachment, and history of childhood adversity and might be made more challenging when there is an underlying psychopathology such as recurrent depression. Evidence is accumulating that Mindfulness-based cognitive therapy (MBCT) increases levels of self-compassion in individuals with recurrent depression. This talk will present data from a study in which we investigated the effects of MBCT on psychophysiological responses to a self-compassion induction in remitted depressed individuals (N = 25) before and after the participation in MBCT as compared to a untreated control group (N = 25) tested at similar time intervals. The results of the study suggest that, compared to the untreated control group, MBCT might be particularly beneficial for individuals at risk of depression, because it helps them to develop skills to access and activate the positive affiliative affect system when invited to direct compassion towards the self. This was crucially reflected in an altered post-treatment...
physiological response pattern towards one similar to that of healthy individuals whereas the untreated control group showed signs of threat sensitisation. Clinical implications will be discussed.

**DBT-Informed Therapy for mood instability and problematic high mood within Bipolar Spectrum Disorder: An open feasibility trial**

**Kim Wright, Mood Disorders Centre, University of Exeter;** Mahmood Javaid, University of Exeter; Mohammad Mostazir, University of Exeter; Lyn Carew, Devon Partnership Trust; Joanna Mackenzie, University of Exeter; Peter Mason, University of Exeter; Tom Lynch, University of Southampton

A substantial proportion of people with Bipolar Spectrum Disorders experience ongoing, frequent fluctuations in mood across days and weeks (Bipolar Mood Instability: BPMI). This may be within the experience of Cyclothymic Disorder, or in addition to full episodes of depression or mania / hypomania in people with a diagnosis of Bipolar I or II Disorder. There is a clear need for effective interventions for BPMI. Despite appearing to be both relatively common and associated with significant distress and impairment, there are no established pharmacological strategies and no purpose-built, evidence-based psychological interventions for BPMI. To address this treatment gap we have developed a Dialectical Behaviour Therapy (DBT) informed approach, the ThrIVe-B programme. This has required adaptation of standard DBT techniques and concepts to address problematic high mood, a significant issue for those with BPMI but not a treatment target within standard DBT.

Here we report an initial evaluation of the ThrIVe-B programme. Twelve individuals with a diagnosis of Bipolar I Disorder, Bipolar II Disorder or Cyclothymic Disorder participated in a controlled feasibility study of the programme in two treatment cohorts (n=5, n= 7). Follow up assessments were completed at therapy mid-point, therapy end-point and 6 months post treatment. Retention rates within the therapy programme and clinical outcomes were encouraging. Interviews with participants and discussion with therapists indicated that the treatment is broadly feasible and acceptable, but recommended changes to the number and frequency of individual sessions, content and conduct of group sessions and study entry criteria. The findings will be discussed with particular reference to the potential of such an approach to aid regulation of problematic high mood.

**Development and case series evaluation of Augmented Depression Therapy (ADepT): A positive affect and wellbeing focused treatment for acute depression**

**Barney Dunn, Mood Disorders Centre, University of Exeter;** Emily Widnall, Mood Disorders Centre, University of Exeter; Nigel Reed, University of Exeter; John Campbell, University of Exeter; Willem Kuyken, University of Exeter; Rod Taylor, University of Exeter; David Richards, University of Exeter; Christabel Owens, University of Exeter

It is now increasingly argued that it is important to help clients regulate positive emotions in addition to negative emotions to effectively treat depression (see Dunn, 2012; Dunn & Roberts, 2016). This talk will outline the development and early stage evaluation of a novel psychological therapy for depression that aims to cultivate wellbeing and positive affect – Augmented Depression Therapy (ADepT). It will discuss how the intervention was developed via application of basic science findings and widespread stakeholder consultation, underpinned by the Intervention Mapping framework. A randomised multiple baseline case series preliminarily evaluating the outcomes of ADepT in terms of depression, positive affect, and wellbeing outcomes for depressed clients recruited from primary and secondary settings will be presented. Qualitative feedback from clients and therapists about the intervention will be discussed. The design and current state of progress of an ongoing feasibility randomised controlled trial comparing ADepT to IAPT high intensity CBT for the treatment of depression will be presented.

**What psychological processes should be targeted in the context of medically unexplained symptoms and long term condition**

**The competence framework for people with LTCs and 'MUS'**
Tony Roth, UCL
The competence framework for work with people with LTCs and 'MUS' was developed under the auspices of NHS Education for Scotland and the English IAPT programme. It is intended as a clinician support tool, indicating (but not prescribing) the range of competences that underpin work with this client group. Its development was guided by an Expert Reference Group comprising leading researchers and clinicians with expertise in this area, whose input ensured that (as far as possible) the framework is evidence-based, but also professionally-informed and applicable to everyday practice. The framework has application in the development of training curricula, and underpins the IAPT training agenda for work with people with LTCs and 'MUS'.
The framework identifies those areas where specific sets of competences can be deployed for specific conditions but is underpinned by generic competences, recognising that many individuals present with coexisting difficulties, and that there are important cross-cutting themes that characterise work in this area.
This presentation will provide a short introduction to the principles underpinning the development of the framework, its structure and content, and its application.

The role of high expectations of self and social desirability in emotional processing in individuals with Irritable Bowel Syndrome: A qualitative study
Alice Sibelli, Institute of Psychiatry, Psychology & Neuroscience (King's College London); Prof. Rona Moss-Morris, Institute of Psychiatry, Psychology and Neuroscience (King's College London); Prof. Trudie Chalder, Institute of Psychiatry, Psychology and Neuroscience (King's College London); Dr. Hazel Everitt, University of Southampton; Paul Workman, Institute of Psychiatry, Psychology and Neuroscience (King's College London); Dr. Felicity L. Bishop, University of Southampton;

Introduction
Although high levels of distress are associated with IBS, it is unclear how this relates to emotional processing, particularly in relation to maintenance of symptoms and treatment outcome. This qualitative study embedded within a randomised controlled trial aimed to explore how individuals with refractory IBS experience, express and manage their emotions after either therapist-delivered Cognitive Behavioural Therapy (TCBT) or web-based CBT (WBCBT) compared to Treatment as Usual (TAU).

Method
Fifty two semi-structured interviews were conducted at post-treatment with 17 TCBT, 17 WBCBT and 18 TAU participants. The transcripts were analysed using inductive thematic analysis with grounded theory elements. Functions in NVivo 10 were used to compare themes across groups.

Results
High expectations of self and social desirability were recurring reasons for how participants experienced and expressed their emotions to others. In all, three main themes captured how these high expectations influenced specific aspects of emotional processing: perceived causes of emotions, strategies for coping with emotions and the bidirectional relations between emotions and IBS symptoms.

Although participants mentioned the use of active coping strategies, many across all groups bottled up emotions and used emotional avoidance to cope with negative emotions. Bottling up was not perceived as an all-or-nothing strategy but was applied selectively depending on context. The theme around the two-way relationship between emotions and IBS symptoms helped to clarify how participants perceived the interactions between their emotional states and their physical symptoms. Anxiety and stress were described both as triggers and consequences of IBS symptoms while the rest of the reported negative emotions (frustration, low mood and embarrassment) were perceived mainly as consequences of symptoms. On the other hand, positive mood and happiness were labelled by participants as buffers of symptom severity. Moreover, participants also described positive and negative emotions unrelated to IBS, linked to other general aspects of their life. In turn, these general emotions were perceived to have either a positive or negative impact on IBS symptoms.
Specific differences amongst the three groups were identified. The CBT offered during the trial seemed to improve the participants’ understanding of emotional triggers. Furthermore, only participants from the CBT groups tended to describe their personalities as resilient when talking about problem solving emotions, and explained the analytical processes which allowed them to reframe a situation in the context of finding a new perspective.

Discussion
Despite these promising group differences, there was still a clear need to address unhelpful emotional coping strategies and deep seated high expectations of self in all groups. Future psychological interventions in IBS may benefit from addressing negative beliefs about expressing emotions, promoting assertive emotional expression, improving self-efficacy in terms of emotional coping and encouraging the experience of positive emotions.

Conclusion
Promoting the regulation of both positive and negative emotions may reduce the negative effects of psychological distress on IBS symptoms, increase the patients’ well-being in the short and long term and in turn improve physical outcome.

Mechanisms of Cognitive Behavioural Therapy Efficacy in Irritable Bowel Syndrome
Sula Windgassen, King’s College London

Cognitive Behavioural Therapy (CBT) is established as an effective treatment for reducing symptom severity and enhancing quality of life (QoL) in Irritable Bowel Syndrome (IBS). Recently research has begun to focus on investigating the psychological mechanisms by which the treatment may have effect. We conducted a systematic review to collate findings of mediation studies conducted in the context of psychological therapy for IBS. Nine studies met inclusion criteria, 8 of which were CBT based and 1 a mindfulness based stress reduction study. Typically studies included variables such as anxiety, gastrointestinal specific anxiety, cognitions and behaviours in analysis. Results suggested that cognitions were a key mediating factor of treatment, over general anxiety. Preliminary evidence also indicates that gastrointestinal specific anxiety and behaviours have mechanistic roles in treatment efficacy. It is concluded that psychological treatment in IBS should target IBS related cognitions and gastrointestinal specific anxiety rather than general anxiety.

Building on the results of the systematic review, mediation analysis was conducted using data from a study comparing the efficacy of CBT plus Mebeverine to Mebeverine alone. Mediation analysis was designed to address the hypothesis that general anxiety is no longer found to mediate treatment effect on the outcome of work and social adjustment, when cognitions are included in the mediation model.

Cognitive Behavioural Therapy focusing on beliefs and behaviours around emotional expression in participants with IBS: Single Case Experimental Design
Hannah Bowers, Royal Holloway University of London; Abigail Wroe, Royal Holloway University of London

Objective: Previous research suggests potential benefits of targeting beliefs about the unacceptability of emotions in treatment for persistent physical symptoms with uncertain aetiology. The current study developed and tested a targeted an intervention focusing on beliefs and behaviours around emotional expression for people with Irritable Bowel Syndrome (IBS).

Methods: Four participants with IBS took part in five group sessions that used cognitive behavioural therapy techniques to focus on beliefs and behaviours around expression of emotions. This included work on the relationships between emotions, beliefs and behaviours around emotions, and IBS symptoms as part of a possible maintaining cycle; consideration of consequences of beliefs and behaviours around emotional suppression; thought evaluation; goal setting; testing out making changes with regards to the expression of emotions; and maintaining helpful changes. Bi-weekly questionnaires were completed/administered and an interview conducted to evaluate the intervention.

Results: Participants showed decreases in beliefs about unacceptability of emotions and emotional suppression during the intervention. Furthermore, scores in affective distress,
and quality of life improved during the follow-up period. Qualitative data suggest that participants felt that the intervention was beneficial and well-received, with participants referencing the value in sharing their emotions specifically.

Conclusions: This study suggests the potential for beliefs about emotions and emotional suppression to be addressed in cognitive behavioural interventions in IBS. In particular, the order in which the measures improved (beliefs and behaviours preceding outcomes) suggests beliefs about emotions and emotional suppression may be important process variables to investigate in treatment for people with IBS. Future research should trial this intervention with a larger sample and control condition.

Low intensity interventions for children and young people with anxiety and/or depression

No abstracts submitted.

LGBT Mental Health in Young People and Adults: UK Research

Psychosocial factors associated with suicide attempts, ideation and future risk in lesbian, gay and bisexual youth: The Youth Chances Study
Sandhya Shivakumar, King’s College London; Katharine A. Rimes King’s College London;
Elizabeth West, University of Greenwich; Greg Ussher, Metro Charity, London; Dan Baker, University of Greenwich; Qazi Rahman, King’s College London
Suicidality rates in lesbian, gay and bisexual (LGB) young people are about three times those of heterosexual youth. Improved understanding of factors associated with suicide risk in LGB young people is needed. Most previous research has been conducted in the US. This study investigated LGB-related and general factors associated with suicide attempts, suicidal ideation and future suicide risk in young adults in England. Logistic regression analyses were used to investigate factors associated with suicidality in 3275 LGB young adults from the Youth Chances project in England.

Suicide attempts were reported by 13.6% of participants; 45.2% had suicidal ideation in the past year and 9.5% said future suicide was likely. LGB stigma and discrimination experiences were significantly associated with all three aspects of suicidality. Risk factors included school stigma factors (e.g. lessons being negative about LGB issues, teachers not speaking out against LGB prejudice), negative reactions from family and friends after coming out, and a range of LGB victimisation experiences—from being outed to physical assault or blackmail. Bisexual young adults were at greater risk of suicidality than lesbian or gay participants. Identifying as LGB at a younger age was also associated with increased risk of suicidality. Factors associated with suicidality that have also been identified in general population samples included female gender, lower social support, anxiety / depression help-seeking, abuse / violence and sexual abuse.

In conclusion, a wide range of stigma and discrimination experiences are associated with increased suicidality in LGB youth. Health professionals should assess and address the impact of such experiences when working with LGB individuals. Suicide prevention interventions should target schools, families and friends as well as supporting the LGB young person.

Mental health among UK inner city non-heterosexuals: the role of risk factors, protective factors and place
Billy Gazzard, King’s College London; Charlotte Woodhead, King’s College London;
Matthew Hotopf, King’s College London; Qazi Rahman, King’s College London; Katharine A. Rimes, King’s College London; Stephani L. Hatch, King’s College London
Sexual minorities experience excess psychological ill health globally, yet the UK data exploring reasons for poor mental health among sexual minorities is lacking. This study compares the prevalence of a measure of well-being, symptoms of common mental disorder
(CMD), lifetime suicidal ideation, harmful alcohol and drug use among inner city non-heterosexual and heterosexual individuals. It is the first UK study which aims to quantify how much major, everyday and anticipated discrimination; lifetime and childhood trauma; and coping strategies for dealing with unfair treatment, predict excess mental ill health among non-heterosexuals. Further, inner city and national outcomes are compared. Self-report survey data came from the South East London Community Health study (N = 1052) and the Adult Psychiatric Morbidity Survey (N = 7403). Prevalence of mental health outcomes (common mental disorder, mental wellbeing and substance use), discrimination, stressful life events and coping strategies were estimated by sexual orientation. Odds ratios were calculated to assess the association between health outcomes and sexual orientation in adjusted logistic regression models.

Adjustments for greater exposure to measured experiences of discrimination and lifetime and childhood trauma had a small to moderate impact on effect sizes for adverse health outcomes though in fully adjusted models, non-heterosexual orientation remained strongly associated with CMD, lifetime suicidal ideation and drug use. There was limited support for the hypothesis that measured coping strategies might mediate some of these associations. The inner city sample had poorer mental health overall compared with the national sample and the discrepancy was larger for non-heterosexuals than heterosexuals. Childhood and adult adversity substantially influence but do not account for sexual orientation-related mental health disparities. Longitudinal work taking a life course approach with more specific measures of discrimination and coping is required to further understand these associations. Sexual minorities should be considered as a priority in the design and delivery of health and social services.

**Treatment outcomes for lesbian, gay, bisexual and heterosexual individuals receiving a primary care psychological intervention in Improving Access to Psychological Treatment (IAPT) services in four South London boroughs**

David Hambrook, South London and Maudsley NHS Foundation Trust; Katharine A. Rim, King’s College London; Mathew Broadbent, King’s College London; Janet Wingrove, King’s College London

Lesbian, gay and bisexual individuals are at greater risk of mental health problems such as anxiety and depression than heterosexual people. This study compared baseline characteristics and treatment outcomes across sexual orientation groups, for people receiving a primary care psychological intervention from Improving Access to Psychological Treatment (IAPT) services in four boroughs in South London. Participants were 182 lesbians, 213 bisexual women, 6382 heterosexual women, 619 gay men, 72 bisexual men and 2901 heterosexual men. Changes between first and last session scores on measures of depression, anxiety and daily impairment were compared between groups, controlling for potential confounders such as age and ethnicity. IAPT-defined recovery was also compared across groups. The implications for primary care psychological service provision for lesbian, gay and bisexual individuals will be discussed.

New innovations in low intensity CBT: Enhancing engagement and improving outcomes

**The development and pilot evaluation of a web based intervention for physical activity and depression**

Jeffrey Lambert, University of Exeter; Colin Greaves, University of Exeter; Adrian Taylor, Plymouth University; Paul Farrand, University of Exeter; Anne M Haase, University of Bristol

Background: In trials, moderate effect sizes have been found for physical activity as a treatment for depression. Physical activity may also help to prevent depressive relapse, and provide additional psychological benefits such as positive self-regard and a sense of competence. However, trials often recruit highly motivated individuals limiting the transferability of this evidence to depression in the real world. As such, evidence on scalable, community based interventions which promote physical activity in people with
depression are needed. Aims: This talk aims to describe the development of a web based intervention to reduce depressive symptoms and promote physical activity in a community setting (eMotion). The protocol and preliminary results relating to recruitment, retention, fidelity and feasibility of the intervention will also be reported. Method: eMotion was adapted from the existing (face to face) BAcPAc intervention using the Centre for eHealth Research and Disease management Roadmap (CeHReS) for the development of online interventions with a user centred approach. eMotion combines Behavioural Activation (an evidence-based psychological therapy for depression) and behaviour change techniques for physical activity based on theories of self-regulation and self-determination. Results/Conclusion: Preliminary results will be reported along with key insights so far. This study will add to the body of literature exploring the utility of adding physical activity to treatments for depression along with adding to the emerging research investigating web-based delivery systems for both mental health and behaviour change.

Qualitative analysis of interviews with community health workers delivering a group based intervention to Somali refugees in Minnesota
Scott Duncan, University of Glasgow; Carrie-Anne McClay, University of Glasgow; Rebekah Pratt, University of Minnesota
Background – Somali refugees living in Minnesota encounter very large difficulties in their daily lives which may be exacerbated as a result of the civil war in their homeland. There is sometimes a lack of willingness by refugees to engage with the American health care system due to a cultural mismatch in values.
Objective – To investigate participants’ experiences of delivering a culturally tailored Low intensity CBT intervention to members of their own community, and gain insight into how the course was received.
Methods – 11 Somali women community health workers were trained to deliver the intervention. Focus groups were then conducted with the community health workers after they delivered the intervention. Interviews were conducted in Somali before being translated and transcribed into English. Analysis took place in English using a 6 step thematic analysis process.
Results - Saturation was achieved and 4 themes identifies in the data set. These were; 1) Becoming a trainer, 2) Benefits to the trainer, 3) Benefits of the course to attendees and the community, and 4) Culture and religion.
Conclusions - The culturally adapted LI-CBT intervention was deemed to be culturally acceptable and well received within the Somali community due to its focus on culture.

A community based pilot study of life skills classes for individuals with low mood and depression.
Christopher Williams, University of Glasgow; Carrie-Anne McClay, University of Glasgow; Katrina Collins, AWARE Defeat Depression; Caroline Haig, University of Glasgow; Alex McConnachie, University of Glasgow; Pat Lynch, AWARE Defeat Depression; Jill Morrison, University of Glasgow
Background: Cognitive behavioural therapy (CBT) is recommended for the treatment of depression and anxiety. However, access is limited. Low-intensity approaches such as guided CBT self-help (bibliotherapy) can increase access to treatment and is recommended by UK guidelines. No previous research has explored the provision of group-based guidance/support for a bibliotherapy approach for depression and anxiety in community settings. The objective was to carry out a pilot study of a group guided self-help intervention, using community based recruitment methods.
Method: A randomised controlled comparing an 8 week CBT group guided self-help intervention to usual care. Recruitment and the delivery of the intervention were carried out in Glasgow and Derry/Londonderry in partnership with national depression charities. Fifty-three people were randomised, however we refer only to the forty-six participants who provided baseline data: 16 males and 30 females, aged 16 or over, with a PHQ-9 score of ? 5, were recruited from the community. The mean age of the sample was 43.7 (sd = 13) and 93.5% of participants had suffered from low mood for a year or more.
Results: There was effective recruitment, randomisation, uptake and adherence with 21 Immediate Access (IA) and 25 Delayed Access Control (DAC) participants. The intervention was highly acceptable to participants attending on average 4.46 of the 8 sessions (sd 3.06), 65.2% attended more than half of all sessions. The mean satisfaction on the Client Satisfaction Questionnaire was 28 out of 32 (sd 4.8). The provisional results in the pilot suggest the intervention may improve both anxiety and depression. Participation significantly improved both levels of anxiety \((p=0.001, 95\% \text{ CI} (1.87, 12.09))\) and depression \((p=0.002, 95\% \text{ CI} (2.34, 16.23))\) in individuals taking antidepressant medication at 3 months compared to a delayed access control. At three months, data collection was achieved from 74% of participants. The trial successfully provided estimates of the sample size needed for the future planned trial.

Conclusions: Low-intensity group-based classes may offer an alternative method of managing depression and anxiety and warrant further research.

**Behavioural activation self-help to improve mood and quality of life in people with dementia supported by informal carers: The PROMOTE Study**

Joanne Woodford, University of Exeter; Paul Farrand, University of Exeter; Martin Anderson, University of Exeter; David Llewellyn, University of Exeter; Obioha Ukoumunne, University of Exeter; Chris Dickens, University of Exeter

Introduction: Around 50% of people with dementia experience depression resulting in poor quality of life. Currently access to evidence-based psychological support is limited due to costs of delivery and lack of trained professionals. A potential solution may lie with developing services based upon written cognitive behavioural therapy (CBT) self-help, informed by a behavioural activation approach.

Methods: The MRC Complex Interventions Framework was adopted to develop and examine the feasibility of a CBT self-help intervention, supported by informal carers and delivered by psychological wellbeing practitioners, for people living with dementia. Feasibility objectives such as effectiveness of recruitment methods, attrition, data collection and intervention acceptability were examined.

Results: People with dementia and carers reported high acceptability for the proposed intervention. However carer involvement in supporting the intervention at home and provision of regular guidance by mental health practitioners was essential. Data collection was completed in December 2016. Results from the PROMOTE study will be presented concerning feasibility objectives and primary outcomes of depression and quality of life.

Conclusion: Significant need exists to involve people with dementia and carers in the development of psychological interventions to maximise acceptability. CBT self-help interventions for people living with dementia seems a promising approach, however the involvement of informal carers in supporting the intervention and providing carers with professional guidance appears fundamental.

**Innovations in the assessment of anxiety-linked attentional bias to threat**

Do individuals allocate more attention to fear cues with high versus low efficacy?

Sam Parsons, University of Oxford

The media commonly uses fear appeals that focus on the health risks of certain behaviours to attempt to influence individuals to alter the targeted behaviour. It has been demonstrated that fear appeals are more successful if viewers believe that they are able to perform the required danger mitigation actions and that they will yield an effective result. In contrast, if individuals do not believe that danger reduction behaviours will be effective, they may become avoidant of the fear-inducing stimuli. Cognitive approaches to anxiety vulnerability have developed paradigms to assess and modify attentional bias to threat. To test the proposed attentional underpinnings of the effectiveness of fear messages, we investigated whether attention is allocated to threat cues to a greater extent in contexts where these threat cues signal dangers that are more controllable, as compared to contexts where threat cues signal dangers that are less controllable. Using a novel cognitive task, participants were explicitly instructed as to whether responding to threat cues would be effective in reducing...
the likelihood of danger exposure, or not. As hypothesised, the level of control participants were able to exert on the likelihood of danger exposure predicted the degree to which participants allocated attention to the threat cue. Specifically, greater control over danger exposure predicted increased attentional bias to the threat cue. This suggests that under certain contexts, biases that may be considered maladaptive may serve an adaptive purpose, and therefore, it is important to conceptualise patterns of attentional bias with respect to the contextual appropriateness of such biases.

**Misaligning your bias: impaired alignment between attentional bias and variation in controllability of danger in heightened trait anxiety**

**Lies Notebaert, University of Western Australia, Australia**

Heightened trait anxiety is associated with a number of negative outcomes across a range of domains, and is known to be underpinned by an attentional bias to threat. This attentional bias is typically considered to be a maladaptive process, although selective information processing models contend that it is an important neurocognitive function critical for survival. Indeed, attending to threat can be adaptive in situations in which individuals have some degree of control over the impending danger. In these situations, rapid attentional allocation can facilitate engagement in appropriate danger mitigation behaviours. While most research until now has examined attentional bias in one, static context, critically in order to function adaptively in an every-changing environment, attentional processes need to be flexibly regulated and calibrated to these contextual characteristics, attending more to threat cues predicting dangers that are more controllable, than to threat cues predicting dangers that are less controllable. The current study was designed to test the hypothesis that heightened anxiety vulnerability may be associated with impaired alignment between attentional bias to threat and variation in the controllability of dangers predicted by the threat. In a novel Attentional Bias Alignment Task, we presented participants with threat cues that predicted a danger (money loss and aversive noise burst). In some blocks, participants (n=79) had a high degree of control over the occurrence of this danger, whereas in other blocks, participants had only a low degree of control. The task generated a measure of attentional scanning in the absence of threat, and attentional orienting towards the threat cue. Results showed that low anxious participants showed increased attentional scanning and orienting in high control blocks than in low control blocks, which was interpreted as evidence for proper attentional bias alignment. In contrast, while high anxious individuals showed proper alignment in orienting, they showed a marked misalignment in scanning, displaying no significant difference in scanning in high control and low control blocks. This pattern of misalignment of attentional bias and variation in controllability of danger could contribute to increased levels of anxiety in contexts where these processes cannot contribute to behavioural risk reduction, and may help to refine our understanding of the attentional processes contributing to heightened anxiety vulnerability.

**Anxiety-linked variability in attentional bias: the importance of controlling for variability in raw reaction times**

**Ben Grafton, University of Western Australia, Australia**

People differ in their tendency to experience elevated state anxiety, reflecting the individual difference dimension known as trait anxiety. An influential hypothesis, which has clear explanatory power, is that an increased tendency to experience elevated state anxiety (i.e. high trait anxiety) results from an increased tendency to preferentially attend to negative information. To test this hypothesis investigators typically have had participants, who differ in trait anxiety, complete a dot-probe task. In this task, participants are briefly presented with stimulus pairs, often comprising one negative word and one neutral word, and are required to process a probe that subsequently appears in the location of one of these two stimuli. For each participant, an index of their tendency to preferentially attend to negative information is obtained by computing the degree to which the participant is, across all trials, generally speeded to identify probes appearing in the location of the negative vs neutral stimuli. Consistent with this hypothesis, it has repeatedly been found that high trait anxious
participants display an increased tendency to preferentially attend to negative information. However, in recent years, some investigators have put forward the quite different hypothesis that an increased tendency to experience elevated state anxiety results from increased variability in whether or not individuals preferentially attend to negative information. The explanatory power of this hypothesis is less clear. To test this latter hypothesis, these investigators have also had participants, who differ in trait anxiety, complete a dot probe task. They have then computed an index of variability in attentional preference for negative information, by calculating variability in the degree to which participants are speeded to identify probes appearing in the location of the negative vs. neutral stimuli, across a moving window of immediately prior trials (i.e. < 5 trials). It has been reported that high trait anxious participants display greater variability in attentional preference for negative information. However, such findings could simply reflect greater raw RT variability in more anxious participants. The present study was carried out to test this possibility. We recruited participants who differed in trait anxiety, and exposed them to a dot probe task. Critically, in our dot-probe task, we also included additional trials on which the stimulus pairs comprised two non-words (rather than words), to enable assessment of variability in raw RT. Our findings showed that high trait anxious participants displayed an increased tendency to preferentially attend to negative information, greater variability in attentional preference for negative information, and also greater variability in raw RT. Of most importance to the issue under consideration, when controlling for such variability in raw RT, the association between trait anxiety and variability in attentional preference for negative information was eliminated. This was not the case when considering tendency to preferentially attend to negative information. The implications of these findings for the assessment of different facets of attentional selectivity will be discussed.

Attentional Bias Mediates the Effect of Transcranial Direct Current Stimulation on Emotional Reactivity to Stress

Patrick Clarke, Curtin University, Australia

Transcranial direct current stimulation (tDCS) is a neuromodulatory technique which has garnered recent interest in the potential treatment for emotion-based psychopathology. While accumulating evidence suggests that tDCS may attenuate emotional vulnerability, critically, little is known about the cognitive processes that underlie this effect. The present study examined whether tDCS may affect emotional vulnerability via its capacity to modulate attentional bias towards negative information, using a novel assessment of attentional bias delivered during exposure to a stressor.

Fifty healthy participants were randomly assigned to receive either anodal tDCS (2mA/min) stimulation to the left dorsolateral prefrontal cortex (DLPFC), or sham stimulation. Participants were then eye tracked during a stressor task which simultaneously presented two different videos, one depicting emotionally threatening information (disaster and rescue situations) and one depicting emotionally neutral information, to different (left and right) screen positions, with corresponding audio presented to the left/right headphone audio channel. Periodically during the task, the screen position (and audio channel) would switch to the opposite side, meaning that participants would have the option of either remaining in the same screen position or following the attended video. As such the task had the capacity to both elicit emotional reactivity, and also provide a concurrent in-vivo measure of attentional bias.

Results showed that greater attentional bias towards negative information was associated with greater emotional reactivity to the stressor task. Furthermore, the active tDCS group showed reduced attentional bias to negative information, compared to the sham group. Importantly, negative attentional bias was found to mediate the effect of tDCS on emotional reactivity, while no direct effect of tDCS on emotional reactivity was observed. The findings suggest that the effect of tDCS on emotional vulnerability may be mediated by changes in negative attentional bias, and hold implications for the application of tDCS in emotion-based psychopathology. The findings also highlight the utility of in-vivo eye
tracking measures in revealing a crucial cognitive mediator which may underpin the impact of DLPFC neuromodulation in remediating emotional vulnerability.

New advances in understanding the nature and role of emotional processing biases in maintaining clinical problems

Cognitive biases towards social information in people with eating disorders
Valentina Cardi, King's College London; Janet Treasure, King's College London
Anorexia nervosa is a mental disorder characterised by persistent restriction of food intake followed by severe weight loss. It has the highest mortality rates amongst psychiatric disorders. Prolonged starvation impairs the ability to benefit from treatment due to poor concentration, cognitive and behavioural rigidity, difficulties regulating emotions and understanding others. Approximately the 25% of patients with anorexia nervosa develop a severe form of illness. Inpatient care focused on nutritional rehabilitation is indicated for these difficult cases, but re-feeding is associated with high levels of anxiety, resistance, and conflicts with staff. Patients abandon treatment prematurely and relapse frequently. Recent studies show that therapeutic alliance is key to improve the effectiveness of treatment for those with long term anorexia nervosa. However, interpersonal relationships are difficult for these patients, who experience high levels of social anxiety and an automatic tendency to overestimate negative outcomes during social interactions. The aim of this study was to examine the impact of a novel intervention designed to reduce attention and interpretation biases towards negative social stimuli in patients with anorexia nervosa admitted to hospital. A cognitive bias modification training was developed in which participants were trained to attend to compassionate facial expressions and to benign outcomes of ambiguous social scenarios. Twenty-eight patients completed 5 training sessions and a baseline and end of intervention assessment. At baseline, patients displayed an attention and interpretation bias towards negative social stimuli. At the end of intervention, they showed a medium sized increase in attention to positive faces and fewer negative interpretations of ambiguous social stimuli. Levels of self-compassion in response to a video of a social challenge were higher. A cognitive bias modification training targeting attention and interpretation biases towards negative social information is feasible and acceptable and associated with a more positive reaction to social challenges in patients with anorexia nervosa. The next steps are to test this novel intervention using a randomised control design and to assess the impact of the training on eating behaviour.

Investigating the role of negative interpretation bias in maintaining worry and rumination in generalised anxiety disorder and depression
Charlotte Krahé, King's College London; Colette Hirsch, King's College London; Andrew Mathews, King's College London; Jessica Whyte, King's College London
Worry and rumination are two forms of repetitive thinking (RNT) characterised by their negative content and apparently uncontrollable nature. Although worry and rumination share common features, it remains unclear whether they are both maintained by the same cognitive mechanisms. We investigated the tendency to generate negative interpretations in regards to ambiguous information (termed negative interpretation bias) as part of cognitive mechanism underlying RNT. To assess the causal role of negative interpretation bias, we compared multi-session cognitive bias modification for interpretations (CBM-I) to an active control condition to examine whether repeatedly training positive interpretations would reduce worry and rumination in individuals with generalised anxiety disorder or depression, respectively. Furthermore, we examined the potential modulatory effects of engaging in RNT immediately prior to CBM-I. A community sample of individuals meeting diagnostic criteria for either generalised anxiety disorder or current major depressive episode were randomly allocated to CBM-I with prior RNT, CBM-I without prior RNT (i.e., standard CBM-I), or an active control (no resolution of ambiguity) condition. All conditions received a three-week internet-based intervention consisting of one initial session at the first study visit and 9 home-based sessions of CBM-I training (or active control). We
assessed and compared the effects of CBM-I with and without prior RNT on ‘near-transfer’ measures of interpretation bias closely related to the training as well as ‘far-transfer’ outcomes related to RNT and psychological distress. Additionally, we investigated the impact of our CBM-I training vs active control on questionnaire measures at 1-month follow-up. Our findings shed light on the cognitive mechanisms contributing to the maintenance of worry and rumination in generalised anxiety disorder and depression.

A longitudinal investigation of information processing biases and self-reported cognitions and behaviours in chronic fatigue syndrome.

Alicia Hughes, King’s College London; Trudie Chalder, King’s College London; Rona Moss-Morris, King’s College London; Colette Hirsch, King’s College London

Chronic fatigue syndrome (CFS) is characterized by severe, persistent and disabling mental and physical fatigue. Cognitive behavioural models propose the way in which people with CFS perceive and respond to symptoms and other illness related information, contributes to the maintenance of fatigue and disability. However, there is limited experimental work in this area. This research presents a series of studies which investigate how individuals with CFS process information; specifically, whether people with CFS have illness specific processing biases in attention and interpretation and the role these biases play in the cognitive behavioural model of CFS.

Study 1. To assess whether cognitive biases occur in CFS, a quasi-experimental study, with 52 CFS participants and 51 healthy controls was conducted. Participants completed self-report measures of symptoms, disability, mood, cognitions and behaviours as well as three experimental tasks, designed specifically to tap into CFS salient cognitions: (i) Visual-Probe task measuring attentional bias to illness (somatic symptoms and disability) versus neutral words, (ii) Attention Network Test measuring general attentional control and (iii) interpretive bias task measuring positive versus somatic interpretations of ambiguous information. Compared to controls, CFS participants were significantly more likely to show an attentional bias for illness-related words and significantly more likely to interpret ambiguous information in a somatic way, even when controlling for depression and anxiety. These attention and interpretation biases were associated with unhelpful illness beliefs (fear avoidance and catastrophizing) and all-or-nothing behaviours; factors which previous studies have identified as key mechanisms of effective treatments for CFS. CFS participants had significantly poorer general attentional control than healthy individuals however this was not related to illness specific cognitive processing biases, fatigue or disability. Thus, cognitive biases have a role to play in precipitating and perpetuating cognitive and behavioural factors in CFS. Given that treatments for CFS target these cognitive and behavioural factors what effect, if any do cognitive processing biases have on how patients respond to treatment?

Study 2. To address this question participants from study 1 who received either Cognitive Behavioural Therapy (CBT) or Graded Exercise Therapy (GET) for CFS in routine clinical practice, were followed up. The study assessed whether cognitive processes of attentional bias, attentional malleability and interpretation bias predicted response to treatments in terms of fatigue and functioning. Separate regression analyses were conducted with pre-treatment cognitive processing variables as the predictors, fatigue or functioning scores at end of treatment as the outcome variables and baseline scores as covariates. As expected both fatigue and functioning improved pre to post treatments. Attentional bias and attentional malleability emerged as important predictors of functioning post treatment, but not fatigue. Interpretation biases pre-treatment did not predict either outcome. Thus having an attentional bias towards illness-related information pre-treatment and more flexible attention, predicts larger improvements in functioning post treatment for CFS.

Attentional bias and Interpretation bias in People with Parkinson’s Disease who Worry

Lonneke van Tuijl, King’s College London; Colette Hirsch, King’s College London; Richard Brown, King’s College London
People with Parkinson’s (PwP) not only have increasing cognitive impairment and functional disability, but often report symptoms of depression, worry, fatigue, and even addiction (e.g., gambling). Rates of these symptoms in PwP also appear to be a lot higher than in other comparable disease population, and are thought to be related to biological changes associated with Parkinson’s disease. Worry, particularly, is a prominent complaint within this population. Cognitive theories of anxiety and worry highlight that there is an increased tendency to process information in a negative way, which in turn maintains and worsens symptoms. One such process refers to the tendency to attend to threatening information when there is the opportunity to do so; attentional bias (AB). AB has been observed in many anxiety disorders. For example, people with a spider phobia are often faster to spot a spider in the room, and once spotted, find it harder to divert their attention away from the spider. In worry, more generally, an AB for threatening information, like negative words or pictures, has been observed. Another process that appears to be related to the maintenance of worry is a negative interpretation bias (IB). Every day we are confronted with ambiguous information, and we often have to draw conclusions based on the little information that we have. Anxious individuals tend to interpret ambiguously threatening information as negative. For example, a friend who fails to wave back may have simply not have seen you. However, an anxious individual might think that they were being purposefully ignored. Together with an AB, IB can trigger and prolong periods of worry. It is currently unknown whether worry in PwP manifest due to purely biological reasons, or whether cognitive processes like AB and IB, as observed in other anxiety populations, are also present. Until now, no research has been conducted to see whether AB and IB are present in high worrying PwP. In order to improve current psychological treatments for this population, it is important to establish which cognitive processes play a role. This will be done by recruiting both high and low worrying PwP. Participants will complete computer-based tasks measuring AB and IB. This study will help create a model of worry in Parkinson’s, which will enable us to refine psychological interventions to improve efficacy. Previous studies have suggested that CBT can be effective in reducing symptoms of anxiety in Parkinson’s, but their long-term effect is highly variable. It is feasible that uncorrected AB and IB may partly explain this limited effect.

Voices in context: understanding and working with auditory hallucinations in relation to experience and internal representations

Pilot findings of SAVVy: an ongoing multicentre randomised controlled trial of a coping-focused intervention for voice hearing experiences supported by smartphone ecological momentary assessment and intervention

Imogen Bell, Swinburne University of Technology; Sarah Fielding-Smith, University of Sussex; Mark Hayward, University of Sussex; Susan Rossell, Swinburne University of Technology; Michelle Lim, Swinburne University of Technology; Neil Thomas, Swinburne University of Technology

Over the past two decades, research using a technique called ‘ecological momentary assessment’ (EMA) has provided an in-depth analysis of how experiences such as hearing voices relate to events within a person’s life. EMA involves the completion of short surveys multiple times a day over a period of several days, providing data to examine the way in which phenomena interact in the moment and over time. Now commonly delivered via smartphones, this technology has important therapeutic applications. In particular, the way in which voice-related phenomenon interact in the moment on an individual level may elucidate important factors amenable to treatment. In addition, a related approach called ‘ecological momentary intervention’ (EMI) extends these capabilities in to the therapeutic context by providing real time prompts to promote self-management of mental health. EMIs have shown to be feasible and acceptable to people with psychotic experiences and there is growing support for their efficacy. Capitalising on approaches which provide real time, contextualised assessment and support in daily life may offer a particularly useful avenue for
treatment of distressing psychotic experiences. In this presentation, pilot findings from an ongoing multicentre randomised controlled trial of 'SAVVy' (Smartphone-Assisted coping focused InteVention for Voices) will be presented. SAVVy targets improved coping with distressing voice hearing experiences through a brief, four session intervention supported by smartphone EMA and EMI between sessions. Initial stages of the intervention involve the use of daily EMA to capture data on factors which may influence the intensity of the individual’s voice hearing experiences. Analysis of this data provides a basic functional analysis which can be used as a basis for choosing appropriate coping strategies to self-manage the voice hearing experiences. The smartphone app is then coded to send EMI reminders of these coping strategies to the individual during their daily life. The SAVVy trial is an ongoing evaluation of the feasibility, acceptability and preliminary efficacy of the intervention in a group of individuals with persistent and distressing voice hearing experiences. The details of this intervention will be described with reference to case examples and data on acceptability, feasibility and pilot participant outcomes. The use of smartphone apps to facilitate enhanced assessment and intervention via EMA and EMI is a highly novel approach which may soon become a part of mainstream psychological treatment. The SAVVy intervention is a demonstration of such capabilities and their application to treating distressing psychotic experiences.

Voice Dialogue: A Case Series
Craig Steel, University of Reading; Dirk Corstens, Joachim Schnackenberg, Eleanor Longen, University of Manchester

Voice Dialogue: A Case Series
The work of Marius Romme and Sandra Escher is widely considered as seminal within the ‘normalisation’ of voice hearing. However, the clinical approach which they have put forward has received relatively little attention and is often considered part of a broad CBT approach. One component of their approach includes active ‘Voice Dialogue’ in which the clinician engages in prolonged communication with a voice (via the voice hearer) in the aim of opening up communication. An underlying premise of the approach is that even a voice with current negative content is unlikely to have malevolent intent towards the voice hearer. Opening communication is seen as a process to facilitate the resolution of conflict. The approach raises anxieties in some clinicians and has not been systematically evaluated. We present a case series with 15 voice hearers adopting the Making Sense of Voices approach (Romme & Escher, 2000) in which voice dialogue is adopted where appropriate. A multiple baseline design is employed (random baseline of between 4 and 8 weeks), followed by up to 20 clinical sessions within a 9-month period. Full assessment is conducted at the start and end of the baseline period, end of intervention and after a 3-month follow-up period. Weekly distress measures are collected throughout. Results will be discussed in relation to individual differences (e.g. level of dissociation) as well as group outcome and any adverse events associated with the intervention. Implications for the potential widespread use of the approach will be considered.

Understanding the role of Self in Voice Content
Monique Scott, Swinburne University; Rossell Susan, Swinburne University; Toh Wei Lin, Monash Alfred Psychiatry Research Centre; Thomas Neil, Swinburne University

Understanding the role of self in voice content may provide valuable insights into the phenomenon of hearing voices. Self-discrepancy models stipulate that multiple selves exist within one’s self concept, and that psychopathology is indicated by discrepancies between one’s dimensions of self. Our study aimed to investigate the relationship between voice content and dimensions of self, using a self-discrepancy paradigm to examine correspondences between voice content and internalised representations of self. We modified a self-discrepancy questionnaire to include a rating of ‘how similar the voices would say you are’ as well as ‘how similar you think you actually are’ to self-generated traits within each dimension of self. This produced total similarity scores used for comparisons. Clinical interviews were conducted with participants (N=180) with a diagnosis of
Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, and non-clinical persons, all of whom were hearing voices either currently or in the past. Employing multiple diagnostic groups allowed for comparison between populations in relation to mood, in line with mood congruency theory. Results on the correspondences between voice content and dimensions of self will be presented, along with differences in relation to mood. Understanding the role of self in relation to voice content will help to identify a potential target for cognitive therapy in working with negative voices.

Hearing Voices and Personal Goals: A study of Clinical and Non-clinical Auditory Verbal Hallucinations Informed by Perceptual Control Theory
Filippo Varese, University of Manchester
The content of voices (auditory hallucinations) is often self-referent, and related to salient aspects of voice-hearers’ lives. Based on a cybernetic theory of cognition and behaviour known as Perceptual Control Theory, this study examined whether the content of voices is thematically linked to the more fundamental construct of goals, i.e. internal representations of desired and undesired states. We also examined whether voice-related distress is a consequence of the degree to which voices interfere with goals, and whether positive affective reactions (perceived pleasantness of voices) are determined by the extent to which voices facilitate goals. 22 clinical and 18 non-clinical voice-hearers completed interviews and self report measures assessing (i) personal goals, (ii) content, characteristics and affective reactions to voices, and (iii) ratings of the extent to which voices facilitated and/or interfered with achievement of important personal goals. Qualitative analysis of the interview data revealed that 82.5% of participants reported voices that thematically matched at least one of their reported goals. As predicted, affective reactions were strongly correlated with measures of goal interference/facilitation. Regression analyses revealed that these associations remained significant when controlling for important covariates (e.g. Participant grouping; voices’ content, frequency and duration and disruption to functioning caused by voices). Goal interference was specifically associated with distress, whereas goal facilitation was specifically associated with perceived pleasantness of voices. This study provides preliminary evidence that the content of voices is frequently associated with voice-hearers’ goals, and that the perceived impact of voices on important personal goals is strongly predictive of emotional reactions to voices.

Are voices shaped by fragments of the past? The role of trauma memory fragmentation in psychosis.
Sophie Marsh-Picksley, Department of Clinical, Education, & Health Psychology, University College London; Miriam Fornells-Ambrojo, Department of Clinical, Education, & Health Psychology, University College London; Sarah Carr, Department of Clinical, Education, & Health Psychology, University College London; Amy Hardy, Institute of Psychiatry, Psychology and Neuroscience, King’s College London
Trauma has been implicated as a causal factor in psychosis although the role of traumatic memories as a mechanism in this relationship is poorly understood. Encoding of memory is disrupted during trauma, resulting in involuntary retrieval of sensory-perceptual intrusions lacking in contextual information (Brewin, 2001; Brewin et al, 2010; Layton & Krikorian, 2002). Contextual processing difficulties may be more marked in psychosis, and provide a potential pathway between trauma and psychotic experiences (Fowler et al, 2006; Steel et al, 2005). We investigated the phenomenology of intrusive trauma memory in people with psychosis, and hypothesised memory fragmentation would be specifically associated with hallucination severity. Twenty participants with a diagnosis of schizophrenia-spectrum disorder completed semi-structured interview and questionnaire assessments of trauma, trauma memory and psychosis. Intrusive memories were typically seen from a field perspective, and were vivid, distressing, multi-modal and uncontrollable. Findings indicated self-reported, but not objective, fragmentation of intrusive memories was associated with more severe hallucinations but not persecutory beliefs. The small size and cross-sectional design limits the conclusions that can be drawn. Replication is required in a larger sample, with prospective assessment. Assessments of memory contextualisation should also be
developed, to ensure the validity of subjective and objective ratings. In conclusion, memory fragmentation may play a role in voices. Trauma-focused treatments supporting elaboration of trauma memories could have a beneficial impact on psychosis.

Recent research and clinical developments in hoarding disorder

An investigation into the profiles and processes associated with Hoarding Disorder
Mark Banham, Newcastle University; Claire Lomax, Newcastle University; Mark Freeston, Newcastle University

Hoarding Disorder (HD) was defined by Frost and Hartl (1996) as the acquisition of and failure to discard large amounts of items resulting in increasingly restrictive clutter. Initially HD was conceptualised as part of the Obsessive Compulsive Disorder (OCD) presentation until 2013, when the Diagnostic and Statistical Manual of mental disorders fifth edition (DSM-V; American Psychiatric Association, 2013) re-defined it as a distinct disorder. Frost and Steketee (1998) theorised that HD incorporates three key processes (i) acquisition which concerns decisions taken by those with HD to acquire possessions (ii) difficulty discarding involves the reluctance of those with HD to part with items and finally (iii) a lack of organisation refers to the impairment in those with HD to organise possessions in a way that is meaningful and maximizing of living space. The CBT model suggests hoarding is a multifaceted problem developing from several difficulties or proposed deficits, including information processing deficits, emotional attachment problems, behavioural avoidance and erroneous beliefs about the nature of possessions. Since this original model was proposed, a number of further mechanisms have been implicated with HD including intolerance of uncertainty, stressful life events, and the feeling that items need to be kept for sources of comfort and security. A variety of CBT interventions have been developed to achieve the treatment tasks identified by Frost and Hartl (1996) of reducing clutter and assisting the individual to maintain an acceptable amount of possessions. However, the course of CBT needed to achieve these tasks is lengthy (26 sessions), and shows only moderate success (see Tolin et al. for a review). This limited success could be due to the lack of clarity over which of the above mechanisms and characteristics are the most important in driving and maintaining HD behaviour. Further, it has not been investigated whether there are different profiles of hoarders, so whether some mechanisms naturally co-exist together or whether certain mechanisms are more important in particular individuals. Broadly, HD has been treated as a homogenous entity, a difficulty this exploratory study will start to address. The aim of the current study is to attempt to identify and categorise hypothesised underlying mechanisms and characteristics contributing to hoarding behaviour, and to then determine whether they can be clustered together into hypothesized hoarding 'profiles'. We will aim to map out the processes of acquisition, storage and organization and difficulties discarding to discover if particular profiles can be mapped on to these processes believed to comprise HD. In order to capture the mechanisms and processes across stages in the hoarding process, an assessment measure has been designed (the Hoarding Profiles and Processes Scale; HPPS). This has been piloted with an analogue sample (n=220) alongside a group of pre-existing standardized measures of symptoms and beliefs theorized to underpin and drive HD. The data from the measure will be presented, as will descriptive data of individuals who meet diagnostic criteria for Hoarding Disorder. The extent to which profiles and characteristics can be generated through the clustering of results from standardised measures of symptoms and beliefs will then be presented. Finally, some of these profiles will be compared across the HPPS. This study should contribute to a greater understanding of HD by disentangling the profiles and processes driving and maintaining it.

The relationship between traumatic life events, attachment styles and symptom onset in Hoarding Disorder
Claire Lomax, Newcastle University; Sinead Lambe, University of Bath; Paul Salkovskis, University of Bath; James Gregory, University of Bath
This study examines the relationship between the presence or frequency of reported Traumatic Life Events (TLEs) with the onset and course of hoarding symptoms, as well as the potential role of attachment styles and reported childhood emotional deprivation in the course of this relationship. Several studies have explored a potential relationship between frequency of traumatic life events (TLEs) and presence of hoarding behaviour. Few studies however have gone beyond simply relating presence or frequency of TLEs to attempt to investigate the relationship of such events more specifically with the onset and course of hoarding symptoms. A difficulty with current research (and treatment) is that the term hoarding refers to a number of process that encompass a series of behaviours and decisions which involve acquisition of objects and difficulty discarding them. In order to understand the process of hoarding better, the current study aims to explore hoarding as defined by the different parts of it, which is acquisition, difficulty discarding and clutter. In the only study to date which has tried to relate life events to parts of the hoarding process, Grisham et al. (2006) used a semi-structured interview to ask self-reported hoarding participants to identify two significant events from each decade of their lives and then rate the severity of acquisition, difficulty discarding and clutter at each of these memory time points. They found that on average people reported mild symptoms in early teens moving to moderate in early to mid-20s before becoming severe in mid to late 30s. Acquiring behaviours were reported to be significantly later than difficulty discarding, and that recognition of symptoms occurred significantly later than onset of symptoms. A second related area which has been proposed as influential in onset and maintenance of hoarding is that of childhood adversity and emotional deprivation. It seems very likely that there will be an association for at least some individuals between this dimension and TLEs, though this has not yet been explored. A consequence or related aspect of childhood adversity can be disruption to attachment relationships and the development of insecure or disordered attachment (Bifulco et al., 2002). It has been suggested that hoarders’ emotional attachment to objects is linked to poor parental attachment relationships in childhood (see Nedelisky and Steel, 2009). There is some evidence, although limited, to support this suggestion (Alonso et al. 2004). A group of 35 individuals who met DSM-V criteria for Hoarding Disorder was compared to a benchmarking group of 19 individuals. They completed an online battery of questionnaires which included measurement of Hoarding Disorder, depression, anxiety and a screen for neuropsychiatric symptoms. Adult attachment styles, interpersonal functioning and perceived emotional and material deprivation reported from childhood were also measured. Finally a semi-structured interview was employed to investigate the relation between life events and onset of symptoms. This invited participants to retrospectively and freely recall any stressful life events experienced through their life, and then to recall the age at which symptoms of hoarding (divided into three core characteristics of difficulty discarding, clutter, and excessive acquisition) first began to emerge, then age of onset of clinically significant problems. Results will be reported regarding potential differences between the groups in attachment, interpersonal functioning and perceived emotional and material support during childhood. Data from the semi-structured interview will be presented to explore the constructs of emotional deprivation, attachment and traumatic or stressful life events in relation to these different stages of the hoarding process. An improved understanding of the specific contributions of these constructs will help us to develop a better understanding of the development and maintenance of hoarding disorder, and hence refine our cognitive-behavioural models.

An exploration of beliefs and experiences of individuals with current or past hoarding problems regarding treatment and hoarding behaviour

Catherine Reid, Newcastle University; Claire Lomax, Newcastle University; James Gregory, University of Bath; Mark Freeston, Newcastle University

It is known from research evidence and anecdotal evidence from clinicians that individuals with hoarding problems often fail to seek treatment. Those who do seek treatment, in the majority of cases, seek it after living a very lengthy time with the problem. Potential hypotheses have been put forward as to why this may be the case including, the proposal that individuals with hoarding problems may lack insight and awareness of the extent of
their problem and the negative impact this is having on their life and that of others; or that families may accommodate an individual's hoarding behaviour until it becomes unmanageable. We wished to explore the reasons for this failure or delay in treatment seeking further. This study aimed to explore and develop a greater understanding of the perspectives of individuals with current or previous hoarding problems (with or without OCD) regarding accessing treatment for hoarding (regardless of whether they had previously received treatment or not). Individuals with hoarding problems were asked if they thought they would be able to, or would want to change their hoarding behaviour. The perspectives of those with hoarding problems were gathered through the use of Q-methodology, using an online platform instead of the traditional face-to-face methodology. The findings and clinical implications of this research study will be presented and discussed. This research study is of interest and contributes to the field of hoarding research as it is the first study to have employed Q-methodology with those who have hoarding problems, and is one of very few studies to ask for the opinions of those with hoarding problems. This research study was conducted as a research thesis within the Clinical Psychology Doctorate training and is part of a programme of research at Newcastle University that aims to increase our understanding of hoarding so that we can improve our engagement of those with hoarding problem, assessment, treatment effectiveness and ultimately improve the quality of life for those with hoarding problems.

Making space in life, in the mind and in the home - An empirically grounded intervention for Hoarding Disorder
James Gregory, University of Bath; Claire Lomax, University of Newcastle; Paul Salkovskis, University of Bath
Although recent meta-analytic research suggests that cognitive behavioural interventions produce positive symptomatic change for hoarding disorder (HD) (Tolin, Frost, Steketee, & Muroff, 2015), the benefit is modest compared to treatments for other mental health conditions, with sub-clinical outcomes the exception rather than the rule. Furthermore, treatment drop-out is disproportionately high (e.g. Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002). New approaches to understanding and treating hoarding disorder are therefore required. Drawing on case study material and hoarding related empirical findings from the fields of clinical and general psychology, a case for a novel approach to helping people with hoarding difficulties will be made. For example, we know that people with HD experience impoverished lives, have experienced disproportionately high levels of stressful life events and traumas - many of which are likely to be unprocessed - and form close emotional attachments to objects that are hard to let go of such that their homes become cluttered. Drawing on the presented evidence and case study material, we will suggest that focusing on helping people with HD to 1) increase the sense of value and meaning in their day to day lives (Make Space in life), 2) de-clutter their minds by, for example processing avoided experiences and tasks (Making Space in the mind) before then 3) focussing on organising and letting go of possessions to reclaim their living space (Making Space in the home) will produce an effective treatment that is relatively simple to deliver by health professionals trained in cognitive-behavioural approaches and, in contrast to the drop-data for current approaches, be accepted by the many rather than the few.

Researching and Utilising a Core Process of Change in Therapy

A Core Process within a Clinical Sample of Anxiety and Depression
Warren Mansell, University of Manchester; Peter McEvoy, Curtin University
Many cognitive and behavioral processes, such as selective attention to threat, self-focused attention, safety-seeking behaviors, worry and thought suppression, have their foundations in research on anxiety disorders. Yet, they are now known to be transdiagnostic, i.e. shared across a wide range of psychological disorders. A more pertinent clinical and theoretical question is whether these processes are themselves distinct, or whether they reflect a shared ‘core’ process that maintains psychopathology. The current study utilized a
treatment-seeking clinical adult sample of 313 individuals with a range of anxiety disorders and/or depression who had completed self-report measures of widely ranging processes: affect control, rumination, worry, escape/avoidance, and safety-seeking behaviors. We found that only the first factor extracted from a principal components analysis of the items of these measures was associated with symptoms of anxiety and depression. Our findings supported the ‘core process’ account and we discuss the implications for theory, clinical practice and future research across psychological disorders.

A Conversation Analysis of Method of Levels
Caitlyn Cannon, University of Manchester; Joanne Meredith, University of Salford; Susan Speer, University of Manchester; Warren Mansell, University of Manchester

Method of Levels (MOL) is a cognitive therapy with an emerging evidence base. It is grounded in Perceptual Control Theory and its transdiagnostic nature means techniques are widely applicable and not diagnosis-specific. Similarities to the core processes of this psychotherapy have been identified in a wide range of therapies, including psychodynamic and cognitive behavioural approaches. This purpose of this research was to contribute to psychotherapy process research by investigating a key technique of MOL psychotherapy, asking about disruptions. By doing so the research aims to refine the process and aid the understanding of related techniques in other psychotherapies.

Conversation Analysis (CA) is a data driven and inductive method that provides a perspective to process research simply based on how conversation and interaction work. It is descriptive and does not attempt to describe internal processes or experiences within the client. Through investigating the surface-level structures and involved in therapy talk CA allows for the examination of the actual working practices of psychotherapy. It studies real-world naturally occurring conversation: talk-in-interaction and has been used to analyse wide variety of psychotherapeutic processes, including therapist interpretations, client resistance and formulations. CA was used here to analyse the technique of asking clients about disruptions in their speech, such as pauses, smiles and changes in tone and body language. Instances were drawn from twelve real-life therapeutic interactions. Analyses explored how and when therapists ask about disruptions; and examples are presented in terms of their degree of adherence to the MOL approach. It provides support for a number of MOL practices, including how and when to ask about disruptions, and what the technique is theorised to achieve. The majority of identified instances projected responses consistent with MOL aims, encouraging further talk which was focused on the client’s problem, with a shift from descriptive to more evaluative talk including an assessment of previous talk. Examples of a disruption not thought to fit the theory guiding MOL, and of a client recognising their own disruption, are also presented.

Parallels are drawn between the CA definition of an assessment and the MOL definition of a disruption, with the shift to evaluative talk taken as observational evidence of clients reflecting on their previous talk. From a PCT perspective this is suggested as evidence of clients moving up levels of perceptual hierarchies. Findings indicating that questions using present tense and asking immediately following the disruption, were most likely to receive these consistent responses, also supports theory.

Asking about disruptions can be seen to have overlaps with techniques in a wide range of other psychotherapies. This includes ‘thought catching’ in cognitive therapy, emotional coaching and the identification of ‘microexpressions’ in emotion focused therapies, and questioning about nonverbal signs in exposure therapy and behavioural experiments. As such, we believe that the findings can also be used to understand important components of related techniques in other psychotherapies.

Coding the common and distinctive components of diverse therapies
Vanessa Macintyre, University of Manchester; Hannah Brown, University of Manchester; Warren Mansell, University of Manchester

Method of Levels therapy (MOL) is designed to help clients shift and sustain awareness to the systems driving goal conflict. If MOL is distinct in its ability to directly tap into a core
process of change, one would expect that the therapy would be distinct from other psychotherapeutic approaches. The aim of this study was to compare the therapist utterances in MOL to those in a range of other therapies, thereby identifying unique characteristics of MOL. Seven publicly available videos of therapy sessions were transcribed, and two independent raters used the Hill Counsellor Coding system to classify therapist utterances in all of the sessions. Each video demonstrated the application of a different type of therapy with real clients, and the following therapies were included: MOL, Cognitive Behaviour Therapy, Transactional Analysis Psychotherapy, Person-Centred Therapy, Existential Therapy, Rational Emotive Behaviour Therapy, and Gestalt Therapy. As hypothesised, MOL showed significantly elevated frequencies of therapist utterances that were shorter in length, and more of which were open and closed questions or restatements, compared to the other therapies. In addition, only MOL included questions about disruptions in speech (a key aim of the therapy). These findings indicate that MOL is distinct from other therapies, and this may reflect its intensive focus on facilitating the core mechanisms of change. Future research should aim to replicate these findings over a greater number of therapy sessions, and include a wider variety of different therapies.

The Cognitive Behavioural Processes Questionnaire: Replication of a single factor in a diverse mental health sample

Harry Horgan, University of East London

Harry Horgan reports on a study of 928 participants who completed the Cognitive Behavioural Processes Questionnaire (Patel et al., 2015). This measure has 15 items that together tap the diverse range of processes known to be shared across psychological disorders, i.e., transdiagnostic. The study sample was recruited online and included participants with and without mental health difficulties. A principal component analysis revealed a single factor accounts for the majority of the variance, which supports the single core process hypothesis. Participants also completed measures of depression severity, suicidality-related psychological constructs, and self-reported any diagnoses that they felt contributed to their current level of psychological distress. The relationship between these variables and the hypothesised single core process were explored.

Psychometric properties of the reorganisation of conflict scale in clinical and non-clinical samples: investigating the core process of change

Lydia Morris, University of Manchester; Sara Tai, University of Manchester; Tim Bird, University of Manchester; Sally Higginson, University of Manchester; Warren Mansell, University of Manchester

Numerous psychological and neurobiological processes have been found to maintain varied psychological disorders. An emergent strand of evidence suggests that a few core processes may explain why certain such processes are commonly associated with psychological distress and psychopathology. Perceptual Control Theory is a transdiagnostic theory that proposes that the core process is unresolved conflict between personally important goals. The corresponding core process, which supports psychological change, is sustained awareness towards the systems driving goal conflict. Two studies are presented to establish the validity of a measure of this process, the Reorganisation of Conflict (RoC) scale. Results are reported of a large analogue sample (N = 294) and a clinical sample (N = 156) and examine the factor structure and psychometric properties of the RoC. Participants completed the RoC scale and measures of psychological inflexibility (including experiential avoidance), intolerance of uncertainty and mindfulness at baseline. For the analogue sample follow-up data was collected at 1-month and 3-months; for the clinical sample follow-up data was collected at 6-months and 12-months. Two complementary factors were extracted from the analysis of the analogue sample – ‘Inflexible, conflicted and arbitrary responding’ and ‘Components of goal conflict reorganisation’. Internal consistency was high for both factors (α = 0.83). Example items from the ‘Inflexible, conflicted and arbitrary responding’ factor include: ‘I try so hard to solve one problem that it creates other problems for me’ and ‘I notice that I’m driven to do lots of different things that get in the way of each other’. Example items from the ‘Components of goal conflict reorganisation’ factor include: ‘When I
have a problem I find myself listening to my thoughts to get a sense of perspective on them' and 'When I have a problem, I tend to face it to try to understand it better’. The ‘Inflexible, conflicted and arbitrary responding’ factor correlated with symptom measures (anxiety, stress and depression), measures of intolerance of uncertainty and psychological inflexibility. The ‘Components of goal conflict reorganisation’ factor correlated with both the curiosity and decentering subscales of the Toronto Mindfulness Scale. Findings regarding the predictive validity of the RoC and analyses from the clinical sample will be reported in the talk. Results provide support for the psychometric properties of the RoC. They suggest that the core process specified by Perceptual Control Theory can account for psychopathology across presentations.

Developments in research with families with a parent living with serious mental illness

Community-based interventions aimed at improving or maintaining quality of life in children of parents with serious mental illness: Where are we starting from and what do we know?

Penny Bee, The University of Manchester

Improving the lives of children born to parents with serious mental illness (SMI) is an urgent political and public health concern. Best estimates suggest that more than 4.2 million parents suffer from mental health problems in the UK, and that 50-66% of people with serious mental illness may be living with children under the age of 18 years. A lack of recognition of the family circumstances of many service users, and historically poor integration between adult and child mental health services, means that many of these children remain invisible to health professionals. The burden placed on children and young people living with serious parental illness is substantial. Research shows that serious parental mental illness is associated with increased risk of adverse outcomes in children. Short-term outcomes include poorer mental and physical health as well as increased risk of a range of behavioural, social and educational difficulties (Goodman et al 2011, Somers et al 2007, Bella et al 2011). Longer-term outcomes can extend into adulthood and include social or occupational dysfunction, lower self-esteem, increased psychiatric morbidity and alcohol or substance misuse (Weissman 2006). The key challenge for health and social care services is in knowing when, and how best, to intervene. With an increasing emphasis being placed on evidence-based practice, there is a pressing need to demonstrate the clinical and cost-effectiveness of interventions for children, young people and their families. Interventions that focus on user-centred values are an important aspect of this agenda.

Funded by the National Institute of Health Research (NIHR), we have recently completed a major review of the international evidence base underpinning community-based interventions for children of parents with serious mental illness (Bee et al 2014). This is the first and only review focused on children and children’s quality of life. Our review has revealed that the current evidence base for community-based interventions to enhance the quality of life of children living with parents with serious mental illness is severely underdeveloped. The scale of the evidence gap indicates a clear need for a new programme of intervention and service development. In this presentation, we will set out the key issues and headlines of our review, and provide insights into the importance of involving children, young people and their families, as well as practitioners, in intervention design. We will present the results of our review and our subsequent primary research, including the development of a new intervention for children and young people living in families with serious mental illness. This intervention, the YoungSMILES intervention, has been developed in collaboration with the NSPCC, and is currently being evaluated across third sector and NHS settings via a feasibility trial funded by the NIHR.

Exploring the experiences of young children and their parents living in families with a parent with bipolar disorder
Clare Backer, Greater Manchester Mental Health NHS Foundation Trust; Rebecca Murphy, Priory Healthcare, Cheadle Royal Hospital; Rachel Calam, The University of Manchester; John E Fox, Royal Holloway University of London; Fiona Ulph, The University of Manchester

A pair of qualitative studies explored the lived experience of parenting with bipolar disorder (BD), alongside the experiences of young children living with a parent with BD and how this impacts on their emotional well-being. Eight parents with BD and their ten children aged between 4 and 10 years were identified via a national organization for people whose lives were affected by BD. Parents and children were interviewed separately about their experiences of family life and parenting. The children were interviewed using a computer-assisted semi-structured interview, ‘In My Shoes’ (IMS). Following transcription, Interpretative Phenomenological Analysis (IPA) was used for the parent interviews, and Thematic Analysis was used for the child interviews.

Parents’ experience

Six core themes developed from the parents interviews that illustrated important aspects of the experience of parenting with BD: ‘BD stops me from being the parent I want to be- the impact of BD on parenting’; ‘Worry, guilt and denial – the impact of BD on family’; ‘Managing guilt, limiting worry – strategies for coping’; ‘Parenting highs and lows – the impact of parenting on personal well-being’; ‘The domino effect – the influence of contextual factors’, and ‘Improvement over time – important temporal factors’. Each theme consisted of a number of subthemes and there were important interactions between the themes that related to the wider literature on parenting, mental illness and BD.

Parents with BD recognise a number of challenges in being a parent and experience feelings of inadequacy, guilt and worry about the impact their illness has on their children and family. Strategies for managing these feelings and limiting the impact of BD can have inadvertent negative effects on the parents’ well-being, and that of their child. Learning to accept the diagnosis and developing strategies for managing symptoms were crucial for positive parenting, although the changing needs of their children often presented new challenges. Contextual factors, including stigma associated with mental illness could either mediate or exacerbate the challenge of parenting with BD.

Children’s experience

Four main themes emerged from the child experiences: perception of parents; knowledge and awareness of BD; managing family life with a ‘bipolar’ parent; and living in a family with BD. Four-year-old children could participate in the IMS interviews and discuss their parent’s mood, behaviour, and mental health. Children had candid and insightful discussions about their parent’s BD including symptoms and parenting, and could reflect on how having a parent with BD affected them emotionally and practically. However older children were better able to articulate their parent’s illness and its impact.

The child exploratory study represents an important step in examining directly experiences of young children whose parents have BD. Using IMS, it was possible to gather insightful information from children to generate hypotheses and influence service development. Children of all ages had some knowledge and understanding of their parent’s illness, describing both positive and negative experiences in the family. Further research to build understanding of children’s perspectives and the support they feel they and their family would benefit from would enhance the development of appropriate services and interventions.

Web-based integrated bipolar parenting intervention (IBPI) for parents with bipolar disorder: A randomised controlled pilot trial

Steven Jones, Lancaster University

People with bipolar disorder (BD) experience additional parenting challenges associated with mood driven fluctuations in communication, impulse control and motivation. This paper describes a novel web-based self-management approach (Integrated Bipolar Parenting Intervention; IBPI) to support parents with BD developed in partnership with individuals with lived experience of bipolar disorder and parenting.

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Parents with BD with children aged 3-10 years randomised to IBPI plus treatment as usual (TAU) or waitlist control (WL). IBPI offered 16 weeks access to interactive self-management information concerning BD and parenting issues. The trial was designed to access feasibility and acceptability as well as provide initial indications of potential benefits of IBPI. Feasibility was through recruitment, retention and web usage. Clinical outcomes were assessed at baseline, 16, 24, 36 and 48 weeks. A nested qualitative study was conducted focusing on participant experiences of the IBPI intervention.

The intervention and trial design appeared to be both feasible and acceptable. 97 participants were recruited with 98% retention to end of intervention and 90% to final follow-up (56-94% data analysed of retained participants; higher rates for observer measures). 77% of IBPI participants accessed the website (53% accessed parenting modules). There were positive changes in a number of clinical/behavioural outcomes. Child behaviour, parenting sense of competence and parenting stress improved significantly in IBPI compared to WL to end of intervention, sustained to 48 weeks. Impacts of IBPI on family functioning, parent mood and time to mood relapse were not significant. Qualitative feedback indicated participants perception of the value of this approach as well as suggestions for further improvements to intervention delivery.

Online self-management support for parents with BD is feasible, with promising improvements in parenting and child behaviour outcomes. A definitive clinical and cost-effectiveness trial is required to confirm and extend these findings.

**Parental Mental Health: Implementation of a Parenting Intervention**

**Lauren Stockton, The University of Manchester**

Background: Parenting is a source of stress for all families at times. This may foster further challenges when a parent experiences serious mental health problems (SMI). Although many parents experiencing SMI parent very well, some require additional support to develop appropriate coping strategies and decrease risk of custody loss. Such needs can be misunderstood, underrepresented and unmet within services. Parenting interventions (PIs) have the potential to improve parent and child outcomes; thus, intervening is a growing priority.

Methods: The study consists of three phases: the first explores EE and attributions using semi-structured interviews (N=45). The second implements a 10-week guided self-help parenting intervention (N=11) with parents experiencing psychosis. A multiple baseline case series design is employed to assess the acceptability and feasibility of the intervention. Weekly at home sessions occur for three months. Self-report measures examined facets of parenting and mental health weekly. The third uses individual qualitative interviews with parents post-intervention (Interpretative Phenomenological Analysis), and with health care professionals (HCPs) working in the area of parental mental health (Thematic Analysis).

Results: Preliminary data from phase one will be outlined. Findings from phase two demonstrate clinically meaningful change (>25%) in a number of clinical and parenting assessments. Self-report data and qualitative accounts demonstrate that the intervention was acceptable for parents. Additionally, parental empowerment, self-change, and insight was reported. HCPs accounts further validate the need to support families through parenting interventions, with suggestions for further improvements to intervention delivery.

Conclusion: A supported at-home parenting intervention for parents experiencing psychosis is feasible and acceptable, with positive outcomes reported across parent, child and clinical assessments. This work can act as a foundation for future developments of PIs that specifically target the unmet needs of families and HCPs.

**New developments in CBT for adults**

In IAPT services - what is the non-complex client? Do we know the mild to moderate case presentation?

Elaine Davies, 2gether NHS Foundation Trust

IAPT services are increasingly receiving referrals for patients who are more complex than the "mild to moderate presentation of anxiety and depression". It is known that patients
with complexity do not recover as well. This paper raises the question what is the non-complex patient? Do we know the mild to moderate case presentation patient? This paper will be useful to the newly qualified, service managers, providers and commissioners of IAPT services.

This paper presents as a critical conversation drawing on a naturalistic study of case presentations in an IAPT service supervision. During supervision eligibility and the clinical characteristics of patients referred to an IAPT service is one of the main agenda items for High Intensity and Psychological Wellbeing Practitioners. In this paper the author will present case studies for audience participation to claim common ground to answer "what is the mild to moderate patient?". A follow on question from presenting the paper will be "Does everyone have the same definition?".

Critical conversations on the proposed question at relevant conferences, in supervision and at Provider/Commissioned contract meetings are both vital and essential to sustain and maintain IAPT services. The right patient will bring good access and recovery rates for the national programme. More importantly it will bring the right professional, ethical and competent treatment for patients.

There is a concern that both H.I.’s and PWP’s are being socialised to the more complex client. If this continues apart from clinical procedures becoming problematic there is a more worrying aspect to therapy. That would include therapist drift, variety of orientation, multiple techniques and role and responsibility merge. All of which will move away from NICE evidence based practice for IAPT services.

IAPT was set up to treat people with mild to moderate depression and anxiety by applying evidence based therapies according to NICE. Implications for everyday clinical practice are working outside competencies, gaps in service provision for those who need and require other interventions, extension of waiting times and demand will outweigh capacity for the IAPT service.

Cognitive Behavioural Therapy for Insomnia in the Context of Chronic Tinnitus

Elizabeth Marks, University of Bath; Laurence McKenna, University College London Hospitals

Tinnitus refers to auditory perception in the absence of external stimulation. Estimates suggest that 10 – 14% of the population suffer with prolonged tinnitus, with 1 - 2% developing clinically significant psychological distress as a result. Sleep disturbance affects 50-70% of chronic tinnitus patients and those reporting both tinnitus and poor sleep experience may be more distressed than those who sleep well. Yet there is little research into sleep management in tinnitus and few treatment studies specifically address insomnia. There is a strong evidence base that CBT for insomnia (CBTi) is an effective treatment for sleep disturbance when it presents both as a primary problem and when it is co-morbid with other physical (and mental) health problems, for example, chronic pain.

Patients with chronic and distressing tinnitus and significant sleep disturbance were offered group-delivered CBTi as part of routine clinical care. This included standard treatment elements of sleep restriction, stimulus control, psychoeducation, applied relaxation, cognitive restructuring and worry management. Patients attended six, two-hour group sessions, led by two clinical psychologists. Primary outcome measures included the Insomnia Severity Index and measures of total sleep time and sleep efficiency based on sleep diaries. Secondary outcome measures included tinnitus distress (measured on the Tinnitus Questionnaire – TQ) and psychological distress (CORE-OM, GAD7 and PHQ9). All participants were assessed pre and post therapy.

Results are reported from patients who completed CBTi. The treatment was delivered in three separate groups as part of routine clinical care. Results demonstrate that patients completing treatment showed a significant improvement in sleep measures. We will present final analyses of the secondary outcome measures and of qualitative data from patients regarding their experiences of the group.

This pilot study which evaluates routine clinical care suggests that CBTi can offer real improvements for patients with chronic tinnitus and sleep disturbance. This offers a promising avenue for future research. Considering the paucity of research into the
management and treatment sleep problems in tinnitus, this study, although small, is an important addition to the evidence base. The authors are now undertaking a Randomized Controlled Trial for CBTi in a tinnitus population, and we will give a brief overview of this to demonstrate how we plan to further assess the efficacy of CBTi compared to existing standard interventions.

Tinnitus is a disabling and prevalent condition. A large proportion of patients with tinnitus are also plagued by problems with disturbed sleep. Despite this, all existing interventions focus on managing the general impact of tinnitus, and none have yet explored how patients can be best supported in reducing the additional burden of insomnia. Our pilot study evaluating the use of CBTi in routine clinical care suggests that we may be able to offer a new approach to insomnia in tinnitus that is effective and acceptable. This has implications for clinicians working with tinnitus patients in an audiology service, as well as CBT therapists who encounter tinnitus patients in other primary care settings.

Assessing Regularity of Eating as a Purported Mediator of the Effect of Enhanced Cognitive Behaviour Therapy on Frequency of Binge Eating
Katy Sivyer, University of Oxford; Rebecca Murphy, University of Oxford; Elizabeth Allen, London School of Hygiene and Tropical Medicine; Zafra Cooper, University of Oxford; Christopher G Fairburn, University of Oxford

A key intervention in enhanced cognitive behaviour therapy (CBT-E) for eating disorders is the ‘regular eating procedure’, which helps patients implement a structured eating pattern. By increasing regularity of eating it is hypothesised that the frequency of any binge eating will reduce. However, little research has been conducted examining the specific effect of the regular eating procedure during treatment, and its relationship to regularity of eating and frequency of binge eating.

A mediation sub-study was embedded within a randomised controlled trial comparing CBT-E and interpersonal psychotherapy (IPT) in a transdiagnostic sample of patients with eating disorders. Adherence to a structured eating pattern (‘regularity of eating’) and frequency of binge eating was examined during the first four weeks of treatment and were assessed by two blinded independent assessors based on patients’ self-monitoring records. A number of statistical models were run to investigate the hypothesis that regularity of eating mediated the effect of CBT-E on frequency of binge eating compared to IPT, including an alternative model, whereby frequency of binge eating predicted regularity of eating.

Results suggested that regularity of eating increased significantly in CBT-E, but changed little in IPT. Although frequency of binge eating decreased in both treatments, rate of change differed between CBT-E and IPT, with an increase in regularity of eating associated with a decrease in frequency of binge eating in CBT-E only.

Whilst results were consistent with regularity of eating being a mediator in CBT-E, the temporal ordering of change was not clear, regularity of eating cannot be concluded definitively as a mediator of the effect of CBT-E. Further research is needed to establish the temporal sequence of change in regularity of eating and change in frequency of binge eating in CBT-E.

Helping patients to implement a regular eating pattern may help reduce their frequency of binge eating. However, more in depth study of these processes is needed.

For better or worse: An individual patient data meta-analysis of deterioration among participants receiving Internet-based cognitive behavior therapy
Alexander Rozental, Stockholm University, Sweeden and University College London; Kristofer Magnusson, Karolinska Institutet; Johanna Boettcher, Freie Universität Berlin; Gerhard Andersson, Linköping University; Per Carlbring, Stockholm University

Psychological treatments can relieve mental distress and improve well-being, and the dissemination of evidence-based methods can help patients gain access to the right type of aid. Meanwhile, Internet-based cognitive behavior therapy (iCBT) has shown promising results for many psychiatric disorders. However, research on the potential for negative effects of psychological treatments has been lacking.
An individual patient data meta-analysis of 29 clinical trials of ICBT (N = 2866) was performed using the Reliable Change Index for each primary outcome measures to distinguish deterioration rates among patients in treatment and control conditions. Statistical analyses of predictors were conducted using generalized linear mixed models. Missing data was handled by multiple imputation.

Deterioration rates were 122 (5.8%) in treatment and 130 (17.4%) in control conditions. Relative to receiving treatment, patients in a control condition had higher odds of deteriorating, Odds Ratios (OR) 3.10, 95% Confidence Interval (CI) [2.21-4.34]. Clinical severity at pre treatment was related to lower odds, OR 0.62, 95% CI [0.50-0.77], and 0.51, 95% CI [0.51-0.80], for treatment and control conditions. In terms of sociodemographic variables, being in a relationship, 0.58, 95% CI [0.35-0.95], having at least a university degree, 0.54, 95% CI [0.33-0.88], and being older, 0.78, 95% CI, [0.62-0.98], were also associated with lower odds of deterioration, but only for patients assigned to a treatment condition.

Deterioration among patients receiving ICBT or being in a control condition can occur and should be monitored by researchers in order to reverse and prevent a negative treatment trend.

Negative effects of psychological treatments is largely unknown for many researchers and clinicians. However, evidence suggest that 5-10% of all patients deteriorate during treatment and that some also experience other adverse and unwanted events. The results from the current study indicate that deterioration occurs among some patients receiving cognitive behaviour therapy via the Internet. Furthermore, certain sociodemographic variables seem to be associated with lower odds of deterioration; older age, higher educational level, being in a relationship, and having higher symptom severity at pre treatment assessment. In addition, proportionally more patients deteriorated while in waitlist control, suggesting that a better match between patient and treatment format may be required, and that there are ethical and methodological issues surrounding the use of waitings periods in randomised controlled trials.

Developments in CBT for children and young people

Behavioural inhibition, shyness and social withdrawal: Differential risk for adolescent social phobia, generalized anxiety and depression.

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Internalizing disorders such as social phobia, generalized anxiety (GAD) and depression are among the most common and persistent disorders affecting children and adolescents. Behavioural inhibition (BI), a temperament trait characterized by fearful reactions to the unfamiliar, is a well-established risk factor for internalizing disorders. Behaviourally inhibited children do not easily adapt to unfamiliar events (Degnan et al., 2010). Early BI has been associated with persistent shyness, which in turn is also identified as a risk factor for internalizing problems (Karevold et al., 2012). Shyness implies a social component, and is viewed as a fear of social situations or high social avoidance (Asendorf, 1993). Social withdrawal, when children avoid or isolate themselves from social interaction, is also linked to internalizing problems. Few studies differentiate between BI, shyness and social withdrawal, terms that are often used interchangeably. Furthermore, social and non-social components of these different concepts have been differentially linked to internalizing disorders, where, for example, non-social components of BI were linked to anxiety and depression whereas social components were linked to social phobia (Hayward et al. 1998; Hudson & Rapee, 2004). We prospectively examined the development of BI, shyness and social withdrawal in childhood in order to clarify links to adolescent psychopathology, specifically social phobia, GAD and depression, in addition to modelling trajectories of shyness and social withdrawal during early and middle childhood.
1596 singletons born in 1997-1998 were followed over 15 years. BI, defined as a difficulty to adapt to novel situations, was rated by fathers when children were 5 months old. Yearly mother-rated shyness and social withdrawal, between 3½ and 6 years and at 8 years, was used to identify group-based developmental trajectories. Adolescents self-reported their symptoms of social phobia, GAD and depression at 15 years-old. Three distinct stable trajectories (low, moderate and high) were identified for both shyness and social withdrawal. Preliminary analysis linked birth weight and smoking during pregnancy to GAD and depression, whereas child sex, BI and maternal stress were associated with all three types of adolescent internalizing disorders (all ps <.05). Hierarchical regression analyses revealed that being a girl and a high shyness trajectory predicted adolescent social phobia. Being a girl, higher BI and higher maternal stress contributed to GAD symptoms. Similarly, being a girl, smoking during pregnancy and higher maternal stress predicted higher depression symptoms. However, beyond these risk factors, higher shyness trajectories were a protective factor for both GAD and depression symptoms in adolescence.

Early BI (5-month) had enduring effects on GAD symptoms in adolescence. Shyness was a risk factor for social phobia but a protective factor for GAD and depression. Social withdrawal did not significantly impact later psychopathology. Our results underline the long lasting effect of early childhood and maternal factors, particularly the differential impact of social and non-social aspects of temperament traits on adolescent disorders. These results underscore the importance of clearly distinguishing between behavioural inhibition, shyness and social withdrawal which can help identify specific vulnerabilities and customize CBT, thus better addressing adolescent internalizing disorders.

**Resistance to Peer Influence in Adolescents with and without Mild-to-Borderline Intellectual Disability: A Formal Modelling Study**

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Resistance to Peer Influence (RPI) is proposed to act as a protective factor against increased risk taking during adolescence. Adequate measurement of RPI is therefore of importance in identifying adolescents at risk. We here present a study that aimed to formally model responses to items of the Resistance to Peer Influence Questionnaire (RPIQ; Steinberg & Monahan, 2007), to obtain an adequate measure of RPI, which advances comparison of subgroups of adolescents.

RPIQ data were available for 177 Typically Developing (TD) adolescents (N-Boys = 117) and 174 adolescents with a Mild-to-Borderline Intellectual Disability (MBID) (N-Boys = 103). Items of the RPIQ have a tree-based structure. That is, on each item, individuals first choose whether a less versus more peer resistant group best describes them; they then indicate whether it is ‘Really true’ versus ‘Sort of true’ that they belong to the chosen group. Using formal modelling, by means of tree-based Item Response Theory—that adheres to the internal structure of the items of the RPIQ—we (1) studied the dimensionality underlying these items and (2) tested for differences on these underlying dimensions between subgroups of adolescents.

Applying the tree-based modelling approach, we first show that items of the RPIQ tap three dimensions. That is, we found evidence for a Resistance to Peer Influence (RPI) dimension and two Response Polarization dimensions. We then reveal sub-group differences at all three dimensions. That is, MBID, compared to TD adolescents, report to be less RPI and are more polarized in their responses. Also, girls, compared to boys, report to be more RPI, and, after an initial choice to be more RPI, are more polarized in their responses.

Together, the results of this study indicate that applying the tree-based modelling approach to adolescents’ responses to the RPIQ approach yields an adequate measure of adolescents’ RPI as well as their tendency to respond more or less extremely. Applying the tree-based modelling approach to adolescents’ responses to the RPIQ is of relevance in identifying adolescents at risk of either low RPI or a strong tendency to respond extremely, or both. Positioning adolescents on dimensions of both RPI and Response
Polarization is of relevance in deciding on targeted (preventive) treatment of adolescents (at risk).

**Social anxiety in youth with tic disorders: the role of attention biases for social threat**

Victoria Pile, King’s College London; Victoria Pile, King’s College London; Sally Robinson, Guys and St Thomas NHS Foundation Trust; Marta Topor, Guys and St Thomas NHS Foundation Trust; Tammy Hedderly, Guys and St Thomas NHS Foundation Trust; Jennifer Lau, King’s College London

Social anxiety is common and impairing in young people with Tourette Syndrome and Chronic Tic Disorders (TS/CTD), yet there has been limited research investigating cognitive processes that may underlie social anxiety in this population. Attention to threat is a cognitive bias implicated in social anxiety in the general population. This study examined whether selective attention to threat is enhanced in young people with TS/CTD, compared to controls, and whether it is associated with tic severity and social anxiety in this group. Thirty young people with TS/CTD and twenty-seven control participants (matched for age, gender and IQ) completed the study. Participants completed a dot probe task, which is an experimental measure of attention bias towards/away from threat stimuli; participants and their parents completed questionnaire measures of anxiety and depression; and a clinician completed a measure of tic severity.

Young people with TS/CTD showed an attention bias towards social threat words, $F(1,26) = 5.34, p<0.05, \eta^2 = .18$, (but not to faces) and this bias was associated with increasing social anxiety, $r(27) = .47, p<0.05$, and tic severity, $r(27) = .45, p<0.05$. Attention to social threat words mediated the relationship between tic severity and social anxiety (indirect effect: $b = .23, 95% CI = .043–.50$).

This study provides preliminary evidence that young people with TS/CTD have enhanced attention to threat, compared to matched controls, and that this is associated with social anxiety and tic severity. Attention to threat explained common variance between tic severity and social anxiety, implying that it has the potential to be a valuable trans-diagnostic treatment target. These findings offer new avenues for treatment development and the prevention of disability in this population.

This research has several clinical implications. Crucially, it suggests that a key cognitive bias known to underlie anxiety disorders in the general population also has a role in anxiety in young people with TS/CTD. This implies that cognitive models used to understand and treat anxiety could be successfully applied to young people with TS/CTD. Furthermore, metacognitive strategies for treating young people with TS/CTD that target attentional processes (e.g. attention control and the flexible allocation of attention) could be a novel and useful addition to current psychological therapies for the management of tics and co-morbid anxiety disorders. The research also highlights the high prevalence of anxiety in young people with TS/CTD and the importance of assessing for anxiety and formulating the role that anxiety has in the young person’s functioning.

**Struggling to imagine a bright future: the role of impoverished positive future imagery in adolescent depression**

Victoria Pile, King’s College London; Patrick Smith, King’s College London; Jennifer Lau, King’s College London

Enhancing positive future imagery offers promise for treatment innovation but has, as yet, been neglected in the area of adolescent mood problems. Adolescence is associated with increased depression onset, as well as being a period when future orientation increases and cognitive styles stabilise. While negative life events are linked with depression-onset in adolescence, the mechanisms underlying this association are poorly understood. The ability to generate future images may rely partly on past memories, with the same neural circuitry implicated in imagining the future and remembering the past. Disruption to memory processes, following negative events, may impact on the ability to generate positive images. Here, we investigate whether difficulties in positive future imagery characterise depression, compared to anxiety, and moderate the relationship between negative life events and
symptoms of depression. Furthermore, we aimed to develop a novel intervention targeting these mechanisms. We firstly explored the relationships between imagery, negative life events and depression in an adolescent sample (n=375) and, secondly, conducted a case series (n=10) aiming to modify these processes using imagery based psychological techniques. Symptoms of depression were associated with poor image detail for events in general (past and future; positive and negative), whilst anxiety was associated with poor image detail for past negative events only. The relationship between life event severity and depression symptoms was increased for those with poorer image detail for positive future events whilst, in contrast, the relationship between life event severity and anxiety was enhanced by having higher detail for negative past images. Results from the case series will also be presented. These findings suggest that the relationship between prospective positive imagery and negative life events are specific to symptoms of depression in adolescence. This research suggests novel approaches to strengthen psychological interventions for adolescent depression, which we have begun to explore in the case series. The case series will provide initial evidence for the acceptability of targeting these processes in young people with symptoms of depression. This research indicates that techniques aiming to (1) improve access to positive future imagery and (2) process negative images, could provide novel avenues for psychological treatment of adolescent depression. Furthermore, this study emphasizes the importance of assessing for significant life events, symptoms of post-traumatic stress and positive plans for the future in young people. One exciting implication from this study is that having more detailed positive future images may protect young people against developing depression, particularly following negative life events. Positive cognitive processing could be targeted by augmenting positive emotional experience and facilitating the generation and elaboration of detailed prospective positive imagery. From our case series, we will be able to provide initial data on whether it is possible and acceptable to target these processes in young people with low mood.

**Therapist flexibility and treatment efficacy in CBT for childhood social anxiety disorder**

Liesbeth Telman, University of Amsterdam; Francisca van Steensel, University of Amsterdam; Marija Maric, University of Amsterdam; Susan Bögels, University of Amsterdam

Anxiety disorders are common youth psychiatric disorders, and cognitive behavioral therapy (CBT) is the most efficacious treatment for anxiety disorders in children. Nevertheless, about one third of the children is not anxiety free after treatment. In specific, there are indications that children with social anxiety disorder (SAD) respond less well to treatment than children with other anxiety disorders (Hudson et al., 2015). One way to improve CBT for childhood anxiety disorders is the use of a flexible treatment protocol, which is tailored to the individual child. Recent studies have shown that the flexible use of a protocol leads to improvements in client satisfaction and favorable outcomes (Hamilton et al., 2008). In addition, therapist flexibility predicted child involvement, which in turn predicted better treatment outcomes (Chu & Kendall, 2009). In order to study the working mechanisms of CBT for childhood SAD, this study aimed to examine whether a flexible protocol is beneficial for treating children with SAD. The current study examined 10 cases of an ongoing study concerning working mechanisms in CBT for childhood anxiety disorders. Children and adolescents referred to mental health clinics are treated with the CBT manual "Discussing + Doing = Daring" (Bögels, 2008), incorporating cognitive therapy, behavioral therapy, and mindfulness. The protocol was split into modules and therapists were encouraged to use clinical judgement to modify therapy to the individual child. At pre-, during, post-, and 10 weeks follow-up treatment, children and parents completed a questionnaire measuring the child’s anxiety symptoms and child-therapist alliance. On a session-to-session basis, children and parents assessed their treatment satisfaction, child daily functioning, and child anxiety symptoms.
Preliminary results showed a decrease in anxiety symptoms from pre- to posttest. Currently, audio-tapes of therapy sessions are being rated on therapist flexibility. Results will be presented regarding the mediating role of therapist flexibility in treatment efficacy. Clinical implications will be discussed concerning the role of therapist flexibility and therapist-child alliance in treating childhood SAD. This study leads to recommendations whether the use of a flexible protocol for childhood SAD is beneficial or not. Understanding which process variables (i.e. therapist flexibility, working alliance) contribute to the efficacy of treatment could lead to improvements in quality of care.

**Randomised controlled trial of the use of the Blue Room virtual reality treatment to reduce situation specific anxiety in young people with ASD**

Victoria Grahame, Northumberland Tyne and Wear NHS Foundation Trust; Morag Maskey, Newcastle University; Jacqui Rodgers, Newcastle University; Helen McConachie, Newcastle University; Jeremy Parr, Newcastle University

Young people with ASD are prone to anxiety; around 50% of those with ASD meet criteria for at least one anxiety disorder. Specific fears and phobias are one of the most frequent subtypes. Graduated exposure and participant modelling are identified as evidence-based treatments for specific fears/phobias, but may require adaptation for individuals with ASD. One adaptation may be the use of a virtual reality environment (VRE) to reproduce the anxiety provoking situation. This removes the need to use imagination, and provides a way to gradually increase exposure to an anxiety provoking stimulus.

The Newcastle Blue Room Treatment uses state of the art technology ([http://blueroomisv.com/](http://blueroomisv.com/)) to create an immersive VRE within which the child has sessions of adapted CBT with a therapist. Following a successful development study with 9 children (Maskey et al 2014, PLoS One), we investigated further whether the Newcastle Blue Room Treatment may be effective for children attending child mental health services by conducting a randomised trial.

The aim was to test the effectiveness of VRE exposure in overcoming a specific fear/phobia, reporting outcomes at 6 months after treatment.

32 verbally fluent young people with ASD aged 8-14 years, who have a specific fear/phobia, were recruited from two mental health trusts. Children were randomised to immediate treatment (n=16) or delayed treatment (n=16; receiving treatment after their six month follow-up). Each participant received one preparatory home visit, followed by four 20 minute sessions in the VRE with a scene designed specifically around their specific fear/phobia. During each session, they received coaching in relaxation techniques and coping self-statements from a therapist who accompanied them.

Before and after each VRE session, the child and parent (who was observing from another room) rated the child’s confidence in tackling their target situation using a six point scale. Anxiety at baseline and six-month end point was measured using the Spence Children’s Anxiety Scale and the FEAR survey. Vignettes describing the child’s anxiety-related behaviours, and the family impact, were written at baseline. Subsequently, a blinded researcher contacted the families at 3 months and 9 months after baseline and completed vignettes characterising the child’s anxiety-related behaviour. Pairs of vignettes were compared by an expert panel (blinded to time-point and treatment group) to assess degree of improvement/deterioration of symptoms and impact on a 9 point scale. Points 1-3 described a ‘responder’, and 6-9 a worsening of symptoms.

25 boys and 7 girls (mean age 10 years) were randomised; the treatment and control groups were well matched on baseline characteristics. Treatment group children received all planned sessions and contact with all randomised children was retained, showing acceptability of the trial methods, and treatment. Treatment fidelity ratings were high. The improvement in Target Behaviour change scores from baseline to 9 months for the treatment group compared with the control group was significant (3.92 (1.63) vs. 5.40 (0.86) respectively, p=.007, Effect Size 1.14, observed power 0.85). Six (38%) treatment group children were responders at 9 months post-baseline, compared with no control.
children (p=0.018); one third of control group children were rated as having symptoms worse than baseline, compared with one treatment group child. Individually tailored treatment comprising immersive VRE exposure with CBT was feasible to deliver through the UK NHS, and acceptable to children and parents. Treatment led to significant improvements in real life situational anxiety/phobia/fear, with some children able to manage everyday activities/situations. This study has shown that the individually tailored, Newcastle Blue Room Treatment is a potentially effective treatment for children with ASD and situation specific anxiety, specific fears and phobias. The Blue Room VRE Treatment meets the need identified by the UK National Institute for Health and Care Excellence in Guideline 170 (NICE, 2013) for adaptations to CBT in order to make it more effective for children with ASD. NICE suggested a number of adaptations to delivery, all of which were included (for example, greater use of written and visual information, a more cognitively concrete and structured approach, involving a parent or carer to support the implementation of the intervention). There are a number of additional reasons why virtual reality can improve the effectiveness of CBT for children with ASD. The technique allows for precise replication of a level of exposure not usually possible in the real world. This enables therapist and child to repeatedly practice anxiety reduction techniques at one level of exposure to enable mastery to be achieved before moving up the exposure hierarchy. This consolidates learning, confidence and mastery. Developing awareness of different levels of anxiety, and practice in its reduction, naturally develops as the child receives controlled exposure in the VRE. As parents observe the sessions whilst not being directly involved, they gain a clear understanding of the methods used, which they can utilise in real life situations.

As NHS provision of the Newcastle Blue Room VRE Treatment progresses, systematic data gathering with all children seen through the clinical service is planned. This study focused on children, but adults may also benefit from treatment. A small development treatment study of autistic adults recruited through the NHS has also been undertaken and the results are awaited (Maskey et al., in preparation).

Evaluating and Enhancing CBT IAPT therapy training; Developing an evidence base as trainers and supervisors

Professional differences in CBT IAPT Training: Adapting CBT training to the most of different professions and different abilities
Suzanne Byrne, IoPPN/King's College London; Sheena Liness, IoPPN/King's College London

The IoPPN /King's College London has been an IAPT CBT Post-Graduate Diploma since 2008 training over 250 mental health professionals from a diverse professional base, with and without a core profession, such as clinical and counselling psychologists, mental health nurses, occupational therapists, psychological wellbeing practitioners. Studies evaluating competency in CBT therapists have reported professional differences in the attainment of competency (Brosan et al 2006, McManus et al 2010). This study will explore the attainment of competency on the IoPPN/KCL CBT IAPT training course from baseline to the end of training. Trainee differences will be presented in course progression across professions, differences in additional support required, length to graduation, degree class, and number of failed modules between professions will also be reported. The adaptation of training methods to meet these needs will be explored to foster student co-learning and to add to the richness of the student experience.

A Follow Up Study of CBT IAPT Trainees 2008-2015; CBT competence and clinical outcome post-training
Sheena Liness, IoPPN/King's College London

Studies following up CBT trainees post-training to assess the maintenance of therapy skills learned in training are few (Milne, D L., Westerman, C., & Hanner, S 2002; Myles P J, & Milne D L, 2004, Branson A, Shafran R & Myles P, 2015). The UK Improving Access to Psychological Therapies (IAPT) initiative has trained a large number of therapists in
Developing a Measure of Competence in Behavioural Couple Therapy
Sarah Corrie, CNWL NHS Foundation Trust & Royal Holloway; Isabelle Rudolf von Rohr, Royal Holloway, University of London,
Behavioural couple therapy (BCT) is an empirically supported intervention which is included in the NICE guidelines as a treatment for Major Depressive Disorder. Recent clinical outcome data have demonstrated that graduates of a post-qualification training in BCT are able to provide effective treatment in routine practice benefiting the client suffering with depression and their partner. With the introduction and expansion of this treatment modality comes a need to consider ways of accurately and meaningfully assessing therapist competence as part of a broader quality assurance agenda and providing a framework for delivering feedback. This presentation describes the development of an observation-based rating scale (Behavioural Couples Therapy Scale for Depression; BCTS-D) as a means of determining therapist competence in this modality. As (to the best of our knowledge) the first measure of BCT competence, this presentation provides a brief description of the rating scale, therapist and supervisor feedback, its use in clinical practice, and progress in investigating its psychometric properties. Key points of learning as well as next steps are discussed.

What do CBT trainees need to know about other modalities of therapy?
Michael Worrell, Central and North West London Foundation Trust
Training in Cognitive Behavioural Therapy has traditionally been at a post qualification level with trainees demonstrating experience and general competence in mental health work and psychological interventions at the stage of application to training. With the advent of the IAPT programme an increasing number of trainees are entering High Intensity CBT training with a background as Psychological Wellbeing Practitioners (PWP). Whilst in many respects applicants who have substantial experience as PWPs make excellent candidates for training as High Intensity therapists, these individuals often do not have the required theoretical and procedural knowledge about other modalities of therapy that are a prerequisite for training. The BABCP have developed the ‘Knowledge Skills and Attitudes’ framework to allow for some reliable means for assessing applicants’ attainment of such competencies. The present paper describes a training programme that has been developed to assist ‘KSA applicants’ to gain and demonstrate competencies in other modalities of therapy prior to commencing High Intensity CBT Training. The training consists of three full days focussing on Humanistic, Psychodynamic and Systemic models of therapy and includes theoretical instruction, DVD and role play demonstration plus experiential practice of key competencies related to each model. Whilst the training has been met with a high degree of participant satisfaction, little is known about the impact and relevance of this training to trainees subsequent learning and practice of CBT. This paper describes preliminary research to address this issue and focussed principally on trainees’ perceptions regarding the relevance of this training to their eventual practice of CBT. The research looked at how trainees’ perceptions of the relevance of each of the therapeutic models changed following the training and also explored what in particular trainees thought could be taken from each modality into their practice as CBT therapists. The paper also discusses the potential
relevance of this training to trainees’ post CBT qualification work and CPD within the expanding IAPT context which has increasingly involved CBT therapists taking on additional qualifications in other evidence based forms of therapy.

“Do Trainee CBT Supervisors Practice What They are Trained To Do?”
Rita Woo, CNWL & Royal Holloway University; Michael Worrell, CNWL & Royal Holloway University

It has been recognised that specific training in supervision is helpful if not desirable given the complex role that supervisors adopt and there is a growing literature base on what the components of good supervision are. What is less clear is the impact of supervision training on the ability to meet the demands of a supervisory role and whether training has an impact on perceived effectiveness. This paper will summarise the evaluation of a 5-day supervision training course for potential CBT supervisors to High Intensity trainees. It will attempt to explore participants’ views on supervision training, the influences on current supervision practice, and most of all does training have an impact on current supervision practice?

Cognitive Bias Modification: Novel avenues to enhance its effects on cognitive bias and anxiety

Investigating whether sleep enhances the effects of Cognitive Bias Modification in analog posttraumatic stress
Marcella Woud, Ruhr-Universität Bochum; Jan Cwik, Ruhr-Universität Bochum; Birgit Kleim, University of Zürich; Simon Blackwell, Ruhr-Universität Bochum; Emily Holmes, Karolinska Institutet; Dirk Adolph, Ruhr-Universität Bochum; Hui Zhang, Ruhr-Universität Bochum

Posttraumatic Stress Disorder (PTSD) is characterised by dysfunctional interpretations of the trauma and its consequences. Experimental studies have shown that Cognitive Bias Modification – Appraisal (CBM-App) training can reduce dysfunctional interpretations and analog trauma symptoms. One important question is how to enhance the effects of CBM and thus increase potential benefits. Following work suggesting that sleep has beneficial effects on consolidation processes and can thus improve learning, the present study investigated whether the sleep can be used to enhance the effects of CBM-App.

In the present study, all participants watched a stressful movie as an analog trauma induction. After that, participants received either positive or negative CBM-App training. Within each CBM training group, half of the participants then had a 90 minute nap or watched a neutral movie. Results showed that the CBM training induced training congruent interpretations. However, sleep did not enhance the training’s effect. Further, participants who slept experienced less intrusive memories of the analog trauma over the subsequent week, but this effect was independent of the CBM training condition. These results provide us with valuable information about the effects of sleep on encoding of analog trauma and emotional learning paradigms in the context of appraisal and will therefore inspire various routes for follow-up work.

Does attention bias modification training under working memory load increase the magnitude of change in attentional bias?
Patrick Clarke, Curtin University; Sonya Branson, University of Western Australia; Nigel Chen, University of Western Australia; Bram Van Bockstaele, University of Amsterdam; Elsko Salemink, University of Amsterdam; Colin MacLeod, University of Western Australia; Lies Notebaert, University of Western Australia

Attention bias modification (ABM) procedures have shown promise as a therapeutic intervention, however current ABM procedures have proven inconsistent in their ability to reliably achieve the requisite change in attentional bias needed to produce emotional benefits. This highlights the need to better understand the precise task conditions that facilitate the intended change in attention bias in order to realise the therapeutic potential of ABM procedures. Based on the observation that change in attentional bias occurs largely outside conscious awareness, the aim of the current study was to determine if an ABM
procedure delivered under conditions likely to preclude explicit awareness of the experimental contingency, via the addition of a working memory load, would contribute to greater change in attentional bias. Bias change was assessed among 122 participants in response to one of four ABM tasks given by the two experimental factors of ABM training procedure delivered either with or without working memory load, and training direction of either attend-negative or avoid-negative. Findings revealed that avoid-negative ABM procedure under working memory load resulted in significantly greater reductions in attentional bias compared to the equivalent (standard) probe ABM training task delivered under no-load. These present findings are consistent with the position that the addition of a working memory load may facilitate change in attentional bias in response to an ABM training procedure. The current findings will require replication with clinical samples to determine the utility of the current task for achieving emotional benefits.

Gamification of threat-related Cognitive Bias Modification training; A way to enhance user experience and motivation to train?
Elske Salemink, University of Amsterdam; Suzanne de Jong, University of Amsterdam; Bram van Bockstaele, University of Amsterdam; Lies Notebaert, University of Western Australia; Colin Macleod, University of Western Australia

Interpretation bias plays a crucial role in anxiety. Training procedures have been developed to experimentally change interpretation bias; initially to test its causal role in anxiety, and more recently to test beneficial, clinical effects of the training. Generally, when bias is successfully changed, systematic effects on anxiety have been observed. However, there is great individual variability in training effectiveness. Furthermore, training is considered quite boring and this could negatively impact upon motivation for training, and adherence. The aim of the current study was to gamify threat-related interpretive bias training to make the training more fun and thus increase one’s motivation to train. The gamified version involves calibrating speed of stimulus delivery to performance, thereby keeping participants processing at the limits of their ability and potentially maximizing training effectiveness. A 2 (Type of training: Gamified vs. Standard training) x 2 (Valence of training: Benign vs. Placebo training) between-subjects design was used, with random allocation. State anxiety and social anxiety were assessed pre- and post-training. Furthermore, post-training interpretive bias and reactivity to a stressor were assessed. Finally, participants completed an evaluation questionnaire to assess their enjoyment during training and the motivation to complete the training. Based on insights from the gaming literature, the standard training was changed into a gamified training (shooting game) by including extrinsically and intrinsically motivating elements such as points, high scores, time-pressure, fun elements, and adaptive elements so participants train at an individually challenging level. In total, 85 above average anxious individuals participated in the study. Preliminary analyses revealed that participants tended to like the game better than the standard training and were more likely to recommend the training to fellow students. In addition, the positive training conditions (gamified and standard training) were successful in reducing negative interpretations, compared to the placebo conditions. No differential effects were observed on anxiety.

The current study indicated that the gamified training was evaluated more positively by the participants, suggesting that gamification seems to be a promising new approach.

The relationship between attentional control and change in bias in response to attentional bias modification.
Lies Notebaert, University of Western Australia; Julian Basanovic, University of Western Australia; Ben Grafton, University of Western Australia; Colette Hirsch, King’s College London; Patrick Clarke, Curtin University

Procedures that effectively modify attentional bias to negative information have demonstrated the potential to be an effective source of therapeutic change in emotional
vulnerability. However, the degree to which these procedures modify attentional bias is subject to individual differences. This generates the need to understand the mechanisms that influence attentional bias change across individuals. The present study investigated the association between individual differences in attentional control and individual differences in the magnitude of bias change evoked by an attentional bias modification procedure. The findings demonstrate that individual differences in two facets of attentional control, control of attentional inhibition and control of attentional selectivity, positively predicted individual differences in the magnitude of attentional bias change. The present findings inform upon the cognitive mechanisms underpinning change in attentional bias, and identify a target cognitive process for research seeking to enhance the therapeutic effectiveness of attentional bias modification procedures.

**Online Cognitive Bias Modification Training for Attention Targeting Adults with Heightened Levels of Anxiety: Short- and Long-Term Effects of a Randomized Controlled Trial**

**Mae Nuijs, University of Amsterdam;** Leone de Voogd, University of Amsterdam; Anke Klein, University of Amsterdam; Helle Larsen, University of Amsterdam; Elske Salemink, University of Amsterdam; Reinout Wiers, University of Amsterdam

**Background:** Given that cognitive models of anxiety suggest that attentional biases play an important role in the etiology of anxiety, we investigated whether Cognitive Bias Modification for attention (CBM-A) can be a promising online intervention for adults with heightened anxiety symptoms. Recent meta-analyses suggest that the context in which CBM-A is offered, including the emotional state of participants during training, moderates the effect of CBM-A. The first aim of this study was to investigate the effects of online visual search CBM-A on attentional bias and (trait) anxiety and depressive symptoms. The second aim was to investigate whether pre-training state anxiety enhanced the effects of CBM-A.

**Method:** We randomly assigned individuals to 11 sessions of online visual search CBM-A or online visual search placebo training. The primary outcome of trait anxiety and the secondary outcomes of anxiety and depressive symptoms and alcohol use were assessed at pre-, mid- and post-training and at one, two and three months’ follow-up. Attentional bias was assessed pre-, mid- and post-training and at three months’ follow-up and state anxiety was measured before every training. Results: The data collection of this randomized controlled trial has just been finalized. Approximately 570 participants started training and 200 participants finished all training sessions. The results will be presented at the BABCP conference.

**New developments in cognitive behavioural therapy for psychosis**

**A systematic review of meta-analyses of CBT for psychosis**

Filippo Varese, University of Manchester

Cognitive Behaviour Therapy (CBT) is a recommended intervention for individuals with diagnoses of schizophrenia and related psychoses at all stages of the illness (NICE, 2014). A substantial number of systematic reviews and meta-analyses have been carried out in the past 20 years to evaluate the efficacy of CBT as a treatment to ameliorate psychotic symptoms, and preventing transition to psychosis in at-risk individuals. Although these reviews have generally found support for the efficacy of CBT, there are considerable discrepancies amongst the findings of different meta-analytic studies, with some reviews suggesting moderately sized treatment effects (e.g. Wykes et al., 2008), and others being more cautious about the efficacy of CBT for psychosis (e.g. Jauhar et al 2014).

It is increasingly recognised that the findings of meta-analytic studies are not only influenced by the quality of the primary studies considered, but also by variances in the methodological, statistical and reporting quality inherent to these research syntheses. Given the pivotal role played by meta-analysis in informing clinical guidelines and implementation policies, as well as day-to-day evidence-based practice and decision-making, we carried out a systematic review and quality assessment of existing meta-analyses of CBT for psychosis.
The findings of this review of review will be discussed to provide a better understanding of the current state of the evidence of CBT for psychosis, and it will therefore be relevant to clinicians, researchers, future meta-analysts and policy makers. Furthermore, they review will provide methodological recommendations for future syntheses of this research area, with particular emphasis on answering two fundamental questions for future research: for whom and for what outcome does CBT for psychosis work?

**CBT for thought disorder in psychosis.**

**Jasper Palmier-Claus, Psychosis Research Unit**

Formal thought disorder (FTD) is a term used to describe disorganised thinking as evidenced through speech. In extreme forms of FTD, it may be difficult for the clinician to start a meaningful dialog with a service user. However, in mild or moderate FTD, there may still be scope for effective communication, and the opportunity to conduct talking therapies, such as cognitive behavioural therapy (CBT). In this presentation, Jasper Palmier-Claus will outline recent analyses exploring the effectiveness of CBT in individuals experiencing FTD. He will also present strategies for targeting and reducing the impact of disorganised speech/thinking within therapy as proposed by psychological therapists working in the North West of England. The presentation will finish with a discussion of possible future research.

**CBT for internalised stigma in psychosis.**

**Lisa Wood, North East London Foundation Trust**

People who experience psychosis are one of the most stigmatised groups in current western society with 87% of them reporting experiences of stigma. Internalised stigma occurs when an individual internalises the negative stereotypes, shame, blame, and hopelessness associated with stigma. Internalised stigma is a significant difficulty for those who experience psychosis and has been conceptualised in detail using social psychology theory. However, it has never been conceptualised using cognitive theory despite CBT being utilised as a psychological intervention for internalised stigma in psychosis. The aim of this presentation is to describe cognitive model conceptualising internalised stigma in people who experience psychosis. Previous literature is reviewed and critiqued which has informed the development of the model. The model draws upon previous social cognitive models of internalised stigma and integrates cognitive-behavioural theory and social mentality theory. The key cognitive processes which contribute to the development of internalised stigma and coping strategies to ameliorate it are described. Moreover, clinical implications are explored and the recommendations for future research are outlined. The evidence base of CBT for internalised stigma in psychosis will be described with particular emphasis on how it can be practically applied in clinical practice. CBT strategies and their use for internalised stigma will be explored to demonstrate its applicability in clinical practice.

**The possible adverse effects of CBT for psychosis.**

**Rory Byrne, Psychosis Research Unit**

Cognitive behavioural therapy (CBT) is a recommended treatment approach for people who experience psychosis. CBT is one of a number of psychological approaches developed as an alternative or compliment to the standard treatment for psychosis, antipsychotic medication. While antipsychotics are known to confer substantial risks of serious side-effects, CBT is thought to be a comparatively safe and well-accepted treatment. However this assumption has not been well-tested to date; systematised research examining the potential for CBT for psychosis to also confer unwanted adverse effects has only emerged in recent years. This presentation will summarise quantitative findings regarding adverse effects from meta-analyses of trials of CBT for psychosis, along with recent findings from individual trials that have systematically assessed this question. In addition, a summary of qualitative research findings will be presented to illustrate service users’ personal understanding and experience of adverse effects of CBT for psychosis.
CBT or medication for psychosis – The results of a randomised evaluation.
Tony Morrison, University of Manchester
Psychosis is amongst the largest challenges for the NHS and is repeatedly a priority for policy makers, commissioners and service providers, on the basis of significant personal, social and financial costs. The first line treatment for psychotic disorders is often medication. However, there is evidence to suggest that as much as 40-50% of service users will refuse or stop taking medication over an 18-month period, which may be due to their significant side effects. An alternative treatment option is cognitive behavioural therapy (CBT). Several large meta-analyses have suggested that CBT is effective at reducing psychotic symptom severity. Unfortunately, there is little evidence to support the use of one treatment over the other in terms of symptom reduction, especially in early phases. This would provide useful insights into the most appropriate first line treatments for psychosis. In this presentation, Tony Morrison will present the results of the ‘cognitive behavioural therapy or medication for psychosis - a randomised evaluation’ (COMPARE) trial. This feasibility study compared the effects of CBT to medication to the combination of both treatments. Results will be presented and implications considered.

Systemic approaches to embedding Cognitive-Behavioural interventions within acute inpatient settings

Using a timeline tool to help service users make sense of their crisis on admission to an acute psychiatric ward
Pamela Jacobsen, King’s College London; Humza Khan, King’s College London
When people experience a mental health crisis and are admitted to a psychiatric ward, they are usually asked to give a narrative of their understanding of what has brought them into crisis, and any problems or difficulties they identify in their life in the days and weeks leading up to admission. This telling of the “story” of their crisis is likely to be repeated several times over the coming days with different members of the care team and in different meetings (e.g. ward round with full multi-disciplinary team, 1:1 with primary nurse). This rather fragmented process can sometimes hinder the development of a coherent narrative between service users and staff and the development of a shared formulation. This project aimed to pilot a simple questionnaire tool which might help patients to better understand what has brought them into crisis, and to work towards a more coherent narrative which can be shared between staff and service user. The purpose of this service evaluation project was to evaluate whether a timeline tool administered within a semi-structured interview was feasible to implement and whether service users considered it an acceptable approach. The timeline tool developed for this pilot project was based on a card sort method where service users were asked to identify any relevant domains of functioning they found were affected in the run-up to admission, and to put these into chronological order. Service users within the first 14 days of their admission on an acute psychiatric ward in London were invited to participate by completing the timeline tool with an assistant psychologist. Data will be presented from the first 50 service users who consented to complete the timeline tool. The timeline tool was generally well-received by service users, and qualitative and quantitative data will be presented on the feasibility and acceptability of this approach within an acute inpatient setting.

‘Give us something to do’: reflections on running a group therapy programme
Catherine Clark, Canterbury Christ Church University; Pamela Jacobsen, Kings College London
People on psychiatric wards often report feeling bored, and say that they would like access to therapy groups on the ward to help aid their recovery. However, there are many challenges to providing groups on wards, including lack of staff with the requisite time and expertise. Small-scale service evaluation projects have reported universally positive outcomes from MDT group programmes on acute inpatient wards. However a review of the
literature suggests limitations in existing studies and much more research is needed in this area.

This presentation describes how a therapy group programme was designed and set up on a psychiatric triage ward in an inner London Borough. The group programme was psychology-led with involvement from nursing colleagues as co-facilitators. Catherine Clark worked as the group coordinator and facilitator for 15 months and will reflect on the opportunities and challenges of setting up and running the programme. Informal feedback on the groups provided by patients was positive and motivating for facilitators. Nursing staff also typically gave positive feedback after co-facilitating a group, for example that it was valuable to spend protected talking time with patients and that they had seen a ‘different side’ to patients in the group context. A persistent challenge in running the groups often related to the allocation of nursing co-facilitators. Catherine will reflect on her perceptions that the therapy groups were at times not valued or prioritised by the wider team and how this impacted on team working and morale. It was not unusual for nursing co-facilitators to be largely silent throughout the group and possible explanations for this such as lack of confidence, training and ownership of the programme are discussed. Catherine will also reflect on successful measures adopted over the programme to address some of the challenges discussed, as well as additional suggestions for future group programmes.

**Developing psychological understandings and interventions within acute mental health: Impact of a transdiagnostic staff training programme**

Olwyn Maiter, Northern Health and Social Care Trust

This project explores the impact of a new psychology service across acute inpatient mental health care within one Health and Social Care Trust in Northern Ireland. A core component of the service is delivery of a transdiagnostic staff training programme to foster availability of psychological understandings and interventions within inpatient care. This is in line with recommendations around the development of distributed expertise in psychological approaches within inpatient mental health care. The staff training has been based broadly on the model for Cognitive Behaviour Therapy in acute care developed by Isabel Clarke and colleagues. The training was made available to services across the acute care pathway (e.g. Crisis Resolution and Home Treatment Team, acute admissions wards, Psychiatric Intensive Care Unit), fostering a whole system approach to psychological interventions in acute care. A baseline survey was conducted in the initial stages of service development, prior to delivery of the training programme. This explored issues such as rates of staff access to training and supervision, staff confidence in utilising psychological approaches, staff compassion satisfaction and compassion fatigue, and service user ratings of the perceived recovery focus of the service. Results of the survey are discussed, alongside consideration of the impact of the training programme on staff and service user experience, and reflections on the process of service development.

**Depression presentations in an Acute Inpatient Mental Health Unit**

Catherine Donaldson, Belfast Health and Social Care Trust

This paper reports on data from all inpatient mental health referrals to an Acute Clinical Psychology Service for depression over a 5 year period. People who are admitted to an acute, inpatient mental health ward tend to range in age from 18 years upwards, be in a period of crisis and invariably carry some risk (to themselves, others, of exploitation, etc). We aimed to examine these referrals in order to look at patterns and care pathways that map onto those patterns and address both the inpatient and immediate post-discharge part of this pathway. Many clinical subgroups of depression have been suggested in the past (e.g. melancholic, atypical etc) often with distinct underlying biological mechanisms. However, cognitive therapy involves careful investigation of initial episodes, and, in this presentation, onset episodes were used to categorise the material from affective cases. A preliminary analysis of part of the data suggests 5 presentations: a loss-based depression; trauma-related depression; dissocial-based depression; adjustment-based depression; and, an organic group. Loss-based depressive admissions covered all the age ranges, several sets of circumstances (e.g. bereavement, divorce) and many of the clients in this group had earlier
experiences of loss. The trauma-related group seemed to be on a continuum with post-traumatic stress disorder and self-harm was a prominent feature. Often the trauma was childhood or early adulthood sexual abuse which seemed directly relevant to the thoughts (e.g. of deserving degrading treatment) and feelings (e.g. of being unclean, indecent, wicked) presented. The dissocial group often had some level of a forensic history. Substance misuse was prominent and guilt was often present. Periods of deep despair alternated with angry rumination and hostility. The adjustment group often involved those who struggled in the face of their own, their family's or their communities' attitudes to their sexual orientation or gender-identity. The organic depressions tended to overlap with dementia or head-injury. These 5 common presentations tended to require similar individual care plans, though with distinctions from one group to another - these will be discussed.

Exploring the similarities and differences between three cognitive-behavioural approaches to psychotherapy: Acceptance and Commitment Therapy (ACT), Method of Levels (MOL) and Motivational Interviewing (MI)

Robert Griffiths, Greater Manchester Mental Health NHS Foundation Trust; Rory Allot, Greater Manchester Mental Health NHS Foundation Trust; James Dixon, 5 Boroughs Partnership NHS Foundation Trust; Joe Oliver, University College London; Sara Tai, University of Manchester

The number of approaches to psychotherapy is growing, leading to increasing divergence between practitioners in their research and training priorities, underlying theoretical assumptions and clinical practice. This session aims to provide a forum to explore similarities and differences between three distinct cognitive-behavioural approaches: Acceptance and Commitment Therapy (ACT), Method of Levels (MOL) and Motivational Interviewing (MI).

ACT is a ‘third-wave’ CBT that combines mindfulness-based acceptance techniques with commitment and behaviour change strategies with the aim of increasing psychological flexibility (Flaxman, Blackledge & Bond: 2011). MOL is a transdiagnostic approach to CBT that directly applies a theory of human behaviour, called Perceptual Control Theory, to the practice of psychotherapy. It aims to reduce psychological distress by helping clients resolve goal conflict (Mansell, Carey & Tai: 2013). MI was first described by William Miller over 30 years ago in the BABCP journal, Behavioural Psychotherapy (Miller, 1983). It is a person-centred counselling style that guides clients to resolve their ambivalence about health damaging behaviour by selectively reinforcing client talk about change.

Robert Griffiths will introduce this clinical roundtable and provide an overview of the session. The practitioners of each therapy will then outline the key theoretical and clinical features of their approach before giving a practical demonstration of the therapy. Joe Oliver, Sara Tai and Rory Allott are widely recognised as experts in the approaches they will be describing and demonstrating (ACT, MOL and MI, respectively). James Dixon, clinical psychologist, will take on the role of ‘client’ for each of the practical demonstrations, providing feedback on the subjective experience of receiving the three different therapies. Reflections on theoretical and practical differences will be sought from the therapists, ‘client’ and attendees throughout the session, including differences in the theoretical assumptions about the mechanisms of change and active ingredients of therapy. The session will conclude with a discussion of the similarities and differences between the three approaches.

Clinical Skills Classes

Repairing anhedonia in depression; How to identify and work with positive dampening appraisals

Barney Dunn, University of Exeter

The primary focus in CBT for depression has been on down-regulating negative thinking and feeling. However, it is increasingly realised that anhedonia, a reduction in the ability to
experience pleasure, is also central to the onset and maintenance of depression, particularly more chronic presentations. Augmenting positive emotional experience and positive information processing has received less attention in the CBT literature to date. This skills workshop will focus on ways to work with one key mechanism shown to blunt pleasure experience in depression - the use of dampening appraisals in response to emerging positive feelings (e.g. “I don’t deserve this”, “this is too good to last”).

The workshop will briefly review evidence that dampening appraisals are related to anhedonia and then develop skills to:

i) recognise and categorise dampening appraisals
ii) use cognitive defusion techniques to step back from dampening appraisals
ii) modify dampening appraisals (moving from a 'truth' to a 'utility' frame when doing so)

Participants will be able to listen to tape examples of this work and then practice applying these techniques via role play.

By better targeting anhedonia, treatment outcomes for CBT for depression may be improved.

Barney Dunn is a research and clinical psychologist, currently employed as an Associate Professor at the University of Exeter Mood Disorders Centre. He leads a research programme characterising positivity deficits in depression and developing novel ways to build positivity in CBT. From 2015 to 2020 his positivity research programme is funded by an NIHR Career Development Fellowship. He has recently completed the Beck Scholar programme at the Beck Cognitive Therapy Institute in Philadelphia. He is BABCP accredited and was awarded diplomate membership of the Academy of Cognitive Therapy in 2013. He co-directs the AccEPT clinic, a NHS commissioned research clinic developing novel treatments for mood disorders and in his ongoing clinical practice treats anhedonic depressed clients (see: http://psychology.exeter.ac.uk/staff/index.php?web_id=Barney_Dunn).


Cultivating Self-Compassion in Meditation-Based Interventions

Thorsten Barnhofer, University of Exeter

Increases in self-compassion are a main pathway through which meditation trainings exert their beneficial effects in the prevention and treatment of emotional disorders. Yet, programs differ considerably with regard to how this quality is cultivated. Mindfulness-based interventions such as mindfulness-based cognitive therapy (MBCT) follow an “implicit” approach, in which self-compassion is seen as an overarching quality modeled through the relational stance of the teacher and reflected in their embodiment of the practice. Self-compassion trainings, such as the mindful self-compassion program by Germer and Neff, emphasize the importance of cultivating self-compassion explicitly, through exercises and meditation practices. The aim of this class is to explore the indications and the respective strengths and advantages of these different approaches.

The class will draw out the different traditions underlying implicit and explicit approaches, look at definitions of self-compassion in order to enhance our understanding of the concept and its relation to mindfulness, review findings on potential paradox effects of self-compassion (“backdraft”), provide an opportunity for personally exploring exercises and practices for cultivating self-compassion, and outline the implications and consequences of teaching self-compassion implicitly or explicitly.

Meditation, inquiry, group reflection, dialogue, talk

A deeper understanding of the concepts of mindfulness and self-compassion will inform participants’ clinical work regardless of their particular mode of therapy. For those who are teachers of meditation-based approaches, the class will provide practical insights into how
to skillfully teach self-compassion, with awareness of the potential for paradox effects, within an implicit or explicit approach.

Thorsten Barnhofer is an associate professor at the Mood Disorders Centre, University of Exeter, and leads mindfulness workshops and retreats for mental health professionals internationally and in the UK. He has been involved in research programs on the effects of Mindfulness-Based Cognitive Therapy (MBCT) in highly vulnerable patients, and is currently exploring, in collaboration with Drs Germer and Neff, the use of mindfulness and self-compassion training for patients with a history of early trauma.


Socratic Methods – the why and when of guided discovery

**Helen Kennerley, University of Oxford**

This skills class will introduce the audience to the concept of Socratic methods – thus going beyond the familiar Socratic questions. It will enable participants to explore the wide diversity of Socratic methods and the wide clinical applicability using clinical examples and video. Participants will also be encouraged to consider why not to use Socratic methods but instead opt for direct questions or didactic teaching.

Key learning objectives:
1. Recognition of the range of Socratic Methods
2. Appreciation of when to use them and when not to

**Training modalities**
- PowerPoint / verbal presentation
- Video illustration
- Brief role play
- Short discussions

Socratic methods can be used with a wide range of clinical presentations and a wide range of therapist tasks (assessment, formulation, setting up BEs etc etc), this session will help participants to do this to best effect - which means knowing when not to use them, too!

Helen Kennerley is a Consultant Clinical Psychologist and a founder member of the Oxford Cognitive Therapy Centre, where she was the director of the University of Oxford / OCTC postgraduate short-courses in Advanced Cognitive Therapy Studies and MSc for many years. She is an experienced clinician specialising in childhood trauma, dissociative disorders, and self-injurious behaviours. She has also taken a lead role within OCTC for developing Supervision training and the use of Socratic Methods. She has made valuable contributions to the field of cognitive therapy through her popular workshops and her writings. Amongst other publications, she is the author of Overcoming Childhood Trauma, co-author of An Introduction to Cognitive Behaviour Therapy, co-editor of Cognitive Behavioural Approaches to Dissociation. Her self-help book, Overcoming Anxiety has been highly commended by the British Medical Association.


**Chronic fatigue: low and high intensity cognitive behavioural interventions**
Katharine Rimes, King’s College London

Fatigue is often viewed as being on a continuum from fatigue as a symptom, to fatigue that has become persistent or chronic and ending with profoundly disabling chronic fatigue syndrome (CFS / ME). Cognitive behavioural approaches are evidence-based interventions for chronic fatigue and CFS / ME. They are now being delivered in many different settings – including acute general hospital services and IAPT as well as specialist chronic fatigue syndrome services.

This skills class will provide an overview of the cognitive behavioural model of chronic fatigue to help therapists understand the rationale for different treatment elements. The practical elements of both low and high intensity interventions will be described to help therapists feel more confident in working with people with chronic fatigue.

Key learning objectives:
1. Understanding the cognitive behavioural model of chronic fatigue
2. How to support client engagement
3. When to offer low or high intensity intervention
4. Low intensity interventions – what is involved and how to deliver.
5. High intensity interventions – incorporating more cognitive methods.

The workshop will outline the cognitive behavioural model of chronic fatigue and describe how to provide low and high intensity interventions. There will be opportunities for discussion and role play.

Implication for everyday clinical practice of CBT
The workshop should provide attendees with an understanding of a cognitive behavioural model of chronic fatigue, what is involved in high and low intensity interventions and resources available to assist clients and therapists.

Dr Katharine Rimes is a clinical health psychologist and cognitive behaviour therapist. She is a Senior Lecturer at the Institute of Psychiatry, Psychology and Neuroscience, King’s College London. She has worked at the Chronic Fatigue Syndrome Unit at King’s College London, the CFS / ME service for children and young people in Bath, and is now the lead for Long Term Conditions / Medically Unexplained Symptoms in Southwark IAPT. She has undertaken research and clinical work in chronic fatigue syndrome for fifteen years. She has been involved in developing both cognitive behavioural and mindfulness-based interventions for chronic fatigue syndrome. She was a member of the Expert Reference Group for developing the Competence Framework for Psychological Interventions for people with persistent physical health conditions. https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/pdfs/Physical_Health_Problems/Physical_Background_Doc.pdf

Key references

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

Richard Bennett, The University of Birmingham and Joe Oliver, King’s College London
Are you a therapist with a fledgling interest in third wave approaches? Are you curious about concepts such as values and acceptance? Are you interested in dipping a toe in the water to see if this approach fits with your practice? If so, then this workshop is for you. ACT is a unique transdiagnostic psychological intervention that uses acceptance and mindfulness strategies, together with behaviour change strategies, to increase psychological flexibility. It is concerned with helping individuals identify what is important to them and taking committed action in order that their behaviour is more consistent with their values. ACT also promotes skills that help to change the relationship between an individual and their experience. It is rapidly developing a wide-ranging evidence base across numerous areas of clinical practice. This 2-hour clinical skills workshop is designed for therapists working in physical/mental health care who want to enhance and develop their practice by developing skills in values procedures. You will learn:

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

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

Dr Richard Bennett works as a Clinical Psychologist and Cognitive Behavioural Psychotherapist. He works on the CBT Programmes at The University of Birmingham where he leads the Postgraduate Diploma in CBT (High Intensity). He has trained and supervised a wide range of healthcare professionals across the UK, as well as overseas. He worked in the NHS for over 20 years in adult and forensic mental health and is now in independent practice in Birmingham, as Director of Think Psychology. He is an active member of the Association for Contextual Behavioural Sciences (ACBS) and the British Association for Behavioural and Cognitive Psychotherapies. He is a BABCP accredited Psychotherapist, Supervisor, and Trainer and an ACBS Peer-reviewed ACT Trainer.

Dr Joe Oliver is a Clinical Psychologist who has worked within the UK National Health Service for over twelve years. He currently holds a position within a North London NHS Trust as Cognitive Behavioural Therapies Training Lead. He has additionally been developing and researching ACT/mindfulness individual and group interventions at the Institute of Psychiatry, King’s College London. He is also Director for Contextual Consulting, a London-based consultancy offering ACT focused training, supervision and psychological therapy. He is co-editor of the book, "Acceptance and Commitment Therapy and Mindfulness for Psychosis" with Wiley-Blackwell, and co-author of the self-help book, "ACTivate Your Life" with Constable Robinson. He is an ACBS Peer-reviewed ACT Trainer.

Engagement and Cognitive Behavioural Therapy for hoarding disorder (Reclaiming your space and life)

Satwant Singh, Waltham Forest Talking Therapies

Hoarding disorder (HD) or compulsive hoarding as it was previously known has until recently received little attention. However with the increased media attention and the introduction of HD in the DSM 5 as a condition in its own right and the introduction of self-neglect in the Social Act 2014 has resulted in an increase number of individuals presenting to primary and secondary care psychological services. HD presents a challenge for a range of professionals in dealing with this presentation. Despite with the increase in presentations, there are still no specific services available for the treatment of HD. The research indicates that individuals with HD benefit from CBT in dealing with their hoarding issues. This workshop based on the London Hoarding Treatment Group treatment protocol - Reclaiming your space and life is aimed at helping CBT therapist to develop their skills in engaging and treating individuals with HD.
1. To understand the psychological presentation of HD
2. To develop a collaborative formulation and engagement in therapy
3. Using visual methods in the assessment and treatment of HD
4. Developing innovative and creative interventions in dealing with their hoarding behaviours and underlying beliefs
5. Dealing with obstacles and challenges in the treatment of HD
6. Relapse prevention reclaiming their life

In this workshop will be facilitated through instruction, DVD presentations, role plays, participants interactions.

Currently there is no treatment model for the treatment of individuals for hoarding issues. This workshop which is aimed at Experienced CBT therapists who have the experience of working across a range of psychological disorders (depression and anxiety) and those who are likely to treat individuals with hoarding issues (primary and secondary care psychological services). It is aimed at improving the access to timely, effective interventions for individuals presenting with hoarding issues who often are not able to access treatment due to the lack of understanding of the disorder and complexity, lack of training to provide effective interventions. The improve understanding and treatment of the disorder will better inform the current knowledge to promote better treatment pathways and models in the future.

Satwant Singh is Nurse Consultant in CBT & MH and Professional and Strategic Lead for IAPT. He has been facilitating the monthly London Hoarding Treatment Group since 2005, engaged in research with Kings College London and with colleagues in understanding HD. Satwant has co-authored the UK’s first self-help book titled Overcoming Hoarding.


**Burnout in Cognitive Behaviour Therapists: using supervision to prevent, identify and reduce its impact**

**Andrew Beck, Salford Cognitive Therapy Training centre, ELCAS**

Over half of mental health professionals in recent surveys report high levels of burnout and mental health problems and there is compelling evidence that this can impact negatively on quality of patient care. Organisational pressures clearly play a major role in the cause and maintenance of burnout and there needs to be considerable work done within the NHS to improve the culture of looking after front line mental health staff however Supervisors can also play an important part in reducing burnout and promoting the good mental health of staff.

This workshop will support supervisors to:
identify staff at risk of burnout or who are struggling with burnout
identify and formulate factors contributing to this
differentiating between organisational and individual factors contributing to this
advocating for organisational change
support staff to respond to challenges in more adaptive ways

The skills class will include the use of role play and small group discussion to look at how these difficult topic can be raised with colleagues and how the supervisory relationship can be used as a basis to protect staff from burnout and bring about positive changes in working practice to reduce the impact of chronic organisational stress.

The workshop will use current theory from organisational psychology, supervisory practice and CBT to provide a practical framework to address this topical problem in mental health services.

Participants will be able to:
identify staff at risk of burnout or who are struggling with burnout
identify and formulate factors contributing to this
differentiate between organisational and individual factors contributing to this
advocate for organisational change
support staff to respond to challenges in more adaptive ways
The skills class will be 50% didactic, 15% role play by myself on the stage, 15% role play in pairs by participants and 20% large or small group discussion.
The skills class will improve supervisors ability to recognise staff burnout and act to support staff at risk of or experiencing burnout.
This will lead to more effective and well engaged teams and ultimately better patient outcomes.
Andrew Beck is senior lecturer on the SCTTC IAPT and CYP-IAPT programme and Hon Senior Lecturer on the University of Manchester DClinPsych course. He has published original research and a recent book on Transcultural CBT and is lead for the SCTTC Supervisor Training programme.

Using positive mental imagery in CBT: overcoming barriers to engagement

Simon Blackwell, Ruhr-Universität Bochum, Bochum, Germany

Mental imagery is a form of thought with close links to emotion, and positive mental imagery can be used in many powerful ways within CBT. For example, it can be used to elicit positive emotions, to facilitate belief change, to neutralise negative memories, create new positive representations of the self or future, and enhance memory for positive information. However, people can sometimes struggle to engage with positive imagery, for a broad range of reasons. These include struggling to generate positive images, or any imagery at all; not experiencing an emotional response to the imagery they generate; experiencing a negative reaction (e.g. negative rumination) in response to positive imagery; or objecting to the idea of engaging in positive imagery, for example dismissing it as unrealistic or ‘silly’. This skills class will review different ways in which positive imagery may be used in CBT, before focussing on identifying difficulties people might be experiencing and developing methods to help people engage with positive imagery.

Key learning objectives:
1. To understand the scientific background underlying the use of positive imagery
2. To understand ways in which positive imagery may be incorporated into CBT
3. To be aware of and be able to recognise potential barriers to engagement with positive imagery
4. To be equipped to find ways to overcome these barriers and help people engage with positive imagery

Training modalities
The skills class will be a mixture of didactic content, and partner/group exercises and role-play.

Implication for everyday clinical practice of CBT
Positive imagery can be incorporated into CBT in many ways and provides a powerful tool for helping people connect with positive emotional experiences. Being able to overcome
potential barriers to engagement is important to take full advantage of the range of techniques available.

Simon Blackwell is a post-doctoral researcher at Ruhr-Universität Bochum, Germany, and a visiting scientist at the Medical Research Council Cognition and Brain Sciences Unit, Cambridge, UK. Simon trained as a clinical psychologist in Oxford and subsequently worked in Oxford Health NHS Foundation Trust. Since 2010 he has conducted research focussing in particular on positive imagery and its potential use in novel treatment approaches. The material in the skills class is in part drawn from his research in depression and his experience delivering imagery-focused cognitive therapy in the context of bipolar disorder.

2-3 key references


Sleep well and live better: overcoming insomnia in adults using evidence-based psychological therapies

Colin A. Espie, University of Oxford

Insomnia is the most common expression of mental disease in the UK. It affects not only sleep, but also daytime quality of life, and confers particular risks for the development of depressive illnesses. Although medication is the most frequently used treatment, psychological therapy is recognised as the treatment of choice for persistent insomnia. The purpose of this workshop is to explain why psychological therapy is an appropriate treatment for insomnia, to describe methods for treating insomnia, and to summarise the evidence regarding its effectiveness. There will be a particular focus upon practical evaluative and interventional skills and clinical case examples will be used to illustrate their applications.

Key learning objectives:
1. To understand the clinical features of insomnia and screening tools that may be useful when working with sleep disorders
2. To become more familiar with clinical psychological interventions for insomnia that may be used in everyday clinical practice

Training modalities

Powerpoint presentation, audiovisual materials, discussion, Q&A

Sleep disorders are ubiquitous and very commonly present in people with mental and emotional disorders. Historically, problems such as insomnia have been considered ‘secondary’. However, there is increasing evidence for a more primary role for sleep in emotional health, and for the existence of bi-directional relationships e.g. between sleep and depression. This Skills Class will provide clinicians with assessment and treatment skills to begin to address sleep difficulties in a more focused way and to integrate these skills into their clinical practice.

Colin Espie is Professor of Sleep Medicine at the Sleep & Circadian Neuroscience Institute, University of Oxford. He was formerly Professor of Clinical Psychology and Head of Department of Psychological Medicine, University of Glasgow. His research interests include the pathophysiology of insomnia, CBT for insomnia, critical mechanisms in CBT, issues of sleep therapy compliance, and clinical effectiveness trials investigating community and digital delivery models of insomnia care. He has published around 200 research papers and
several books. Colin is Deputy Editor of the Journal of Sleep Research and is Membership Chair of the World Sleep Federation.

2-3 key references

Integrating and optimising imagery rescripting in PTSD treatment – from practice to research to practice

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

Imagery rescripting techniques are increasingly integrated into CBT, to directly modify the emotional impact of distressing mental imagery and associated meanings. Distressing imagery is a hallmark symptom of PTSD; hence imagery rescripting has found a particular application in this area. There is evidence for imagery rescripting as a stand-alone treatment for PTSD symptoms including nightmares, and also that it can enhance the efficacy of imaginal reliving in trauma-focused CBT (Tf-CBT).

However there are gaps in our understanding about how imagery rescripting works and what makes an effective rescript. The existing literature describes a range of rescripting techniques across disorders, and for key emotions/meanings in PTSD such as fear, helplessness, guilt, shame and disgust. Despite this, there is limited clinical guidance on how to select and implement techniques effectively, how to routinely integrate them into Tf-CBT models, and how to overcome common obstacles and difficulties in their application.

With reference to cognitive models of PTSD and memory, the workshop will provide an overview of the imagery rescripting literature and its application in both simple and complex PTSD presentations. We will also present novel results from a number of quantitative, qualitative and single case studies of imagery rescripting conducted in routine clinical settings. From this we will derive a clinical framework to help participants effectively implement rescripting techniques, integrate them within a Tf-CBT model, and formulate and overcome common obstacles.

- Learn about the range of rescripting techniques applicable in PTSD treatment
- Understand how to conceptualise imagery rescripting within existing cognitive models of memory and PTSD
- Draw on emerging research findings to optimise effectiveness of imagery rescripting techniques
- Practice developing and delivering creative imagery rescripts while maintaining fidelity to cognitive models

The workshop will give both an overview of the extant literature, and present a range of case material of the application of imagery rescripting within Tf-CBT. We will discuss how to understand both the mechanism of action and the factors affecting efficacy using cognitive models and theories. We will show how clinically-derived research can help inform and enhance practice in this area. Practical examples and tips on how to implement these techniques will be given, including through video case material and live demonstrations. Participants will be invited to reflect on and role-play how they will apply similar strategies to their own cases.

The workshop will equip therapists working with PTSD and other trauma-related difficulties with principles, conceptual frameworks and practical skills to enhance their use of imagery rescripting techniques.

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


An introduction to BeatIt; an adapted behavioural activation intervention for people with learning disabilities and depression

Andrew Jahoda, University of Glasgow

Depression is at least as common in adults with learning disabilities as in the general population and is the most common type of mental ill-health experienced by adults with learning disabilities. Depression is more enduring than for the general population, suggesting it is either a more severe condition, or more poorly managed.

In 2016, the National Institute for Health and Care Excellence (NICE) identified that the only available evidence on psychological interventions for depression in people with a learning disability was for cognitive behavioural therapy (CBT), adapted for people with a learning disability. While this work showed great promise, it was of low quality. Behavioural activation is another psychological intervention for depression that might prove effective for people with learning disabilities.

Behavioural activation has been shown to be as effective as CBT among individuals with more severe depressions in the general population, and to have effects as lasting as CBT following treatment termination. Behavioural activation could be more accessible than CBT for some people with learning disabilities, as it focuses on behaviour more than on cognition and is therefore less reliant on expressive and receptive communicative abilities or the ability to grasp abstract concepts. The importance of purposeful routine activities such as household chores and self-care are emphasised, alongside achievement, pleasure and closeness to others. The aim is to increase engagement with potential environmental reinforcers.

Avoidance is another key target for change; with the aim of breaking the vicious cycle linked to mood and activity, whereby reduced activity lowers mood. In turn, the worse people feel, the more withdrawn they become. Given the marginalised social status of many people with learning disabilities, behavioural activation is likely to be relevant to their life experience.

Key learning objectives:
1. Developing an understanding of the key adaptations in a behavioural activation intervention tailored for people with learning disabilities – including working alongside a significant other in the person’s life.
2. Learning about an assessment exercise to develop a picture of clients’ activities - past, present and what they may wish to do in the future.
3. Picking and scheduling activities alongside people with learning disabilities and a support person, and how to make them happen.

Training modalities
This workshop will consist of training about the main suggested adaptations to behavioural activation for people with learning disabilities and depression. There will also be a chance for attendees to practice: i) the assessment exercise used to develop an initial picture of clients’ activities, and ii) negotiating activities to schedule between sessions. The workshop should help the attendees gain clinical skills in relation to behavioural activation and tackling depression faced by people with learning disabilities. Moreover, gaining know how about an adapted therapeutic approach should increase the attendees’ confidence in delivering a broader range of psychological therapies to clients with learning disabilities.

Andrew Jahoda is Professor of Learning Disabilities in the Institute of Health and Wellbeing at the University of Glasgow. He has a clinical role as honorary Consultant Clinical Psychologist at NHS Greater Glasgow and Clyde. Andrew’s research interests concern the
mental health and wellbeing of people with learning disabilities, and the contribution made by a range of psychological and social factors, including stigma and social exclusion. He is also interested in adapting psychotherapeutic approaches in a manner that is sensitive to the lived experience of people with learning disabilities.

2-3 key references:

Enhancing CBT through chairwork: Bringing cognitive therapy to life

Matthew Pugh, Central and North West London NHS Foundation Trust

Whilst traditional cognitive interventions often succeed in bringing about head-level belief change, many therapist find they less effective in facilitating cognitive restructuring at a deeper, more emotional level (the “head-heart lag”). Chairwork refers to a collection of experiential interventions which utilise chairs and their relative positions for therapeutic purposes (Pugh, 2016). Chairwork techniques have a long history of applications within CBT and are consistent with underlying theories of cognitive science. Preliminary research also indicates these interventions are clinically effective and may be advantageous compared to pen-and-paper cognitive interventions (Chadwick, 2003; de Oliveira et al., 2013).

Unfortunately, chairwork is often neglected in clinical practice. Using dyadic teaching and interactive demonstrations, this workshop will introduce participants to basic chairwork techniques used in CBT. Participants will better understand when and why to incorporate chairwork into their clinical work, and feel more confident applying these techniques in work with problematic cognitions.

By the end of the workshop, participants will be able to:
1. Describe the core forms of chairwork utilised in CBT.
2. Critically evaluate the evidence-base for cognitive-behavioural chairwork.
3. Understand how chairwork achieves therapeutic effects using theories of cognitive science.
4. Utilise basic chairwork techniques in work with negative automatic thoughts and metacognitive beliefs.
5. Understand common pitfalls in cognitive-behavioural chairwork and methods for enhancing the effectiveness of such techniques.

Chairwork is both an engaging and clinically effective cognitive-behavioural intervention. Accordingly, such techniques have the capacity to enhance clinical practice and are a valuable addition to therapists’ repertoire of interventions. Whilst chairwork is an exciting direction for CBT, it is not without limitations and further research in this area is needed.

Matthew Pugh is a Principal Clinical Psychologist at Central and North West London NHS Foundation Trust and is Lead Therapist for the Vincent Square Eating Disorders Service. He is a Behavioural and Cognitive Psychotherapist and Advanced Schema Therapist (in training). He has published on subjects including applications of chairwork in CBT and schema therapy applied to eating disorders. He has previously facilitated conference workshops on motivation-focused chairwork and experiential approaches to therapy.


Monika Parkinson and Lucy Willetts, University of Reading

Anxiety disorders are among the most common mental health problems in childhood (Kessler et al., 2005). CBT treatments are effective for many children with anxiety disorders and actively involving parents in treatment in particular ways can significantly improve children’s outcomes (e.g. Manassis et al., 2014). Recently, a number of trials have shown positive outcomes when the treatment has been focused exclusively on parents (e.g. Rapee et al., 2006; Cartwright-Hatton et al., 2011; Thirlwall et al., 2013). There are a number of advantages of working exclusively with parents, including reducing the burden on children and minimising school absences due to treatment appointments, reducing overall amount of therapy time, empowering parents with effective strategies that can be used when anxiety arises in everyday situations and potentially addressing parental practices that may be maintaining child anxiety. The Parent-Led approach, which is based on a self-help book (Overcoming Your Child’s Fears and Worries – A self-help guide using Cognitive Behavioural Techniques, Creswell and Willetts, 2007), has been evaluated and has shown similar or better outcomes to those reported from standard, more intensive, child and family-focused CBT approaches (Creswell et al, 2010; Thirlwall et al, 2013). One of the key aims of the programme is to increase parents’ confidence in their ability to help their child overcome their anxiety. As such, the philosophy of the programme is non-blaming and one that highlights positive skills and responses of the parent, in order to build their confidence and empower them to support their child. The skills class aims to familiarise participants with the philosophy and structure of the approach. Focus will be given to demonstrating and teaching three key skills from the programme so that attendees can apply these with confidence in their CBT practice with anxious children and their parents.

1. Become familiar with the philosophy and structure of the Parent-Led approach, with particular focus on empowering parents
2. Understand possible parental maintaining factors in child anxiety and incorporate these in the overall formulation
3. Observe and practice three key CBT strategies from the programme to use with parents of anxious children
4. Become confident in using the new strategies in clinical practice and know where to find further treatment materials, training and reading

The skills class will be a mixture of didactic teaching, audio examples of treatment sessions and live role play demonstrations, as well as opportunities for practising therapeutic skills in small groups or pairs.

The Parent-Led programme is an evidence-based and novel CBT approach shown to be effective for a significant proportion of children with anxiety disorders. The skills class will equip attendees with 3 key CBT skills from the programme to use with the parents of anxious children. This may enhance usual CBT practice in a number of ways, including improving understanding of potential parental maintenance factors in child anxiety, introducing novel concepts and ways of teaching parents CBT techniques, showing clinicians innovative ways of making CBT more accessible to families and signposting to treatment materials and further training and reading.

The skills class will be delivered by Dr Monika Parkinson (Research Fellow/Clinical Psychologist, University of Reading), Dr Lucy Willetts (Consultant Clinical Psychologist/Honorary Research Fellow, University of Reading) and Dr Kerstin Thirlwall (Clinical Psychologist/Honorary Research Fellow, University of Reading). The leaders have published a number of papers evaluating the approach and more recently have published a clinician’s guide to Parent-Led CBT (Guilford Press). The leaders all have extensive experience in developing, evaluating and delivering the Parent-Led CBT programme, as well as training and supervising professionals from various backgrounds in the delivery of the treatment approach.

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

Richard Stott, Kings College London

Technology is transforming many areas of our lives. The pace of change is dramatic, signalling opportunity for some, and alarm for others. The devices in our pockets are, for many, the primary means by which to connect with others, record our lives in words and pictures, and seek answers to our questions and our troubles. Numerous apps purport to help us relax or meditate. Few would deny the enormous potential of the smartphone, but there are also many pitfalls. Until now there has been little guidance for therapists who wish to harness the best of this technology within their practice while remaining committed to the conceptual focus and discipline of cognitive therapy.

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

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

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

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

Dr Richard Stott is a Clinical Psychologist at King’s College London and the Centre for Anxiety Disorders and Trauma at the Maudsley Hospital, and is also a technology specialist. For the past 10 years he has worked in the Wellcome anxiety disorders group headed by Professors David Clark and Anke Ehlers. There he has helped develop and refine the cognitive treatments for anxiety disorders, including internet-based treatments.
Understanding and Managing Dissociation in PTSD

Adele Stevens and Sam Akbar, Woodfield Trauma Service, CNWL NHS Trust

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

The main objectives are:

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

We will provide a brief overview of relevant theory before explaining the clinical skills for managing dissociation using a detailed step-by-step approach. There will be an opportunity for attendees to role play these techniques and a demonstration of the techniques by case discussion will also be included.

Many clients with PTSD experience dissociative symptoms. This is even more common in clients who have suffered repeated or prolonged traumas and present with complicated and complex PTSD. This skills session aims to provide clinicians working with clients with PTSD to be able to provide an evidence-based explanation of these symptoms, which is de-shaming for clients and helpful. This explanation provides a rationale for engaging clients in symptom management and grounding strategies which will help them to manage.
dissociation. This also facilitates engagement in memory processing as part of trauma focused CBT, as well as other evidence based approaches to PTSD i.e. EMDR and NET. Dr Stevens and Dr Akbar are both BABCP accredited Clinical Psychologists who have specialised in treating PTSD. They both currently work at Woodfield Trauma Service (formerly known as Forced Migration Trauma Service, CNWL NHS Trust) with refugees who have suffered severe and prolonged traumatic events. Dr Stevens has also worked at Berkshire Traumatic Stress Service and currently works at South Central Veteran Service (Berkshire NHS Trust). Both Dr Stevens and Dr Akbar have experience in delivering teaching and training on treating PTSD, in academic and clinical settings.


**Poster Presentations**

**Functional Imagery Training versus Motivational Interviewing: Effects on motivation and self-efficacy to lose weight and increase physical activity**

Linda Solbrig, Plymouth University and NIHR CLHARC South West Peninsula; Jackie Andrade, Plymouth University

Targeting self efficacy and motivation can improve weight loss and increase physical activity. Functional Imagery Training (FIT) is a new motivational intervention, based on the Elaborated Intrusion Theory of desire, that trains individuals in the habitual use of positive, vivid and emotive goal imagery. FIT is delivered in short interview sessions, in the person-centred counselling style of motivational interviewing (MI). FIT, like MI, involves individuals in thinking about the benefits of change, reviewing past successes, specific strategies that have worked before, concretely planning for the future and overcoming possible proximal obstacles to change. Uniquely in FIT, these key steps are rehearsed via the individuals own imagination, rather than verbalisation only. Because imagery is more emotive than other types of thought it should strengthen motivation and self-efficacy for achieving weight loss and physical activity goals further than MI. We tested the specific impact of FIT compared with MI on motivation and self-efficacy, as part of a randomised controlled trial of the efficacy of FIT and MI for weight loss in a community sample of 121 individuals with BMI ≥ 25.

As part of a 12-month randomised controlled trial, 111 of 121 participants completed questionnaires assessing their motivation and self-efficacy for losing weight and increasing physical activity. We used the Motivational Thought Frequency Scale (MTF) to assess how often motivational cognitions for weight loss and being more active occurred amongst participants. Self-efficacy for diet changes was measured using the Weight Efficacy Lifestyle Questionnaire (WEL) and the Exercise Self-Efficacy Scale (SCI) for physical activity changes. Motivation and self-efficacy scales were emailed to participants via an online link one week before randomisation to the first FIT or MI interview session. The second and final assessment point followed at one month into the trial, after two interview sessions, contact and time-matched, of MI or FIT and the first booster support call.

Motivation overall increased in both groups from baseline to follow-up at one month, F (1,109) = 39.7, p<.001, as did self efficacy for dietary changes F(1,109) = 395.3, p<.001 and physical activity changes F (1, 109) = 374.3, p <.001. All three measures showed significant time x group interactions. Motivation: F (1,109) = 5.7, p=.02, self-efficacy for dietary changes: F (1,109) = 977.5, p=.01 and self-efficacy changes for physical activity: F (1, 109) = 4.3, p =.04. Post-hoc tests found that motivation and self-efficacy for both, dietary changes and physical activity changes were higher in the FIT group than the MI group at follow-up.
Motivation in the FIT group increased from baseline mean of 6.7 (SD=1.9) over that of the MI group’s mean of 6.4 (SD=1.5) to follow-up (FIT M= 8.4, SD=.69; MI M= 7.1, SD=.89) p<.001. The FIT participants also experienced higher levels of self-efficacy for dietary change from baseline (M= 53.6,SD=16.8) than the MI group, from baseline (M= 54.4,SD=13.0), to follow up (FIT M= 89.4, FIT SD=7.6; MI M= 81.9, MI SD= 8.4) p<.001. Self-efficacy for physical activity was increased more in the FIT group from baseline (M=2.7, SD=.56), compared to MI ( M=2.7, SD=.41), to follow up (FIT M=3.8, FIT SD=.21, MI M=3.6, MI SD=.38) p = .02. These data support previous evidence that Motivational Interviewing is effective in building and fostering motivation and self-efficacy, known to be essential in behaviour change. The data further show that Functional Imagery Training can be more effective than MI in eliciting and boosting motivation and self-efficacy for change, at least in the context of weight management. Functional Imagery training can be easily incorporated into existing CBT therapies that wish to target self-efficacy and motivation for functional behaviour change more effectively.

The Relationship of the Components of Rumination to Depression and Anxiety

Jennifer L. Prentice, University of Calgary, Canada; Lauren Allan, Calgary Foothills Primary Care Network; Keith S. Dobson, University of Calgary

Rumination is frequently shown to be an important construct for mood and anxiety disorders in women. Two distinct components of rumination have been identified: brooding and pondering. However, limited research has been conducted on the relationship between these components and mood. The goal of the present study was to examine the correlation between rumination and its sub-constructs, symptoms of depression and anxiety, and behavioural coping styles for mood problems. 79 previously depressed women, assessed at baseline and at six months’ follow-up, were randomly assigned to one of three mood inductions procedures: rumination, reflection, or distraction. Rumination, problem-solving, acceptance, cognitive and behavioural avoidance, acceptance, and depressive and anxious symptoms were assessed using self-report and compared between the three groups. Across all groups, rumination/brooding, but not pondering was associated with lower behavioural activation and acceptance, while pondering was positively associated with acceptance. Brooding was also positively correlated with current mood and anxiety disorder symptoms, avoidance and positive and negative beliefs about rumination. Between group comparisons showed that participants in the distraction group reported smaller decreases in mood after the induction procedure than those in the rumination and reflection conditions. Rumination and metacognitive beliefs did not appear to predict symptoms of depression or anxiety at the six month follow-up. The results provide support for breaking down rumination into sub-constructs, as the two may be differentially related to mental health symptoms in women. However, results did not support the utility of rumination in predicting future mood and anxiety symptomatology. Implications of the results for theories of rumination as well as future research will be discussed. Based on the findings, clinicians working with women with symptoms of anxiety or depression are encouraged to assess for brooding and pondering separately. Therapies such as rumination-focused cognitive-behavioural therapy may need to take into account the differing relationships of brooding and pondering thoughts to its behavioural antecedents.

Treating thunderstorm phobia in an individual with a learning disability

Nick Stewart, University of Bath

Mr Y was referred to a community adult learning disabilities team with a phobia of thunderstorms. Mr Y’s phobia was causing him a great deal of distress. Furthermore, his
help-seeking behaviour was having a negative impact on his relationships with other service users. Mr Y had seen phobias treated successfully on television, and he was keen to try therapy to overcome his fear. Although Mr Y could not identify a specific childhood incident, he understood that his difficulty may have started with a frightening experience in early life. Mr Y had developed catastrophic beliefs about the potential consequences of being hit by lightning (i.e., electrocution by fork lightning), and monitored weather forecasts for signs of danger. Unpleasant anxiety symptoms, distressing mental images and going outdoors to find help all helped to reinforce Mr Y’s fear that something terrible might happen. Following Hassiotis et al. (2012), CBT approaches were adapted for a client with a moderate learning disability. A succinct formulation was developed collaboratively with Mr Y. An idiosyncratic scale (incorporating horror films as anchors) was developed to measure progress. In vivo exposure using videos of forecasts and thunderstorms was used to encourage habituation, and to enable discussion about maintenance cycles. Finally, ‘safe place’ imagery was developed with Mr Y to provide a means of tolerating thunderstorms. Mr Y’s anxiety levels decreased with successive exposure during each in vivo exercise, indicating that he was becoming habituated to the artificial thunderstorm stimuli. He also reported cognitive change (e.g. realising that TV weather forecasts was sufficient on their own to create high levels of anxiety). No thunderstorms occurred during the period of treatment, making it difficult to tell how well Mr Y would be able to put ‘theory into practice’. However, he reported feeling more confident about his ability to comfort himself when the next storm came.

Phobic disorders are up to four times as prevalent in learning disability populations compared with the general population (Deb, 2001). While exposure techniques for treating specific phobias are underpinned by a strong evidence base in the general adult setting, approaches developed for the general population do not necessarily take account of the unique needs of learning disability populations (Oliver et al., 2003). This case shows how a specific approach can be adapted, evaluated and adapted again for an individual with a learning disability using in session experiments. Therapists need to bring a flexible and creative approach to treating phobic disorders in the context of learning disability. Adaptations need to be evaluated at all stages of treatment, with further adaptations made as required.

The effect of negative thoughts on QOL in patients with schizophrenia

Tomoya Takeda, Department of Psychiatry, Institute of Biomedical Sciences, Tokushima University Graduate School, Japan; Masahito Nakataki, Department of Psychiatry, Institute of Biomedical Sciences, Tokushima University Graduate School, J; Masashi Ohta, Department of Psychiatry, Institute of Biomedical Sciences, Tokushima University Graduate School, Sayo Hamatani, Department of Psychiatry, Institute of Biomedical Sciences, Tokushima University Graduate School; Kanae Matsuura, Department of Psychiatry, Institute of Biomedical Sciences, Tokushima University Graduate School; Tetsuro Ohmori, Department of Psychiatry, Institute of Biomedical Sciences, Tokushima University Graduate School;

Recently, negative thoughts, such as the dysfunctional attitudes and the negative automatic thought, have been attracting more attention in the treatment of schizophrenia because these are associated with lower Quality of Life (QOL). However, since the dysfunctional attitudes and negative automatic thought are also associated with depressive symptom and negative symptom, it is unknown whether these negative thoughts affect QOL independently from depressive and negative symptoms. In the present study, we investigated whether the dysfunctional attitudes and negative automatic thought directly affect QOL in patients with schizophrenia by statistically controlling the effects of depressive and negative symptoms. Twenty-two patients with schizophrenia and twenty-one demographically matched healthy controls participated in this study. The patients were outpatients of the Department of Psychiatry of Tokushima University Hospital. We used the Japanese version of the National Adult Reading Test, the Positive and Negative Syndrome Scale, the Calgary Depression Scale
for Schizophrenia, the Dysfunctional Attitudes Scale, the Automatic Thoughts Questionnaire, the Quality of Life Scale (QLS) and the Schizophrenia Quality of Life Scale (SQLS) to assess the intelligence quotient (IQ), positive and negative symptom, depressive symptom, dysfunctional attitudes, negative automatic thoughts, objective QOL and subjective QOL, respectively. Data analysis was conducted using the PASW Statistics 18 software and R “ppcor” package with R Studio. The comparison of demographic indices between patients and controls was carried out using chi-squared test, unpaired t-test and mann-whitney u test. Next, we calculated the spearman rank partial correlation coefficients between dysfunctional attitudes, negative automatic thought and QOL in order to control the effect of depressive symptom and negative symptom.

IQ (t (33.84)= -4.73, p<0.01), negative automatic thought (t (26.64)=3.49, p<0.01) and dysfunctional attitudes (t (41)=3.03, p<0.01) showed significant differences between the two groups. As for objective QOL, total score of QLS (U=33.00, p<0.01) showed significant differences between the two groups. Futhermore, interpersonal relationship (U=42.00, p<0.01), instrumental role (U=70.50, p<0.01), intrapsychic foundations (U=54.50, p<0.01) and common objects and activities (U=136.50, p<0.01), which are subscale of QLS, also showed significant differences between the two groups.

As for subjective QOL, psycho social in SQLS (t (32.78)=2.06, p<0.05) showed significant differences between the two groups. Spearman partial rank correlation analysis showed significant correlation of negative automatic thoughts with interpersonal relationship in QLS (Spearman's partial rank rho = -0.48, p<0.05), motivation and energy (Spearman's partial rank rho=0.51, p<0.05) and symptom/side effect (SS) in SQLS (Spearman's partial rank rho=0.68, p<0.01). Dysfunctional attitudes had significant correlation with SS in SQLS (Spearman's partial rank rho=0.55, p<0.05).

The present findings suggested that dysfunctional attitudes and negative automatic thought affects QOL and these are key targets of treatment to improve their subjective and objective QOL in patients with schizophrenia.

Cognitive behavioural therapy for anger in an adult with a learning disability: a single case experimental design

Dawn Lindsay, University of Bath; Claire Delaney, 2gether NHS Foundation Trust

X, a 25-year-old male with a mild learning disability was referred to the psychology service within the community learning disability team over concerns about increased anger. He lived locally with his family and there were reported aggressive incidents and increased risk within the home environment. A family member’s recent stroke had resulted in personality change and they showed increasingly volatile and aggressive behaviour. X found these changes particularly distressing and he struggled to contain his own emotional response to this aggression.

X’s anger was considered within the context of family difficulties and recent loss of employment. X described being unable to remember the periods when he became angry but described it as a sudden outpouring of emotion which often culminated in injury to himself. It was hypothesised that helping X to learn more about anger, and to recognise personal triggers and manifestations of this emotion may lead to a reduction in the intensity of anger that he experienced. Nine sessions of CBT intervention included psychoeducation about anger, differentiating the levels of anger experienced (cognitions, situations, triggers), developing awareness to physiological arousal, and behavioural strategies.

Primary outcome measure was an idiosyncratic rating scale to record weekly self-reported intensity of anger. Variability in scores made it difficult to interpret whether the intervention led to an improvement in X’s intensity of anger. Scores from session 6 onwards fell within a narrower range suggesting that there may have been slight reduction in intensity of anger. However, as the baseline phase did not demonstrate a stable pattern it cannot be
determined that intervention was effective. Qualitative feedback from X at follow-up suggested that he had found it helpful, as he reported feeling more in control of his anger. This case was formulation-led and adapted to both X’s context-specific difficulties and his learning disability. It did not follow a manualised intervention but incorporated strategies found to be helpful in CBT treatment for individuals with a learning disability. At times, X appeared avoidant of participating in tasks related to the intervention and often had a negative perception of his abilities. Intervention was individualised and made accessible with visual resources, metaphors, and idiosyncratic language, in a bid to facilitate communication in sessions and focus on X’s strengths and abilities. X may have had difficulty understanding some concepts discussed, and his dismissal or avoidance of questions may have been his way of signalling this. Intervention should be adapted accordingly to make it more helpful for clients with a learning disability and to benefit the therapeutic alliance. This case used an idiosyncratic measure, as many standardised measures do not generalise to the life experiences of people with learning disabilities. However, the additional use of goal-based outcomes may strengthen the evaluation of interventions and demonstrate progress towards goals.

The cognitive behavioural treatment of social anxiety in the context of paediatric Chronic Fatigue Syndrome (CFS/ME): A case study

Hannah Rapley, University of Bath; Maria Loades, University of Bath

Chronic fatigue syndrome, also known as Myalgic Encephalomyelitis (CFS/ME) and social anxiety are both disabling conditions that can severely impact the functioning and social development of children and adolescents. High comorbidity is found between these disorders, along with a complex aetiological relationship. Despite high concurrent prevalence rates, little evidence exists on how to best treat young people with this comorbidity.

This case study seeks to describe and discuss the use of a cognitive behavioural approach for social anxiety in a 16 year-old girl with CFS/ME. An intervention combining components of CBT for social anxiety and activity management for CFS/ME is presented, and the challenges of this are discussed.

The intervention saw reductions in both symptoms of social anxiety and fatigue, although results were marginally below clinical significance. Results are discussed in light of combining two approaches. The challenges and successes of integrating components of two evidence-based approaches; CBT for social anxiety and activity management for CFS/ME are discussed, along with adaptations employed.

The prevalence and comorbidity of CFS/ME and social anxiety amongst young people indicates a significant clinical need, for which interventions have been minimally addressed in the literature. This case study seeks to explore the effectiveness and identify challenges of combining two evidence-based approaches; activity management for CFS/ME and CBT for social anxiety, to treat this common comorbidity.

Assessing the impact of co-produced group CBT self-management programmes in cancer recovery

Sareeta Vyas, North Bristol NHS Trust; Nicholas Ambler, North Bristol NHS Trust; Carol Chapman, North Bristol NHS Trust

Recent dramatic improvement in cancer survival rates in the UK has shown 40% reduced mortality in the early stage after diagnosis and a 20% reduction of ‘avoidable deaths’; 2.5 million people in England are currently living with and beyond cancer diagnosis (1)(2)(3)(4). There is a need for self-management interventions, promoting rehabilitation, physical re-activation, risk reduction and tackling depression, anxiety, fatigue, and other challenges arising during recovery.
Might CBT-based self-management interventions provide an effective means for delivering these objectives? If so, what would be the uptake? We describe the results of a co-designed Living Well Programme (LWP) jointly developed with patient-participants, made available to all patients during cancer recovery in an acute hospital setting.

LWPs offer a proactive approach to maximising recovery, following a widely applied CBT self-management group model. Condition-specific protocols were developed jointly with patient-participants for breast, prostate, skin, and colorectal cancer pathways with the highest patient numbers. This meant that the design was steered by patient-experience, for example including content on erectile dysfunction in the prostate course but not elsewhere. A generic programme was established for others with various diagnoses. Recruitment was by self-selection from a patient information session at the end of intensive treatment. The course consisted of 5 weekly 2.5 hour sessions, co-facilitated by healthcare professionals and trained former-patient volunteers.

All courses covered activity management, sleep disturbance, stress, and fatigue and individuals reviewed their quality of life. Goal-setting then promoted re-engagement in work, social, household, physical exercise and leisure activities, and management of ongoing condition-specific symptoms. Participants consolidated what they learned into a self-care plan that included a long-term surveillance strategy regarding risk of cancer recurrence.

Outcome measures administered pre/post-intervention: Functional Adjustment to Cancer Therapy-General, EQ-5D-5L, Hospital Anxiety and Depression Scale and Chalder Fatigue Questionnaire.

Over the period June 2010–February 2017, 19.2% of patients who attended patient information events were recruited and 54 LWPs were completed. 383 (168 men and 215 female, mean age 60) joined LWPs, of whom 327 completed outcome measures pre- and post-intervention. T-test comparisons produced statistically significant (p<0.05) differences on every measure. Qualitative feedback strongly supported the benefits of the LWP for recuperation after cancer treatment.

This survey was unusual in the sense of providing data from a whole-system model promoting access to everyone on a cancer recovery pathway in a large acute hospital. Survey evidence indicates that within a system that promotes this rehabilitative intervention, with strong advocacy from former patients, a minority seek this support and the model is effective for them with low drop-out and evidence of change using standardised measures.

This model aligns with the UK national cancer strategy for developing stratified follow-up care demonstrating effectiveness, equity of access, and financial sustainability. This CBT model addressed each of these and showed benefits for areas that are priorities for cancer recovery, such as depression. Further study is needed to determine if the self-selected group corresponds with those most in need. A randomised evaluation might strengthen these findings as well as testing potential resource savings compared to traditional 1:1 follow-up surveillance clinics that promote improvements in self-care through information only.

References:

'It's Just what We Do': Integrating Bio-Psychosocial Formulation into Day-to-Day Practice on an Acute Inner-City Ward

Julie Owen and David King, Mersey Care NHS Foundation Trust

Skills-Based Level 1 formulation training was provided to every member of the multi-disciplinary team and a formulation template collaboratively developed with service users.
was introduced into daily practice. Subsequently, every service user on the ward had access to Level 1 formulation as a minimum standard. Depending on assessed need, service users may require Level 2 formulation or Level 3 (Specialist Formulation by a Clinical Psychologist).

A collaborative approach to the development of bespoke curriculum development is explored alongside thematic evaluation of curriculum topics and their relevance to day-to-day practice on a ward environment. The usefulness of the formulation template is evaluated and particular emphasis is placed on practitioners' experiences of working with the 'sense making' summary category of the template.

Findings from evaluation of the training and evaluation of the usefulness of the Level 1 formulation template in daily practice is cross-referenced with audit findings. The lived experience of implementing Level 1 Formulation into day-to-day practice on a busy inner city acute in-patient ward by Support Workers, Nurses, OT's, and Psychiatrists is unpacked in detail.

* The effectiveness of integrating the 5 systems approach (Padesky and Greenberger) and the 5P's approach to formulation.
* The potential to move away from conceptualising in-patient service user distress primarily through the lens of risk.
* Facilitation of 'sense making' rather than listing or categorising problems.
* The potential for positive impact Level 1 Formulation has on the daily practices of mental health professionals who do not have formal training in therapy.

Cognitive Behavioural Therapy for Co-morbid Depression, Anxiety and Insomnia in Adolescence – A Single Case Study Design

**Rosalind Cooper, University of Bath**; Fidelma Dowling, 2gether NHS Foundation Trust

CBT for depression and social anxiety in adolescents is effective yet limited compared to its use with adults. Research suggests there is high co-morbidity between depression, insomnia and social anxiety in this population.

A single case design was used to test the effectiveness of combining CBT for depression, insomnia and social anxiety with a 17-year-old male who presented with low mood. The client identified depression and insomnia for primary intervention, with social anxiety as a further focus after improvements began to emerge. Collaboratively developed formulations are described.

Routine outcome measures showed a decline over intervention for depression, insomnia and social anxiety, from clinical levels at assessment to non-significant at review. This was confirmed via client and family feedback.

A combined CBT treatment approach appeared beneficial in reducing the impact of all presenting problems. This study supports the hypotheses that using a combined approach of CBT for sleep, depression and social anxiety results in improved mood, improved sleep and decreased social anxiety. This is in line with previous findings that combining CBT-I with CBT for mood reduces depression in adolescence (Clarke et al., 2015) and lends support to the transdiagnostic model for low mood and social anxiety in adolescence (Cummings, Colleen, Caporino, & Kendall, 2014).

The simultaneous consideration of CBT models and interventions for insomnia, depression and anxiety may be beneficial for the treatment of low mood in adolescence.

**When Beck meets Bowlby: A case study demonstrating attachment-informed cognitive behavioural therapy with an older adult**

**Hannah Shilling, University of Bath**; Suzanne Davis, Avon & Wiltshire Partnership Trust

Liz, 74, had a long history of contact with mental health services. After receiving a diagnosis of mild cognitive impairment, attention turned to the impact of her low mood, anger, anxiety and stress on her current functioning and relationships. Liz was referred for a time-limited course of therapy, due to concerns about her potential dependence on the service.
Liz reported a history of difficult relationships and insecure attachments with her parents, physical and mental health services, and her own children, throughout which she had often felt abandoned and rejected. While Liz had spent her life trying to ‘get things right’ in order to meet others’ expectations and avoid being seen as ‘incapable’ or ‘inferior’, several incidents throughout her life had made this difficult. Admissions to mental health units meant she wasn’t always around for her children; losing her job under accusations of misconduct stripped her of her professional identity and pride; and her poor physical health and cognitive difficulties meant she needed support and wasn’t living the retirement she and her husband had hoped for. As Liz struggled with her physical and cognitive difficulties she experienced an increasing sense of inferiority and incapability, while remembering her past ‘failures’ on a daily basis. This resulted in a stream of negative thoughts about herself and others, difficult emotions, and unhelpful behaviours to ‘cover up’ her difficulties; with her close relationships suffering as a result. Liz was offered 12 sessions of CBT, the application of which was guided by attachment theory in order to fulfil Bowlby’s ‘five therapeutic tasks’: providing a secure therapeutic base; exploring patterns in relationships; exploring how relationships are construed; examining unhelpful responses; and identifying and altering unhelpful internal models.

Throughout therapy, Liz’s psychological distress and symptoms of depression and anxiety (as measured using the CORE-10, PHQ-9 and GAD-7) reduced to sub-clinical levels. Endorsement of more helpful beliefs about herself was dramatically increased by the end of therapy. Changes on all measures were maintained or improved at two-week follow up.

Outcomes indicate that attachment-informed CBT can be a successful intervention where there is a history of personal and relational difficulties. Qualitatively, Liz and her husband reported that intervention had provided the first therapeutic encounter in which Liz had not felt abandoned or rejected, helping her to develop a new model of professionals as trustworthy and supportive; while increased awareness of her own unhelpful responses enabled her to take positive steps in her other relationships and strengthen her social connections. This indicates that paying specific attention to achieving Bowlby’s five therapeutic tasks while working within a CBT framework can create powerful shifts in both personal and relational difficulties.

A Transdiagnostic Cognitive Behavioural Treatment Approach for Depression, Social Phobia and Low Self-Esteem in an Adolescent with Gynecomastia: A Single Case Experimental Study

Rachel Phillips, University of Bath; Laura Dixie, Oxford Health NHS Foundation Trust; Rachel Davies, Oxford Health NHS Foundation Trust

Despite an increasing recognition of the variety of psychological difficulties that adolescents with gynecomastia can and do experience, surgical intervention continues to be the only recommended treatment for those for whom the condition persists beyond 3 years. There is yet to be any research looking into the potential benefits of utilising psychological interventions. This study addresses this gap in the literature in exploring the utility of a cognitive behavioural approach for depression, social phobia and low self-esteem in an adolescent with gynecomastia referred to a child and adolescent mental health service. An A/B single-case experimental design (SCED) was used to evaluate a 14 session CBT treatment. A transdiagnostic cognitive behavioural approach was used, utilising techniques shared across the disorder-specific models (Beck, 1979; Clark & Wells, 1995; Fennell, 1997). Such an approach is receiving increasing recognition in the literature given the level of co-morbidity that is commonly seen in clinical practice as compared to the homogenous groups
of research, with a recent systematic review and meta-analysis concluding that transdiagnostic treatment is a promising clinical approach (Reinholt & Krogh, 2014). SUDS were completed weekly with additional routine outcome monitoring (RCADS & SDQ) completed at the beginning and end of treatment. Self-reported subjective benefits of the intervention included “feeling more normal”, understanding that other people’s emotions change in the same manner as his, feeling more able to consider a future and feeling less restricted by gynecomastia. In addition to these subjective benefits, objective measures showed an improvement in MM’s global emotional well-being as evidenced by improved SUDS scores over the intervention period as compared to baseline, as well as an overall trend of reduced RCADS scores and a reduction in impact scores on the SDQ for both MM and his parents’, alongside a reduction in evident difficulties on the parent SDQ also. This consequently supported our testable hypothesis that CBT will improve MM’s overall mood and reduce his levels of distress.

The case study has provided evidence supporting the use of psychological interventions, specifically cognitive behavioural approaches, for pubertal gynecomastia in adolescents presenting with issues of depression, social phobia and self-esteem as an adjunct to surgical intervention. It supports the recommendations in the literature of a two-fold approach (i.e. surgical and psychological) in treating this condition (Schonfeld, 1962; Wassersug & Olliffe, 2009) as well as challenging the suggested ‘preventative’ management of psychological impact through earlier surgery for pubertal gynecomastia (Davanço et al., 2009); a controversial suggestion due to younger age of surgery candidates.

The case study serves to challenge the dominance of the medical model which presides within the field of physical health by providing evidence for a role of psychological support, specifically cognitive behavioural approaches, for adolescents with gynecomastia. It also highlights the importance of regular monitoring of psychosocial factors in primary care with referral for psychological support if deemed necessary. The case demonstrates that CBT may also act as an alternative for those for whom surgical interventions are not possible or wanted, although this requires further research before drawing conclusions.

Cognitive-Behavioural Treatment of Medically Unexplained Symptoms (MUS) in a Patient with Co-morbid Schizophrenia and Obsessive Compulsive Disorder (OCD)

Priya Patel, University of Bath

“Adam” is a 32-year-old male with co-morbid schizophrenia (medically managed), OCD (mild) and depression (medically managed), experiencing Medically Unexplained Symptoms (MUS) including light-headedness, dizziness and disorientation. Though thorough medical examinations found no physical cause for the symptoms, a lack of certainty and reassurance and exacerbation of MUS in public led to ruminative, obsessive worries about the sensations. A lack of confidence in being able to cope with this subsequently also led to increasing reliance on the use of a non-medically indicated walking-stick. Further, Adam’s mood and motivation to engage in previously enjoyable work, social and leisure activities had also consequently dropped.

Adam’s reliance on a walking-stick was understood as an attempt to minimise the impact of the MUS. His rigid belief that “there must be a medical explanation for all physical sensations” caused him to seek constant advice and reassurance from medical professionals. However, in the absence of a clear diagnosis Adam’s worry about his health and reliance on the walking-stick escalated, and led to assumptions that he would never recover. These worries were compounded by co-morbid OCD and earlier experiences relating to his psychosis.

Based on the conceptualisation, it was hypothesised that cognitive restructuring and behavioural experiments would allow Adam to explore and develop alternative perspectives regarding his MUS. Further, it was hoped that specific worry management techniques would improve his confidence in tolerating uncertainty and alleviating any anxiety-induced symptomology. A 12-week intervention based on CBT principles for the treatment of health anxiety (Salkovskis, Warwick & Dean, 2003) was therefore utilised.
By the end of treatment, Adam was no longer using his walking stick, and reported finding CBT helpful in managing his anxiety and low mood. Adam's scores on four standardised outcome measures were consistently in the low-mild range for measures of depression, anxiety and overall wellbeing at the end of therapy, and he no longer met diagnostic criteria for hypochondriasis (SHAI). These scores were maintained at a 3-month follow-up. The limitations of using self-report measures are evident in the current study, as Adam's initial reluctance to acknowledge the level and role of anxiety in his difficulties was seen in his assessment scores. Having said this his scores increased following the start of treatment, perhaps reflecting his new understanding of the problem, before reducing again in response to improvements in his subjective mood and wellbeing.

CBT has proven to be an effective treatment for many individuals experiencing MUS and health anxiety, yet patients with a history of psychosis are routinely regarded as less able to engage in CBT due to the cognitive demands required. Adam's case demonstrates the importance of looking beyond diagnostic labels when working with complex, co-morbid presentations, and highlights how minor modifications such as slower pacing of sessions and more frequent reflective summaries can lead to good engagement, active participation, and successful outcomes. Finally, this case reinforces the idea that patients with more complex presentations can, and do, benefit from simpler interventions, when they are able to focus on just one particular aspect of their difficulties.

A case study integrating CBT with Narrative Therapy externalising techniques with a child with OCD: How to flush away the Silly Gremlin. A Single-Case Experimental Design

Rosemary Banting, University of Bath; Susannah Lloyd, CAMHS

Lucas (pseudonym) is a ten year old boy with severe Obsession Compulsive Disorder (OCD) who was experiencing painful dermatitis due to excessive hand washing. He believed that by washing his hands he prevented the contamination of himself and his family of a deadly disease. Lucas had been experiencing these difficulties for a couple of years and had sought previous help from another CAMHS as well as his school counsellor.

The case was conceptualised using the Cognitive Behavioural Therapy model for OCD integrating externalising techniques from Narrative Therapy. Lucas's externalisation of his OCD, which he labelled it 'The Silly Gremlin', was used in the development of a collaborative conceptualisation which included his own narrative and pictures around 'The Silly Gremlin'. The subsequent CBT intervention, as recommended by NICE, continued to incorporate Lucas's externalisation of his OCD. This included the 'Theory A' that Lucas was at risk of contamination and 'Theory B' that 'The Silly Gremlin' was causing Lucas to worry and this is where the problem lay. Whilst moving through Lucas's fear hierarchy Lucas was given the role as a 'pest controller' and asked to design behavioural experiments to test out 'The Silly Gremlins' beliefs.

The CY-BOCs and the OCD symptom tracking from the RCADS both showed clinically significant change from pre-intervention, to end of intervention and follow up. The CY-BOCS reduced from an overall score of 26 (severe) to 7.5 (sub-clinical/mild) at the end of treatment and 12 (mild) at 1 month follow up. The idiosyncratic data captured showed a reduction in Lucas's obsessions and compulsions by around 6 hours a day. The use of externalising proved to be effective and developmentally appropriate and gave autonomy to Lucas, however there is no control to compare the findings against. Lucas did express how helpful he had found the process of externalising his OCD and he reported imagining flushing 'The Silly Gremlin' away. The new OCD narrative was taken on and used by Luca's family who all started to talk about 'The Silly Gremlin' which opened up conversations between them and Lucas. The case highlights the need for more research detailing and evaluating externalising processes. The Single Case Experimental Design of the study means that the results are only based upon one subject, and therefore lack external validity and the ability to be generalised to the wider population.

For clinicians using CBT in their everyday practice the case gives an example of how to incorporate externalising techniques within a CBT intervention for OCD when working with
children and young people. The case demonstrates the use of externalising in initial conceptualisation of a case and how this can be carried forward and be used as the narrative in treatment. Externalising can be adapted by clinicians to meet the developmental needs of the children or young people they are working with which may improve their engagement and autonomy over the intervention. Clinicians working with children and young people may also wish to share the externalisation with family members to help change the narrative.

Transdiagnostic CBT for comorbid adolescent depression and mixed anxiety: A single case experimental design

Jara Falkenburg, University of Bath; Eddy Draper, Oxford Health NHS Trust

Comorbid depression and anxiety is a well-known element of youth psychopathology (Cummings et al., 2014). Unfortunately, youth depression and anxiety are growing public health concerns: each is related to impairment, but adverse effects are compounded when presented together (Ehrenreich-May & Bilek, 2012). Unfortunately there is much uncertainty regarding treatment. Research often excludes comorbidity, meaning it has been difficult to develop clear guidelines for therapists (Chu et al., 2012).

Recently, theory-building, studies, and clinical practice have been shifting to transdiagnostic approaches (Barlow et al., 2013). Rather than treating one symptom-group, central groups of mechanisms underlying symptoms are addressed (Mansell et al., 2008). Despite positive early findings, transdiagnostic interventions are still less well-developed than other approaches and consequently have smaller bases of empirical support. There have been calls for studies evaluating transdiagnostic therapy as stand-alone treatment, especially for youth (Chu, 2012).

This case study aimed to respond to this need by assessing the effectiveness and acceptability of transdiagnostic therapy through a single experimental case of 19-session transdiagnostic CBT for an adolescent with comorbid depression and mixed anxiety. Alice, a White-British 17-year-old, was referred to CAMHS for having self-harmed and feeling depressed and anxious for one year. CBT-informed formulations regarding the maintenance of her difficulties highlighted the transdiagnostic mechanisms underlying her difficulties. Alice was thus offered transdiagnostic CBT, evaluated using an A-B single case experimental design. Three measures were used throughout therapy: the Outcome Rating Scale (evaluating Alice's overall distress); Revised Child Anxiety and Depression Scale (specific depression and anxiety symptomatology); and Session Rating Scale (treatment acceptability and therapeutic alliance). Alice attended four weekly one-hour assessment sessions during phase A; to determine baseline, no intervention was given. During phase B, she attended individual 60- to 90-minute intervention sessions and did homework between these. RCADS scores (depression and anxiety symptomatology) demonstrated an overall trend of improvement from beginning to end and no longer met clinical threshold for RCADS total and all subscales except panic in the last session. The ORS (overall distress) was comparatively more stable: steady improvement was seen until session eight, followed by an overall trend of improvement (albeit with slight variability) until the last session. Alice also reported full positive SRS scores (treatment acceptability and therapeutic alliance) every week, except the first couple.

The improvements support previous research and theoretical models suggesting that addressing transdiagnostic processes underlying depression and anxiety through CBT (in this case, sleeping difficulties, situational and emotional avoidance, and distress intolerance) can lead to overall improvement and be acceptable to and adapted successfully for adolescents whom experience them concurrently. However, findings do not correspond with studies demonstrating efficacy of transdiagnostic treatment of panic (e.g. Norton, 2008). CBT therapists are often confronted with complex clinical profiles in everyday clinical practice. Transdiagnostic intervention can reduce worries about time-constraints that frequently accompany modular approaches, offer an alternative to the mixing and matching that is a danger of the flexible implementation of focal treatments, and provide skills that can help even those who do not complete treatment (Chu et al., 2012).
CBT for child separation anxiety: The role of parental involvement when there is parent-child disagreement about the presenting problem

Dawn Lindsay, University of Bath; Olivia Payne, South Bristol Children and Adolescent Mental Health Service

X, a 10-year-old boy, was referred to a Children and Adolescent Mental Health Service over concerns about separation anxiety. X refused to sleep alone at night and slept on a separate bed to the side of his parents but did not have any particular fears about sleeping alone. He displayed lower levels of separation anxiety in other situations, although attended school happily and played in the park without showing anxiety. It appeared as though X had never learned the ability to self-soothe and had become dependent on his parents. Sustained use of avoidance of sleeping in his own room meant that he had never been able to gather evidence that could disconfirm any negative beliefs that he held about his ability to sleep alone. Although well-intentioned, family accommodation maintained this avoidance. Intervention was a modified version of the Coping Cat programme, adapted to suit X's individual needs, delivered in 10 1-hour sessions over a period of 15 weeks. Adaptations included assessment of motivation, changes in the order of content delivered and one parent present at each session (although not always actively involved).

Child ratings on the Separation Anxiety Subscale of the RCADS served as the dependent variable. Baseline ratings only moved within three points, suggesting that stability in this phase was achieved. However, X's scores fell within the normal range. In contrast, his parent's ratings of the same measure indicated that he was in a high range for separation anxiety. Scores on both the child and parent ratings stayed within their respective ranges during intervention, indicating no change.

Results on formal measures showed there was no improvement after delivering a CBT intervention based on the Coping Cat programme. On goal-based outcomes, X did make some progress, and by the final session he had moved into a separate room with his mum or dad sleeping next to him. Although CBT interventions for anxiety within children have been shown to be effective, there are approximately 40% of children who continue to show no improvement. In X's case, his low motivation for change was a factor in the outcome of intervention. Continuing to avoid sleeping alone may have felt safer than potentially increasing his anxiety levels through graded exposure. In contrast, his parent's frustration and own anxiety may have prevented them from facilitating X's exposure to feared situations, and inadvertently contributed to the maintenance of separation anxiety. This case may have benefited from an alternative CBT intervention with increased structured parental involvement (e.g. the TAFF programme) or a systemic intervention from the outset.

Primary caregivers are central to the nature of separation anxiety, indicating that adapting therapeutic interventions to increase parental involvement may be worthwhile, when appropriate to the needs of the child and their family. When goals of therapy are not consistent with a child’s understanding of presenting problems, then this can impact on their motivation. Administering the Child Session Rating Scale could have helped to evaluate the progress of intervention and indicate changes needed at an earlier stage.

Cognitive Behavioural Therapy for distressing visual hallucinations in Lewy Body Dementia: a case study

Juliette Attwood, University of Bath

Mr M was an 84yr old man experiencing distressing visual and tactile hallucinations in the context of Lewy Body Dementia. Mr M reported feeling increasing angered by reoccurring hallucinations of a man in his bedroom at night whom he believed had sexual intentions towards him. He reported wearing additional clothing, making a ‘barricade’ in his bed, and shouting and hitting out at the hallucinations. Mrs M also reported distress at being woken...
most nights. Neuropsychological reports revealed significant problems with executive function and short term memory.

Treatment consisted of ten sessions of Cognitive Behavioural Therapy (CBT) with Mr M and his wife. Initial sessions involved socialisation to the CBT model, weekly self-monitoring, and functional analyses of situations to develop a formulation. A CBT model of distressing visual hallucinations in older people (Collerton & Dudley, 2004) was found to be too complex and threatened the therapeutic alliance by directly challenging Mr M’s beliefs that his experiences were real. In line with protocols for treating anxiety in older people with dementia (e.g. Charlsworth et al., 2015), simpler mini-formulations were developed. When interpreting hallucinations as ‘benign’, Mr M ignored them and remained calm, however, when interpreting them as ‘concerning’, he became involved in a vicious cycle of physical arousal and unhelpful behaviours. The opposing formulations were sensitively discuss using a ‘Theory A/Theory B’ framework (Salkovskis & Bass, 1997). Mr M’s goal to eliminate the hallucinations entirely was also attended to using a decision balance sheet from motivational interviewing (Miller & Rollnick, 1991).

Mr M was supported to practice meditation for relaxation, and behavioural experiments were set-up which included Mr M taking less physical precautions and reaching out to touch hallucinations. Ongoing self-monitoring showed that Mr became more distressed and woke Mrs M more when he shouted and built barricades.

Mr M’s scores on the Generalised Anxiety Disorder 7 (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006) reduced from 11 to 5, and his score on the Psychotic Symptom Rating Scale (PSYRATS; Haddock, McCarron, Tarrier, & Faragher, 1999) reduced from 16 to 11.

Idiosyncratic goal ratings showed a sustained reduction in Mr M’s distress and a maintained low level of distress for Mrs M. There was also a sustained reduction in Mrs M being woken at night despite an increase in the frequency of ‘concerning’ hallucinations over the course of therapy.

This case provides evidence that CBT can be applied to distressing visual hallucinations in the context of LBD. The model proposed by Collerton and Dudley (2004) was useful at the assessment stage, but the protocol of Charlesworth et al. (2015) proved more useful in guiding formulation and intervention. Using a Theory A/Theory B framework to offer a tentative alternative hypothesis, and flexibly applying traditional cognitive-behavioural techniques was more successful than challenging Mr M beliefs directly with psychoeducation about LBD and hallucinations. Mrs M’s involvement in and between sessions was also essential to the success of the intervention.

The implication is that CBT informed by the evidence base for dementia and psychosis can be applied to help treat distress in response to visual and tactile hallucinations in the context of dementia, and that this can have benefits for both clients and their carers.

A critical review of the application of Clark and Wells’ social anxiety model to adolescents, with a case illustration

Taruna Jamalamadaka, University of Bath; Sarah Libby, Bristol East Central CAMHS

Annie (name changed for reasons of confidentiality) previously struggled with depression, which was treated with medication. Interestingly, with her depression under control, she found her social anxiety heightened. Annie described that she felt like going out and meeting people, and that she had more friends, but her social anxiety kept her from enjoying these interactions.

Annie has had some experiences in the recent past that made her believe she is annoying to others when she asks questions or starts a conversation with them. Annie said she was worried about rejection by friends and peers and was afraid of being left alone. She was also concerned her social anxiety might make her relapse and become depressed again. Annie also struggled with low self-esteem.

The Clark and Wells (1995) model of social anxiety was used to conceptualise and treat Annie’s presenting difficulties. A formulation that included predisposing, precipitating, perpetuating and protective factors also informed treatment.

Intervention
Annie was involved in a treatment plan that lasted seven weeks; which involved seven, hour-long sessions.

The content of sessions included:

Session 1: Psychoeducation and shifting attentional focus
Session 2: Video feedback
Session 3: Modifying negative self-images
Session 4 and 5: Modifying assumptions and core beliefs
Session 6: Modifying post-interaction ruminations
Session 7: Therapy blueprinting and relapse prevention planning

Several self-report measures were included in the treatment programme:
- Social Phobia Inventory (SPIN; (Connor et al., 2000).
- Revised Child Anxiety and Depression Scale - Child and Parent versions [RCADS; (Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000)]
- Session Rating Scale [SRS; (Duncan et al., 2003)]
- Outcome Rating Scale [ORS; (Sparks, Miller, Bohanske, & Claud, 2006)].
- Goal Progress Charts (Law, 2013) were used to track two specific goals identified by the client.

Annie’s scores on all self-report measures improved.

With respect to the proposed hypotheses, as a result of CBT for social anxiety:
1. Annie dropped the use of safety seeking behaviours, which promoted disconfirmation of negative beliefs and reduced her social anxiety.
2. Annie began to concentrate on how others respond to her, instead of on constructed images and impressions of how she thought she appeared.
3. Annie prepared less in anticipation of feared social situations; this demonstrated to her that by not over-preparing, conversations and interactions were less likely to get derailed.

This case study describes the successful treatment of social anxiety in a teenager. The cognitive model of social anxiety was used to develop an idiographic formulation of this case. The importance of formulation in directing interventions is reflected upon. The literature suggests that social anxiety is a risk factor for depression and this was evident in Annie’s case. It was therefore critical to address the social anxiety in order to prevent further depressive episodes.

This case study adds to the existing literature for CBT for social anxiety. The results support the use of the CBT model for social anxiety with adolescents provided appropriate adaptations (Belsher & Wilkes, 1994; Stallard, 2005) are made for this age group.

The two-part framework underlying CBT, and how understanding it is essential in the development of effective cognitive treatments for children: A review

John Latham, Oxford University; Sarah Rakovshik, Oxford University

Although cognitive behaviour therapy treatment with pre-adolescent children is much less effective than the adult cognitive behaviour therapy treatments, the theory may still help to deliver strong and effective therapeutic practice.

Objective: To understand the application of CBT for anxiety to children and adolescents in the context of developmental limitations.

Method: Review of literature, including manualised treatments, purporting to be effective CBT treatments with children, compared with adult CBT for anxiety literature and treatment manuals.

Results: Evidence is presented that the distinction between CBT treatment models for adults and children is that adult models are either not thorough enough to apply to children, or children lack the capacity to engage with the clinical treatment protocols.

Conclusions: Child development, and the under-development of cognitive abilities, is a key component that hinders the effectiveness of treatment. However, whilst it is difficult for a child to recognise dysfunctional patterns of thinking and behaviour themselves, cognitive behavioural theory can still be applied to help therapists understand why children have dysfunctional patterns and can therefore act as a guiding paradigm.
Those working with children need to be aware that manualised treatments should not be considered to be as effective as treatment with adults, and instead focus on using CBT as a starting platform; using it to theoretically consider the role and impact of cognition on understanding behaviour. An alternative briefly proposed is a systemic multidisciplinary service, which has CBT supervision to guide approaches.

**Group CBT for Anxiety & Depression in Older Adults**

**Manreesh Baines**, Sheffield Health & Social Care Trust; Shonagh Scott, Sheffield Health & Social Care Trust; Stephen Kellett, Sheffield University

Depression and anxiety co-occur at high rates in older adults e.g. 47.5% of those with major depressive disorder had co-morbid anxiety disorders and 26.1% of people with anxiety disorders had co-morbid major depressive disorders. There is a dearth of literature in relation to group interventions that address co-morbid anxiety and depression for older adults. This research evaluated the clinical effectiveness of a manualised six session cognitive behavioural psycho-educational group programme for older adults.

A pre-post and short term follow-up design was used. Patients (N=34) older adults attended a group (N=8). Outcome measures included: Hospital Anxiety & Depression Scale; Clinical Outcomes in Routine Evaluation-Outcome Measure; & Health of Nation Outcome Scale 65+. Measures were completed at assessment, termination and six week follow up. Patients rated therapy alliance using the Group Session Rating Scale. All outcome measures demonstrated improvement in assessment to termination and assessment to follow-up comparisons. On the CORE-OM, 28% of patients reliably improved and 22% were classified as recovered at termination.

The intervention shows promising findings with anxiety, depression, psychological well-being and staff observations of patients well-being, all improving following intervention. The manualised intervention received positive feedback from different disciplines that facilitated the groups. There is potential for research to consider how manualised psychological interventions influence the clinical practice and confidence of using a psychological model for non-psychological professionals.

**The Modular Protocol for Mental Health: Study protocol for a pilot randomised clinical trial of a transdiagnostic treatment for mood and anxiety disorders in adults**

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Anxiety and mood disorders are common conditions affecting up to 20% of adults and most psychological treatments focus on individual diagnoses. However, these diagnosis-specific interventions are less effective for a large number of people who experience complex problems involving multiple diagnoses. Existing transdiagnostic treatments for emotional disorders are efficacious (Newby et al., 2015), but many packages are “one-size-fits-all” and tailored, modular packages may better address heterogeneity in presentations (Chorpita, Daleiden, & Weisz, 2005). We have developed a new transdiagnostic treatment, the Modular Protocol for Mental Health, which combines several evidence-based treatment techniques to address the gap in effective interventions for people for whom disorder-specific treatments would leave significant difficulties unaddressed. The aim of the current study is to conduct a feasibility trial of the Modular Protocol for Mental Health in preparation for a later-phase randomised clinical trial.
We have tested the Modular Protocol for Mental Health on a series of people (‘cases’), each with a complex mixture of anxiety and mood disorders, with promising results. The current study is a patient level two-arm randomised feasibility trial that compares the Modular Protocol for Mental Health to treatment-as-usual for patients aged >18 years (N=50) with co-morbid mood, anxiety, obsessive-compulsive or trauma- and stressor-related disorder diagnoses, recruited from primary and secondary care within the National Health Service. The preliminary results from the pilot ‘cases’ suggest an overall reduction in depressive and anxiety symptoms. For the feasibility trial, the primary outcomes will be post-treatment and 3-month follow-up responses on a structured clinical diagnostic interview, and scores on depressive symptoms, anxiety symptoms, and disability and functional impairment. The secondary measures are quantitative data on the feasibility and acceptability of the Modular Protocol for Mental Health and basic qualitative and quantitative data to resolve procedural uncertainties in preparation for the later phase clinical trial.

In preparation for a later-phase randomised controlled trial, the current randomised feasibility trial aims to determine the potential efficacy of a new modular treatment that enables the flexible delivery of evidence-based interventions, the Modular Protocol for Mental Health.

The Modular Protocol for Mental Health has the potential to provide a more cost-effective and efficacious intervention for many individuals who experience significant impairment as the result of multiple mood, anxiety, and stress disorders. In addition, this treatment approach may reduce the burden on therapists-in-training and experienced therapists to remain up-to-date with treatment literature and maintain competency in disorder-specific approaches.

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Video-conferencing to Augment Asynchronous Therapist Contact in Internet-Delivered Cognitive-Behavioural Therapy for Generalised Anxiety Disorder: A Pilot Study

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Therapeutic alliance is an important predictor of psychological treatment outcomes. The efficacy of self-guided internet-delivered cognitive-behavioural therapy (iCBT) is enhanced even when minimal therapist contact is included, such as in the form of weekly asynchronous e-mail contact (Johansson & Andersson, 2012). Mental Health Online (MHO) is an open-access online mental health service, which currently offers self-guided and therapist-assisted iCBT programs for mood and anxiety disorders. Therapist-assistance currently involves weekly asynchronous e-mail contact. Of MHO’s suite of iCBT programs, its 12-week program for generalised anxiety disorder (“GAD Online”) is the most popular, having been accessed by >4,800 clients since 2009. Evaluation data demonstrates that, even with asynchronous therapist-assistance, clients are most at-risk of program drop-out at weeks four (identification of negative automatic thoughts) and eight (commencement of exposure). Video-conferencing (VC) has been used to feasibly deliver online counselling, with treatment outcomes and ratings of the therapeutic alliance being equivalent to those of face-to-face therapies (Backhaus et al., 2012). Augmenting therapist-assisted iCBT with intermittent VC sessions may strengthen the development of the therapeutic alliance, and could lead to greater client retention, adherence and outcomes from iCBT.

The aim of this pilot study is to investigate the effectiveness, feasibility and acceptability of augmenting the GAD Online program with 30-minute VC therapist sessions at weeks 1, 4, 8
and 12. Participants receive standard therapist-assistance e-mails during every other week of the program. The project aims to recruit 25 adults aged ≥18 who are seeking online treatment for anxiety and worry. Participants complete validated measures of GAD and depression symptoms, distress and quality of life at baseline and post-treatment. Treatment credibility and expectations are also measured at baseline. After each VC session, participants complete measures of therapeutic alliance, VC ease of use and GAD Online program use. At post-treatment, participants complete a satisfaction survey and have the option to provide further feedback during a semi-structured interview. Recruitment commenced in January 2017. To date, 12 participants have consented to participate and 9 have completed baseline assessments. Of those, 5 have commenced the VC-augmented GAD Online program, with one participant currently completing module/week 5 (challenging negative automatic thoughts). We will present preliminary participant characteristics, therapeutic alliance ratings, symptom outcomes, drop-out rates, and participant experiences and overall satisfaction with this blended iCBT approach. This pilot trial will be the first study examining the effectiveness, feasibility and acceptability of iCBT that is augmented with both asynchronous and VC therapist contact. It is anticipated that this model of blended care will strengthen the therapeutic alliance, and ultimately improve client retention, adherence and outcomes for GAD. Should this model of blended treatment be empirically supported, it has great potential for enhancing access to effective and engaging therapist-assisted iCBT. This novel, blended approach to therapist-supported iCBT may be integrated with stepped care models of public mental health service delivery. iCBT may be positioned as the entry level treatment, for clients with high motivation and the ability to self-manage mild symptoms, for example. At the next level, therapist-assisted VC-augmented iCBT may be particularly useful for clients with mild-to-moderate symptoms and/or need of therapist accountability or motivational support to problem-solve around barriers to self-management. An additional advantage of VC-augmented iCBT is that clinicians can provide coaching and behavioural support for clients who have disorders they may lack specialist training and experience in, but with the structured guide of a manualised iCBT program (i.e., the iCBT programs supports fidelity). This provides a similar advantage to clients in need of disorder-specific evidence-based treatment, but who lack access to specialists in their local community.

Naturalistic Evaluation of "Made-4-Me": An Internet-Delivered, Multi-Disorder Cognitive-Behavioural Treatment Program Tailored to Client Age and Gender

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Internet-delivered cognitive-behavioural treatment (iCBT) is efficacious, cost-effective and acceptable for a range of mood, anxiety and other psychological disorders (e.g., Hedman, Ljótsson, & Linderfors, 2012). To date, iCBT programs have typically delivered standardised content, which is either targeted at a single disorder or is ‘transdiagnostic’ in nature (i.e. the content is relevant to a range of conditions, such as anxiety and depression; see Titov et al., 2015). However, both the range and number of co-morbid disorders in clients seeking online treatment, and broader issues with client engagement and adherence to standardised iCBT treatment protocols, has led to a call for greater individualisation of iCBT program content (Fleming et al., 2016). The selection of disorder-specific content – by the client, the therapist, or via automation – has been successfully trialed (e.g., Carlbring et al., 2011; Helgadottir et al., 2009; Silvernagel et al., 2012), however, no iCBT initiatives to date have tailored program content to both clinical need/profile and individual factors, such as age and gender. The
“Made-4-Me” (M4M) program – delivered via the Mental Health Online web platform, and launched to the public in 2015 – addresses this need.

Intervention.

M4M is an 11-module online program that references best-practice guidelines for the delivery of iCBT, with key modules focusing on psycho-education, relaxation strategies, cognitive restructuring, behavior modification, and relapse prevention. However, rather than containing standardised content – to be viewed by all users – a version of M4M is designed for the individual user, based on his/her demographic profile and clinical needs. In total, 210 possible versions of the M4M program are possible, based on the following: (1) age (18-25; 26-64; 65-85 years); (2) gender (male, female), and (3) clinical problems (the consumer selects up to three of the following six disorders: Depression, Generalised Anxiety Disorder, Social Anxiety Disorder, Obsessive Compulsive Disorder, Posttraumatic Stress Disorder, and Panic). By nominating their responses and preferences in each of these three categories, the user will view only material – including clinical examples and audiovisual content – that is relevant and maximally engaging. It is anticipated that this approach to iCBT delivery will enhance online engagement and adherence, while also more closely approximating the individualised approach of face-to-face interventions.

Evaluation.

A preliminary naturalistic evaluation of the M4M program was undertaken, with service access and clinical data collected from all clients who registered in a treatment program on Mental Health Online between program launch (May 2015) and December 2016 (N = 1,969). The clinical and demographic profile of consumers accessing the M4M program (N = 318) were compared with those accessing a single disorder treatment program (N = 1,651), and feedback was also sought from M4M participants to investigate program usability and perceived effectiveness.

Of the 318 registrants in the M4M program, most (73%) were female, and aged 25-64 years (80.2%), which parallels the profile of Mental Health Online site users more broadly. However, significant differences by both gender and age were noted in the clinical focus of M4M programs: males more frequently selected treatment for Depression and Social Anxiety, whereas females more frequently selected treatment for Posttraumatic Stress Disorder. In addition, adults aged 18-24 most frequently selected treatment for Depression, whereas adults aged 25-64 most frequently selected Generalised Anxiety Disorder. These findings will be presented with reference to iCBT program users more broadly on the site. M4M is an innovative program that allows iCBT content to be tailored to the individual user’s age, gender, and clinical needs. Preliminary findings suggest that this is a useful and accessible option for Mental Health Online site users, who frequently report symptoms of multiple clinical disorders at assessment. Further investigation is required to determine the relative clinical gains that result for registration in this program, and whether individualisation of content improves engagement and adherence, as predicted.

To date, research in the field of iCBT program delivery has typically focused on the effectiveness of standardised online content, which is typically targeted at the symptoms of a single clinical disorder. However, as in the face-to-face treatment-seeking population, clients accessing online treatment present with a range of clinical problems – for example, clients who have completed an assessment on Mental Health Online receive an average of 4.9 diagnoses, based on DSM-IV diagnostic criteria. To date, iCBT has provided only limited options in addressed multiple co-morbidities. Rather than completing a treatment program for each disorder, in sequence, M4M allows the consumer to achieve maximum clinical benefit from online treatment engagement.

“Turtling up” Through 30 Years of Troubles: A Condition Management Programme Case Study

Ann O’Hanlon, South Eastern Health and Social Care Trust, N. Ireland; Tina Watson, South Eastern Health and Social Care Trust, N. Ireland; Jane Mitchell, South Eastern Health and Social Care Trust, N. Ireland
“The Troubles” in N Ireland have had high costs for individuals and whole communities. These costs include over 3000 deaths, and high levels of pathology and mental health distress. The following case study describes the treatment offered to one such individual presenting with significant anxiety. John* took part in the Condition Management Programme (CMP). CMP is a voluntary, CBT-informed N-Ireland wide service that enables people in receipt of certain benefits to address and manage their health related barriers to work.

John* is a 44-year old man who presented with symptoms of anxiety and depression which he reported, had been on-going since adolescence. He also had low confidence, socially and occupationally. John’s symptoms fitted the criteria for Generalised Anxiety Disorder (or GAD), with co-morbid depression and social anxiety (DSM-V, 2013). John was allocated a CBT Therapist to help with his mood problems, and a Clinical Specialist OT to help with his procrastination. A number of measures were used throughout the intervention incl the Patient Health Questionnaire (PHQ-9) (Spitzer et al, 1999), the GAD-7 (Spitzer et al, 2006), and The CORE34. John described growing up in an environment were it was not safe to stand out in any way, given very real dangers both from outside, and within the family home. It is hypothesised that John developed core beliefs: “if I stand out, I will be found to be at fault” and “if I try, I will be criticised”. These core beliefs, lead the young John to develop rules around not trying, and “turtling up” or withdrawing into himself, which then impacted negatively on his confidence, his mood and his ability to engage in work.

John fully engaged in the 12-week CMP programme and had no DNAs or cancellations. His scores pre- and post CMP showed significant improvements on all measures, e.g. GAD-7 (T1=16 vs T2=1), and PHQ9 (T1=16 vs T2=1). These improvements were reinforced by CBT-informed OT support to help John manage time (colour coding challenges in terms of priority), develop his CV, and meet others incl researchers/academics who could help him in time meet his academic aspirations.

John had spent many decades with a paralyzing worry tendency that impacted adversely on many areas of his life including his mood (anxiety, depression, low confidence), his physical health, and his ability to engage meaningfully with others which includes finding work that was meaningful and fulfilling. After CMP John is now working on his OU degree, engaging with others socially and academically, and confident about the future. He reports now that he is engaging in new interests, and is focused on part-time employment while perusing his academic interests.

- Practical applications of CBT to a N-Ireland wide programme that is improving health, well-being, and quality of life.
- Applications of CBT in addressing physical and economic problems as well as problems of mood.

Let’s Talk! Increasing Access to Psychological Therapies in Wales

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Let’s Talk! about evidence based Psychological Therapies is a Welsh based, Hafal initiative funded for three years by the Big Lottery People and Places Programme. Hafal (meaning ‘equal’), is the principal third sector organisation in Wales working for and managed by people with serious mental illness and their carers. Its purpose is to promote access to evidence based psychological therapies for people within Wales with a serious mental illness. Hafal. The Let’s Talk! Team are working with Welsh Government, the Mental Health Alliance, Members of the BABCP in Wales, and the recently formed ‘We Need to Talk Wales Coalition’ to campaign for increased access to evidence based talking therapies for people in Wales.

‘Let’s Talk!’ has a number of innovative activities and services; these include:
• a ‘Psychological Therapies Centre of Excellence Observatory’, with an Observatory Members Network that will support the collection and dissemination of information about the availability of evidence based Psychological Therapies across Wales delivered by the public, private and voluntary sectors in Wales. This will be the first time in Wales that this information has been made available in one place.

• dedicated user-friendly guides to assist people to have a better understanding of the types of evidence based therapies that work best for different mental health conditions. These guides are being designed in collaboration with professionals and people with a lived experience of mental illness, and their carers.

• an online talking therapies Forum available on Hafal’s CLIC service http://www.hafal.org/clic/

• an ‘Advocacy’ training programme designed to up skill Hafal staff and people with a lived experience of mental illness, and their carers. The training aims to support people in Wales to be able to access psychological therapies more swiftly;

• professional awareness raising CPD opportunity for mental health professionals who want to have an understanding of the additional challenges and hurdles faced by people in Wales with a serious mental illness when trying to access evidence based psychological therapies.

80 participants with a lived experience of mental illness and/or their carers, aged between 23-75 years, and residing in Wales, took part in one of two consultation events aimed at obtaining participant views on the format and content of the Advocacy Training Programme. Three key themes emerged from the consultation events:

1- The ‘Advocacy’ training should provide participants with an understanding of NICE guidance for each of the different psychological conditions including a good understanding of CBT.

2- The ‘Advocacy’ training should provide participants with the necessary skills to support them in negotiations with their care provider (GP, CPN etc) whilst trying to access ‘dual treatment’ e.g. medication and ‘talking therapies’.

3- The ‘Advocacy’ training should provide participants with information about accessing evidence based ‘talking therapies’ from the private and voluntary sectors in particular.

It is proposed that similar qualitative research methods will be used to determine the content and structure of the Let’s Talk evidence based professional psychological therapies awareness raising training. The BABCP champions CBT and evidence based practice.

Let’s Talk is working with a broad range of people, including the Mental Health Alliance, the recently formed ‘We Need to Talk Wales Coalition’, and members of the Welsh BABCP to campaign for increased access to CBT as an evidence based talking therapy for people in Wales. These research findings will be taken forward and used in the development of the ‘Advocacy’ Training programme which will be piloted in early 2017 and will support Let’s Talk’s ongoing research.

Let’s Talk’s activities and services will promote access to CBT for people living in Wales with a serious mental illness and this will have a positive outcome on their ability to access evidence based CBT in Wales.

Case Report: Brief Trans-diagnostic CBT for Distressed Carers of Service User with First Episode Psychosis Distress

Miv Riley, Lancashire Care Foundation Trust

This case report will introduce Emily a 45-year-old female of white British, origin living in Lancashire. Emily was referred to Early Intervention Service (EIS) Family Therapy pathway via her son’s case manager. Within the National Health Service, EIS engages with people at risk of, or experiencing First Episode Psychosis (FEP) with the philosophy of recovery as its mainstay (Birchwood, 2014). EIS offers family work based on psychosocial interventions (PSI) such as Cognitive Behavioural Therapy (CBT) and Behavioural Family Therapy (BFT) to carers (NICE, 2015; Wilai, Patraporn, & McCann, 2014). Historically, Emily has been classed as her 18-year-old son’s full-time carer. His case manager had noticed a continued deterioration in the relationship between the son and
mother. This concern led the case manager to complete an additional carers assessment that identified: worry, anxiety, poor concentration and low mood, potentially driven by Emilie’s over involvement in the care of her son (diagnosed with FEP) and her phased return to work. These symptoms were attributed to carer burden (Puig et al., 2014; Tomlinson, Onwumere, & Kuipers, 2014) and expressed emotion (EE) (Kuipers et al., 2007). The flexibility of approach identified within CBT is therefore ideal for Emily, as the referral had no diagnostic criteria linked to DSM-IV. This indicated the need for an assessment on which to base hypothesis’ for Emily’s intervention strategy.

Whilst it is unusual for EIS to offer individual carer therapy, due to the awareness that EE can impact negatively on service user recovery, it was deemed suitable, post reviewing Quality Standard 80, (NICE, 2015) to offer Emily the option of CBT, under the EIS family intervention umbrella, rather than refer her to her GP for CBT. However Emily placed a restriction of six sessions on our meeting as this is when she proposed to return to full time work.

The referral indicated other non-diagnostic psychological constructs were involved in Emilie’s presentation, Expressed Emotion (Barrowclough & Hooley, 2003) (Wainwright, Glentworth, Haddock, Bentley, & Lobban, 2015) and carer burden (Chan, 2010). To acknowledge the effects and interactions as a precursor for GAD presentation, these psychological constructs will need to be incorporated into assessment and formulations, which may include trans-diagnostic considerations. Emily had subsumed her own needs and was intently focused on her son’s recovery. She showed good insight into her situation, however she was unable to see a way forward. Based on the information provided by Emily during this introductory session and the scores of the self-report measures confirmed worry as the core symptom with a comorbidity of depression and anxiety: PSWQ scored 74, (High), BDI scored =22 (Moderate), HAM-A = 21 (Moderate)

These score are and symptoms are indicative of GAD (DSM IV) (Recognising the brief time limitation (six sessions) (Cape & Whittington, 2010; Safran et al., 1993; Turkington & D., 2002) and the complexity of the presentation. The Intolerance of Uncertainty model (Anderson et al., 2012; Bomyea et al., 2015; McEvoy & Mahoney, 2012; Robichaud, 2013) was identified for the simplicity in socialising Emily to the models the key concepts: intolerance of uncertainty, beliefs about worry, negative problem orientation and cognitive avoidance; within CBT the appointments (Thomas & Drake, 2012).

During the proposed therapy sessions, Emily will be able to safely, ethically and collaboratively explore her personal meanings, emotions and behaviours. However, before therapy can commence a detailed ideographic assessment will occur. This will inform and aid in understanding of the client’s problems and potential activating triggers based on Emilie’s thoughts, behaviours emotional and physiological responses, whilst taking into account contributory factors such as life experiences, genetics and environment. To support these investigations various models such as five aspects (Greenerger & Padesky, 1996) can be used to aid case conceptualisation and formulations (Corrie et al., 2016) in association with outcome and person specific measures, and importantly to ascertain Emilie’s suitability for CBT,(Safran, Segal, & Vallis, 1993) i.e.: her motivation to engage with therapy (Renaud, Russell, & Myhr, 2014).

Within four weeks Emily had dropped 14 points on the BDI, 30 points on the PSWQ and 13 points on HAM- A. There was a drop in all scores on the Brief Illness Perception Questionnaire. The SUD score also showed a positive reduction for worry, related to leaving her son at home and going to work. Overall Emily reported improved concentration, decrease in worry, anxiety and low mood

Included in clinical supervision was the discussion related to the link between carer burden, EE and GAD as the final outcome measure indicated a decrease distress and the perception of carer burden. There was an acknowledgement that decreases in the depression and anxiety scores would be expected, as this was the original remit for CBT. With this in mind, the drop demonstrated in the PSWQs scores were of interest, as there is consideration that CBT does not have an impact on the reduction of worry, conversely CBT is known to reduce...
intolerance of uncertainty and this could warrant further investigation linked to the altered perception of threat from her son's illness (BIPQ) and expressed emotion.

The potential implications for practice when working with distress carers of service users who are experiencing psychosis are multiple, including impact on carer well-being, improved home environment, reduced time pressures for all involved. This case study has provided a potential hypothesis for moving forward into Brief CBT-Trans-diagnostic intervention for carers experiencing expressed emotion, but presenting as GAD and its cardinal symptom of worry.

Advancement and retention of the PWP role

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The economic and practical arguments for the IAPT initiative are well known, however the cost effectiveness of IAPT services is brought into question due to an unexpected threat; retention of Psychological Wellbeing Practitioners. Current research suggests that 49% of Psychological Wellbeing Practitioners (PWPs) do not see themselves occupying the same role in two years' time, with that figure increasing to 70% when considering if they still see themselves in the role in 5 years (Saville, 2015). Hope and Turpin (2010) describe that there is currently a "worrying exodus of PWPs, often newly qualified, into High Intensity Cognitive Behavioural Therapy training or seeking admission into clinical psychology training" demonstrating that a large number of PWPs view the role as a stepping stone as opposed to a standalone career. Hope and Turpin (2010) go on to suggest this may be due to the role being largely occupied by "ambitious graduates" who see it as a stepping stone to further their careers.

Despite many issues being raised around retention of the PWP role, at present, the reason why is largely not understood. Understanding why PWPs are leaving their jobs may allow necessary changes to take place in order to improve future retention of this key role, making it sustainable for the future.

A 33 item questionnaire was sent out to the Psychological Wellbeing Practitioner workforce of Talking Matters Northumberland. Of a workforce of 22 individuals, 17 responses were gathered (77.27% responses rate). The questionnaire was a mix of both qualitative and quantitative items. The questionnaire was released via survey monkey to ensure anonymity amongst the results. The questionnaire asked Psychological Wellbeing Practitioners to rate and discuss their experiences of being a PWP.

The results from this study highlighted that only 5.88% of the workforce intended to stay in the role longer than 5 years. Which fits directly with the findings of recent research in 2015, suggesting the role is a short term, stepping stone role for further training (Moreea, 2015; Saville, 2015). Whilst there may be several reasons for this result, it highlights an issue with retention of the PWP role. Furthermore, our results showed that 82.35% of PWPs answered that they viewed the PWP role as a stepping stone. Not only did such a high proportion of PWPs view the role as a stepping stone, 76.47% of people want to move on from the role.

PWPs were asked about the most challenging aspect of the role, to help shed some light into why it's a difficult position to remain in. 76.5% of PWPs included in their qualitative responses that time management and targets were the most challenging aspect of their role. As previous research has identified, the retention of the PWP role is under threat. This research wasn't simply to add to an already apparent issue, but to gather evidence about what services can do to retain their PWP force. PWPs were asked what factors would make it more likely for them to remain in the PWP role, and other areas that could lengthen the longevity of the role.

Of the above responses, there appears to be realistic additions to the standard PWP role that could not only enhance the role, but lengthen the amount of time individuals intend to stay in such a role. In particular, advancement in pay, specialising in low intensity therapies,
supervising and research opportunities appear to be key indicators of advancing the role. Qualitative responses of how the PWP role could be advanced included opportunities to specialise, progression on to Band 6 roles, and for an increase in understanding of the role amongst the wider community. Implications of this study should be for governing bodies and managers of IAPT services to consider such changes.

There were concerning responses around the understanding of the PWP role. Only 11.7% of PWP’s within the service felt that GP’s, colleagues, managers, wider community and external services ‘mostly’ understood the role of the PWP. A shocking amount of responses felt that none of the above categories understood the role at all. If people aren’t aware of the role, it creates a question of how valued the role can be. Again, only 11.7% felt the PWP role was valued by all of the above categories. In contrast, 100% of PWP’s reporting that they ‘mostly’ or ‘completely’ valued the role of the PWP.

PWP’s are the forefront of that IAPT service and therefore should be valued. Suggestions for doing so, may be but are not limited to; education and publicising the role amongst the wider community, other staff members and professionals. It has also been considered whether becoming part of a governing body would give protection and status of other similar professionals. Ultimately, if the role of a PWP was something people aspired to stay in to, it’s likely the role might be more valued. Unfortunately, with such a high turnover the role isn’t reaching its full potential, but until the role is more valued the turnover is likely to stay high. Future research could address this relationship by informing positive changes for the role.

Although our staff reported hearteningly high levels of job satisfaction and perceived competence, the majority of respondents have identified issues with increased targets and associated time constraints. Every participant reported some level of stress (with an average stress rating of 54.8%). In keeping with previous research, our respondents also identified a lack of progression within the PWP role (Report of the Psychological Wellbeing Practitioner Review). They see the role as a stepping stone to other careers but chances for specialising, opportunities to supervise, conduct research, or pay increases would encourage people to stay. To avoid any identifying factors, we didn’t ask our respondents to indicate if they were qualified or trainees so we cannot tell if there is a correlation between the length of time in the role, caseload requirements and reported stress levels.

Given the findings of this research, as a service we feel the following changes could overall help improve retention and advancement of the PWP role:

- Introduction of further training sessions to cover short fall of university curriculum and to address complexity of clients currently seen at step 2, e.g. sleep, OCD, anger, GAD, self esteem, trauma, stabilisation work.
- Further training to the wider community on the role of PWP’s- training sessions internally and externally of the service.
- Further assessment training, including personality disorders, bipolar disorder etc.
- The opportunity to train further and specialise with step 2 and develop one to one and group interventions.
- Stress audit- introduction of a regular wellbeing group for PWPs- more emphasis on restorative supervision.

Feasibility and acceptability of a parent-mediated CBT intervention targeting anxiety difficulties in young children with Autism Spectrum Disorder

Jade Bamford, Northumberland Tyne and Wear NHS Foundation Trust; Jacqui Rodgers, Newcastle University; Vicki Grahame, Northumberland Tyne and Wear NHS Foundation Trust; Emma Honey, Northumberland Tyne and Wear NHS Foundation Trust

There is a dearth of research investigating the effectiveness of Cognitive Behavioural Therapy (CBT) in young children (<8 years) with Autism Spectrum Disorder (ASD), despite a growing evidence of the effectiveness of CBT for older children with ASD (Ung et al, 2015) and for younger typically developing children (<8 years; Waters et al, 2009). Fun with Feelings is a parent-mediated, CBT group intervention targeting anxiety in young children (4 – 7 years) with ASD. One small pilot RCT (Cook et al, under review) reports promising...
results following delivery of the programme in Australia. This study investigates the feasibility and acceptability of delivering Fun with Feelings via NHS services. 10 parents of children aged 4 – 7 years, with a diagnosis of ASD and difficulties with anxiety were recruited via NHS clinicians. Prior to attending the intervention, participants completed baseline characterisation questionnaires (Vineland Adaptive Behaviour Scales (VABS II), Social Communication Questionnaire (SCQ)), parent interviews (modified version of Anxiety Disorders Interview Schedule (ADIS) and structured parent interview to collect demographic data and information regarding current healthcare usage), parent-proxy questionnaires (Anxiety Scale for Children – Autism Spectrum Disorder (ASC-ASD), Intolerance of Uncertainty – Parent version (IUS-P), Responses to Uncertainty and Low Environmental Structure (RULES), Repetitive Behaviour Questionnaire 2 (RBQ2)) and parent self-report questionnaires (Depression Anxiety and Stress Scale – 21 (DASS-21), Parent Self-Efficacy Questionnaire). Participants attended the intervention which consisted of 9 weekly sessions of 90 minute duration, with one booster session one month later. After attending the intervention, participants completed the parent interviews, parent-proxy questionnaires and the parent self-report questionnaires immediately post-intervention and 6 weeks post-intervention. Participants also completed an additional interview to provide feedback on the acceptability of the intervention. 7 participants (mean age of children = 5 years 9 months) attended the intervention; 3 participants (30%) withdrew from study prior to intervention due to family commitments (N = 2) and work commitments (N = 1). Baseline measures indicated high levels of child anxiety, intolerance of uncertainty and repetitive behaviours. Parent self-report indicated 71.4% of parents experienced at least moderate difficulties with anxiety, depression and/or stress. The modified ADIS responses demonstrate that young children with ASD experience anxiety difficulties that are consistent with DSM anxiety disorder criteria but also problematic anxiety that does not fit within current DSM anxiety disorder criteria. Participation and retention in the programme was good. Changes from baseline in child and parent measures will be reported. Our findings support the identification of atypical anxiety presentations in young children with ASD which is consistent with literature reporting ‘atypical’ anxiety in older children with ASD. In particular our data indicate atypical and significant difficulties with uncertainty, school, social interactions and phobias highlighting the interaction between core ASD traits and anxiety difficulties. Our findings indicate that Fun with Feelings is an acceptable and feasible manualised parent mediated CBT intervention for young children with ASD and anxiety recruited though NHS services.

**Frequency of Shape Checking as a Purported Mediator of the Effect of Enhanced Cognitive Behaviour Therapy on Concern about Shape in Eating Disorders**

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

Over-evaluation of shape (namely, the importance of shape in judging oneself as a person) is hypothesised to be the core maintaining factor of eating disorder psychopathology in the cognitive behavioural model of eating disorders. Frequency of shape checking (e.g. mirror checking, body touching/measuring) is hypothesised to be both a product of and a maintaining factor to over-evaluation of shape. As such, a key intervention in enhanced cognitive behaviour therapy (CBT-E) for eating disorders is addressing shape checking behaviours. However, to what extent addressing shape checking mediates the effect of CBT-E on concern about shape is unknown. Furthermore, this intervention occurs in the context of treatment personalisation, which makes the study of its effects challenging. A mediation sub-study was embedded within a randomised controlled trial comparing CBT-E and interpersonal psychotherapy (IPT) in a transdiagnostic sample of patients with eating disorders. Frequency of shape checking and concern about shape were assessed using
patient self-report once a week, prior to each treatment session. Intervention implementation was recorded by the therapist after every session. Statistical models were used to examine the relationships between implementation of shape checking addressing frequency of shape checking and concern about shape. Whilst frequency of shape checking and concern about shape decreased in both CBT-E and IPT, preliminary results suggested that implementation of the shape checking procedure in CBT-E was associated with additional decreases in both the frequency of shape checking and concern about shape. Temporal ordering of change in frequency of shape checking and concern about shape was unclear. Although initial results suggested that decreasing frequency of shape checking might be a potential mediator of the effect of CBT-E on concern about shape, questions regarding the temporal ordering of change in these variables, as well as limitations in methodology (e.g. difficulty in quantifying effects due to treatment personalisation) mean these conclusions are tentative and require further replication. Future research should focus on identifying the course of change in these variables during treatment and following treatment personalisation, and further explore statistical methods to more accurately model these effects in the context of treatment personalisation. Addressing frequent shape checking may help reduce concern about shape in patients with eating disorders. However, more in depth study of these processes is needed.

Process evaluation of a DBT-informed interpersonal effectiveness intervention delivered to people with intellectual disabilities and their support staff as co-participants

Kristina Bennert, University of Bath, Department of Psychology; Melissa Bell, CTPLD South Bristol; Megan Cowles, University of Bath, Dept of Psychology; Cathy Randle-Philips, University of Bath, Dept of Psychology

Group-based interventions are an effective and cost-effective way to deliver psychological support to people with intellectual disabilities (ID). Group environments can employ naturally occurring group processes for therapeutic effects: helping to normalise distress whilst building confidence, self-esteem and positive relationships with peers. However, the heterogeneous presentation and abilities of people in ID groups may present a challenge for facilitators in terms of adequately supporting less able participants. Previous research suggests that assistance from support staff during therapy is of particular importance for people with ID and can aid with the transfer of skills learned in sessions into real-life situations. This poster describes the process evaluation of an adapted version of the interpersonal effectiveness module (‘People Skills’) from Ingamell’s and Morrissey’s (2014) ‘I can Feel Good’ manual, based on the principles of dialectical behaviour therapy, with a group of people with mild intellectual disabilities and their support staff as co-participants in the group process.

The group intervention was delivered in a community setting over eight 2-hour weekly sessions. Process evaluation combined qualitative and quantitative methods. This included weekly feedback on goal attainment and experience of exercises, as well as formal ratings and open discussion of module contents and specific session elements (such as role play and relaxation) at the end of the intervention from the perspectives of both people with ID and their support staff.

People with ID and their support staff readily identified benefits from attending the group as co-participants. Themes included facilitating greater understanding of material, being able to revisit session contents and recognise use of skills between sessions and opportunity to reflect on the nature of the carer-service user relationship. Consistent involvement of a dedicated member of staff was seen as essential but difficult to achieve in practice. Whilst clinical outcomes did not show improvement in terms of group-specific goals and overall mental well-being for the group as a whole, individual participants’ scores on pre- and post-intervention measures, carer comments and facilitator observations suggested that individual gains had been made. Participants demonstrated increased ability and willingness
to discuss their difficulties and described the module contents and the group process as helpful and validating.
The adapted version of the ‘People skills’ module was well-received by People with ID and support staff but regarded as too short to achieve sustained change in people’s problematic relationships patterns. The benefits and challenges of delivering the module to service users and support staff as co-participants are discussed and suggestions for improvements in future delivery are detailed.

Flexible Delivery of the 'Coping Cat' Programme Guided by Systemic CBT Case Conceptualisation for a Young Child with Separation Anxiety

Kristina Bennert, University of Bath, Dept of Psychology; Sarah Buttler, Child and Adolescent Mental Health Services, South Bristol

Separation Anxiety Disorder (SAD) is one of the most common anxiety disorders in childhood. The current research base indicates manualised approaches based on CBT principles as most effective for childhood anxiety. CYP-IAPT recommends the Coping Cat Programme (Kendall & Hedtke, 2006) as the first-line treatment for children aged 7-17 years with SAD. However, there is a lack of studies examining effectiveness of generic CBT treatment for younger (i.e. <7) children.

This single case study describes the successful treatment of a 6-year old child with SAD to illustrate how the Coping Cat Programme can be adapted and augmented to address the developmental needs of a child at the young end of the programme’s age range as well as parental beliefs and behaviours that are implicated in the problem maintenance cycle. The structure of the ‘Coping Cat’ Programme was adapted to be delivered over 12 weekly sessions. The sequence of behavioural and cognitive components was reversed, with parent guided exposure between sessions. Workbook tasks were supplemented with additional materials and techniques in view of the young age of the child and to address systemic maintenance factors. The individualised course of treatment included nine clinic-based parent-child sessions, one home visit and three parent-only sessions.

Clinical outcomes were measured at baseline, midway and end of therapy using the parent versions of the Revised Child and Adolescent Anxiety and Depression Scale (RCADS) and the Strengths and Difficulties Questionnaire. In addition, the ‘Young Child’ version of the Child Session Rating Scale (CSRS) and a Goal Progress Chart were used session by session, alongside recording of progress towards specific interim goals.

RCADS scores were slightly reduced from baseline at 8 weeks, and at 12 weeks had dropped below clinical threshold for all the anxiety disorders and for depression. For the SDQ, overall stress and behavioural difficulty scores were returned from ‘very high’ and ‘slightly raised’ to ‘average, and the emotional difficulty score dropped from ‘very high’ to within the ‘high’ range. Diagnostic predictions were returned to ‘low risk’ across disorders.

The therapeutic gains expressed in the parent-reported outcome measures can be regarded as at least partly due to the cognitive shift achieved through the parent-directed work. The case study demonstrates the efficacy of involving parents as both co-therapists and co-clients when individual case conceptualisation suggests that anxiety symptoms are maintained primarily by systemic factors.

The case illustrates the principle of “flexibility within fidelity” and highlights the value of systemic CBT formulation as proposed by Dummett (2006) over one that is solely focused on the child’s cognitions and symptoms.

References

A preliminary validation of the Young Schema Questionnaire in older adults
Despite the wide body of evidence concerning the importance of identifying and treating personality disorder in younger adults, comparatively little research has been done with older adults. Schema therapy (Young, 1990) has been established as an effective, We administered a battery of questionnaires to a group of 94 older adults, aged 60-84 years, including the YSQ-S3 and measures of psychopathology and core emotional needs. The YSQ-3 was re-administered approximately 2 weeks later.

Pearson correlation coefficients revealed positive associations between early maladaptive schemas (EMS) and measures of anxiety (r = .26 to r = .72), depression (r = .24 to r = .70), personality disorder traits (r = .38 to r = .69), as well as core emotional needs (r = .38 to r = .69). There was one exception to this: The self-sacrifice schema did not correlate with disordered personality. Satisfactory internal reliability (>0.70) was found for 13 of the 18 EMS but was questionable in the remaining 5 EMS (.60-.69). Reproducibility analyses supported test-retest reliability of 17 of the 18 schemas; α = .70 to 89. The exception was the enmeshment/underdeveloped self schema (r = .64).

By and large the YSQ-S3 demonstrates convergent validity, as well as internal and test-retest reliability in older adults. Notwithstanding this some re-development of EMS items appears to be required for the enmeshment, and self-sacrifice schema, so as to be more relevant to older people.

The YSQ-S3 may be of use in work establishing the utility of schema therapy in older adults. Schema therapy with older people warrants further exploration.

The Impact of Exposure to Fashion Blogs on Young Females’ Self-Representations, Physical Appearance Anxiety, Self-Esteem, and Affect

A considerable body of research suggests that exposure to fashion and media images representing the thin ideal has a negative impact on young women’s self-esteem, body satisfaction, and eating behaviours. This research has focused primarily on images presented in traditional media outlets such as magazines. To date, the effects of exposure to fashion and lifestyle blogs, which are a more recent phenomenon, have not been investigated from a psychological perspective. With the popularity of such blogs increasing (the most influential fashion bloggers count millions of followers worldwide), it is important for psychologists to understand their impact on young females and whether this impact is different from that of more traditional media. This paper presents two online studies that aimed to address this issue. Study 1 involved 46 females (MAge = 23.7 years, SD = 3.12) residing in Norway or the United Kingdom. Participants were randomly allocated to one of two conditions: exposure to fashion and lifestyle blogs consisting of both images of the bloggers and text or exposure to the blogs’ fashion images only. Participants in both conditions completed self and affect measures before and after exposure. Results supported previous findings on exposure to fashion and media images, indicating that the participants in both conditions experienced a reduction in state self-esteem and positive affect following exposure. The reduction in positive affect was marginally greater in the fashion blogs condition than in the images-only condition. One of the limitations of this study was that the blogs included a combination of average-sized bloggers and bloggers representing the thin ideal. Study 2 aims to expand on the findings of Study 1 by taking its limitations into account. Specifically, it investigates whether the bloggers’ body size and the presence of the blog text play a role in the impact that blogs have. Participants (females aged 16 – 30 years) are randomly allocated to one of four conditions: exposure to blogs featuring images of bloggers representing the thin ideal, exposure to images of bloggers representing the thin ideal (no text), exposure to blogs featuring images of average-sized bloggers, and exposure to images of average-sized bloggers (no text). Before and after exposure, participants complete state measures of self-representations, positive and negative affect, self-esteem, and physical appearance anxiety. Data collection for this study is in progress. Based on the existing literature on fashion and
media images and the findings of Study 1, it is hypothesised that exposure to blogs with thin ideal images will affect participants more negatively than the other conditions, leading to the activation of more negative self-representations and affect. Taken together, the findings of these two studies are expected to highlight the importance of understanding the multiple fashion- and media-related phenomena affecting young females' perceptions of themselves and their physical appearance these days. This understanding may inform the conceptualisation of the psychological issues they experience and lead to better cognitive-behavioural treatments tailored to the lives of 21st century youngsters. The current study is believed to help clinicians understand the multiple factors influencing young women's perceptions of themselves and body image nowadays, and will accordingly help tailor cognitive-behavioural treatments to their needs.

Psychologists' Use of and Attitudes towards Cognitive Behaviour Therapy Based Technology in Clinical Practice

Angela McNaught, Massey University; Kirsten van Kessel, Auckland University of Technology
Technology is becoming ever present in our personal and professional lives, and the development and use of Cognitive Behaviour Therapy (CBT) based applications and e-Health interventions in clinical practice are increasing. It is only recently that international studies have begun to explore psychologists' attitudes to the increasing use of technology in clinical practice, and indeed, the ways in which they are incorporating technology into their interventions. To date, there is no New Zealand research in this area, and few guidelines to help practitioners make professional and ethical decisions about incorporating technology. This project aims to elicit clinical psychologists’ current use of, and attitudes towards CBT-based technology in their clinical practice.

A survey gathering both quantitative and qualitative data was developed and distributed to clinical psychologists in New Zealand. Qualitative data explored the current technologies employed in clinical practice, how and for what purpose it is used, and with what kind of frequency. It also explored what the clinical psychologists’ perceived to be both the benefits and disadvantages of including technology in their practice.

Qualitative findings from the 55 participants will be discussed to illustrate the wide range of technology-based tools that New Zealand clinical psychologists’ report using in their practice. In addition, participants expressed disparate views in terms of the advantages and disadvantages of technology, and these are also summarised. Focus is given to the CBT based technologies employed.

The findings of the study have begun to expand our understanding of psychologists’ use of, and attitudes towards CBT based technologies, and the broader implications for integrating technology into clinical practice have also being further explored. Ultimately, these findings will also be used to develop guidelines for appropriately integrating technology into psychological practice, and area which, as yet, seems largely unexplored.

Adapted CBT for Emotion Regulation Difficulties: A Single Case Experimental Design in Learning Disabilities

Charlotte Whittle, University of Bath
People with learning disabilities (LD) experience mental health problems at a higher rate than the general population. McClure et al. (2009) argue that individuals with LD may be more vulnerable to difficulties in the awareness and understanding of their emotions, their ability to effectively relay this information to others, and an increased tendency to rigidly follow maladaptive short-term coping strategies (e.g. aggression or self-injury). There is currently no evidence for the treatment of emotion regulation in the LD literature, however, cognitive behaviour therapy (CBT) has shown to be effective for treating intense emotions in LD populations. Due to the lack of research in this area, this case study provides evidence for
the effectiveness of using adapted CBT with a man with a mild LD to improve his emotion self-regulation ability and increase his self-defined emotional experiences of ‘Coping’. An A/B single-case experimental design (SCED) was used to evaluate an 11 session adapted CBT treatment. The CBT treatment adapted standard CBT protocol to address issues of engagement and level of intellectual disability. The main treatment components consisted of engagement and agenda setting, encouraging self-monitoring, building up an awareness and understanding of emotional states labelled by the client as ‘Hyper’, ‘Breakdown’ and ‘Coping’, rating moods, consistent and repeated formulations and alternative coping patterns and problem-solving.

The client kept idiosyncratic mood ratings daily. The intervention caused a gradual but clear change in mood ratings; reduced rapid fluctuations of intense moods (Hyper and Breakdown), to increased ratings of ‘Coping’ and ‘normal’ mood fluctuations. The findings provided evidence for the testable hypotheses; increased awareness and understanding of emotional experiences and positive strategies to regulate mood through adapted CBT treatment, increased the frequency of the client’s emotional experience of ‘coping’.

According to the standardised CORE-LD measure, the client’s scores reduced over sessions indicating a reduction in his overall psychological distress. The client’s care team also reported several positive behavioural changes post-treatment. The case study provided evidence supporting the use of adapted CBT for the treatment of emotional dysregulation in a man with a mild LD. It also demonstrated the importance of using the client’s language and understanding of their difficulties to improve engagement. Additionally, it highlighted the need for validated assessment measures in LD, whilst also recognising the importance of idiosyncratic measures that became an important therapeutic tool.

This case report adds to the existing literature by filling a much-needed research gap in the emotion regulation and LD field as outlined by McClure et al. (2009). It provides a rationale for performing research of this kind on a larger scale to develop evidence-based treatments. It has demonstrated that a person with LD is able to develop effective self-regulation skills rather than relying on external controls; this is becoming more and more important as support for people with LD continues to shift from institutionalization to community based independence (Chapman, Shedlack, & France, 2006).

Emotion Recognition and its Underlying Mechanisms in Males high on Psychopathic Tendencies

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Previous research is inconsistent concerning the role of distorted face processing in affective-interpersonal problems characteristic for psychopathy and little is known in regard to underlying mechanisms. The current research aims to examine the affective deficit of psychopathy regarding facial emotion identification by shedding light on underlying working processes, which are theoretically: deficient recognition of distress in others, insufficient attention to the eyes to infer emotional information and increased selective-attention to individual goals, respectively.

Firstly, regarding the distress-specific hypothesis, defective recognition of facial, vocal and bodily fearful expressions could explain the absence of remorse when violating social norms and consequently, result in self-serving, antisocial behavior. The attention-to-the-eyes theory builds on reduced eye-contact between children with CU-traits and caregivers, which potentially interferes with the development of empathy and conscience. Insufficient attention to the eye-region could, however, also underlie problems identifying distress e.g., especially fear is mainly expressed via the eye-region. The enhanced-selective-attention theory covers that psychopaths perform better on attentional tasks (e.g., Stroop) assuming a link between psychopathy and the ability to suppress information irrelevant to predominant
goals (e.g., ignoring emotions of a victim). We argue that these theories do not exclude each other, though they were mainly proven in isolation, yet.

Due to higher prevalence of psychopathy in men and gender differences in facial processing, 100 male students and 40 male craftsmen will conduct a questionnaire battery, as well as execute the Expressed Emotion Multimorph Task (EEMT) accompanied by eye-tracking and the Facial Emotional Stroop Task (FEST).

Psychopathic tendencies are operationalized by the Inventory of Callous Unemotional Traits (ICU) and the Levenson Self-Report Psychopathy Scale (LSRPS). Accuracy and duration of emotion recognition will be assessed by a variation of the EEMT. Here, neutral facial expression (0% intensity) morph into expressions of each of the six basic emotions (100% intensity) through 39 incremental frames within 100ms. Participants stop the video when they first recognize an emotional expression (duration) and indicate which emotion they see (accuracy). Open options will be provided to offer the possibility to interpret the facial expressions individually.

Enhanced selective-attention will be assessed by interference effects in the FEST. Participants are presented with displays of 30 faces at the same time, expressing the same emotion in varying colors. Facial stimuli will be created out of 10 different identities displaying seven expressions (happy, sad, angry, disgusted, surprised, fearful, neutral) in four colors (yellow, green, blue, red). Displays with 30 ovals in the four respective colors will serve as control stimuli. Participants are asked to name the color of each face/oval. Latencies will be recorded after participants have finished one screen. To calculate interference effects, reaction times for ovals are subtracted from reaction times for faces. A higher interference effect would indicate that the participant had more difficulty to disengage from the emotional faces, thus reduced selective-attention.

**PRELIMINARY**

We expect that males high on CU-traits show a deficit in emotion recognition i.e., naming emotions less accurately and more slowly, than males low on CU-traits.

Furthermore, the link between CU-traits and emotion recognition might be mediated by less fixations to the eyes. However, we do expect that males high on CU-traits have enhanced selective attention, i.e. are faster to name the colors of emotional faces, while suppressing emotional information.

**PRELIMINARY**

We suggest that it is crucial to incorporate attentional biases when examining affective interpersonal problems in psychopathy. In more detail, deficient attention to the eyes may indeed lead to worse emotion recognition, while enhanced selective attention may actually improve emotion recognition - if an accurate recognition of another’s emotions is in line with the psychopath’s goal. Thus, the link between psychopathy and emotion recognition seems to be more complex and needs further examination.

In boys with conduct disorder scoring high on CU-traits, emotion recognition can be enhanced by simple instructions to fixate another person’s eyes. By understanding maintaining factors of the affective deficit of psychopathy, treatments could be developed to reduce individual and societal burden.

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**Mannequin Phobia and rapid treatment with CBT**

**Lisa Bluff, University of Salford;** Gillian Rayner, University of Salford; Leah Green, Manchester Metropolitan University

Simulation is becoming an accepted part of nursing education as it allows students to rehearse clinical interventions prior to entering clinical practice. Within the University of Salford, Adult nursing students are required to undertake an assessed clinical simulation in emergency and critical care. However, it became apparent that some students had a phobia of the high fidelity mannequins.

A three session, intensive cognitive behavioural group therapy treatment programme was developed by two qualified therapists. Graded exposure was utilised (Choy, Fyer & Lipsitz 2007) and involved the development of a formulation that was specific to the phobia,
exposure to images and sounds in a traditional clinical setting and then interaction with the high fidelity mannequins. Students were able to complete the module and successfully passed their assessment. This process also had the supplementary effect of reducing their anxiety of mannequins outside the academic environment. This rapid treatment for a specific phobia could be applied to other phobias that impact on educational attainment and engagement, including needle phobia and exam phobia. This three step protocol could be utilised for any specific phobia not just those relating to healthcare education.

A Single-Case Experimental Design Exploring the Effectiveness of Adapted CBT and Distress Tolerance Skills in a Learning Disability Setting

Emily Norris, University of Bath

Considerable co-morbidity between learning disabilities and mental health difficulties indicates the need for evidence-based interventions. Evidence at present is limited, but suggests that cognitive-behavioural therapy (CBT) based on the cognitive distortion model (Beck, 1976) and Dialectical Behaviour Therapy (DBT) interventions may be applicable with adaptations to a learning disability population. The present case study explored the effectiveness of CBT based on a cognitive distortion model with the addition of practical distress tolerance skills. The client, a lady in her 50s with a mild learning disability, was referred to a Community Learning Disability Team (CLDT) by her GP, presenting with low mood in the context of low self-esteem, self-directed anger, self harm and suicidal ideation; and emotional dysregulation as a result of past trauma and difficult family relationships. The formulation was based on Beck’s cognitive model of depression (1976), with the addition of complex emotional difficulties in the context of limited emotion regulation skills. This was conceptualised in line with a DBT framework (Linehan, 2014) as linking to past experiences of invalidation. A single-case experimental design was used, with the client attending 10 sessions of CBT with the addition of DBT distress tolerance skills in the form of a self-soothing box. This included 3 sessions of assessment (pre-intervention) and a final review, with the intervention focusing on challenging negative thoughts, building low self-esteem and contextualising difficulties systemically. It was hypothesised that the intervention would be effective in stabilising mood, and leading to an overall improvement in mood and wellbeing, as measured by the CORE-LD, PHQ-9 and an idiographic mood rating scale. Furthermore, it was hypothesised that the addition of distress tolerance skills would reduce scores on measures of risk (suicidal thoughts and self-harm). Unstable scores on outcome measures during the baseline (assessment) phase meant that causal conclusions could not be drawn. However, a number of trends in results suggested an overall stabilisation in mood over the course of therapy, with some increase in mood and wellbeing as reflected in the client reporting progress on goals in these areas, in line with proposed hypotheses. A downward trend in self-harm and suicidal thoughts was also shown on outcome measures, and supported by client self-report of reduced risk behaviour in sessions.

Despite limited causal conclusions and generalisability from a single case design, the case study adds to developing evidence around the implementation and adaptation of evidence-based approaches in a learning disability (LD) setting. In particular, the case study tentatively lends support to the use of adapted CBT for LD, and indicates possible benefits of including DBT distress tolerance skills to target risk behaviours which is an important area for further research. Limitations of a single case design methodology were highlighted through an unstable baseline, reflecting the challenges of a clinical setting. In addition, the intervention was limited in timeframe and further sessions may have been beneficial to recap information due to difficulties with retention.

This case study adds to the growing body of evidence to support the use of adapted CBT for LD, enabling clinicians to offer evidence-based interventions when working with this population. In addition, the possible benefits of including DBT distress tolerance skills has implications for targeting risk behaviours in an accessible and practical way.
A cognitive model of psychological resilience: current research and future directions

Sam Parsons, University of Oxford; Anne-Wil Kruijt, University of Oxford; Elaine Fox, University of Oxford

Resilience is considered to be the process by which individuals demonstrate more positive outcomes than would be expected, given the nature of the adversity experienced. We propose that a cognitive approach has the potential to guide studies investigating the relationships between adversity, stress, and resilience.

We outline a preliminary cognitive model of resilience in order to facilitate the application of cognitive approaches to the investigation of resilience in the face of adversity. We argue that the situationally appropriate application of flexibility or rigidity in affective-cognitive systems is a key element in promoting resilient responses.

We propose that this mapping of cognitive processing can be conceptualised as being undertaken by an overarching mapping system, which serves to integrate information from a variety of sources, including the current situation, prior experience, as well as more conscious and goal-driven processes. We propose that a well-functioning mapping system is an integral part of the cognitive basis for resilience to adversity.

Our preliminary model is intended to provide an initial theoretical framework to guide research on the development of cognitive functions that are considered to be important in the resilience process. Here, we build on the initial model to discuss current and future research directions in elucidating the role of aligning contextually appropriate emotional information-processing in promoting psychological resilience.

The model we propose integrates cognitive and resilience approaches to positive mental health. These fields have remained largely separate, however, they offer complementary approaches to mental health research. Incorporating psychological flexibility as a central cognitive process to resilience and positive adaptation offers a framework to examine the cognitive processes underpinning positive mental health, resilience, and wellbeing.

Expert consensus on the clinically effective components of CBT: a Delphi study

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Cognitive behavioural therapy (CBT) is a well-established psychological treatment for depression. CBT encompasses several constituent components, including cognitive and behavioural strategies, and there is wide variation in how these are delivered. Evidence on which components contribute most to clinical effectiveness is lacking. This study aims to use Delphi methodology to explore expert consensus on the components of CBT that bring about clinically helpful change.

120 clinicians and researchers with CBT expertise were invited to complete an online survey. Participants rated the clinical effectiveness of 35 CBT components for depression on a scale of 1-9 (1=not at all important; 9=very important) and suggested additional items. In the second round, participants were given feedback on the group median scores and their round 1 score and asked to re-rate items. Predefined criteria determined retention of items in each round. Consensus was defined as less than 15% of participants rating an item 1-3 and at least 70% of participants rating the item 7-9.

32 (27%) of 120 invited experts completed Round 1. Of these, 23 (72%) responded to Round 2. Participants endorsed 12 of the 35 components in Round 1, and 4 additional components were included. 12 of 39 components were endorsed in Round 2.
The responses indicated strong support for “behavioural” components such as activity scheduling. There was less consensus around “cognitive” components such as identifying and challenging key cognitions and unhelpful thinking styles, and “process” components such as frequency and duration of treatment.

This Delphi study found consensus amongst experts for some but not all of the major components of CBT for depression. Lack of consensus was greatest around procedural components and delivery components. These findings suggest some experts disagree on the effectiveness of aspects of CBT traditionally considered “core” to the cognitive behavioural approach, such as identifying and challenging unhelpful thinking styles. Further analysis of the individual components of psychological treatments is warranted to identify those essential to efficient and effective therapy.

Although the evidence base for CBT for depression overall is strong, there is little evidence on which components are the most clinically useful. The lack of expert consensus in this study suggests that we may need to de-emphasise some of the “core” aspects of CBT if these are found in component analyses to be less helpful, and to increase attention on other aspects, in particular those that focus on behavioural change over cognitive techniques.

Brief BA for depressed adolescents delivered by PWP: Two case studies

**Mona Jones and Simon Brett, University of Reading**; Laura Pass, University of Reading

The presenting problem for both case studies was Depression. Depression in adolescents is a common mental health problem worldwide (Lopez, Mathers, Ezzati, Jamison & Murray, 2006), although it is often goes unrecognised (Thapar, Collishaw, Pine & Thapar, 2012) for a myriad of different reasons. For treatment of mild to moderate depression in young people, NICE guidelines recommend group or individual Cognitive Behavioural Therapy (CBT) (NICE, 2015). However, it is often found that there are a limited number of adequately qualified therapists and evidence-based treatments which often results in services being unable to meet the demand of young people with depression (Pass, Lejuez & Reynolds, IN PRESS). Depression in adolescence predicts a variety of long term difficulties, including mental illness in adulthood (McLeod, Horwood & Ferguson, 2016). There is a clear economic argument to support increasing the number of CBT therapists (Layard & Clark, 2014), but this is still significantly limited by cost.

Behavioural Activation (BA) is a carefully structured and controlled intervention which aims to help people become more active, tackle avoidance (Jacobsen, Martell & Dimidjian, 2001) and encourages a balance of routine, necessary and enjoyable activities. The two current case illustrates the outcomes of 8 1 hour sessions of Brief BA and 1 review session delivered by a Psychological Wellbeing Practitioner with limited clinical experience. These sessions were delivered in a school setting. To increase treatment accessibility for adolescents, Brief BA (Pass, Brisco & Reynolds, 2015) has been developed and adapted from Brief Behavioural Activation Treatment for Depression (BATD) (Pass & Reynolds, 2014). Group supervision led by a qualified Clinical Psychologist was scheduled before the first session and after every BA session for the training case.

A clinically significant and reliable change was observed in depression symptoms and functioning (On Routine Outcome Measures and self/parent report).

This advocates that Brief BA can be successfully delivered by a PWP with limited clinical experience under clear supervision. Suggesting that Brief BA can delivered all across the country by PWP, hence improving access to psychological therapies for adolescents. The key adaptations from the PWP role were considering how much to involve the parent in the session, and involving the young person in this decision and altering the confidentiality agreement and ensuring the young person is aware of this.

PWP appear to be ideally suited to complete Brief BA training for adolescents at minimal cost, subsequently improving access to psychological therapies for adolescents.

**Barriers to Accessing Psychological Therapies for Ethnic Minorities Residing in Western Countries: A Systematic Review**
Kanza Khan, University of Manchester; Waquas Waheed, University of Manchester; Maria Panagioti, University of Manchester; Ujala Shahmalak, University of Liverpool; Nadine Mirza, University of Manchester

Ethnic minority patients residing in western countries have higher prevalence of anxiety and depressive disorders as compared to the general population. However, ethnic minority access rates to psychotherapy services are low which is not reflective of the needs of this community. These patients experience a number of barriers during access to psychotherapy, thus it is important to understand the barriers being experienced and the extent to which they hinder access and treatment of this population.

Studies published up to March 2017 were identified from literature searches on three databases; Embase, PsychINFO and Medline. Papers were included if they described ethnic minority access to psychological therapy in western countries in order to capture potential barriers experienced by this population. Thematic analysis was conducted to develop key themes and subthemes from extracted data.

Eight qualitative papers were included in this review. Six included papers were from the USA and 2 from the United Kingdom. Thematic analysis highlighted 21 barriers which were later organised under five over-arching key barrier themes: Patient related barriers, Community related barriers, Family related barriers, Health service related barriers and Practical issues barriers.

The aim of this review was to increase awareness around the barriers ethnic minorities face when accessing psychotherapy services in western countries. Barriers to accessing mental health services share similarities across ethnicities, however the underlying intensity and culturally underpinned stigma, stereotype and experiences differ in ethnic minority patients. These cultural differences do not only vary internationally but on a national level with the needs of ethnic minority populations varying between catchment areas specific to individual services. There are many barriers under each theme, however each barrier is multifaceted and can extend under multiple themes. Thus further research is required to understand the emphasis required to develop appropriate solutions to overcoming barriers to accessing psychological therapies for ethnic minorities, with the aim of improving both access and retention of this population during treatment.

This review will provide a patient centered insight for health care professionals to better understand the barriers experienced by the ethnic minority population accessing CBT. Therefore encouraging the delivery of culturally sensitive CBT.

Sub-types of Safety Behaviours and their Effects on Social Anxiety Disorder

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Cognitive models suggest that safety behaviours, such as avoiding eye contact or rehearsing what to say prior to a conversation, are an important maintaining factor in social anxiety disorder. However, recent research has indicated that different safety behaviours have different effects on conversations. This study comprises of two parts. The first is a data analysis, examining data from clients with social anxiety disorder to confirm the subtypes of safety behaviour found in previous studies. The second is an experimental design where non-socially anxious participants performed these types of safety behaviour in conversation and their effects on conversational outcomes were examined.

The first part of the study was an exploratory factor analysis of responses to the Safety Behaviour Questionnaire in 161 patients with social anxiety disorder. This was to identify safety behaviour subtypes. The second study used a randomised control design on a cohort of 48 dyads of participants who had two 5 minute conversations. During one conversation, one member of the dyad performed one of the types of safety behaviour. This was to examine the effects of the types of safety behaviour on conversational outcomes.

The exploratory factor analysis confirmed that safety behaviours can be differentiated into two main types, avoidance and impression management strategies. The second study showed that these two types of strategy have different effects on conversational outcomes. Avoidance strategies have a more globally negative outcome, making both conversational participants report feeling more anxious, and enjoying the conversation less. Performing
avoidance safety behaviours also made an individual appear more anxious and less socially successful, a result reported both by their conversational partner and an independent rater blind to the experimental condition.

This study confirms that in social anxiety disorder safety behaviours can be differentiated into subtypes, and that some are less disruptive to social situations than others. Although both types may have similar outcomes for an individual in terms of maintaining beliefs and increasing self-focused attention, their effect on the external situation is very different. This study shows that individuals performing impression management behaviours are more successful in social situations than those performing avoidance behaviours and as such are more likely to receive positive social feedback.

When treating individuals with social anxiety disorder who are more reliant on avoidance safety behaviours, one therapeutic technique may be to encourage the individual to first focus on dropping avoidance behaviours whilst continuing to use impression management strategies. The client can then be encouraged to move to stopping safety behaviours entirely. This is likely to be an easier transition for clients than stopping all safety behaviours at once. Selectively using only the safety behaviours which are less disruptive to social interactions may also help to provide positive social feedback to the individual with social anxiety disorder. This may help encourage an individual that dropping safety behaviours is beneficial to them, and help them move towards doing away with all safety behaviours in the future.

Apparent Emotional Expression Predicts Perceived Trustworthiness with Changes of Head Posture, but a Measure of Facial Width Does Not

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People make trustworthiness judgments on the basis of facial cues rapidly and with high consensus (Willis, & Todorov, 2006). Previous studies have shown that head tilt changes the attribution of traits such as dominance (Mignault, & Chaudhuri, 2003). These attribution changes are thought to arise from changes in emotional and structural cues (Stirrat, & Perrett, 2010). Changes in emotional expressions and the apparent width of the face are likely to affect perceived trustworthiness but the effect of variation in head posture on apparent trustworthiness are not known.

Our studies therefore examined how head posture (level, up, or down) affects perceptions of trustworthiness. In Study 1, participants rated faces in three postures for apparent trustworthiness on seven-point Likert scales. In Study 2, participants scrolled through face images and manually manipulated vertical head angle to maximise perceived trustworthiness.

Results of ratings reveal that the head down posture decreased perceived trustworthiness compared to the level and raised head; the head up posture was perceived as less trustworthy compared to the neutral posture. The optimal head angle to make the facial images most trustworthy was found to be slightly lowered with respect to the level posture. This posture made the facial expression appear more positive. There was no correlation between change in facial width with head rotation and change in perceptions of trustworthiness.

Our results suggest a marked effect of posture on apparent trustworthiness with a change in head posture. Our analysis reveals that apparent emotional expression provides a better explanation of perceived trustworthiness compared to cues to facial structure.

An evaluation of a compassion-focused therapy (CFT) group within acute clinical settings
Evidence suggests the provision of psychological interventions on UK psychiatric wards is unsatisfactory and there is also a paucity of research in this area. Patients admitted to acute settings often present with high levels of shame, self-criticism and low self-worth. Compassion-focused therapy was developed to treat people with these difficulties who have histories of complex trauma (Gilbert & Irons, 2005). Heriot-Maitland et al (2014) designed and evaluated a CFT group which they adapted to account for the needs of this patient group. The four session programme focused on the key elements of CFT, including psychoeducation, mindfulness, compassion and imagery. This programme was then further adapted by Hopkins et al (in press).

In this evaluation, the groups were run on two acute wards and a day hospital. Measures of self-criticism, shame and self-compassion were collected to evaluate the overall effectiveness of the group. All participants were also given a range of within-subject measures of emotional distress at the beginning and end of each session. All participants were also asked to answer an eight item self-report measure after completing the group. Preliminary analysis found no significant statistical differences between pre and post scores on the measures of self-criticism, shame and self-compassion. There were also no significant differences between the within subject measures for emotional distress. However, results from the self-report evaluation forms indicated that 87% of participants found the group ‘helpful’ or ‘very helpful’ and 93% would recommend the group to somebody else. Qualitative feedback also indicated that participants found the group useful for learning practical coping skills, described it as helpful to learn about self compassion and felt it gave them some hope for the future.

Our results contrast to previous research. Our results may indicate that this type of psychoeducation group may not provide a sufficient ‘dose’ of treatment to result in meaningful clinical change for this patient group. However, the patient feedback indicated that subjectively patients did experience the group as ‘helpful’, indicating these groups may still provide an important supplement to the care provided in acute settings. There may also be difficulties capturing clinical change over a short time period. Alternatively, there may other benefits from the group aside from decreasing shame, for example it may be an emotionally validating experience. The study also revealed the challenges of conducting research in acute settings, including issues around capacity to consent, motivation to engage and level of insight.

Overall, the evaluation indicates the challenges of providing CBT in acute settings, including meeting the needs of patients with severe and chronic difficulties with very limited resources. The CFT group provides a psychoeducation approach to treatment, and was well received by patients. This indicates that patients do value these type of approaches, although the nature of the group with this patient group has not been found to be clinically effective. It is important for clinicians to continue to conduct research on the use of CBT in acute settings, particularly focused on shame.

Communication Challenges with Autism: A Condition Management Programme Case Study

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Autism is a lifelong, developmental disability. It affects how a person communicates with other people, and how they experience and interpret the world around them. It can also occur on a spectrum from high-low functioning. Prevalence rates for autism in the U.K. is 1% (or 1 in 100), and in the U.S. 1 in 68 (CDC, 2015; Brugha et al., 2011); this rate translates into millions of people. Those with autism experience some unique health, developmental and social challenges that can impact adversely on employment prospects. The following case
study describes the treatment offered to one such individual presenting with significant anxiety. John* took part in the Condition Management Programme (CMP). CMP is a voluntary, CBT-informed N-Ireland wide service that enables people in receipt of certain benefits to address and manage their health related barriers to work.

Michael* is a 35-year old man who presented with problems of depression, worry, and social anxiety alongside autism. Specific work challenges included communication problems with colleagues and managers, difficulties taking the initiative; worry; and confidence problems. Michael was allocated a CBT Therapist to help with his mood problems, and a Clinical Specialist OT to help regain structure and routine, and build work-relevant skills including communication. A number of measures were used throughout the intervention incl the Patient Health Questionnaire (PHQ-9) (Spitzer et al, 1999), the GAD-7 (Spitzer et al, 2006), and The CORE34. Struggles academically, and with others, may have contributed to Michael developing core beliefs: “I will make mistakes” and “people will criticise”. Rules and strategies to manage these beliefs included not trying: “It is hard to see the importance of things”.

Michael fully engaged in the 12-week CMP programme and had no DNAs or cancellations. A range of interventions were used incl psychoeducation, role plays, and experiments in which Michael was encouraged to test out learning from sessions in real world environments. Results on pre- and post CMP measures showed significant improvements over the twelve weeks, e.g. GAD-7 (T1=14 vs T2=7), and PHQ-9 (T1=16 vs T2=9). Michael continues to build his confidence and skills in social settings by joining several local groups, and by interacting on a weekly basis with new friends and peers.

Michael made huge progress towards his goals to become a more happy, confident and socially active young man. He is now actively seeking out volunteering opportunities that will allow him to continue to build his confidence and skills within workplace settings especially. The CBT-informed Condition Management Programme offered focused and needed multi-disciplinary support that proved very effective. His future is now very exciting with huge potential for a variety of job- and social opportunities.

Implications for everyday practice of CBT
- Practical applications of CBT to a N-Ireland wide programme that is improving health, well-being, and quality of life
- Applications of CBT in addressing physical and economic problems as well as problems of mood