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Basic Processes

Keynote Address

Psychosocial Predictors of Bipolar Disorder: Disentangling Depression and Mania

Professor Sheri L. Johnson, Ph.D. Associate Professor of Psychology, University of Miami

In this talk, I will discuss longitudinal research on the psychosocial predictors of manic and depressive episodes. Overall, it appears that the predictors of mania and depression are fairly distinct. Variables that predict unipolar depression appear to be quite predictive of bipolar depression—negative life events, low social support, poor self-esteem, and negative cognitive styles. Mania, on the other hand, appears to be better predicted by a set of variables related to sleep deprivation and excessive goal engagement (life events involving goal pursuit, confidence, and sensitivity to reward) appear more related to increases in mania. Mood dysregulation may help increase susceptibility to either mania or depression, but more research is needed to understand the nature and form of mood dysregulation in bipolar disorder. The implications of the polarity-specific model for psychosocial treatment will be discussed.

Optimizing fear reduction: violation of expectancies, level of excitation and retrieval cues

Professor Michelle Craske, UCLA, USA

Basic science in fear learning and cognition is advancing far more rapidly than is the clinical application of this knowledge. Clinical applications are often based on models that are outdated and oversimplified. For example, for some time now, models of exposure therapy for fears and phobias have emphasized the importance of initial activation of fearful arousal followed by reduction of physiological responding, or habituation, within and across sessions, as evidence for effective treatment. However, empirical and theoretical developments indicate that learning (including extinction) is facilitated by sustained physiological excitation. Sustained physiological arousal is likely to facilitate processes of reflexive learning as well as propositional learning throughout exposure, especially since sustained excitation provides a potent context for disconfirmation of negative outcome expectancies; and violation of outcome expectancies (as opposed to habituation) is viewed as critical to learning and eventual fear reduction. Methods and initial findings from exposures designed to optimally violate outcome expectancies versus control conditions will be described. In addition, basic science has established that fear reduction does not erase original fear memories, and that individuals remain vulnerable to the return of fear. Methods and findings pertaining to the manipulation of context variables and retrieval cues as means for minimizing the renewal of fear will be described.

Symposia

Inhibition of emotion and autobiographical memory

Convenor and Chair: Lynn B. Myers, UCL

Do childhood memories colour social judgements of today? The case of repressors

Lynn B. Myers (1) and Nazanin Derakshan (2) (1) University College London (2) Birkbeck College, University of London

Previous research has shown that individuals who possess a repressive coping style have significantly poorer recall of negative childhood memories and also exhibit more comparative optimism for negative events than nonrepressors. The current study investigated whether there is a relationship between recall of childhood memories and comparative optimism. Repressors (REP, low trait anxiety-high defensiveness, N=20) were compared with specific nonrepressor groups on trait anxiety and defensiveness: low-anxious (LA N=16), high-anxious (HA, N= 16) defensive high anxious, (DHA, N=13) and a non-extreme group (NE, N=15) chosen from an initial pool of 163 female participants. For REP

compared with all nonREP, age of earliest negative memory recalled was significantly older and REP recalled significantly fewer negative childhood memories. For REP only there was a significant correlation between number of negative memories recalled and comparative optimism, with high comparative optimism correlated with a low number of negative childhood memories recalled. There were no other significant correlations with comparative optimism, overall, or for any of the sub groups. These results indicate a link between childhood and adult measures of social judgements for REP only.

Prevalence of repressive coping style in young and old adults and its possible impact on involuntary autobiographical memories.

Erskine, J.A.K. University of Hertfordshire. Schlagman, S.J. University of Hertfordshire. Kvavilashvili, L. University of Hertfordshire

Research on repressive coping style has been focussed almost exclusively on younger adults. Very little is known about the prevalence of repressive coping style in older adults and its possible effect on their cognitive processes. In Study 1 the rates of repressive coping style, using the criteria developed by Weinberger et al. (1979), were examined in a group young undergraduates (N=93) and a group of healthy, community dwelling older adults over 64 (N=64). The results showed that a significantly higher proportion of the older adults were classified as repressors (36%) when compared to the younger sample (10%). In addition, older adults (and especially old repressors) scored significantly lower on a wide range of psychopathological measures such as depression, neuroticism, etc. Study 2 examined how the prevalence of repressive coping style in older adults might impact on involuntary autobiographical memories that are experienced in everyday life without a deliberate attempt to retrieve them. The content analyses of these memories recorded by older and younger adults over the course of one week indicated that older adults reported significantly fewer memories of typically negative events (e.g., accidents/illnesses and stressful events) than younger adults. On few occasions when such memories were recalled they were rated by older adults as neutral or even positive. Implications of these findings on older adults' psychological well being are discussed. It is concluded that further research is necessary to examine whether the increased repressiveness of older adults is due to cohort or developmental effects.

Retrieval inhibition of trauma-related words in women reporting repressed or recovered memories of childhood sexual abuse

Geraerts, E., Jelicic, M. & Merckelbach, H., Maastricht University, Department of Experimental Psychology, The Netherlands

Several authors have argued that survivors of childhood sexual abuse (CSA) who report to have repressed their traumatic memories are more skilled in forgetting emotional stimuli than survivors who have always remembered the CSA. The experiment that will be discussed employed a list-wise directed forgetting task to investigate whether women reporting repressed (n = 16) or recovered (n = 23) memories of CSA are better at forgetting disturbing material, relative to women reporting having always remembered their abuse (n = 55) or reporting no history of abuse (n = 20). Replicating earlier work (e.g., R.J. McNally, S.A. Clancy & D.L. Schacter, 2001), we found no support for the hypothesis that women reporting repressed or recovered memories of CSA are especially versed in inhibiting retrieval of trauma-related words. Additional analyses revealed that participants characterized by a repressive coping style did not display a superior retrieval inhibition mechanism for negative material.

Mental Imagery, evaluative conditioning and emotion

Holmes, E.A., MRC Cognition and Brain Sciences Unit, Cambridge, UK

We propose that there is a special relationship between mental imagery and emotion, whereby use of mental imagery strategies has a more powerful affect on anxiety than verbal processing of the same material. This has been experimentally demonstrated using a cognitive interpretation bias paradigm (Holmes & Mathews, in press, Emotion). However, convergent evidence is needed from other methodologies. Initial data will be presented using another experimental paradigm - evaluative conditioning. In brief, neutral pictures can be paired with words that in combination generate emotional outcomes. This pairing appears to lead to greater emotion if done via mental imagery than verbal instructions. Also, participants report drawing on their autobiographical memory in the creation of novel mental images. Overall, results support the hypotheses of a special link between imagery and anxiety, but leave open the question of whether this also applies to other emotions. Implications for the role of mental imagery in clinically modifying anxiety will be discussed [Holmes & Hackmann, 2004, Mental Imagery and Memory in Psychopathology - Special Issue, Memory, 12(4)]. Further, the relationship between mode of processing and emotional inhibition will be discussed.

Inhibiting Autobiographical Memories

Conway, M.A., University of Leeds, Barnier, A., University of New South Wales, Australia, Research Group on Neuropsychology and Psycholinguistics, University of Szeged

Three series of experiments examined whether recently recalled autobiographical memories, for emotionally neutral, negative, and positive events, could be inhibited using standard laboratory procedures. Inhibition was found in both directed forgetting and retrieval practice. Inhibition was not observed when the recently recalled memories were simply not thought about. Moreover, inhibition of memories of negative experiences proved difficult to attain. The findings are discussed in terms of 'episodic inhibition' which proposes that representations of recently recalled memories contained in a memory the recall episode are inhibited. The memories themselves are, however, unaffected by inhibition. Some implications for this in clinical domains are considered.

The Transdiagnostic Approach: Cognitive Behavioural Processes Across Psychological Disorders And Their Implications For Theory, Research And Treatment

Convenor and chair: Warren Mansell, Institute of Psychiatry, London

Discussant: Roz Shafran, Department of Psychiatry, University of Oxford

Treatment of co-occurring disorders in individuals with panic disorder

M.G. Craske, University of California, Los Angeles

Several independent studies have shown that cognitive behavioral therapy for a given anxiety disorder results in declines in co-occurring disorders, at least in the short term. The current study evaluated whether co-occurring disorders would benefit even further from CBT that simultaneously addressed both a targeted principal anxiety disorder and a co-occurring disorder. Patients with a principal diagnosis of panic disorder were randomized to CBT for panic disorder only or CBT that targeted panic disorder and a co-occurring disorder, over 18 sessions (12 group, 6 individual). Results indicate that CBT that targeted panic disorder only resulted in greater declines in co-occurring disorders than did CBT that targeted both panic disorder and co-occurring conditions. Results are discussed in relation to shared processes among anxiety disorders.

A transdiagnostic approach to cognitive and behavioural processes: The example of worry and rumination across disorders.

Harvey, A .G., University of California, Berkeley. Ed Watkins, University of Exeter. Warren Mansell, University of Manchester. Roz Shafran, University of Oxford

This paper is motivated by three sets of empirical findings. First, there is a marked similarity in the cognitive and behavioural processes that have been identified as important across the different psychological disorders. Second, individuals seeking psychological services rarely present with a pure case of just one psychological disorder (i.e., comorbidity is common). Third, cognitive behaviour therapy focused on one specific disorder results in improvement to that one disorder, as well as to comorbid disorders. In an attempt to make sense of these three sets of findings, the aim of this talk will be to examine the utility of developing an 'across disorder', or transdiagnostic, perspective to researching and treating the cognitive and behavioural processes that maintain psychological disorders. This approach proposes that psychological disorders are more similar than different in terms of the cognitive behavioural processes that maintain them and that there is much to be learned from comparing processes across disorders. The advantages and disadvantages of adopting a transdiagnostic perspective will be outlined. Then the evidence for this approach will be evaluated in detail, for worry and rumination, by describing the results of four empirical studies that were conducted by the authors across four different psychological disorders (insomnia, PTSD, depression and generalised anxiety disorder). Taking these results together, it will be concluded that worry and rumination appear to be transdiagnostic. Finally, the theoretical and clinical implications of these results, and the transdiagnostic process perspective, will be outlined.

Understanding Perseverance, Persistence And Perfectionism: Development Of A Multifactorial Measure

*Serpell, L. Central and North West London Mental Health NHS Trust / St Mary's Hospital.
Waller, G. South West London and St Georges NHS Trust. Fearon, P. University College London. Meyer, C. University of Warwick*

This paper describes the development of a self-report measure of three constructs hypothesised to be of importance in a range of psychological disorders - perfectionism (having high standards for oneself); persistence (the ability to keep going with a behaviour to reach a goal, even when the task is difficult or takes a long time); and perseverance (the tendency to continue a particular behaviour, even when it ceases to be effective or rewarding). Initial development involved defining the three constructs on the basis of previous literature and developing test items. The resulting measure (the Perfectionism, Persistence and Perseverance Questionnaire (PPPQ)), was administered to 325 non-clinical participants, along with standardised measures of general psychological disturbance and eating disorder symptoms. Factor analysis resulted in a 22-item version of the PPPQ, consisting of three subscales, corresponding to the theoretical constructs of persistence, perseverance and perfectionism. These scales had good psychometric properties and clinical validity. Persistence was related to positive mental health, whilst perseverance was broadly related to psychopathology. Perfectionism was also associated with psychopathology, but less strongly than perseverance. These findings will be related to the existing empirical and theoretical literatures. The relationship between the PPPQ scores and psychopathology should be explored in further research with clinical populations. However, perhaps treatment approaches should be targeted on reducing perseverant traits, while enhancing persistence as a more adaptive trait.

Metacognition and the Cognitive-Attentional Syndrome

Wells, A. The University Of Manchester, UK

Wells and Matthews (1994) identified a set of core cognitive processes occurring across disorders that they linked to psychological vulnerability. According to their S-REF theory a style of thinking characterized by worry/rumination, attentional monitoring for threat, and coping behaviours that fail to modify beliefs, constitute a pathogenic Cognitive Attentional Syndrome (CAS). The CAS emerges from maladaptive metacognitive beliefs, which may be positive (e.g. "I must worry about the future in order to be prepared") and negative in content (e.g. "Intrusive thoughts are a sign of madness"). This theory has led to the development of Metacognitive Therapy aimed at directly treating the CAS across psychological disorders. In this paper basic principles of metacognitive theory and treatment will be explained and data on the effects of metacognitive manipulations presented.

Facets of the Approach System Involved in Bipolar Disorder

Convenor and Chair: Johnson, S. L. University of Miami

Reward Sensitivity and Bipolar Disorder: What are the Mechanisms?

Johnson, S. L. University of Miami

In this talk, I will review the basic theory and evidence for reward sensitivity in bipolar disorder. A set of findings have suggested that this model provides some predictive power. That is, people with bipolar disorder do endorse being more reward sensitive on self-report scales, believing that goals are more important in their life, and developing manic symptoms after they are exposed to a life event involving reward. I will then discuss some of the gaps in understanding how this system works: What are the biological, cognitive, and goal-setting processes that are involved in the shift into manic symptoms? How does mood state influence these mechanisms?

BAS-related Processes and Mania-Vulnerability: Resistance to Advice and Exaggerated Goal-Pursuit

Meyer, B., Centre for Clinical and Health Psychology Research, Roehampton University

High sensitivity in the behavioural activation system (BAS) has been construed as a vulnerability to mania, but little is known about the psychological and interpersonal processes that explain why high-BAS individuals might be more likely to become manic. In this study, three such processes were investigated: (1) The tendency to resist advice that encourages reflection and restraint, (2) the tendency to appraise potentially rewarding situations overly optimistically and to approach such situations with greater enthusiasm, and (3) the tendency to set more personal goals and be overly confident with regard to the attainment of such goals. Eighty-one adults from the general UK community (mean age =

33) completed self-reports of mania and depression history (the GBI), current symptoms of mania and depression (brief version of the BDI and Altman Self-Rating Scale for Mania), and BIS/BAS sensitivity (the BIS/BAS scales). Three new measures (e.g., vignette-based tasks) were devised to assess advice-acceptance, approach motivation, and goal-setting. The main findings were (1) that depression-vulnerability correlated with a tendency to comply with restraint-encouraging advice whereas hypomania and BAS strength correlated with a tendency to reject such advice; (2) that depression-vulnerable people were less likely to appraise situations positively and less likely to approach potentially rewarding situations, whereas high-BAS people were more likely to positively appraise and approach such situations; and (3) that depression-vulnerable people had less positive goal-attainment expectancies. These findings point to potential mediators of BAS-related psychological vulnerabilities in bipolar disorder, but more longitudinal and experimental studies with clinical samples are needed.

Approach Behaviours in Remitted Bipolar Patients and Analogue Participants at High-Risk of Bipolar Affective Symptomatology

Knowles, R University of Manchester, Tai S University of Manchester, Jones S University of Manchester & Bentall R University of Manchester

The Behavioural Activation and Inhibition Scales (BIS/BAS) were administered to both an analogue and a clinical population as part of a wider program of research into cognitive vulnerability factors in bipolar disorder. The analogue sample was comprised of students who had been screened for risk of bipolar symptomatology using their scores on the HPQ and DAS, and divided into three groups hypothesised to be at low, medium and high-risk of developing bipolar affective symptoms. Significant differences in the expected direction were observed between the risk groups in their scores on the BIS and BAS-drive and fun-seeking subscales. When the analogue participants were regrouped according to the presence or absence of bipolar affective symptomatology, both BIS and BAS reward responsiveness distinguished the symptomatic participants from their non-symptomatic counterparts. In the clinical study, remitted bipolar patients were compared to remitted unipolar depressed patients and healthy controls. Both remitted patient groups displayed a clear trend towards elevated BIS scores relative to the controls, and the unipolar patients scored significantly lower than both the controls and bipolar patients on the BAS subscales. The remitted bipolar group was not significantly different from the controls on behavioural activation although there was a trend for them to score higher on all subscales as predicted. The results suggest that approach behaviours as measured using the BIS/BAS inventory are indeed involved in bipolar affective symptomatology and are useful concepts in behavioural high-risk studies of bipolar disorder.

Cognitive biases in bipolar disorder

Joormann, J., Stanford University, Johnson, S. L., University of Miami and Gotlib, I. H., Stanford University

The goal of this study was to examine information-processing biases for positive and negative stimuli in bipolar disorder. If bipolar disorder is related to increased sensitivity to reward stimuli, one might expect this to be manifested in a bias to attend to and recall positive stimuli. If, on the other hand, bipolar disorder is related to increased emotionality in general, one might expect this to be manifested in a bias to attend to and recall both positive and negative stimuli. In this paper, we will present findings using a well-validated measure of attentional bias towards positive and negative stimuli, drawn from the unipolar literature. To date, relatively little research is available on cognitive processes in bipolar disorder, but the few available studies suggest that cognitive processes and content might be extremely mood-state dependent among persons with BP disorder. We hypothesized that participants with BP I disorder would demonstrate increased attention towards and recall of positive stimuli compared to control participants. We further hypothesized that these biases depend on the participants mood states. In our study we used the dot probe task, a task assessing attentional biases in the processing of emotional faces to investigate whether bipolar participants would orient their attention towards happy or sad faces. Although some researchers have used semantic stimuli, pictures of faces, have the advantage of being more closely related to naturalistic social feedback cues. In the dot-probe task, participants are presented with a pair of stimuli (typically words or faces) consisting of one neutral and one emotional stimulus. After the offset of these stimuli, a dot probe appears in the location of either the neutral or the emotional stimulus. Allocation of attention is measured by the participant's latency to detect the dot probe. If participants orient selectively towards the emotional stimulus, they will be faster to detect dot probes that replace that stimulus (where they are already attending), and slower to detect dot probes that replace the neutral stimulus. In addition, we asked our participants to perform a recognition task including previously presented and new faces. In one of our groups we used a negative mood induction to test the hypothesis that biases would be mood-state dependent. Overall our results show that participants diagnosed with bipolar disorder selectively attend to positive faces. However, the group with the negative mood induction did not exhibit this bias towards happy faces. These results suggest that bipolar disorder is associated with a specific bias in attentional processing which is clearly mood-state dependent.

Conclusions from the Symposium

Johnson, S. L., University of Miami

On the one hand, we have data from an increasingly diverse set of paradigms that support the role of reward sensitivity in bipolar disorder, and some intriguing clues into some facets of the process. Current research appears to be in a fertile phase of drawing on strong methodological paradigms to understand these mechanisms. On the other hand, there remains some ambiguity across studies about which features of reward sensitivity and approach motivation are most elevated within bipolar populations. There is also considerable need for careful attention to mood state as a moderator of reward sensitivity, as depression appears to suppress reactivity, and hypomania may intensify reactivity. Once a person becomes energized by goal pursuit or a positive mood, current findings point towards the importance of understanding goal regulation and attentional biases towards positive stimuli. Some goals for future research will be outlined.

New Advances in Training Benign Cognitive Processes

Convenor and Chair: Hirsch, C, Institute of Psychiatry

Mental imagery and it's impact in cognitive bias training

Emily A Holmes, MRC Cognition and Brain Sciences Unit, Cambridge, UK

In cognitive therapy, cognitions are assumed to take the form of either verbal thoughts or mental images. Therapists often assume there is a special association between imagery and emotion, though empirical evidence has been lacking. Recent experiments using the interpretation training paradigm have tested this assumption by asking participants to either imagine unpleasant events, or to listen to the same descriptions while thinking about their verbal meaning. Recently we found that those in a negative imagery condition reported more anxiety, and rated new descriptions as more emotional, than did those in a negative verbal condition (Holmes & Mathews, in press, Emotion). This effect was replicated for negative training, but did not extend to a benign training. While the results support the hypothesis of a special link between imagery and anxiety, they leave open the question of whether this also applies to other emotions. For cognitive therapy we are particularly interested in whether positive emotions can be improved using such novel cognitive bias modification techniques. In the current paper we will report the results of a new experiment which examines whether positive interpretation training can be enhanced by the use of imagery as opposed to verbal training instructions. This study also provides the first test of a computerised cognitive interpretation training procedure using imagery to successfully improve positive mood. Implications for innovations in cognitive therapy will be discussed. For future methodological developments in training cognitive processes, the reported studies suggest that interpretation bias training may best be achieved through mental imagery techniques. If imagery instructions are omitted training effects may be reduced or even lost.

Generalisation of training physical interpretation bias on social and physical imagery

Susie Frost, Great Ormond Street Hospital for Children, London Colette Hirsch & Andrew Mathews, Institute of Psychiatry, King's College, University of London, UK

Anxious individuals lack the normal positive interpretation bias. Other research has shown that they often experience negative imagery in anxiety provoking situations. There may be a reciprocal relationship between biased interpretation and imagery which help maintain anxiety. The question addressed in this paper is whether interpretation bias influences imagery. The study reported here investigated whether training volunteers to develop a more positive or a more negative physical interpretation bias influenced the valence of self-imagery. Volunteers were randomly allocated to read scenarios about ambiguous physical situations. For the negative group, the scenarios were consistently resolved in a threatening manner, whereas for the positive group the scenarios were consistently resolved in a positive way. After training, participants listened to ambiguous physical and ambiguous social scenarios, where the ambiguity was not resolved. Participants were asked to generate an image of themselves in the situation and then describe the image. Participants then rated how aversive it would be to be in the imagined situation. An assessor, who did not know which group the participants were allocated to, rated the recordings of participants images on the same scale. Participants who had been trained to develop a more negative physical interpretation bias reported more negative images (self and assessor ratings) than participants who had been trained to generate positive interpretations. This effect applied equally to physical and social situations. Hence, training physical interpretation bias influences physical and social self-imagery. Given this, then the negative interpretation bias may interact with imagery to maintain anxiety.

Training a benign interpretation bias in social anxiety

Murphy, R., Hirsch, C., Mathews, A., Smith, K., Clark, D.A. Institute of Psychiatry, Kings College London

Research has found that socially anxious individuals lack the positive interpretation bias present in non-anxious individuals (Hirsch & Mathews, 2000). Manipulating interpretation biases in the general population has led to congruent changes in state anxiety when participants actively generate these biases (Mathews & Mackintosh, 2000). This provides evidence that interpretation biases may be causal in the development of anxiety. We have found in our study that benign interpretation biases can also be facilitated in a highly socially anxious community sample. A similar methodology to that employed by Mathews and Mackintosh (2000) was used. Participants in the positive training condition listened to 85 descriptions of positive social scenarios and imagined themselves as described. A comprehension question came after each description that referred to the required interpretation and answers were followed by feedback (a correct answer or wrong answer message) reinforcing the valenced interpretation. For example: You've been working for the same company for a number of years. Your boss asks you to give a speech at an upcoming conference and you agree to do it. On the day, you walk up to the podium and you are very steady. Were you trembling as you walked to the podium? No. We also used a non-negative training condition similar to above but where participants were given information that their performance was not negative. For example: You've been working for the same company for a number of years. Your boss asks you to give a speech at an upcoming conference and you agree to do it. On the day, you walk up to the podium and you aren't shaking. Were you trembling as you walked to the podium? No. A control group was presented with similar social scenarios which gave no feedback on performance. For example: You've been working for the same company for a number of years. Your boss asks you to give a speech at an upcoming conference and you agree to do it. He tells you that a couple of other colleagues will also be speaking. Were you the only one from your company giving a speech? No. The presence of interpretation biases was tested by exposing participants to ambiguous social scenarios and later testing their recognition of disambiguated versions of these. Group comparisons revealed that those in the benign training groups (positive and non-negative conditions) were more likely to rate positive and non-negative versions of the ambiguous scenarios as similar to the original scenario. In addition, participants in the control group were relatively more likely to rate negative versions of these as similar. The effects of training could not be explained by mood. There was no evidence to suggest that the non-negative training differed from the positive training with regards to facilitating a benign interpretation bias. Participants who received training in a benign interpretation bias anticipated lower levels of anxiety in an upcoming social situation. This study has clinical implications regarding the possibility of helping socially anxious individuals to develop more benign interpretation biases to reduce social anxiety.

Computerised training of cognitive biases that influence vulnerability to anxiety

Mackintosh, B Open University, Milton Keynes and MRC Cognition and Brain Sciences Unit, Cambridge Hoppitt L, and Andrew Mathews, MRC Cognition and Brain Sciences Unit, Cambridge

Recent research continues to confirm that biases in interpretation can be quite readily altered experimentally using computerised tasks. Following exposure to a series of ambiguous words or scripts in which the interpretation is constrained, interpretation of new information becomes modified in a direction congruent with 'training'. Procedures in which the meaning is actively generated during training do not seem essential for modifying the cognitive bias itself but can lead to changes in anxiety vulnerability to subsequent stress. To be therapeutically useful the bias must both lead to changes in vulnerability to anxiety and be capable of surviving over time and transferring to novel contexts. We will describe experiments in which induced interpretation biases survive both the passage of time and cross differing contexts. However, the methods used to 'train' the bias, involving active generation or more passive assimilation of meaning have differential consequences on later vulnerability to stress and the bias in interpretation of novel ambiguous material. Inducing a bias in interpretation alone may not necessarily be sufficient for modifying vulnerability to stress.

Memory - what happens when it's not working? Cognitive vulnerabilities across the disorders

Convenor and Chair: Jennifer Wild, Institute of Psychiatry

Thought Suppression and Working Memory Capacity

Brewin, C.R., Beaton, A, & Smart, L, University College London

The literature on working memory (WM) suggests that a person's WM capacity may be related to the ability to suppress unwanted intrusive cognitions on paired associate learning tasks. Such a finding is potentially relevant to understanding individual differences in vulnerability to intrusions and why lower levels of intelligence are a risk factor for PTSD. In two experiments with healthy volunteers we investigated the ability of WM capacity to predict success at intentionally suppressing thoughts. In Experiment 1, 60 participants completed a neutral thought suppression task, and measures of WM capacity (OSPAN), fluid intelligence (Raven's Matrices), and crystallised intelligence (the National Adult Reading Test). As predicted, the results indicated that more effective thought suppression was independently related to higher WM capacity and greater fluid intelligence, but was unrelated to crystallised intelligence. In Experiment 2, 60 participants identified their most frequent intrusive thought and then completed a thought suppression task. Better performance on a measure of WM capacity (OSPAN) was related to having fewer intrusions in the suppression condition but was unrelated to number of intrusions in the expression condition, suggesting a specific association with attempts to inhibit unwanted thoughts. In contrast, a more negative mood was related to having more intrusions in both conditions, suggestive of a more general influence on the accessibility of unwanted thoughts. WM capacity was not associated with negative mood or with the frequency of intrusive thoughts reported in everyday life. The findings support the idea that individual differences in the cognitive abilities supporting inhibitory mechanisms are relevant to clinical conditions such as obsessive-compulsive disorder and posttraumatic stress disorder.

Low working memory capacity as a risk factor for Posttraumatic Stress Disorder in the emergency services.

R. Handley, J. Wild, R. Morris & J. Howard, Institute of Psychiatry, London, UK

Introduction: This study highlights the importance of working memory capacity (WMC) in Posttraumatic Stress Disorder (PTSD). Most research investigating PTSD has lacked integration of neuropsychological and cognitive models. Neuropsychological models focus primarily on memory deficits in PTSD. Cognitive models focus primarily on appraisals of the trauma and traumatic symptoms in the onset and maintenance of the disorder. This study draws on both neuropsychological and cognitive data to explain the role of these factors in the onset of PTSD in the emergency services. **Method:** Sixty-eight London ambulance workers were assessed for working memory capacity using the OSPAN (Turner & Engle, 1989). Intellectual functioning, PTSD, responses to intrusive memories, dissociation, depression, anxiety, general well-being and medical complaints, drug and alcohol use, memory problems, previous trauma, education and years in service were also assessed. Participants were re-assessed for trauma exposure and PTSD at six months follow-up. **Results:** Participants with low working memory had significantly higher scores on the measure of PTSD at assessment ($p < .03$). Perceived control of intrusive memories was significantly correlated with WMC score ($p < .02$). That is, participants with high WMC reported greater control of intrusive memories. Participants who reported severe memory problems had significantly lower WMC than participants who did not report memory problems. Finally, cognitive appraisal strategies at assessment predicted outcome at follow-up. Participants who reported general strategies of negative interpretation and avoidance were more likely to have PTSD following trauma exposure at six months follow-up. **Conclusion:** This study integrates neuropsychological and cognitive findings with respect to PTSD with significant theoretical, clinical and occupational implications. The results highlight the importance of WMC as a moderator in the relationship between intrusions and PTSD. Furthermore, the results suggest that individuals with low WMC are more likely to suffer from PTSD than individuals with high WMC. The effects of working memory capacity are likely to be moderated by unhelpful cognitive appraisal strategies which were correlated with PTSD scores. This finding suggests that training and intervention programmes within the emergency services could usefully target i) education about the negative impact of attempts to avoid intrusive memories of traumatic events and ii) strategies to reduce negative interpretation of traumatic events and their sequelae. The results also indicate that individuals are capable of accurately reporting the severity of their memory difficulties on a simple self-report questionnaire as verified on an objective memory test. This may prove a cost-effective clinical tool to highlight clients with memory difficulties. Therapy could then be tailored to the memory ability of the client. Further research could investigate the long-term utility of suppression of intrusions in individuals with high WMC, particularly in a population (such as this) at risk of repeated trauma exposure. Methods of training individuals on working memory tasks in order to improve attention in the face of distraction, may also be explored as a useful additional component of cognitive therapy for PTSD.

Appraisals of memory problems in Posttraumatic Stress Disorder, Social Phobia, Panic Disorder and trauma exposed non-PTSD adults

Wild, J. Ehlers, A. and Clark, D.M. Institute of Psychiatry, London, UK. Schönfeld, S. Universität Beilefeld, Germany

Clinically, sufferers of Posttraumatic Stress Disorder (PTSD) report memory difficulties. Yet no study has measured self-report of memory difficulties in PTSD. It is unclear whether reported memory difficulties are specific to PTSD or whether they may characterise other anxiety disorders. Further, in PTSD, it is unclear whether perception of memory difficulties improves as sufferers recover. PTSD (N=20), Panic Disorder (N=20), Social Phobia (N=20) and trauma exposed non-PTSD adults (N=20) were assessed with the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID) and completed a self-report questionnaire of everyday memory problems. The PTSD group received 12 sessions of cognitive therapy and were re-administered the SCID and memory questionnaire at this follow-up time point. The PTSD group reported significantly more memory difficulties than the other groups. PTSD patients who improved in treatment reported fewer memory difficulties at intake compared to non-improvers. They rated their memory problems as significantly less distressing and severe. They also rated improvement in the perception of their memory difficulties compared to the non-improvers at follow-up. The improvers and non-improvers did not differ in PTSD severity and comorbidity at assessment. This study suggests that the perception of memory problems is specific to PTSD and not anxiety disorders in general. The perception of memory difficulties improved in those clients who recovered. Further, PTSD sufferers reporting significant memory difficulties at assessment were less likely to improve. These results have clinical implications for the assessment and treatment of PTSD.

Trauma-Related Intrusions in Psychosis

Steel, C. University College London

There has been considerable recent speculation as to the relationship between posttraumatic stress disorder and psychosis. Some researchers have focused on comorbidity, whilst others have speculated whether PTSD may trigger psychosis, or vice versa. However, the underlying assumption of these approaches is that the two disorders are distinct. In contrast to this view, research highlighting the common phenomenology of the symptoms associated with PTSD and psychosis will be reviewed. Key aspects of information processing which may underlie the development of intrusions within both disorders will be discussed, along with recent supporting evidence.

Autobiographical Memory, Mentalizing and the Symptoms of Schizophrenia

Corcoran, R. University of Manchester and Frith, C.D., Institute of Neurology, University College London.

Corcoran (2000) has proposed that the inference of others' mental states is achieved through inductive or analogical reasoning. This model places the ability to retrieve appropriate analogue situations from autobiographical memory at the heart of the mentalizing skill and can explain the differential performance on theory of mind (ToM) tasks of people with schizophrenia with distinct symptom profiles. This paper presents the findings of a study that explored the relationship between autobiographical memory retrieval and performance on 2 distinct tests of theory of mind in people with schizophrenia and healthy adults. Consistent with previous findings, the people with schizophrenia performed poorly on the ToM tasks. Furthermore, a robust relationship was found between ToM ability and autobiographical memory retrieval in the schizophrenia sample where there was also a tendency to recollect odd or negative events. The findings support the view that retrieval of analogous events from autobiographical memory is key to ToM skills in people with schizophrenia. Future work should explore the relationship of these skills in other clinical and non-clinical groups.

Metacognitive Therapy: Application to Anxiety Disorders and Depression

Convenor and Chair: Adrian Wells, The University Of Manchester, UK

Metacognitive Therapy for Obsessive Compulsive Disorder

Fisher, P.L. The University Of Manchester, UK

Wells (1997, 2000) has developed a metacognitive model of OCD in which metacognitive beliefs and processes are fundamental to the maintenance of the disorder. This presentation describes the results of the first investigation of the efficacy of metacognitive therapy (MT) for OCD. MT was assessed in a case series of 4 patients consecutively referred for psychological treatment of OCD. Patients were assigned to no-treatment baselines, followed by 12, one-hour sessions of MT conducted on a weekly basis. At post-treatment, each patient had made clinically significant improvement on a range of standardised OCD outcome measures. These treatment gains were largely maintained through to the six month follow-up assessment. The results indicate that MT is an effective and time efficient treatment for OCD. Implications for the treatment of OCD in primary care settings will be discussed

Metacognitive Therapy for Depressive Rumination

Papageorgiou, C. Institute For Health Research, University Of Lancaster, UK

CBT is an effective treatment for depression. However, a significant proportion of patients either do not fully remit or they relapse and experience recurrences following this intervention. How might treatment effectiveness be maximised? Wells and Papageorgiou (2004) suggest that three lines of work support the development and implementation of a metacognitive therapy, which targets the process, rather than just the content, of ruminative thinking; a core cognitive feature of depression. First, a number of theories have implicated rumination in the onset and perpetuation of depression. In particular, Wells and Matthews' (1994) Self-Regulatory Executive Function (S-REF) theory of emotional disorders accounts for the information processing mechanisms of rumination and provides the foundations for the development of a metacognitive intervention. Second, recent empirical evidence supports a clinical metacognitive model of rumination and depression (Papageorgiou & Wells, 2003, 2004), which is grounded on the S-REF theory. Third, given the considerable overlap between rumination and a related cognitive process, namely worry, similar interventions for these processes might be appropriate, and the metacognitive treatment approach to generalized anxiety disorder (Wells, 1997) is particularly relevant in this context. This presentation will outline the components of a metacognitive treatment for depressive rumination and describe evidence supporting the implementation of a number of these therapeutic components.

Treating GAD with Metacognitive Therapy

Adrian Wells, The University Of Manchester, UK

The metacognitive model of GAD explains the development and maintenance of pathological worry as a maladaptive coping strategy. Negative metacognitive beliefs about worry and use of mental regulation strategies that backfire are central to the disorder. Metacognitive therapy consists of modifying negative beliefs concerning the uncontrollability and dangers of worrying, and increasing the use of alternative non-worry based coping strategies. The treatment appears effective as indicated by data from two recent trials. In this presentation the metacognitive model will be described, data on treatment effects briefly presented, and the implementation of treatment in a particular case outlined.

The RAP Model of PTSD: A case example of session by session metacognitive therapy

Sundeep Sembi, University of Liverpool

In this presentation the session by session treatment of a 35 year old man with a history of severe PTSD following assault is described. Using the techniques described in the RAP model of PTSD (Wells & Sembi, 2004), this new and innovative treatment targets rumination and involves virtually no exposure. In ten sessions treatment was effective with treatment gains being maintained at long term follow-up. The model, formulation and therapeutic techniques used will be described. Some case series and effect size data will be presented which suggests that this is a highly effective brief intervention for severe PTSD.

Open Papers Basic Processes

From Cognition to Metacognition

Chair: Martin Conway, University of Leeds

PTSD with neurogenic amnesia (NA): the Challenges for Cognitive Therapy

Keegan, A. Infection and Immunity, Barts and the London NHS Trust

Memory is central to our understanding of post-traumatic phenomena. The presence of intrusive phenomena such as 'flashbacks' are central to diagnostic classifications such as DSM-IV (APA, 1994), where the presence or absence of these is used, in part, to determine a PTSD diagnosis. The idea that PTSD can develop in individuals who have NA for a traumatic event is controversial. However, there is growing body of evidence, both empirical and case series, which suggests that PTSD symptoms appear to develop in the absence of any apparent or only extremely fragmentary memories of a traumatic event. For example following traumatic brain injury (Bryant and Harvey, 1995) and in survivors of drug facilitated sexual assault (Gauntlett-Gilbert, Keegan and Petrak, 2004). Clinically, individuals with PTSD and NA for a traumatic event can present with a variety of anomalous memory phenomena. Those documented include 'islands' of memory, i.e. small fragments of emotionally charged memory, 'pseudomemories' i.e. memories that are inconsistent with what is known to have happened and 'implicit' memories, based on strong S-S and S-R connections formed during a traumatic event, which can become associated with default predictions of severe danger. I aim to describe these and their contribution to the development and maintenance of PTSD symptoms in such cases. Drawing on current knowledge of memory processes and contemporary cognitive theories of PTSD, I will suggest a framework to understand the mechanisms underpinning PTSD following NA. Contemporary cognitive theorists have incorporated ideas of disturbances to implicit and explicit memory processes to help explain the paradoxical nature of memory phenomena in PTSD generally. I will argue that the phenomena encountered in PTSD with NA are driven by similar mechanisms to those that produce memory disturbances found in trauma survivors generally. Thus contemporary cognitive models can provide a basis both to understand and treat PTSD and NA. The adaptations to standard CT treatments, such as integration and elaboration of the trauma memory, working with self-generated images, working with implicit memories, addressing negative appraisals and maladaptive coping strategies etc needed to treat PTSD with NA are outlined via examples drawn from clinical experience of work within an inner London sexual assault clinic. Although PTSD with NA represent a small and rather anomalous proportion of PTSD cases, the existence of this phenomena is important both for the light it can shed on memory processes within PTSD generally and for the development of suitable treatments for affected individuals

Counterfactual thinking and posttraumatic stress reactions

Kuusniemi, K., Royal Holloway University of London, Brown, G., Royal Holloway University of London, & Tata, P., St Mary's Adult Psychology Service

Rumination, including counterfactual thinking (thinking about alternative outcomes, or 'if only' thoughts), has been suggested to help maintain posttraumatic distress and several research studies have indeed found a positive relationship between rumination and posttraumatic distress. However, it has been argued that as well as negative affective consequences, counterfactual thinking might help a person generate inferences regarding behavioural plans for the future and find meaning (e.g., Roese & Olson, 1995; El Leithy, Brown & Robbins, in press). Research in counterfactual thinking has shifted from social psychology to clinical studies where types and content of counterfactual thinking have been distinguished and suggested to relate differently to variables such as posttraumatic distress (e.g., El Leithy et al., in press). El Leithy et al. (in press) studied assault victims in the general population and the current study used a similar methodology in order to find out whether the results could be replicated in a clinical population. The study aimed to clarify relationships between types of counterfactual thinking, behavioural planning about the future, meaning, posttraumatic distress and thought control strategies. Counterfactual thinking and behavioural planning were divided into frequency scores (how often participants reported thinking in this way) and fluency scores (the number of counterfactual or behavioural planning scenarios generated in a timed thought-listing task), in order to find out whether they related differently to levels of posttraumatic distress. 37 individuals from an Adult Mental Health population who had experienced different kinds of traumatic events completed questionnaires as well as the timed thought-listing tasks in a cross-sectional study. As predicted, higher frequency of counterfactual thinking was found to relate to higher posttraumatic distress and higher frequency of behavioural planning. Counterfactual fluency was not found to be related to distress, as predicted. Unexpectedly, however, the fluency of self-referent counterfactuals was found to be inversely related to distress. Counterfactual fluency overall was not found to be related to behavioural planning fluency, contrary to predictions, but as hypothesised, higher fluency of additive counterfactuals (counterfactuals

where an action is added) was related to higher fluency of planning. Behavioural planning was also found to have a potentially important role in terms of a positive relationship with meaning. Contrary to tentative hypotheses, counterfactual frequency or fluency did not relate to finding meaning and meaning was not related to distress. No evidence was found for the role of thought control strategies as a moderating factor. Overall, the findings gave partial support to suggestions that despite its negative affective associations, counterfactual thinking may also be related to more positive aspects of adjustment to trauma. Theoretical and clinical implications as well as the strengths and limitations of the study will be discussed.

Inflated responsibility and perseverative checking

MacDonald B. & Davey G.C.L. University of Sussex

A common feature of many psychopathologies is perseveration (e.g. worrying and obsessive activities such as checking). The current studies were designed to evaluate a model of such pathological perseveration, namely the mood-as-input hypothesis, which proposes that an individual uses mood as information about whether to continue a task in the context of the stop-rules for that task. Stop rules are the implicit questions individuals ask themselves: 'Have I reached my goal' (as many as can AMA) or 'Do I feel like I want to continue with this task' (feel like continuing, FL). The aim was to assess mood-as-input predictions when applied to an analogue checking task that closely resemble those found in some forms of Obsessive Compulsive Disorder and to evaluate the role of responsibility. Inflated responsibility is a major feature of OCD in a number of contemporary theories. Participants: 122 university students and staff. Using a between-subjects design, an experimental checking task required participants to proof read text. Both studies manipulated mood to produce positive or negative mood states. Study one measured naturally occurring self reported sense of responsibility. In study 1, results of a 2 x 2 ANOVA suggested that participants in negative mood and in the upper tertile of the responsibility measures showed significantly greater task perseveration and mood improvement post checking than participants under other conditions (consistent with mood as input predictions). In Study 2 participants had their sense of responsibility experimentally manipulated. This produced two experimental groups, representing high and low levels of responsibility. The results of a 2x2 ANOVA suggested that participants in a negative mood when combined with inflated responsibility showed significantly greater task preservation and mood improvement post checking than the other three groups. However, it was also noted that inflated responsibility did NOT result in perseveration when it was in combination with a positive mood, and is therefore not a sufficient condition to produce perseveration. These results are consistent with a mood-as-input model of perseveration and as such may offer an explanation for the role of factors, such as a sense of responsibility, that influence compulsive checking.

Subjective Experience and Cognitive Feelings: Insights from Metacognition

Moulin, C.J.A, Souchay, C., Akhtar, S. and Conway, M.A., University of Leeds

Memory has long been considered as critical for the maintenance of self, and healthy memory function is part of psychological well-being. The central thesis of this talk is that mainstream cognitive psychology has focussed on the measurement and the theoretical contribution of objective memory performance (e.g. how many items can you remember from a given list) rather than subjective memory experience (e.g. the metacognitive evaluation of memory performance). Results from our studies on a variety of neuropsychological populations have indicated that people act on the basis of the subjective experience, and hold beliefs on the basis of the sensation evoked by 'remembering'. We introduce two common paradigms for evaluating and researching subjective experience, the recollective experience paradigm and metacognitive predictions of future performance. In the former, participants study lists of words for a memory test. As well as considering objective memory performance, participants make introspections about the nature of their experience. Participants report whether they can 'remember' the word in the sense of re-experiencing cognitions present at the time of first encountering the stimuli, or whether they merely find the item 'familiar' with no contextual information. Rather than discuss specific results, we demonstrate how this paradigm is insightful in several different populations, memory rehabilitation, and how it can be applied to people in psychological distress. We also discuss metacognitive tasks, where participants also study lists of words in the standard manner, but make estimates of subjective performance, often referred to as measures of memory monitoring. Again, we demonstrate how this approach gives insights into memory failure, and the beliefs people have about their own memory function. We conclude with a consideration of the further applications of this subjective approach to understanding memory dysfunction, and the preliminary work we are conducting into clinical groups and in memory rehabilitation.

Adult Mental Health

Keynote Addresses

A Reconceptualization of Posttraumatic Stress Disorder

Professor Patricia Resick, National Center for PTSD, Women's Health Sciences Division and Boston University

Posttraumatic stress disorder has been classified as an anxiety disorder since its inception in 1980. The most recent iteration of the disorder has five criteria: trauma, re-experiencing, avoidance, arousal, and duration. However, these criteria do not capture the range of emotional and cognitive reactions that victims report during or after traumatic events, which predict later symptoms, and which are not captured in prevailing theories of the disorder. Extant theories also do not explain the comorbid disorders that frequently accompany PTSD. This presentation will step back from current criteria that may, in fact, limit our thinking about posttraumatic disturbances. Dr. Resick will introduce an integrated theory of trauma pathology that accounts for the heterogeneity of posttraumatic responses and the functional relationships between them.

Symposia

Change In Social Phobia: Treatment, Basic Processes and Development Of Social Fears

Convenor and Chair: Stopa, L., Department of Psychology, University of Southampton

An Investigation into the Efficacy of Two of the Components of Cognitive Therapy for Social Phobia

Freda McManus¹, David M. Clark², Nick Grey³, Jennifer Wild², Colette Hirsch², Melanie Fennell⁴, Ann Hackmann⁴, Louise Waddington², Sheena Liness³, and John Manley⁵. 1 Oxford Cognitive Therapy Centre, Warneford Hospital, Oxford, 2 Institute of Psychiatry, London. 3 Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Trust, London. 4 University Department of Psychiatry, Warneford Hospital, Oxford. 5 West London Mental Health NHS

Cognitive behavioural treatments have demonstrated efficacy in the treatment of social phobia. However, such treatments consist of a complex package of procedures and there has been little investigation of the individual effects of these different procedures. The current study utilises single session therapy experiments to evaluate the effects of two of the components of cognitive therapy for social phobia (Clark et al, 2003), namely the safety behaviours and self-focus experiment and the video feedback experiment. Results suggest that both of these procedures are effective in (i) demonstrating to patients the role of safety behaviours, self-focussed attention, and excessively negative impressions of how you come across, in the maintenance of social anxiety and (ii) in reducing the symptoms of social phobia.

Updating traumatic memories in social phobia: Positive impact on imagery, beliefs and behaviour

Wild, J. Institute of Psychiatry, London, UK Hackmann, A. University of Oxford Clark, D.M. Institute of Psychiatry, London, UK

Most individuals with Social Phobia have intrusive images in social situations of how they come across. These images are often linked in meaning and onset to early traumatic social experiences. Like intrusive images in Posttraumatic Stress Disorder (PTSD), they are recurrent in nature, distressing and fail to be updated in light of new information. They adversely affect information processing and beliefs about the self, influencing anxiety and behaviour. This study developed and investigated a novel intervention to "rescript" or update trauma memories linked to intrusive images in Social Phobia. The technique draws on effective treatment of intrusive images in PTSD. The study investigated the impact of this intervention on beliefs, anxiety, image frequency, distress and social behaviour in two groups of

adults with Social Phobia (N=20). Group 1 received the rescripting intervention and Group 2 received a control procedure matched for therapist's time and exposure to the social trauma memory. Measures of social anxiety severity, mood, image and memory frequency, distress and strength of main belief were taken pre-session, post-session and at one week follow-up for both groups. Results found significant change within session and at follow-up for the rescripting group, suggesting that it is an effective treatment for intrusive images in Social Phobia and may improve treatment efficacy as part of a regular cognitive therapy programme.

Negative auditory imagery in social phobia and the benefits from audio feedback

Hirsch, C., Institute of Psychiatry, King's College, University of London, UK

Clark, D.M., Institute of Psychiatry, King's College, University of London, UK

Whilst in social situations clients with social phobia report experiencing negative images of themselves performing poorly when in feared social situations. The content of the images appears to be closely related to the person's feared outcomes (e.g. a bright red face and sounding incoherent) rather than being an accurate portrayal of how they actually come across. The imagery is comprised of a number of modalities and whilst the visual modality is most prevalent, distorted auditory imagery is often reported by clients with social phobia. Furthermore, clients with social phobia are often concerned about how they sound and the way in which they express themselves. To date no clinical studies have specifically investigated auditory imagery. The study reported here required clients with social phobia and community volunteers to read a short description and then recount the gist of it out loud. This was recorded on audiotape. The participants then rated how anxious they were and how well they came across during the recording. Participants then received audio feedback. Participants then re-rated their performance. Participants then read a second description, recalled the gist of it out loud and made ratings as before. An independent assessor, who did not know the participants group or whether the tape recording was of the first or second description, rated the tape recordings participant's performance. Clients with social phobia were much more critical of their own performance (as compared to the independent assessor) than the community volunteers. Both groups benefited from audio feedback, with less critical ratings of performance when listening to the tape. The beneficial effects of audio feedback generalized to the second performance which they rated more accurately (i.e. more similarly to assessor) than the first and they also felt less anxious. This study indicates that clients with social phobia have excessively negative auditory imagery and this can be ameliorated by audio feedback. Implications for cognitive therapy will be addressed.

Does anticipation help or hinder performance in a subsequent speech?

Brown, M.A. and Stopa, L. Department of Psychology, University of Southampton, UK

Anticipatory processing is an important maintaining factor in cognitive models of social phobia (Clark & Wells 1995; Rapee & Heimberg, 1997). The aim of this study was to examine anticipation on a subsequent speech in high and low socially anxious participants. Forty participants (n = 20 in each group) gave two speeches, one after a 10 minute no-anticipation period and one after a 10 minute anticipation period. High socially anxious participants were more anxious and publicly self-aware, had more negative thoughts and believed them more, and predicted worse performance in both speeches than low anxious participants. High socially anxious participants used the observer perspective more in the anticipated compared to the unanticipated speech, whereas low socially anxious participants used the field perspective in both speeches. Low socially anxious participants had fewer negative thoughts in the anticipated speech, whereas high anxious participants did not differ. All participants believed their negative thoughts less and rated performance (predicted and actual) better in the anticipated than in the unanticipated speech. Results provide partial support for Clark and Wells' (1995) model of social phobia and offer novel findings regarding the role of anticipatory processing and self-awareness in social anxiety.

Does Fear Information Create Fear Beliefs About Social Situations in Children?

Field, A. P and Lawson, J, University of Sussex

Social fears are common in early adolescence and can reach pathological status in social phobia. Verbal information has long been considered a viable pathway for the acquisition of fear in childhood, but to date there has been little experimental work to substantiate this idea. Several experiments investigated whether giving children and adolescents positive and negative information about different novel social situations altered fear-relevant beliefs (self-report and reaction time tasks such as affective priming) about those situations. Over these studies, the types of situations, the format of the presentation of the information, and the source of the information (adults or peers) were varied. Results showed that information does appear to alter fear-relevant beliefs and could influence the development of social fears: the affective priming task showed that automatically activated positive and negative associations had been formed for the different situations. However, these effects were moderated by the way in which the information was presented.

Evidence For A Revised Conceptualization Of PTSD

Convenor and Chair: Patricia A. Resick, National Center for PTSD, VA Boston Healthcare System and Boston University

Trauma-Related Cognitions and Complex Post-trauma Symptomatology in a Domestic Violence Sample

Patricia A. Resick, National Center for PTSD, VA Boston Healthcare System and Boston University and Debra L. Kaysen, University of Washington

Recent investigations have focused on the role of cognitions in the development and maintenance of PTSD. Two mechanisms proposed to describe problems in the integration of memories of trauma into preexisting schemas are assimilation and over-accommodation. In assimilation, memories of the event are changed so underlying schemas are left intact. In over-accommodation, underlying schemas are over-generalized and become maladaptive. This study examines effects of these two types of processing on posttrauma symptoms. The goals were as follows: (1) to investigate the relationship between aspects of domestic violence (chronicity and severity) and features of complex PTSD and (2) to investigate the extent to which assimilation and over-accommodation predict features of complex PTSD. Standardized interviews and symptom questionnaires were administered to 350 female victims of recent, severe domestic violence within six months of a battering incident. Participants were recruited from domestic violence service agencies and shelters. Measures include the Personal Beliefs and Reaction Scale, Modified Conflict Tactics Scale, Posttraumatic Diagnostic Scale and the Trauma Symptom Inventory. Analyses focused on PTSD, depression, anger, impaired self-reference, and tension reduction behavior subscales of the TSI. The measure of assimilation and over-accommodation was created from PBRs items in a previous research study (Kaysen & Resick, 2002). Exploratory factor analysis validated the two-factor structure of the retained items. Both the 7-item assimilation scale ($\alpha=.77$) and 10-item over-accommodation scales ($\alpha=.81$) had acceptable internal consistency. To test hypotheses 1 and 2, a series of hierarchical multiple regression were conducted. For each regression equation, step 1 included prior childhood physical and sexual abuse, step 2 included aspects of domestic violence severity, and step 3 consisted of cognitive processes. In the final model, assimilation, over-accommodation, and DV emotional abuse predicted PTSD severity; child sexual abuse, domestic violence severity (physical aggression, injuries, emotional abuse), and both assimilation and over-accommodation significantly predicted TSI-depression. TSI-anger/irritability was predicted by assimilation and over-accommodation only. Impaired self-reference was predicted by child sexual abuse, DV-emotional abuse, assimilation and over-accommodation. Lastly, tension-reduction behavior was predicted only by assimilation. The theoretical and clinical implications of these results, as well as suggestions for further research will be discussed.

Developing schema theory: the role of “active” representations

Chris R. Brewin, University College London

I will present data on a potentially important clinical phenomenon in some patients with posttraumatic stress disorder (PTSD): negative thoughts that are experienced as being spoken by a “voice”. Consistent with the idea of a “dialogical self”, these voices may express repetitive, critical content, and can be engaged in a limited form of “conversation” about their goals and values. They are quite distinct from psychotic “voices” in that the patient is clear they represent their own thoughts rather than being, for example, inserted from outside. A semi-structured interview is being used to collect information about the history, current frequency, triggers, controllability, emotional impact, and characteristics of these “voices”, as well as the extent to which the patient is able to disagree with them. These mental phenomena have not previously been described in PTSD and may provide important clues about the factors that maintain the condition. Working therapeutically with these voices changes the emphasis from belief modification to rebalancing different parts of the self. Paying attention to “voices” may offer an opportunity to develop more effective interventions, particularly for negative beliefs that frequently accompany PTSD.

Emotional and cognitive themes in “hotspots” of trauma memories and intrusive images in Posttraumatic Stress Disorder

Nick Grey, Centre for Anxiety Disorders & Trauma and Institute of Psychiatry, London, UK, and Emily A. Holmes, MRC Cognition and Brain Sciences Unit, Cambridge, UK

This study investigated the emotions and cognitions contained in “hotspots” of memory for traumatic events, as well as associated images. Hotspots refer to moments of peak emotional distress during the event. Recent cognitive conceptualisations of PTSD provide the theoretical underpinning for this study (Brewin et al., 1996; Ehlers & Clark, 2000). The study further extends the authors’ previous work in this area (Grey et al., 2001; 2002; Holmes et al., in press). Participants were 72 people who met diagnostic

criteria for Posttraumatic Stress Disorder (PTSD) having experienced a range of traumatic events. Data were collected within an agreed protocol, involving reliving therapy, at two specialist outpatient trauma clinics. Participants described the main intrusive image of the trauma that they were re-experiencing. There was a high degree of match reported between the main intrusive images and hotspots. In addition participants' reports of cognitions and emotions during their hotspots in memory of the traumatic experience were recorded as part of reliving therapy. These cognitive and emotional contents of hotspots were qualitatively analysed into themes. Themes related to threat to physical integrity were less commonly reported than themes associated with psychological threat to one's sense of self. The most common emotional theme was fear but anger and sadness appeared more frequently than helplessness and horror. Further results will also be presented. The findings are discussed relative to our understanding and treatment of intrusive imagery in PTSD, in particular the clear need to address emotional and cognitive themes broader than fear for one's immediate physical integrity. Clinically we suggest that individual hotspots can be updated using both verbal and also imagery based cognitive restructuring. This work may be done most effectively at times of peak affect - i.e. during a reliving type procedure.

Treating PTSD in the context of Borderline Personality Disorder: A Case Example using Compassionate Mind Techniques

Pippa Stallworthy, The Traumatic Stress Clinic, London

Dissociative symptoms are one of the criteria for Borderline Personality Disorder. A tendency to dissociate is thought to increase the risk of peri-traumatic dissociation, which is one of the biggest predictors of PTSD. This suggests that people with BPD should be at increased risk of PTSD. The treatment of PTSD requires detailed discussion and 'reliving' of the traumatic event which is necessarily distressing, so people need to have effective strategies for tolerating distress. When people have relied on dissociation, self-harm, and/or self-induced vomiting (SIV) as affect-regulation strategies, work to develop more adaptive strategies will need to precede trauma-focused work. Schema-focused Cognitive therapy can be used but requires long-term treatment. Compassionate mind techniques may permit more rapid treatment. A case example of a woman presenting with PTSD following a rape with a prior history of dissociation, self-harm and self-induced vomiting will be presented. Compassionate mind techniques (Gilbert 2005, Lee 2005) were used to reduce shame and facilitate tolerance of distress so as to enable the treatment of her PTSD.

Cognitive Behaviour Therapy in Bipolar Disorder I: Therapy Evaluation and Targets for Intervention

Convenor & Chair: Steven Jones, University of Manchester

Early Detection of Bipolar Disorder: Results and Therapeutic Implications of a High-Risk Study of Parents With Bipolar Disorder and Their Adolescent Children

Steven Huntley Jones, Sara Tai, Kate Evershed, Rebecca Knowles, Richard Bentall, and Steven Jones, University of Manchester

Objectives: Although disturbances in cognition, affect, sleep and activity have been identified in individuals with bipolar disorder, little is known about the possible role that these factors play in the development of the condition. We sought to study these variables in a familial high-risk sample (children of bipolar parents) Methods: 25 children (13-19 years) of bipolar parents were compared with 22 similar aged children of age and sex matched healthy controls Participants were assessed using SADS-L and completed self report measures of dysfunctional attitudes, behavioural activation/inhibition, social rhythms, coping styles and subjective experience of sleep. Children completed a seven day recording of actigraphy (sleep and activity) and a seven day diary measuring self esteem, positive and negative affect and reactions to positive and negative events. Parents provided 5-minute speech samples to assess family atmosphere. Results: 56% of children of bipolar parents (CBP) reported mood symptoms compared to 9% of controls children (CC). The CBP group had coping styles and instability of self esteem consistent with abnormal strategies for regulating affect. Both groups also differed on objective and subjective sleep measures. There was no evidence for differences in family atmosphere from parental reports. BD parents also reported dysfunctional coping styles and (to a lesser extent) disrupted activity patterns. Conclusions: The findings from this pilot study indicate that abnormal coping styles, instability of self-esteem and dysregulation of sleep may be early markers of bipolar illness. Implications for future prospective research and clinical interventions are will be discussed.

An Inventory to Assess Key Targets for Belief and Behaviour Change in Bipolar Disorder

Mansell, W, School of Psychological Sciences, University of Manchester

The development in science and practice of cognitive therapy has benefited from coherent models which specify the key cognitions within a psychological disorder that can be targeted in therapy. A scale is required to identify the content of cognitions that characterise bipolar disorder and that may influence the development of mania or hypomania. In an initial study, 104 items were generated within five theory-driven categories: Self-Activation, Self-Catastrophic, Other-Positive, Other-Negative and Response Style. Each item was given a belief rating from 0 to 100%. These formed a preliminary version of a new scale, the Hypomanic Attitudes and Positive Predictions Inventory (HAPPI). The mean score for all items, and for each category of items, was significantly elevated in a group of individuals with a diagnosis of bipolar disorder ($n = 22$) relative to a matched group of non-clinical controls ($n = 22$), even when controlling for current mood. An exploratory analysis revealed the items that were significantly elevated in the bipolar group. A further study will be reported in which this group comparison was repeated in a new, larger sample, using a 30-item version of the HAPPI that included reversed and filler items. The association between scores on the HAPPI and self-reported symptoms of mania and depression was also explored. Examples of how the HAPPI could be used for assessment, cognitive restructuring and behavioural experiments will be described, and the theoretical implications discussed.

Mindfulness Based Cognitive Therapy for Bipolar Disorder: The Current Findings and Areas for Further Research

Anna Swift, University of East Anglia.

Mindfulness based cognitive therapy (MBCT) has been adapted for use in bipolar disorder and this presentation provides an introduction to the theoretical underpinning, the format and the evaluation of the approach used. MBCT was designed for use in preventing relapse in depression and has its theoretical grounding in the Teasdale and Barnard (1993) model of depression. Subsequently, this model has been extended to account for bipolar symptomatology. Teasdale and Barnard's theory, along with existing research, provides a clear rationale for the use of MBCT in reducing relapse in bipolar disorder. Furthermore, the mindfulness framework emphasises the importance of 'decentring' from automatic thoughts, feelings and behaviours which serve to maintain mood states. Additionally, the themes of awareness and acceptance, which are central to the mindfulness philosophy, are important tools in noticing the early warning signs of episodes and managing the stress inherent in modern day life. MBCT is delivered in a group format and the structure for sessions will be introduced along with examples of session tasks. Furthermore, an account of existing evaluative research will be presented which demonstrates some encouraging results. The constructs by which MBCT has been evaluated to date include; experiential avoidance, learned resourcefulness, social adjustment, mindfulness, awareness, acceptance and service contact. Furthermore, this presentation will consider areas for future research, specifically the constructs by which therapy should be targeted and evaluated. These include the concepts of time and spirituality in bipolar disorder and an introduction to the clinical implications of these aspects of experience will be discussed.

Cognitive Behaviour Therapy in Bipolar Disorder II: Cognitive Processes at the Heart of Bipolar Disorder

Convenor & Chair: Steven Jones, University of Manchester

Feasibility of training Care Coordinators to offer Enhanced Relapse Prevention for Bipolar Disorder

Fiona Lobban, Richard Morriss, Peter Kinderman, Carol Gamble, Bill Sellwood, University of Liverpool

Bipolar Disorder (BD) is a common and severe form of mental illness characterised by repeated relapses of mania or depression. Recurrence rates are high at around 50% at one year and 70% at four years (1,2). Pharmacotherapy is the main treatment currently offered, but this has only limited effectiveness (3). Surveys of patient organisations in the US and UK reveal a strong wish by patients for both self-help and psychological treatments in addition to pharmacotherapy (4,5). One form of intervention is to teach patients with BD to recognise and manage early warning signs (EWS) of mania and depressive episodes. This approach was effective in increasing the time to the next manic episode and improving social function, but has no impact on depression (6). In this study we have developed an Enhanced version of Relapse Prevention (ERP). The key enhancements include an increased focus on strategies to manage EWS of depression, involving a relative / friend, and providing a structured manual

that can be offered in six sessions by Care Coordinators, thus increasing availability within the NHS. The approach relies partly on quick responses by Community Mental Health Teams to changes in patients' symptoms and therefore the intervention must be offered by the team as a whole, rather than by individual Care Coordinators. Once trained, these teams would be unable to offer treatment as usual. Thus in order to assess the effectiveness of the intervention, a large cluster randomised controlled trial (RCT) is needed. The aim of this study is to gather information necessary for the design of such a trial. This presentation will cover the background, design, intervention, main hypotheses and interim results for this study. Final outcome data will be available at the end of the study in 2006.

Social rank and mood variation in bipolar difficulties

Paul Gilbert, University of Derby

Social rank theory suggests that mood variation is linked to cognitive, affective and behavioural systems, that evolved for the regulation of interpersonal behaviour within a hierarchical context. This paper will give a brief outline of the theory and then report on a study on the variation of social cognition related to rank in bipolar difficulties.

A cognitive approach to understanding bipolar symptoms

Reid, G. S., Impact Early Psychosis Service, Bolton, Salford & Trafford Mental Health Trust

In this paper, a cognitive approach to the understanding of bipolar symptoms is outlined. This approach focuses on the interpretation of intrusions into awareness as indicating impending depression. It is argued that the nature of these interpretations is affected by specific beliefs about affect and affect regulation. It is also argued that emotional dysregulation associated with the diagnosis may be maintained by cognitive, behavioural, affective and physiological responses to such interpretations within the context of beliefs about affect and affect regulation. Empirical evidence from several studies of cognitive processes that test specific predictions of this cognitive approach will be summarised. The clinical implications of this approach will be discussed.

Family relationships and cognitive styles in Adolescents from Bipolar families.

Jones, S., Vance, Y, Espie, J & Tai, S. University of Manchester

Children of bipolar parents are at elevated risk of developing bipolar disorder adults. However, as yet we know little about what risk-factors might differentiate these children from children of healthy parents. This study explored parenting styles in 23 bipolar parents and 24 controls. It also explored adolescents' perception of family atmosphere and their report of attributional styles and interpretation of symptoms in 23 children of bipolar parents and 24 control children. Results from this study suggest that bipolar parents tend to provide more negative feedback and exercise more negative control. Children of bipolar parents also report their parent as less expressive than controls. Attributional styles were similar in both child groups. However, rates of affective symptomatology were higher in children of bipolar parents. These results will be discussed in the context of current research programmes exploring candidate risk factors for bipolar disorder.

The BOScot findings: A randomised controlled trial of cognitive behaviour therapy for borderline personality disorder

Convenor: Davidson K, Psychological Medicine, University of Glasgow

Chair: Tata P, CNWL Mental Health Trust, London

Trial rationale for trial, method and description of sample.

Davidson K.1, Tyrer P.2, Norrie J.6, Palmer S.5, Gumley A.1, Tata P.3, Millar H.1, Drummond L.1, Seivewright H.2, Murray H.4, Atkins C.1, Hepburn E.1, Macaulay F.1. 1. Psychological Medicine, University of Glasgow. 2. Imperial College, London 3., CNWL Mental Health Trust, London 4. Robertson Centre for Biostatistics, University of Glasgow 5. Centre for Health Economics, University of York 6. Centre for Healthcare Randomised Trials, University of Aberdeen

We present the rationale for a randomised controlled trial, comparing cognitive behaviour therapy in addition to treatment as usual with treatment as usual alone, for borderline personality disorder. We will discuss the pioneering randomised controlled trials of psychotherapies, their methodological weaknesses and strengths. We will describe the recruitment and randomisation, design, and conduct of the now completed randomised controlled trial of one hundred and six patients with borderline personality disorder. All patients randomised to CBT + TAU received up to 30 sessions of CBT in 12 months. The baseline characteristics of 106 patients meeting diagnostic criteria for borderline personality disorder will be described.

BOScot results

Davidson K.1, Tyrer P.2, Norrie J.6, Palmer S.5, Gumley A.1, Tata P.3, Millar H.1, Drummond L.1, Seivewright H.2, Murray H.4, Atkins C.1, Hepburn E.1, Macaulay F.1. 1. Psychological Medicine, University of Glasgow. 2. Imperial College, London 3., CNWL Mental Health Trust, London 4. Robertson Centre for Biostatistics, University of Glasgow 5. Centre for Health Economics, University of York 6. Centre for Healthcare Randomised Trials, University of Aberdeen

Our primary and secondary hypotheses and their planned analyses were stated at the outset of the trial and before we were unblinded to the data. We present the primary outcome of the trial – a composite of the number of episodes in the two years after randomisation of in-patient psychiatric hospitalisation, A&E contacts and attempted suicides and time to event for these three primary outcomes. We also present secondary outcomes, that is, measures of mental state, social functioning and quality of life.

Cost effectiveness of the BOScot trial

Davidson K.1, Tyrer P.2, Norrie J.6, Palmer S.5, Gumley A.1, Tata P.3, Millar H.1, Drummond L.1, Seivewright H.2, Murray H.4, Atkins C.1, Hepburn E.1, Macaulay F.1. 1. Psychological Medicine, University of Glasgow. 2. Imperial College, London 3., CNWL Mental Health Trust, London 4. Robertson Centre for Biostatistics, University of Glasgow 5. Centre for Health Economics, University of York 6. Centre for Healthcare Randomised Trials, University of Aberdeen

We present the results of an economic evaluation to determine the cost-effectiveness of cognitive behavioural therapy plus treatment as usual compared with treatment as usual alone, for patients with borderline personality disorder. Data will be presented on secondary health care utilisation including inpatient, outpatient and day-patient services collected directly from hospital records. Additional economic data will also be presented based on patient self-report (e.g. primary care use, patient costs). We will also present results for the primary outcome measure for the cost-effectiveness analysis - the quality-adjusted life year (QALY) assessed using the EuroQol (EQ-5D) instrument for measuring health related quality of life. The uncertainty surrounding the cost-effectiveness estimates will be demonstrated using cost-effectiveness acceptability curves.

Bringing Mindfulness-based Approaches to Clinical Practice

Convenor and Chair: J.M. Hutton, South London and Maudsley NHS Trust

Mindfulness Based Cognitive Therapy for Obsessive Compulsive Disorder.

Speckens, A.E.M. & Wragg, S., Department of Psychology, Institute of Psychiatry, London and Ruths, F.A., South London and Maudsley NHS Trust

Cognitive behavioural therapy of obsessive compulsive disorder involves challenging the misinterpretation of intrusive thoughts by allowing intrusive thoughts to come and go without reacting to them (Salkovskis, 1991). Mindfulness based cognitive therapy involves a similar process of non-judgmental awareness of the present moment, including any thoughts people may have (Kabat-Zinn, 1990). The aim of this pilot study was to examine the feasibility and acceptability of mindfulness based cognitive therapy for obsessive compulsive disorder. Five patients who had previously been admitted to a specialist inpatient unit for cognitive behavioural treatment of their obsessive compulsive disorder were included in the study. The treatment consisted of 8 weekly sessions, daily homework exercises and two follow-up sessions and was based on the mindfulness based cognitive therapy programme as described by Segal, Williams and Teasdale (2002). Standardised measures of obsessive compulsive symptoms, depression, anxiety and mindfulness were administered every session. One patient did not really engage with the programme and missed four sessions. The others attended all sessions. The mean time spent on homework each week was slightly more than 3 hours. For two patients, the obsessive compulsive symptoms decreased over the course of the treatment and for one patient they increased. There weren't any great changes in depression and anxiety. There was a clear increase of mindfulness in one patient, particularly in terms of being able to tolerate and being less judgmental of his thoughts.

Mindfulness for Voices and Paranoia; A Group CBT for Psychosis

Katherine Newman Taylor & Paul Chadwick, Royal South Hants Hospital, Southampton, Hampshire

Recently there has been much interest in developing and testing cognitive models of psychosis. Both voices and paranoia have been formulated as internal experiences that can be associated with cognitive and behavioural responses that lead to considerable distress. At the same time, theories of metacognition suggest that mindfulness is an effective way of stepping back or 'decentering' from internal experience to disrupt habitual cognitive routines (e.g. rumination and worry) that result in depression and anxiety. This research assessed the application of mindfulness with voices and paranoia in a group treatment setting. It was hypothesised that the practice would reduce affective and behavioural disturbance associated with distressing voices, thoughts and images. Mindfulness was conceptualised with participants as an alternative cognitive response to distressing events. Group members were taught grounded mindfulness of the breath, and invited to practise the skill over the period of treatment. The aim was to facilitate participants' ability to adopt a mindful attitude to voices, thoughts and images in order to reduce the distress and disability associated with these internal experiences. Data from the groups will be presented.

Clinical perfectionism in obsessive compulsive disorder

Speckens AEM, Institute of Psychiatry, London and Roz Shafran, University Department of Psychiatry, Warneford Hospital, Oxford

Clinical perfectionism is a common trait of patients with obsessive compulsive disorder (OCD). The aim of this study was to examine the prevalence of clinical perfectionism in patients with OCD, whether clinical perfectionism changes with cognitive behavioural therapy for OCD and whether it is associated with a worse treatment outcome. The study population consisted of 49 patients with OCD who were admitted to the Inpatient Cognitive Behavioural Therapy Unit of the South London and Maudsley NHS Trust between January 2004 and January 2005. The mean scores on a perfectionism questionnaire at admission were 11.6 (SD 6.6), which is higher than control subjects but lower than, for example, patients with eating disorders. Patients with OCD who were diagnosed with obsessive compulsive personality disorder had significantly higher scores on perfectionism than those who were not. Although obsessive compulsive symptoms, relationship problems and low self esteem significantly improved with treatment, perfectionism did not. Perfectionism was also predictive of a worse outcome, independent from severity of obsessive compulsive symptoms at baseline.

Mindfulness and Cognitive Therapy: Compatible or Contradictory?

Anna Solly, West London Mental Health Trust

Mindfulness practise has been incorporated into an increasing number of clinical treatments that, amongst others, include the treatment of chronic pain and borderline personality disorder. So successful, applicable and accessible has it been that its use is burgeoning into many other diverse areas of practise. Mindfulness has been explicitly linked to cognitive therapy in relapse prevention for depression to provide a new treatment called 'mindfulness based cognitive therapy'. The two approaches are united into one treatment but are they compatible or do they stem from radically different perspectives? Mindfulness encourages 'accepting' and 'letting go' of thoughts whereas cognitive therapy's emphasis is on identifying meanings, interpretations and beliefs and working on the content of distressing thoughts. I will put forward what I see as fundamental differences between these two approaches. I will also provide an example of potential conflict that can result in clinical practise when the two approaches don't always sit comfortably together. For example, using mindfulness in treating borderline personality disorder as well as schema focussed therapy.

Open Papers

Psychological treatment in Diverse Groups

Chair: Christine D'Netto, Milton Keynes PCT

Help seeking behaviour of patients attending psychiatric Department at Al-Ain Hospital, UAE

Salem MOM, Attia H M and, Yousef S, UAE university

Introduction: The pathways to psychiatric care are diverse, as a substantial number of patients suffering from psychiatric disorders seek non-professional care. A wide range of agencies including traditional healers, faith healers, GPs, psychologists, and psychiatrists cater to the needs of mentally ill patients. **Method:** This study was a descriptive cross-sectional epidemiological survey conducted at Al-Ain. Al-Ain is a big town in UAE with a total of 300,000 population. All new patients attending the psychiatry outpatient clinic at Al-Ain Hospital, and all patients admitted to the psychiatric ward of the same hospital were screened for 8 consecutive months starting from March - November 2003. Those who gave their consent to participate were taken up for the study. The data-collecting instruments used was a questionnaire, devised for the purpose of this study, aiming at exploring the different agencies attended before presenting to the psychiatric service, and from different aspects. **Results:** Sample consisted of 106 patients, 52 males, and 54 females. 44.3% Consulted Faith Healers before presenting to the psychiatric service, 31% of whom had a previous experience with them. 22.6% improved but their symptoms recurred later, 23.6% reported no improvement, while in 3.8% their symptoms worsened for the current episode. Treatment received was herbal (34%), and prayers (60.4%). 43.4% of the sample consulted a Primary Care physician only, before presenting to the secondary psychiatric care. **Discussion:** The findings in this study are consistent with previous studies in other countries. In one study on USA population, it was concluded that religious faith in healing is prevalent and that most people believe that God acts through doctors. Traditional and faith healers were found to be a major source of care for people with mental health problems in Pakistan, Ethiopia, and Turkish communities in other studies. **Conclusion:** Psychiatrists are preferred the least due to stigma. Psychiatric illness is often accompanied by social stigma, leading to tendency by the sufferer and his family to hide the problem and avoid psychiatric treatment. Instead they might prefer to approach the alternative therapy provider. Also, non-medical causes are attributed to the aetiology of mental illness in some cultures, making it more logical for them to seek help from other non-medical facilities. So, different factors operate in the decision-making process in choosing the preferred agency consulted. Physicians need to be sensitive to patients' beliefs about faith and healing, and must know why patients sometimes reject medical treatment. Fortunately, many patients combine traditional healing practices with conventional medicine therapies and rarely perceive conflict between them.

A consideration of the methodological and conceptual factors in understanding what may lead people to jump to conclusions

Dudley, R, Grevetts, C, Freeston, M. University of Newcastle upon Tyne

People with delusions have been reported to jump to conclusions. In essence they make decisions on the basis of less evidence than other people without delusional beliefs. The exact explanation for this characteristic reasoning style has not been well explored. One theory for why people with delusions jump to conclusions postulates that people with delusions are applying normal confirmatory reasoning

processes to inappropriate situations. In contrast people with obsessive compulsive disorder are thought to demonstrate an opposite style, and are particularly cautious in their reasoning style owing to having a disconfirmatory reasoning style. In this presentation we will review the results of meta-analysis incorporating the results of previous research to help us understand the strength of the relationship between jumping to conclusions and delusional, and obsessional beliefs. Then we will present the results of two studies run with non clinical participants. In study 1 (N= 140) participants completed measures of delusional ideation (PDI), obsessional ideation (Padua), a person's need for closure, threat perception and level of anxiety, and as well as two trials of the beads task (at a 60:40 ratio, or difficult to discriminate task). Multiple regression analyses were used to investigate the factors that would best predict JTC. A non-significant model emerged, and it was felt that this could have been due to methodological issues concerning how data was collected from the beads task, whereby participants were required to respond in a manner that revealed how many beads they would see before they needed to make a decision. This led to the participants waiting to a point of seeing 20 beads which is a very uncharacteristic reasoning style. This methodological issue was addressed in study 2. Here non clinical participants (n=70) completed the same measures as before but used a different response sheet. This produced a significantly earlier decision than in study 1 indicating that the methodological manipulation had the desired effect. We then ran a regression as in study 1. While a significant model emerged, delusional ideation only predicted JTC when coupled with the measure of OCD. This was actually a negative finding in that the higher the non clinical delusional beliefs, the more beads were viewed prior to a decision being made. This is the first time such as result has been reported. The methodological and theoretical explanations for these findings are explored.

Use of Dolls in the Treatment of Challenging Behaviour in Dementia

James, I., 3 Ns Mental Health NHS Trust, Newcastle; Mackenzie, L. 3 Ns Mental Health NHS Trust, Newcastle; Morse, R. University of Newcastle upon Tyne

Introduction: Over the years, a number of psychological strategies have been developed to treat residents displaying challenging behaviours. Many of those strategies are aimed at 'acting out' behaviours (aggression, wandering, disinhibition), as these tend to cause the greatest difficulties to staff in institutions. However, 'non-active' challenging behaviours (withdrawal, unresponsiveness), which may be associated with depression, have received little attention. A potentially useful approach for both 'acting-out' and 'non-active' presentations is Doll Therapy. This intervention has been utilised with people suffering from dementia who are agitated or distressed, have communication difficulties, or are withdrawn. Up until now, however, Doll Therapy has been employed rather inconsistently, as there are neither empirical studies nor published manuals concerning its use. Method: Given increasing anecdotal evidence for Doll Therapy, but lack of empirical evidence, staff in the Newcastle Challenging Behaviour Service at Newcastle Centre for the Health of the Elderly decided to systematically investigate the impact of dolls. The study employed a post-hoc analysis with a questionnaire devised for the investigation. Results: Dolls were used by 14 residents in two care homes; the views of 46 carers regarding the impact of the dolls were assessed. The findings of the study were positive for both residents and carers. All carers, apart from one, felt that there were clear benefits in using the dolls. Six areas were monitored specifically: resident interaction with carer; interaction with other residents; level of activity; happiness/contentment; amenability to care interventions; and agitation. Care staff noted that improvements were apparent in all of these areas. Discussion: While acknowledging the success of the approach, there are evidently ethical concerns about the use of dolls. One of our concerns is whether the approach is 'person-centred'. Indeed, it could be argued that the intervention involves 'infantilizing' the individual and does not pay sufficient respect to the residents' status, skills and personal histories. This clearly needs to be examined. In addition, there are also practical problems associated with using dolls. For example, in our study arguments occurred between some residents over ownership of the dolls

An innovative exploratory use of Cognitive Therapy for OCD sufferers working in groups

D'Netto, CM; Healy, N.; Price, L.; Fairchild, H. Milton Keynes PCT

A group treatment format was used for the cognitive therapy treatment of OCD sufferers in outpatient community setting. Clients range in age from 19 to 61, all had co-morbidity problems and Axis 1 disorder for OCD. All were on anti-depressant medication with a mean five-year history. Method: An introductory meeting was held in which the twelve-session group programme was outlined. Reading material was available and ex-service users were present to feedback experience. All referrals to the Clinical Psychology Service were invited. All had been seen by team members or primary care staff in advance. Individuals were given the choice to attend if they felt they might benefit from the outlined programme. Pre/post-treatment measures included: 1) Maudsley Obsessive Compulsive Inventory Beck Anxiety Inventory 2) Yale Brown Obsessive Compulsive Scale 3) Quality of Life Measure (St Georges' Hospital); unreferenced 4) Foa's Checklist of OCD Categories (Foa and Kozak, 1997) Co-therapists ran the group each week. Three and six monthly follow up was offered. An anonymised client satisfaction scale was undertaken. Content included: psycho-education, explanation of the CBT

model (Wells and Salkovskis (1985), Wells and Mathew's ,(1994) and Wells (1997), behavioural experiments, response prevention and exposure, the physiological role of anxiety, core beliefs, managing thoughts, planning for setbacks. We added cognitive elements to the programme. (Vogel, Stiles and Götestam, 2004). Each session was structured, used exercises, flip charts and handouts. Post treatment, individual work focused on persistent symptoms. Results: A total of 37 people were seen. Retention rate for completion was 20 (54%) at session 12. T – tests were performed on the MOC and the quality of life measure. This showed a non-significant result at $p > 0.05$. Qualitative outcomes showed 50% improvement in control over obsessions. There was significant missing data. User feedback identified the most helpful components to be: the support of others, information, friendship, coping strategies, modifying beliefs of threat and responsibility. Positive change centred on a new cognitive “mantra” –“ you have CHOICE, it is just a thought”. Discussion: Group support had a powerful role in maintaining attendance, motivation and hope. Behavioural experiments were done in pairs. The programme has been an effective use of scarce clinical resources. Individual follow-up resulted in a marked reduction in compulsive rituals. Conclusions: The work is in progress. There are significant co-morbidity problems, which require further modification in this chronic population. The powerful ‘normalising’ effects of the therapists in promoting motivation, including; a fine balance between giving supportive direction, empathic engagement, humour and limited self-disclosure needs further investigation.

Posters

Poster Session 1: Clinicians’ Cognitions and New Therapy Approaches to Challenging Behaviour and OCD

Study of Knowledge and Attitude Changes After an Introductory Session of CBT in a Mental Health Setting .

Rao S, County Durham and Darlington Priority Services NHS Trust, Postma K, Newcastle Primary Care NHS Trust, Jackson K, County Durham and Darlington Priority Services NHS Trust

Introduction: Cognitive Behaviour Therapy (CBT) has been recommended in an evidence-based guideline published by the Department of Health and the National Institute of Clinical Excellence has recommended CBT several disorders. Therefore it is contextual to develop and assess models of CBT training. Methods: This study was designed to assess the change in attitude, confidence and knowledge after half day introductory workshop on CBT. The package covered basic concepts of CBT like formulation, cognitive and behavioural theories along with a brief over view of change techniques. The taught concepts were accompanied by exercises based on clinical case materials. The participants applied for the CBT workshop through an intranet email advertisement within the mental health trust. 47 applicants attended the course and 42 filled in the questionnaires related to the course. Two types of questionnaires were used. The first questionnaire was administered before and after the course. It assessed subjective ratings of the participant on a scale of 0-10. The areas assessed were confidence in CBT skills, utility of CBT in their practice and theoretical knowledge of CBT. The second questionnaire was a standard feedback form regarding the course (content, presentation, exercises) with space for comments. Results: The response rate of questionnaire was 89% making it representative of people attending the workshop. Past experience of CBT training was low in this group: on a 1-10 scale the responses were either 1 (74%) or zero 0 (24%). Improvement in subjective knowledge scores was statistically significant (wilcox signed rank test $p = 0.0001$) with a median change of 2.5 (CI= 2-3). Confidence in the use of CBT skills also showed a statistically significant change (Wilcox signed rank $p = 0.0001$) with a median change of 1.5 (CI 2-1.5. Change in attitude about utility of CBT showed an upward trend, which was statistically not significant. Subjects scoring 5 or less on knowledge score were more likely to have greater than 2 point increase in knowledge compared to those scoring above 5 (fisher’s test $p = 0.01$). Previous knowledge of CBT had a modest correlation with confidence scores (Kendal’s Tau $b = 0.66$, $p = 0.0001$). However change in knowledge correlated poorly with change in confidence (Kendal’s Tau $b = 0.39$, $p = 0.003$) indicating that improvement in knowledge did not lead to comparable increase in confidence. Baseline scores on knowledge did not correlate well with utility scores (Kendal’s Tau $b = 0.25$, $p = 0.11$). In other words participants attitude about usefulness of CBT were not influenced by their knowledge of CBT. Quality of presentation was as ‘high’ by 80% of the participants although 100% felt that the presentation was appropriate. 91% considered the exercises relevant although high ‘relevant’ scores were awarded by 57%. 64% considered the session length as ‘just right’ whereas 27% found it too short

The Effects of Diagnosis and Therapy Non-Compliance Attributions on Alliance Processes in Acute Psychiatric Settings.

Angus Forsyth, Newcastle, North Tyneside & Northumberland NHS Trust

Introduction: To investigate the effects of the diagnoses of Borderline Personality Disorder and Major Depressive Disorder and causal attributions for clients who fail to complete a therapy task, on mental health nurses' ratings of anger, empathy and helping behaviour. Method & Design: Utilising a 2x2x2 factorial design, eight vignettes were constructed and contained a combination of controllable/uncontrollable and stable/unstable attributional dimensions for clients who fail to complete a therapy task. The diagnoses of Borderline Personality disorder and Major Depressive Disorder were added to the vignettes to determine whether diagnoses affected alliance factors. Mental health nurses were asked to read the vignettes and complete a 15 item modified Empathy Questionnaire (Burns & Nolen-Hoeksema (1992) for each vignette. Results: 26 mental health nurses participated in the study and interaction effects were found for anger reactions, which were related to attributions of controllability. Nurses also had more helping for the diagnosis of major depressive disorder compared to borderline personality disorder. There was also an interaction effect between helping and attributions of stability. There was no significant difference between empathy and helping. Discussion: The finding in this study that diagnosis had an effect on helping was not reported or measured in the earlier studies on attributional research. The effects of increased anger and reduced helping may have implications for the therapeutic alliance with complex clients. Diagnosis may be a possible explanatory mechanism that mental health nurses' use to make sense of their emotional reactions and the client's presentation. Conclusions: Results show some support for Weiner's (1980) model of helping behaviour, which is negatively effected in controllable/stable dimensions and in the diagnosis of Borderline Personality Disorder. The importance of a model of supervision which focuses on the attributional framework used by nurses to explain behaviour of mental health clients is discussed and the role of case conceptualisation is explored as an approach to mediate these reactions.

Formulating Delusional Beliefs From a Cognitive Therapy Perspective: The Effects of Disorder Specific and CBT-specific knowledge.

Park, I. Dudley, R., James, I., & Dodgson, G.

The scientific basis of formulation is under researched, particularly in psychosis. This study considered whether clinicians can produce reliable formulations of an individual's psychotic beliefs. It also explored whether the ability to reliably formulate is dependent on qualifications and experience. Eighty-two clinicians were shown a video vignette of an individual presenting with delusional beliefs, and were asked to provide case formulations using a CBT template. Agreement with a benchmark formulation provided by a panel of three experts was measured, using detailed scoring criteria. A reasonable level of reliability was observed especially for overt behaviours, emotions, and some aspects of early experience, although reliability was weaker for the theory driven or inferential components such as core beliefs, or assumptions. It was demonstrated that greater clinical experience in general improved the reliability of formulations overall, and greater CBT specific experience improved formulation of the inferential items. The more experience a person had of working with people with psychotic illness had a negative relationship with the reliability of formulations. The implications for training in CBT and psycho-social interventions are considered.

How Could the Theory of Planned Behaviour Affect the Outcome of Screening Assessments in an Adult Psychology Service.

Sinha, A (University of Newcastle upon Tyne) & Stace, J (South of Tyne & Wearside Mental Health NHS Trust)

The demand for adult mental health psychology services in the UK is high, which results in long waiting lists. The problem is heightened by inappropriate referrals, and by patients having unrealistic expectations of what 'talking therapy' can offer them. A 'Triage System' for screening and assessing patients referred to the Adult Psychology department in Sunderland was introduced in 2001. All patients are offered an initial ('triage') assessment appointment, within a target of 6-8 weeks of referral. The purpose of this meeting is to check whether the referral is appropriate to the service, if the person is likely to benefit from therapy (and from what kind), or whether they need to be referred elsewhere. If a patient is then accepted for therapy they are placed on the waiting list for treatment (which is currently more than a year long, although patients at risk can be seen sooner). Because of the length of the waiting list, attempts are also made to help patients engage in appropriate self-help or stepped care whilst they are waiting. This piece of research seeks to evaluate whether the Triage System is meeting patients' needs and expectations. The project explores whether or not people act on the advice they are given at Triage, whether it was useful and how it might be improved. Health research has explored factors that influence people's health behaviour choices; knowing these factors can enable health professionals to help patients change their behaviours. The Theory of Planned Behaviour (Ajzen, 1991) is a model used to research change in people's behaviour. It has been widely used by health services in

the field of smoking cessation and can be applied when looking at other health behaviours. At Triage, clinicians could be using components of this model to inform the outcome of the session and to influence what advice is given. At the time of writing, the project is on-going. A series of semi-structured qualitative interviews is being conducted with patients on the waiting list for treatment, asking about experiences and opinions about triage, and whether they took any of the advice they were offered. Questionnaires will be completed to assess any changes in circumstances since triage. The results of this exploratory study will be considered in the light of the Theory of Planned Behaviour, and practical suggestions will be offered to clinicians as to how they might make their triage sessions more useful to their patients

An Investigation of the Impact of Self-representations on the Interpersonal Problem-solving of Carers Working with Individuals with a Learning Disability and Challenging Behaviour.

Manning J, Ridgeway N and Adams M, University of East Anglia

Aims and background of this study. Possible-selves are suggested to be developed through mental simulation, and have been linked to personal control, affect, optimism and competence (Markus & Nurius, 1996). Although clear clinical potential for the use of possible-selves had been highlighted, very few experimental studies have examined the direct impact of inducing possible-selves. In order to further research in this area, this study attempted to discover whether the induction of a positive self-representation would provide an experience of more improved problem-solving than the use of an everyday-self representation, on interpersonal problems experienced by carers working with individuals with a learning disability and challenging behaviour. Design/method. This study used a mixed-design. There were two levels of imagery induction - future most resourceful-self (FMRS) imagery versus everyday-self (EVS) imagery and two levels of order - order 1 (FMRS then EVS) versus order 2 (EVS then FMRS). A comparison of carer self-reports after problem-solving with each self-representation was made for affect, self-efficacy, attributions of control, solution outcome ratings, and dysfunctional attitudes. Results. Analyses of results indicated that carers generally reported more positive responses after problem-solving with a FMRS representation than after problem-solving with an EVS representation. Discussion. Results of the study are discussed in terms of possible-selves, self-schemata, and models of information processing. Following this, arguments are raised for the potential clinical integration of possible-selves frameworks with commonly used therapeutic approaches such as cognitive and behaviour therapy.

DSPD Unit, HMP Whitemoor: The Development of Schema-focused Therapy Groups.

Stirling, J. & Talbott, T., DSPD, HMP Whitemoor

Background information: The Dangerous and Severe Personality Disorder (DSPD) Unit at HMP Whitemoor, is part of a pilot project which is aimed at evaluating the delivery of services specifically for people who present a high risk of committing serious offences as a result of a personality disorder. The intervention at HMP Whitemoor is based on cognitive interpersonal models and involves both one-to-one and group based sessions. One of the group based interventions currently in development is a schema-focused therapy group. This is based on the work of Jeffrey Young (Young et al., 2003). Development of groups: The literature relating to schema-focused therapy groups is presently limited. The group is, therefore, being developed on the basis of existing literature and clinical experience within this area. In addition, factors pertinent to this population are also being considered, these include group attendance, differing levels of ability and issues relating to individual's psychopathology. The schema-focused therapy group is divided into three phases: psychoeducation (teaching about what schemas are, how they are developed and how they are maintained); formulation (identification of group members own schema); intervention (use of a variety of strategies to challenge existing schema). Way forward: The aim is to pilot the schema-focused therapy group with all groups currently on intervention. A particular focus as part of this pilot will relate to evaluation.

Attacking the Shame in OCD.

Katherine Wright, South West Yorkshire Mental Health Trust

Introduction: Shame has been acknowledged as a powerful developmental and maintaining factor in psychopathology for over twenty years, but does not appear to have been incorporated into CBP models and treatments. Reflecting their behaviourist origins, these models and treatments have tended to highlight fear at the expense of other emotions, and in addition, shame has often been confused with guilt. In OCD in particular, an inflated sense of responsibility for causing harm is ascribed solely to guilt (Salkovskis 1985.) This study sought to develop new definitions of guilt and shame and to use these to demonstrate that shame is a powerful factor in OCD. Clinical and research implications were explored. Method: A literature review was carried out to test the hypothesis that there is empirical evidence that shame is linked to a wide range of pathologies, and that it has been overlooked in models. The review also enabled the development of new definitions of shame and guilt. These were used to re-analyse the automatic thoughts of OCD patients in case studies presented by Salkovskis. Additionally, fresh clinical

data was analysed in the same way. Results: The literature review revealed substantial empirical evidence to support the hypotheses. New definitions of shame and guilt were developed by integrating evolutionary (Gilbert 2003,) and Rational Emotive Behaviour Therapy (Dryden and Yankura 1993) models. These definitions took from sociobiology the idea that emotions have developed because they have been selected for to increase reproductive fitness. Shame is seen as facilitating social ranking behaviours, and guilt as facilitating affiliative, caring behaviours. Shame is allied to powerlessness, fear, self focus, and concealment. Guilt on the other hand is allied to capability, remorse, other-focus and reparation. These definitions were modified by the REBT conceptualisation that both guilt and shame are driven by inflexible beliefs, and have healthy counterparts (remorse and regret) which are not. The new model defined guilt-remorse and a shame-regret continua. It appeared that evolutionary models may fail to distinguish between guilt and remorse, and between shame and regret. But powerlessness, self focus, fear and concealment still distinguish shame from behaviours along the guilt-remorse continuum. Analysis of patients' automatic thoughts using these distinctions showed it is mostly shame rather than guilt which is driving an inflated sense of responsibility in OCD. Discussion And Conclusions: As long as current OCD treatments continue to fail many patients, it is important to refine models and treatments. There are several theoretical and treatment implications raised by the findings in this paper. Firstly, there is good evidence that guilt and shame arise from different developmental factors. Possible origins of the shame behind inflated responsibility are discussed. And the maintaining influence of shame in OCD can now be examined. It is suggested that the client-therapist dynamic may be a source of shame. Group work may reduce shame. Treatments targeted specifically at reducing shame may be useful additions to traditional ERP and cognitive therapy. Principle among these is REBT 'shame attacking' or graded exposure to shame experiences. These are all areas for future research.

Emotional Reasoning and Inflated Responsibility for Harm in OCD: A Matter of Guilt and Regret.

Postma, K & Freeston, M, 3Ns Mental Health NHS Trust, Newcastle upon Tyne

The literature suggests that inflated responsibility for harm to self or others is a core theme in OCD. For example, Salkovskis' (1985) model of OCD suggests that the perceived meaning of an intrusive thought (e.g. 'I am responsible for what happens next') is what makes an individual act on it (e.g. 'I should prevent harm occurring'). This perceived personal responsibility for outcome has been found to be a useful target of therapy for OCD. However, effect sizes of both cognitive and behaviour therapy for OCD are moderate at best (Deacon & Abramowitz, 2004). This suggests that the essential treatment targets in OCD, and the correlations between variables that play a role in its maintenance, may still be incompletely understood. Recently, links between responsibility beliefs and emotions, in particular guilt, in OCD have been found (Robinson, Maisey, & Freeston, in preparation). The authors used OCD relevant scenarios in an analogue population. Wroe & Salkovskis (2000) found that people show more obsessional behaviour and feel more responsible when they fear harm occurring following their conscious decision not to act to prevent the harm. However, no discussion on the difference in emotional response linked with a sense of responsibility for harm to self or others in OCD has taken place. From the social psychology literature it appears that there is an association between perceived harm to self and to others and the emotions of regret and guilt respectively (Berndsen, Van der Pligt, Doosje, & Manstead, 2004). This study aimed to investigate whether such links exist in situations relevant to OCD as well. To do so, a replication and extension of Berndsen et al. (2004)'s study was carried out with OCD-relevant scenarios. Participants were 1st year psychology students in the Northeast of England. The task was developed from three main sources, namely, Berndsen, Van der Pligt, Doosje & Manstead (2004), Rheaume, Ladouceur, Freeston, & Letarte (1995) and Robinson, Maisey, & Freeston (in preparation). Participants were presented with scenarios describing different levels of harm and vignettes describing different consequences of harm to self and others. They were asked to imagine themselves in the described situations and to rate their response on a range of items, including guilt, regret, responsibility, pivotal influence and seriousness of the consequences to self and others. The results of the experiment show a partial replication of Berndsen et al. (2004)'s findings in OCD-relevant scenarios for the link between guilt and seriousness of harm to others. This confirms a link between perceived threat to others and the emotion of guilt and suggests that guilt is potentially a useful target in the treatment of OCD. The link between regret and seriousness of harm to self was not replicated and no significant links were found between responsibility and perceived threat of harm to self or others.

Mobile Phones within Mutual-Help Groups: A CBT Vehicle for Relapse Prevention?

Kelley, M.J. and Campbell, S.W.; Hawaii Pacific University

We have commenced a program to investigate the use mobile phones by mutual-help groups, with a long-term plan to reduce relapse by enhancing the structure and content of such within-group communications with interventions from cognitive behavioural therapy (CBT). The central thesis is that use of mobile phones is 1) associated with process & outcome measures in these groups indicative of a positive influence, and 2) that the applications of CBT theory can be added to experimentally test how the content/structure of the mobile-phone communications might be modified to improve relapse

outcomes in mutual-help groups. Because Alcoholic Anonymous (AA) is currently the most pervasive form of mutual-help group, we commenced our exploration of mobile-phone use with a psychometric survey of some members. While this is convenient for starting this research program, we do not anticipate that AA groups will be the optimal format for the experimental phase of our investigations. This is because the AA traditions of non-alliance with outside groups and the rigid structure of content/process (12 Steps) will likely preclude any long-term constructive cooperation with a systematic experimental approach involving a CBT interface with AA. Our poster will focus on some of our current psychometric findings. Perhaps by July, we may be able to provide some pilot data on an experimental approach. Below is a brief descriptive summary of some of our preliminary findings using a 5-point Likert-format survey of some AA members from several groups on the island of Oahu in Hawaii. Eighty-nine percent ($n = 91/102$) of the mobile-phone users agreed or strongly agreed with the statement, The mobile phone is a helpful tool in the recovery process. In fact, 73% ($n = 74$) strongly agreed with this statement, while only 2% ($n = 2$) either disagreed or strongly disagreed with it. The mean score for this item was very high at 4.58/5.00 ($SD = .81$). A second question examined the extent to which mobile-phone owners used the technology for recovery-related purposes. On average, these participants reported that 370 of the 548 minutes (67%, $SD = 27.54$) of their total mobile-phone use was for recovery-related purposes. A third question compared mobile-phone use for recovery-related purposes to other communication channels. Participants rated face-to-face interaction the highest for recovery-related interaction ($M = 4.69$), followed by use of the mobile phone ($M = 4.38$), landline telephone ($M = 4.36$), e-mail ($M = 2.74$), and other Internet functions ($M = 2.59$). To summarize, these results reveal that these AA members regarded mobile phones as a very useful AA resource, and that they used them heavily for interactions pertaining to addiction recovery. In addition, survey participants reported heavy use of face-to-face interaction, the mobile phone, and the landline telephone for recovery-related communication, while computer-mediated communication and other channels were reportedly used considerably less for interactions pertaining to addiction recovery.

Mindfulness Based Cognitive Approaches for Acute Psychiatric Inpatients with Psychotic Symptoms: A Work in Progress.

Susan Ross, Gordon Mitchell, Robbie Bennet, Nancy Galloway, Trixy Heather NHS Fife

Bach and Hayes (2002) used a brief adapted "mindfulness" based approach with acutely ill psychotic patients (Acceptance and Commitment Therapy, ACT) in order to help individuals "de-fuse" from internal sources of distress (e.g. negative thoughts or emotions) rather than to continually avoid or disrupt these disturbing feelings. The ACT group showed no difference to the TAU group when reporting psychotic symptoms, but there was a significant decrease in related distress and believability levels. Most strikingly, they displayed a 50% reduction in re-admissions rates at 4-month follow-up. This current case series examines a similar 6 session adjunctive psychological intervention delivered by direct care nursing staff, who have received training and continued supervision. The intervention incorporates Baer's (2004) conceptualisation of mindfulness, basing the treatment sessions around the components of observing, describing, acting with awareness and accepting without judgement. Additionally we are exploring the processes that could lead to the effect reported by Bach and Hayes, looking at source monitoring, recovery styles, mindfulness, insight, self esteem and metacognition. So far we are able to report on a single case study.

Modifying the CORE outcome measure for use with people with an intellectual disability.

Marshall, K, NHS Lothian : Willoughby-Booth, S, NHS Lothian

Introduction: Self-report measures like Clinical Outcomes in Routine Evaluation (CORE) are widely used in general adult mental health services throughout the UK. There are very few reliable measures used with people who have an Intellectual disability (ID), for assessing psychological distress or measuring therapeutic outcome. The present pilot study tested the reliability of the modified version of CORE for people with mild ID. Method: The CORE was modified by a group of professionals from different specialisms working with people who have an ID. The modified CORE incorporated simplified statements with supporting symbols, and a boxed histogram rating scale. Two groups of 10 subjects completed the test-retest of the modified CORE one week apart. One group completed a sequencing task of the histogram rating scale, before completing the measure. The other group completed the measure using a binary Yes/No scale in combination with the histogram rating scale. Results: Half the sequencing group completed the sequencing task incorrectly on the first attempt. On the retest, most subjects sequenced all the cards correctly indicating that some learning had taken place. This group showed excellent test-retest reliability (0.891). The Yes/No group showed good reliability on the binary scale (0.701), but reliability with the histogram scale produced a poor correlation (0.345). Conclusion: This preliminary study demonstrates that the modified CORE showed excellent reliability when used with the histogram rating scale on its' own, and good reliability on the binary scale. Confusion arose when subjects were asked to complete a combination of a binary and histogram scale, which produced less favourable results. The modified CORE has the potential to be a valuable pan-theoretical tool for use with a population who face higher than usual levels of mental ill health and emotional distress.

Poster Session 2: Stress, Trauma and Vulnerability

A Proposal for Life Review Interview For Cancer Patients Based on Cognitive Therapy.

Ando, M. (St. Mary Junior College) and Tsuda, A. (Kurume University)

Introduction: Since about 40 % of cancer patients experience depression in Japan, some kind of support is needed. The life review interview is one of the reminiscence therapy which is effective for depression or life dissatisfaction in the elderly. Thus, we surmised that life review interviews would be useful for cancer patients, and we subsequently examined this hypothesis. Method: The experimental group composed of fifteen cancer patients who were receiving radiation treatments in a hospital, and who participated in individual life review interview once a week for about a month. The control group was composed of twenty-one patients undergoing medical treatment at a different hospital who did not receive the psychological therapy. All patients completed both the Zung's SDS for depression and Rosenberg's test for self-esteem during two testing periods, a pre-test and post-test. Results: Depression scores decreased while self-esteem scores increased significantly in the experimental group following the life review therapy session, whereas the scores in the control groups showed no change. The contents of the patients' life review were analyzed qualitatively, and it was found that life reviews were useful toward better problem solving, stabilizing identity, spiritual care development, better coping skills, increasing life satisfaction. Discussion: Life review therapy is psychologically beneficial for cancer patients. There are commonalities between life review therapy and Adjuvant Psychological Therapy (Moorey & Greer, 2000) or Problem Solving Therapy (Nezu & Nezu, 2002). Therefore, it may be possible to associate life review interview with cognitive therapy. Conclusion: Life reviews based on cognitive therapy may be one of the supports for cancer patients.

Basic Behavioural Processes in Bereavement: A DISC Analysis.

Dillenburger, K. Queen's University of Belfast & Keenan, M. University of Ulster at Coleraine

Theories of bereavement abound. The endeavour to understand this complex process has moved from intra-psychic explanations and stage theories to cognitive rationalizations and, most recently, process orientated explorations of bereavement. What has been missing in most of the literature to date is a detailed analysis of the context in which bereavement behaviours occur. Most people in Northern Ireland have been affected by bereavement in one way or another over the years. In total, over 3,600 people have been killed since 1969. In this paper, first the Northern Ireland Bereavement Study (NIBS) is described. NIBS is a long-term study of violently bereaved widows that shows that even 30 years after the loss, many still find it difficult to come to terms with their loss. This paper then outlines a contingency analysis that includes consideration for the context of Death itself, Individual factors of the bereaved, Social factors, and influences of Cultural norms and systems (D.I.S.C.). The paper concludes by proposing that a comprehensive D.I.S.C. analysis might lead to holistic evidence-based practice in helping those who have experienced bereavement

Emotional Suppression When Processing Trauma: Consequences For Mood and Memory.

Dunn, B (MRC CBU); Brewin C R, University College London CL; Dalgleish, T. MRC Cognition and Brain Sciences Unit

The thought suppression literature (e.g. Wegner et al., 1987) illustrates the costs of suppressing the cognitive content of conscious experience. A 'thought rebound' effect has been demonstrated in healthy populations and psychopathology (Purdon, 1999), whereby the harder a thought is suppressed the more likely it is to subsequently return. It is increasingly acknowledged that people try to control affect as well as cognition (e.g. Gross, 1998), but as yet the secondary consequences of different forms of emotion regulation have not been extensively studied. In particular, whether an 'emotional rebound' effect occurs following suppression of emotions while processing traumatic material has not been investigated. This poster reports results of a study examining the concurrent and subsequent impact of attempting to suppress emotion while processing traumatic information, and is intended as a preliminary investigation of whether emotion suppression contributes to PTSD like symptoms. Healthy participants were asked to watch a video trauma induction, either under emotional suppression (n = 21) or control (n = 23) conditions. The consequences of emotional suppression on mood, emotional response to novel material, episodic memory, and occurrence of intrusive memories were then measured, using self-report and psychophysiological methods. Results found that emotional suppression did not alter self-reported emotional experience, led to a more variable heart response, and did not change electrodermal response while watching the trauma induction, suggesting that emotional suppression is an ineffective way of regulating emotional experience. Subsequently, emotional suppression impaired free recall but

not recognition memory of the trauma material and had no significant effects on trauma intrusions. There was no change in self-reported experience of emotion following suppression. There was, however, increased heart rate deceleration when viewing subsequent emotional material and a slight increase in depression scores at one week follow-up, perhaps indicative of ongoing emotional costs of suppression. These findings, replicating and extending work from the normative emotion regulation literature (Gross, 1998), suggest that emotional suppression is not an effective form of emotion regulation and that it leads to some subsequent emotional and mnemonic changes. A provisional clinical implication is that clients should perhaps be discouraged from using emotional suppression as form of mood control. Further, it seems plausible to tentatively suggest that emotional suppression could contribute to the hyper-arousal and impaired recall of trauma seen in PTSD. It is important, however, to replicate and extend these findings to clinical populations to support these conclusions. While emotional suppression appears not to lead to a 'rebound' effect directly analogous to thought suppression, it does appear to have some unexpected secondary costs that could contribute to symptoms of PTSD.

Mood Affects the Fluency With Which We Imagine Future Events.

Garnsey, S. R., Barnhofer, T., & Williams, J. M. G., Oxford University Dept of Psychiatry

Introduction. This study examines the effect of mood on the processes underlying future thinking. People who judge their future as bleak or pointless become hopeless, and suicidal people report having few things to look forward to in their lives. This research tests the hypothesis that low mood decreases fluency for positive future events, and examines whether this is mediated by a mood effect on the perceived valence of anticipated events. **Method.** Two groups of healthy volunteers (N = 52) were asked to generate examples of things they were looking forward to and things they were not looking forward to in the future. This fluency task was performed before and after either a positive or a negative mood induction, using happy/sad statements and music. Participants rated each event they had generated for valence both in induced mood and at baseline. **Results.** Before the mood induction, the groups generated comparable numbers of future events. After the negative mood induction, participants reported fewer positive events than before, but showed no increase in negative events. The opposite effect was found following the positive mood induction. Mood had no significant influence on valence ratings. **Discussion.** These results suggest a differential effect of mood on accessibility of positive and negative future events which is not mediated by the process by which events are evaluated for valence. **Conclusion.** Clinical research shows that hopelessness and poor positive future fluency are central factors in suicidal depression. This study shows that such thinking patterns can be triggered by subtle shifts in mood, even in healthy samples. In vulnerable people with chronic life stress, this mechanism may have a key role in precipitating escalation into suicidal crisis

Artists Vulnerability to Psychopathology: An Integrative Cognitive Perspective.

Papworth, M. A., Jordan, G., Backhouse, K., Evans, N., Kent-Lemon, N., Morris, J. & Winchester, K. J. G.; University of Newcastle

Introduction: Cognitive theories of depression have proposed that negatively biased patterns of appraisal (e.g., overgeneralisation), escalate negative mood which can eventually result in a depressive episode. Cognitive bias has also been proposed to have a role in the aetiology of psychosis. Many highly creative individuals have been noted to suffer with mental health problems. Remarkably, there seems to be some overlap between the creative cognition or divergent thinking style found in artists, and the patterns of cognitive appraisal associated with psychological dysfunction (e.g., Papworth & James, 2003). However, surprisingly little empirical work has been undertaken to investigate the commonalities between creative cognition and patterns of appraisal associated with psychological dysfunction. The authors found no previous research investigating probabilistic reasoning bias in the artistically creative. They hypothesised that artists will perform less well on such tasks which will also, in turn, affect problem solving ability. They will also experience lower mood and higher levels of divergent creativity than their scientist peers. **Method:** Participants were young undergraduate volunteers drawn from selected degree courses: art (N=66) and science students (N=85). The following measures were administered: the Torrance Tests of Creative Thinking, the Zung Depression Inventory, the Means-Ends Problem-Solving Procedure and the Problem Solving Inventory (the latter measures self-appraisal of abilities). Basic reasoning abilities were assessed via two probabilistic reasoning tasks. **Results:** Groups were compared over each of the measures via independent sample, Analyses of Covariance which controlled for any sex effect. Significant differences were found between the samples in the hypothesised directions over: the measures of mood, ($F(1,148)=8.11, p<.01$), creativity ($F(1,148)=16.61, p<.001$), probabilistic reasoning ($F(1,148)=3.83, p<.05$), problem solving ($F(1,148)=3.47, p<.05$) and self-appraisal of solving abilities ($F(1,148)=18.29, p<.001$). **DISCUSSION:** The findings support a number of the experimental hypotheses. Students drawn from arts degrees were found to be more creative but also reported lower mood. The prevalence of psychopathology in practicing professionals has been observed to be of a level keeping with, or greater than, that observed for other acknowledged vulnerable groups. Whilst other factors will invariably be influential, the current project highlights a possible moderating/mediating role for appraisal style in the development of psychological difficulties for the

artistically creative. Papworth and James (2003) previously found that art students displayed a negative and distorted bias in their 'higher-order' appraisal processes, i.e., those associated with explanations for their personal reactions, performance or functioning within real-life situations. However, it appears that additionally, artists are more 'hasty' in their basic decision making; both of which may additionally impact upon their problem solving ability (which was found to be significantly less effective). These processes have been differentially associated with depression and psychosis, and the findings may raise practical issues associated with therapy for the artistic. For instance, they might have greater difficulty in undertaking certain tasks associated with cognitive therapy

Cognitive Distortions and Impulsiveness in a Sample of Non-clinical Population.

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Rationale: Cognitive theory (Beck, 1976) is based on the idea that our emotions and behaviours are often the outcome of the way we interpret the situations around us. Individuals with psychological problems have a tendency to make negative interpretations and dysfunctional predictions of events. Our knowledge of these cognitive distortions (errors) is central for cognitive-behaviour therapy (CBT). Lists of cognitive distortions can provide us with vital information in identifying themes to be addressed in the treatment of psychological problems. Impulsivity is a prominent feature of many psychiatric problems, particularly personality disorders. In a recent study, Najvits et al (2004) found that patients with the dual diagnosis of posttraumatic stress disorder (PTSD) and substance use disorder reported higher levels of cognitive distortions than the single diagnosis patients, and there appear to be specificity for dual diagnosis distortions. As high impulsiveness has been reported in both PTSD and drug abuse patients, impulsivity may be a common factor relating these psychiatric problems with specific cognitive distortions. Furthermore, it has been reported that core belief related to 'abandonment' are positively associated with high levels of impulsive self-harming behaviour in a psychiatric population (Dench et al., 2005). However, it is not clear how impulsive individuals interpret the situations preceding their response that may contribute to premature emotional and behavioural responses. This study aimed to investigate cognitive distortions in individuals with high and low impulsiveness in a sample of non-clinical population. Methods: The Barratt Impulsiveness Scale (BIS), the Cognitive Distortion Scale (CDS), the Beck Depression Inventory and the Beck Anxiety Inventory were administered to a sample of 100 participants, mainly undergraduate students. To control depression and anxiety effects, individuals who scored high in the BDI and the BAI were excluded from the data analysis. Also, participants with one standard deviation (SD = 7.00) above the mid-point (score 60) in the BIS were not included in the data analysis. In total, data derived from 66 participants (n = 33) were analysed. Results: High impulsive individuals scored higher in all 20 cognitive distortions measured by the CDS as compared to low impulsive individuals. A one-way analysis of variance revealed significant differences between low and high impulsiveness in 11 out of the 20 cognitive distortions ($p < 0.05$, and $p < 0.01$): instant satisfaction, shoulds, fooling yourself, arbitrary inferences, confusing needs, dichotomous thinking, catastrophizing, regret orientation, short-term thinking, emotional reasoning, blaming. Conclusion: Consistent with Beck's cognitive theory (1976), the findings of the present study indicate that individuals with high score in cognitive distortions are more likely to interpret the events maladaptively and to display mood and behaviour difficulties which can be attributed to impulsivity. These findings also have clinical implications suggesting that cognitive-behavioural interventions targeting information processing characterised by the specific cognitive distortions may help impulsive clients control their behaviour more effectively. Keywords: Cognitive distortions, impulsivity, clinical implications.

What Are the Differences Between Positive and Negative Voice Experiences?

Dudley, R, Grevetts, C, Freeston, M. University of Newcastle upon Tyne

People with delusions have been reported to jump to conclusions. In essence they make decisions on the basis of less evidence than other people without delusional beliefs. The exact explanation for this characteristic reasoning style has not been well explored. One theory for why people with delusions jump to conclusions postulates that people with delusions are applying normal confirmatory reasoning processes to inappropriate situations. In contrast people with obsessive compulsive disorder are thought to demonstrate an opposite style, and are particularly cautious in their reasoning style owing to having a disconfirmatory reasoning style. In this presentation we will review the results of meta-analysis incorporating the results of previous research to help us understand the strength of the relationship between jumping to conclusions and delusional, and obsessional beliefs. Then we will present the results of two studies run with non-clinical participants. In study 1 (N= 140) participants completed measures of delusional ideation (PDI), obsessional ideation (Padua), a person's need for closure, threat perception and level of anxiety, and as well as two trials of the beads task (at a 60:40 ratio, or difficult to discriminate task). Multiple regression analyses were used to investigate the factors that would best predict JTC. A non-significant model emerged, and it was felt that this could have been due to methodological issues concerning how data was collected from the beads task, whereby participants were required to respond in a manner that revealed how many beads they would see before they

needed to make a decision. This led to the participants waiting to a point of seeing 20 beads which is a very uncharacteristic reasoning style. This methodological issue was addressed in study 2. Here non clinical participants (n=70) completed the same measures as before but used a different response sheet. This produced a significantly earlier decision than in study 1 indicating that the methodological manipulation had the desired effect. We then ran a regression as in study 1. While a significant model emerged, delusional ideation only predicted JTC when coupled with the measure of OCD. This was actually a negative finding in that the higher the non clinical delusional beliefs, the more beads were viewed prior to a decision being made. This is the first time such as result has been reported. The methodological and theoretical explanations for these findings are explored.

Delusional Reasoning Bias in People with Schizophrenia and College Students.

Tanno, y., Yamasaki, s. & Arakawa, h., University of Tokyo

Previous workers pointed out the reasoning bias called "jumping to conclusion" in the formation and maintenance of delusion. Experimental studies using the Bayesian probabilistic judgement task revealed that people with delusion obtain less information before reaching a decision and express higher conviction than the non-deluded people. Previous research also revealed that delusion-prone normal people have a similar reasoning bias. In the present study, jumping to conclusion bias in people with schizophrenia and delusion-prone normal college students was examined. In Study 1, twenty patients with schizophrenia and 26 college students participated. Using the score of the Peters et al. Delusions Inventory (PDI), college students were divided into the high PDI student group and the low PDI student group. Experimental task was the probabilistic judgement tasks. Two jars (jar A and jar B) containing different ratio of red and green beads were presented to the participants. The experimenter draw the sample of the beads one by one sequentially from one of the two jars. Participants were required to guess whether the experimenter draw from jar A or jar B. Participants were asked whether they required more draws before they came to a decision. After each draw, participants indicated the relative probabilities that the jar was jar A. The patient group drew significantly less than the low PDI student group ($p < 0.05$). The high PDI student group reached significantly higher initial posterior estimate than the low PDI student group and the patient group ($p < 0.01$). The high PDI student group reached higher conviction after 10 draws than the patient group ($p < 0.10$). These results were consistent with the previous studies. The data-gathering bias was more likely to be influential in the formation of delusional ideation, whereas the bias in probabilistic reasoning was more likely to be associated with the presence and maintenance of delusional ideation. In Study 2, three hundred and forty-one college students participated. The Cloninger's Temperament and Character Inventory (TCI) and Peters et al. Delusions Inventory (PDI) were administered to all of the participants. The PDI can assess the numbers of delusional ideation and their distress, conviction and frequency multi-dimensionally. The probabilistic judgment tasks was administered to the part of the participants. The novelty seeking in TCI had significant positive correlations with the variables of PDI. The harm avoidance correlated positively with distress of PDI. The combination of some dimensions of temperaments may reflect vulnerability of delusional ideation. Again the high PDI student group showed higher conviction about their judgment than the low PDI student group in the probability judgment tasks, indicating that the delusion-prone normal people have a reasoning bias.

Cognitive Behavioural Therapy Reduces Suicidal Ideation in Schizophrenia.

Bateman K, Hansen L, Kingdon D and Turkington D, University of Southampton

Context: Patients with schizophrenia are at high risk of suicide but randomised controlled studies have not yet demonstrated the efficacy of psychosocial in the reduction of suicidal ideation. Cognitive behaviour therapy has been shown to reduce a range of symptoms in schizophrenia while suicidal behaviour has been reduced in personality disorder. This poster examines CBT's influence on suicidal ideation in schizophrenia. Objective: To determine whether cognitive behaviour therapy changes the level of suicidal ideation in patients with schizophrenia compared to a control group. Design, Setting and Patients: Ninety ambulatory patients with symptoms of schizophrenia resistant to conventional antipsychotic medication were randomised to cognitive therapy or befriending to receive up to twenty sessions over a nine month period. They were assessed by raters blind to intervention group, using the Comprehensive Psychopathological Rating Scale at baseline, post intervention and after nine months to ascertain comparative changes in symptomatology. This included a rating of levels of suicidal ideation at each time interval. The suicidal ideation was analysed post-hoc and was not a main-outcome measure. Main outcome measure Change in suicidal ideation as measured by the Comprehensive Psychopathological Rating Scale, item seven. Results: Suicidal ideation reduced significantly with cognitive therapy compared to the control group at end of intervention and at follow up, nine months later. Suicidality (CBT/BEF) ($n = 90$) 0.830 (baseline), 0.010 (after treatment) and 0.033 (follow up). This occurred regardless of whether or not suicide was addressed in therapy. As the data was not normally distributed Mann Whitney U test was used to compare groups and Friedman's test to evaluate groups over time. Conclusions: Cognitive therapy provided significant reductions in suicidal ideation over a relatively short period of time in this post-hoc analysis. This improvement is sustained in the follow-up.

Further research is required to substantiate these findings and determine the process and mechanisms through which this reduction is achieved.

Correlates and Experience of Hopelessness in Undergraduate Students.

Bill Spence, University of Oxford Brookes

The role of hopelessness as a proximal and significant cause of depression (Abramson et al. 1989) has been fairly well established although the significance of its correlates predictive abilities is far from clear. Dysfunctional attitudes (Weissman and Beck, 1978) are frequently assessed by practitioners, prior to therapy, but the ability of this assessment to predict hopelessness and depression is limited. Dysfunctional attitudes are important to all therapists although the factor structure of the dominant assessment instrument varies for different client groups and this has important practice implications. This study is nearing completion and comprises a quantitative aspect (n=162) and qualitative aspect (n=6). Undergraduate health care students completed ratings of hopelessness, dysfunctional attitudes, depression and anxiety between November and December 2004. Six of these students were interviewed to explore their future orientation and the role of negative emotions in this. It is envisaged that the findings will be completed by the date of the conference and that journal publication will take place shortly after this. Findings largely support the dominant model of hopelessness where regression analysis indicates the significant contribution of hopelessness to depression. The dysfunctional attitude factor structure identified has implications for the way that practitioners approach therapy with students in higher education and the contribution to depression of performance evaluation and anxiety found in this study presents a challenge to educators! The themes identified in the interviews indicate the importance of several variables often overlooked in the assessment of hopelessness in modern Britain. The study challenges established client assessment tools and underpinning assumptions, if the sample sizes are relatively small. The design challenges posed here by the requirement for participants to reflect on complex issues will be familiar to therapists. The study offers some support for the prevailing model of hopelessness, and some challenge to the predictive role of dysfunctional attitudes and the structure of this phenomenon in this predominantly young group. Further work on the experience of hopelessness in particular social and clinical groups is indicated with a view to further refining the assessment and value of this to practitioners.

The Role of Counterfactual Thinking in the Psychological Distress and Adjustment following Recurrent Miscarriage.

Callander, G & Brown, G. Royal Holloway University of London,, Tata, P Central North West London NHS Mental Trust . & Regan, L. St Marys Hospital, London.

Introduction: Recurrent miscarriage is the loss of three or more consecutive pregnancies before 24 weeks gestation. Counterfactual thinking (CFT) is a type of rumination in which individuals imagine ways in which the outcome of an event might have been different (or "if only..." thoughts). Research has indicated that CFT may have both maladaptive and adaptive functions following traumatic events, in that it may increase distress, but may also help the individual to find meaning and make future plans. The aim of the study was to investigate the relationship between CFT, distress, future planning and search for meaning and to examine the role of thought control strategies in the inhibition of CFT in a sample of women who had experienced Recurrent Miscarriage. Method: Participants were 62 women who had experienced Recurrent Miscarriage and were attending the Recurrent Miscarriage Clinic for investigations into the cause of their miscarriages. They were recruited on their first visit to the clinic and completed measures of anxiety and depression, thought control strategies, and a series of thought listing tasks. Results: Findings indicated a significant association between anxiety and both counterfactual frequency and fluency, but no relationship between counterfactual thinking and depression. Contrary to predictions, counterfactual fluency was neither associated with a reduction of distress as a function of time since miscarriage, nor associated with a search for meaning or future plans. Counterfactual frequency was positively associated with future plans, and negatively correlated with acceptance. Fluency of plans was not associated with lower distress. Anxiety, depression, duration of counterfactual thoughts and state orientation were all negatively correlated with search for meaning items, whereas action orientation was positively associated search for meaning items. However, there was no evidence of thought control strategies influencing fluency or frequency of counterfactuals. Conclusion: Overall, findings indicated that women who had experienced Recurrent Miscarriage did engage in CFT, and that this was related to anxiety, but there was little support for CFT having an adaptive function, or any support for the role of thought control strategies in the inhibition of counterfactual thoughts.

Psychosis

Keynote Addresses

The Schizophrenia Envirome

Professor Jim van Os, Maastricht University, The Netherlands

A new understanding of psychosis appears to emerge, in which conceptually the role of the environment is coming more to the fore. The clinical observation that many young people who seek help in the context of psychotic symptoms are heavy cannabis users has given rise to the biologically plausible hypothesis that cannabis is a causal risk factor for psychosis. However, given the hypothesised causal role of certain cannabinoids, how to explain the fact that cannabis use is much more prevalent than is psychosis and psychotic disorder, and why, if cannabis is driving the morbidity force of psychosis in populations, has the incidence of psychotic symptoms and psychotic disorder not dramatically increased over the past decades in parallel with the increase in cannabis use? In addition, if cannabis is a risk factor, how does it relate to other hypothesised environmental risks? For example, the urban environment is, in terms of attributable risk, the most important proxy environmental risk factor. It has been hypothesised that the mechanism involves the cumulative effects of altered social interactions at the individual level and possibly also at the level of the wider social environment such as the neighbourhood. Early trauma is another aspect of the environment that has recently been linked prospectively to psychosis, and meta-analytic work demonstrates conclusively that minority status is a risk factor, part of which may be mediated by chronic exposure to discrimination. Can we make sense of these risks in terms of an underlying unifying mechanism? Is there evidence that the mechanism by which the environment is likely to impact on risk is through cognitive and emotional pathways, and can these be considered as functional states of altered dopamine signalling? Can we reconcile the evidence of environmental risks and cognitive mechanisms with the hypothesis of genetic liability, and what type of research do we now need to elucidate widely hypothesised but under-researched gene-environment interactions?

Mindfulness, CBT and psychosis

Professor Paul Chadwick, Royal South Hants Hospital & University of Southampton

In this talk I will first introduce our understanding of mindfulness, and how it is integrated with CT. I will present a mindfulness based model of distress in psychosis. I will introduce a measure of mindfulness derived from this model, and will present some preliminary data from the first 11 people with distressing psychosis to attend one of our mindfulness groups. I will discuss some key practical issues around using mindfulness with psychosis, and conclude with a grounded theory of the process of responding mindfully to unpleasant psychotic sensations.

Symposia

Psychosis and Emotion

Convenor & Chair: Craig Steel, University College London

How Does Trauma impact on Hallucinatory Experience? Evidence from the PRP Trial.

Hardy A, Institute of Psychiatry, London; Fowler D, University of East Anglia; Freeman D, Garety P & Kuipers E, Institute of Psychiatry and Bebbington P, University College London.

Higher rates of trauma and PTSD are found in individuals with severe mental illness compared with the general population (e.g. Neria et al, 2002). Recent research indicates that there may be associations between trauma and the specific symptom of hallucinations (e.g. Reed et al, 2003). However, there are significant weaknesses in some of this emerging literature. For example, small sample sizes; retrospective case note data collection; no multidimensional assessment of hallucinatory experience and comprehensive measurement of trauma; and limited investigation of the psychological processes underlying the relationship between trauma and hallucinations. As part of the Wellcome Trust funded Psychological Prevention of Relapse in Psychosis trial (the PRP trial) a number of these issues have been addressed. The associations between severity and types of trauma, and multidimensional aspects of hallucinatory experience will be reported in a sample of two hundred and twenty-eight patients with

non-affective psychosis. Further, the role of emotion in mediating the relationship between trauma and hallucinations is investigated.

Trauma-related intrusions within high schizotypy individuals following an RTA

Craig Steel, University College London. Misbah Mahmood, Institute of Psychiatry. Emily Holmes, MRC Cognition and Brain Sciences Unit, Cambridge

Currently, little is known about the role of trauma-related intrusions in psychosis. Further, little is known as to which personality types may be vulnerable to suffering from trauma-related intrusions. A study is discussed which aimed to link personality type, vulnerability to trauma-related intrusions and vulnerability to psychosis. Individuals who had recently received hospital treatment after a road traffic accident (RTA) were followed up in order to explore the relationship between positive schizotypy, peritraumatic information processing and posttraumatic symptoms. Those scoring high on positive schizotypy reported increased levels of data-driven processing to have occurred during the trauma (RTA), along with increased levels of posttraumatic symptomatology. When considering the subjective severity of the RTA, positive schizotypy was only a predictor of data-driven processing and posttraumatic symptomatology within those individuals who did not fear for their life. The results are discussed within the context of an information processing account of trauma-related intrusions within psychosis.

A cognitive approach to understanding relationships between emotion and psychosis

Anthony P. Morrison 1,2. 1 Psychology Services, Bolton Salford & Trafford Mental Health Trust, 2 Department of Psychology, University of Manchester

Several recent approaches to the understanding of psychosis suggest that the development and maintenance of psychotic experiences may be related to emotional processes. Similarly, emotional difficulties may be experienced as a result of psychosis. This paper will examine the prevalence of anxiety, post-traumatic stress and depression in people with psychosis. Data from several recent studies will be described and used to consider the psychological processes that may be involved in the mediation of emotional responses to psychotic experiences (such as appraisal and perseverative processing). In addition, a number of empirical studies testing hypotheses regarding the role of emotion in the development of psychotic experiences will be described, involving both clinical and non-clinical populations. The theoretical and clinical implications of these studies will be discussed.

Staying Well After Psychosis: Psychological determinants of remission and emotional recovery.

Gumley, AI, University of Glasgow; Reilly, J, Greater Glasgow Mental Health Division; Macbeth, A, University of Glasgow; Power, KG, University of Stirling.

Staying well after psychosis is an important priority shared by individuals with psychosis, their families and loved ones, and services. Despite this there is little evidence to show that Cognitive therapy is effective in the maintenance of recovery and the prevention of recurrence of psychosis. This paper will present data collected over a six-month follow-up period on 169 individuals diagnosed with schizophrenia. The paper presents two definitions of recovery after 6-months. The first definition is based on remission criteria developed by Andreasen and colleagues (American Journal of Psychiatry, March 2005, pp 441 - 449). This definition emphasises recovery in terms of positive symptoms, negative symptoms and disorganisation. The second definition of recovery emphasises emotional well-being in terms of anxiety, depression, guilt and social avoidance. These two outcomes are described and the cognitive appraisal factors linked to remission and emotional recovery are investigated. These psychological factors include autonomy and sociotrophy, dysfunctional attitudes, personal beliefs about illness, metacognitive beliefs, and positive and negative self esteem. The implications for understanding and facilitating staying well after psychosis are discussed.

Does Cannabis Raise the Expression of Psychosis in Populations?

Convenor and Chair: Jim van Os University of Maastricht

Linking cannabis and psychosis in the population

Jim van Os, University of Maastricht, The Netherlands

The observed deleterious effect of cannabis use on the prognosis of patients with psychotic disorder may involve the same mechanism as the observed deleterious effect of cannabis use on the prognosis of individuals with high levels of liability to psychosis. The study of gene-environment interactions is likely to help elucidate the exact role of cannabis in the onset and the persistence of psychotic disorders but there is an urgent need for human and animal studies examining the cognitive and biological mechanisms involved

Psychological Therapy for Psychosis and Cannabis Use

Barrowclough, C, University of Manchester

Despite high rates of problematic substance use in psychosis, the evidence base to direct treatment remains limited. In Manchester we have been developing an individual treatment intervention that combines motivational interviewing (MI) and cognitive behaviour therapy (CBT). In clients with psychosis, cannabis is most often used alongside other harmful drugs or alcohol, and the intervention may be directed at a range of substances. The therapy aims to take account of the dual and interactive nature of substance use and psychosis problems and the motivational stage of the patient. The outcomes of studies to date including the Manchester studies will be reviewed, an outline of the treatment model currently being evaluated will be presented, and some issues of adapting an integrated MI/CBT approach to this client group will be addressed.

The pharmacology of the human cannabinoid system and related psychiatric and psychological consequences of cannabis use

Dagmar Koethe & F. Markus Leweke Dept. of Psychiatry and Psychotherapy, University of Cologne, Cologne, Germany

After the discovery of membrane receptors for the psychoactive principle in Cannabis, Δ^9 -tetrahydrocannabinol and their endogenous ligands, we know meanwhile about a whole signalling system that comprises cannabinoid receptors, endogenous ligands and enzymes for ligand biosynthesis and inactivation, the human cannabinoid system. This neurotransmitter system represents the target for exogenous cannabinoids like the major psychoactive compound of herbal cannabis, Δ^9 -Tetrahydrocannabinol. It consists of naturally occurring endocannabinoid lipids - of which anandamide (Devane et al. 1992; Di Marzo et al. 1994) is the first characterized example - and their attending CB₁ cannabinoid receptors, which are expressed in brain areas involved in the control of motor functions, cognition and motivation (Herkenham et al. 1990; Matsuda et al. 1993; Glass et al. 1997; Piomelli 2003). While this system seems to be involved in an increasing number of pathological conditions, it has been suggested to play a role in the pathogenesis of psychosis by Emrich et al. (1997), based on the investigation of experimental cannabinoid psychoses in healthy volunteers. Activation of cannabinoid CB₁ receptors produces intense emotional and cognitive responses, suggesting that dysfunction in the endocannabinoid system may contribute to the pathogenesis of mental disorders. The hypothesis that a dysfunction in endocannabinoid signalling may be associated with schizophrenia is further supported by studies showing that endocannabinoid levels in cerebrospinal fluid (Leweke et al. 1999; Giuffrida A, Leweke FM et al., 2004) and plasma (Yao et al. 2002; De Marchi et al. 2003) as well as CB₁ receptor expression (Dean et al. 2001) are abnormal in schizophrenic patients. We examined the role of endocannabinoid signalling in psychotic states by measuring levels of the endocannabinoid anandamide in cerebrospinal fluid (CSF) and serum of various groups of healthy volunteers (n=84) and patients suffering from acute psychiatric disorders (n=187). The level of anandamide in CSF is significantly elevated in acute, antipsychotic-naïve, first-episode schizophrenic patients (n=47) when compared to controls. This is reversed by the administration of antipsychotics, which antagonize dopamine D₂-like receptors (n=37), but not by those, which preferentially antagonize 5HT_{2A} receptors (n=34). Furthermore, we found that in antipsychotic-naïve, acute schizophrenics, CSF anandamide is negatively correlated with psychotic symptoms. Further we investigated the effects of cannabis use and found that levels of anandamide in CSF are related to the patterns of cannabis use in schizophrenic patients. Acute psychotic patients with less than 5 times of cannabis use lifetime and no acute use show significantly higher levels of anandamide in CSF than comparable healthy volunteers. They differ significantly from respective patients with a history of more than 20 times but no recent use of cannabis. Interestingly we found elevated levels of anandamide in acute psychotic patients who used cannabis recently, as was detected by a positive urine drug screening for cannabis. Anandamide levels were inversely correlated to psychotic symptoms depending on the history of cannabis use. Our findings are specific for psychosis. These results suggest that anandamide elevation in psychosis may reflect a compensatory adaptation to

dopaminergic hyperactivity. This reveals an unexpected adaptive role for this endocannabinoid lipid in psychotic states, which is possibly influenced by ingestion of external cannabinoids.

An experimental paradigm of gene X cannabis interaction in psychosis; evidence that a functional polymorphism in the catechol-O-methyltransferase gene moderates cannabis effects on the endophenotype for psychosis.

*Cécile Henquet^{*a}, Araceli Rosa^{ab}, Lydia Krabbendam^a, Lourdes Fañanás^b, Sergi Papiol^b, Jan Ramaekers^c and Jim van Os^{a,d}* Maastricht University, The Netherlands ^bLaboratori d'Antropologia, Facultat de Biologia, Barcelona, Spain. ^cMaastricht University, Brain and Behaviour Institute, The Netherlands ^dInstitute of Psychiatry, London

Objective There is accumulating evidence that cannabis use is a risk factor for psychosis. Recent findings suggest that a functional polymorphism in the catechol-O-methyltransferase (COMT) gene moderates the long term effect of adolescent cannabis use on development of adult psychosis, with carriers of the Val allele having the highest risk compared to carriers of the Met allele. In the current study, we further investigated this relationship by studying moderation by COMT genotype on the acute effects of cannabis on cognition and transient psychotic symptoms. **Design** A double blind placebo controlled cross-over design was used in which patients with a psychotic disorder (n=30), first degree relatives of patients with a psychotic disorder (n=12) and healthy controls (n=32) were examined. Subjects received 300 µg THC per kilogram bodyweight in tobacco cigarettes in the exposure condition, and 0 µg THC per kilogram bodyweight in tobacco cigarettes in the placebo condition. Cognitive performance was tested during separate placebo and exposure conditions by using computer tests on verbal and visual learning as well as attention. Transient psychotic symptoms were furthermore evaluated by use of self-report. **Analyses** Linear regression analyses were conducted in order to investigate main effects of genotype and condition on cognition scores and symptom outcomes, as well as interaction effects between genotype and condition on cognition scores and symptom outcome. **Results** Cannabis impaired performance on memory and attention scores. Carriers of the Val allele were more sensitive to transient memory impairment after experimental exposure to cannabis and experienced more psychotic symptoms compared to carriers of the Met allele. **Conclusion** The results confirm earlier epidemiological data and provide direct evidence of gene X environment interaction, as a functional polymorphism in the COMT gene moderated the vulnerability to the effects of cannabis on the endophenotype for psychosis.

What Can We Learn From Studies Of Psychotic Experiences In The Normal Population?

Convenor: Peters, E., Institute of Psychiatry, London

Chair: Jim van Os, University of Maastricht, the Netherlands

The Clinician's error and the psychosis continuum

Jackson, M.C. Consultant Clinical Psychologist, North West Wales NHS Trust/ Honorary Lecturer, School of Psychology, University of Wales, Bangor

The 'clinician's illusion' usually refers to the way that our view of a specific disorder is restricted to those examples which present for treatment – a form of sampling bias. For the psychoses, this illusion has been effectively undermined by recent large scale epidemiological studies, which establish the existence of a significant continuum of psychosis outside the clinical population. In this paper, the concept of the clinician's illusion is developed further, to consider clinical biases in the methodologies which are used to sample psychotic phenomenology, and in the interpretative and explanatory models which are brought to bear on the psychosis continuum. These filters on our understanding of psychosis support a 'quasi-dimensional' view of the continuum, as one of degrees of disorder, deficit or dysfunction. Alternatively, a fully dimensional conceptualization of the continuum requires the consideration of a wider range of 'normal' psychotic phenomena, as well as explanatory models which do not depend on the notion of dysfunction. Brief case vignettes of 'benign psychosis' are presented, and their implications for our understanding of the psychosis continuum are considered.

How do benign and distressing episodes of 'psychotic' anomalous experiences differ?

Introduction: Studying sub- or non-clinical forms of psychotic phenomena has the potential to elucidate factors leading to the distress and disability associated with psychotic disorder, as well as potential avenues to a positive outcome. A study was carried out to assess the factors that distinguish individuals endorsing psychotic-like anomalous experiences (AEs) without a need for care, from those who are diagnosed with a psychotic disorder. Method: Two groups of age- and gender-matched participants were recruited: (i) a 'Diagnosed' group (D) who had been diagnosed and treated for a psychotic disorder (n = 35; mean age = 32.6 yrs); (ii) an 'Undiagnosed' group (UD) who reported AEs associated with psychosis, but who had never received a diagnosis or treatment for psychosis (n = 36; mean age = 34 yrs). Participants were assessed using a novel semi-structured interview (the Appraisals of Anomalous Experiences interview). This was designed to rate the incidence and frequency of 40 AEs, and a range of contextual and psychological variables, including appraisals, emotional and behavioural responses, and social context. PCA was used to summarise the AE ratings into 5 continuous component scores. A series of cross-sectional group comparisons and regression analyses were carried out to assess the predictive value of phenomenological variables and context, appraisal and response variables for (a) anomaly-related distress and (b) diagnostic status. A qualitative analysis of the participants' views of the impact of the anomalies on their view of the world and themselves was also performed. Results: The two groups reported an overlapping range of phenomenology; the D group reported more non-psychotic cognitive and attentional anomalies than the UD group, and more frequent First Rank Symptoms and ideas of reference/(hypo)manic experiences. 16% and 45% of the UD group (respectively) reported experiencing these kinds of AEs with => frequency than the mean of the D group. Forms of appraisal were semi-independent of AEs, and differentiated the two groups: appraising experiences as being caused by other people strongly predicted distress and diagnostic status, but externalising appraisals per se did not predict distress. The UD group were more likely to make 'spiritual' or normalising appraisals of their experiences. The D group was characterised by response styles involving avoidance and cognitive control, compared to the UD group which reported more neutral responses to AEs. The UD group were more likely to report onset of AEs following spiritual practices, or associated with a cultural context which acknowledged or valued the experiences. In the qualitative analysis, benign instances of psychotic phenomena were associated with high salience for the individual's worldview and self-image, primarily in a positive direction. Discussion: The phenomenological, psychological and contextual factors showed inter-associations suggesting a multifactorial aetiology of distress and need for care, in which normalisation of AEs by social contacts was important. 'Paranoid' appraisals appear to form an independent dimension of variation from the presence and frequency of AEs. Conclusion: Psychotic-like AEs may not lead to distress and disability.

Aspects of the psychosis continuum and the Cardiff Anomalous Perceptions Scale (CAPS): Are there multiple factors underlying anomalous experience ?

Bell, V., Halligan, P.W. and Ellis, H.D., School of Psychology Cardiff University

This study investigated contributory factors to anomalous perceptual experience and the role of such experience in delusion formation. This was facilitated by development of the Cardiff Anomalous Perceptions Scale (CAPS), a valid, reliable self-report measure designed to use neutral language, have high content validity and include provision for differing levels of insight. The CAPS was completed by a general population sample of 336 participants and 68 psychotic inpatients. A principal components analysis of the general population data revealed three components: 'clinical psychosis', 'temporal lobe disturbance' and 'chemosensation', suggesting multiple contributory factors. No significant difference was found between general population participants and deluded inpatients without hallucination, with adequate power to accept the null hypothesis. This suggests, contrary to current theories, anomalous experience is neither necessary nor sufficient for delusion formation.

The relationship between trauma and beliefs about hearing voices: Learning from a non-psychiatric population

Andrew, E. M. Clinical Psychologist, Pontypridd and Rhondda NHS Trust & Research Fellow, Cardiff University. Gray, N.S. Consultant Clinical Psychologist, Bro Morgannwg NHS Trust & Reader, Cardiff University

In recent years there has been a growing interest in the relationship between traumatic life events and the symptoms of psychosis, in particular the experience of hearing voices. It has been shown that both the content of, and beliefs about voices can be associated with an individual's life history and the way that they feel about themselves. It could therefore be hypothesised that life events, particularly traumatic life events, could represent a mediating or contributory factor in the development of beliefs about voices and any associated distress. Non-psychiatric voice hearers, almost by definition, do not experience the same degree of distress as those individuals that come into contact with psychiatric services. Is this because of their beliefs or their coping strategies? Is it because they have not experienced the trauma that is often observed in a psychiatric population and thus their voices have a

different 'cause' or meaning? This talk will present the findings of a study that aimed to examine, in detail, the role of trauma in understanding beliefs about voices and distress by comparing two groups of voice hearers: a group of psychiatric voice hearers distressed by their experience of voices and a group of non-psychiatric voice hearers who were not distressed by their experience. It will discuss the way in which research involving voice hearers in the general population can help to inform our clinical and theoretical understanding.

A framework analysis of recovery from psychosis.

Reader D W, North West Wales NHS Trust

The study described in this presentation is an attempt to learn more about recovery from the narratives of individuals who do not use mental health services. Participants in the study were recruited via advertisements in local newspapers seeking people and/or their relatives who had personal experience of voice hearing or 'bizarre' beliefs. Transcripts of interviews were then analysed using a framework based on the recent NIMHE model of best practice in recovery to assess the 'fit' between the model and the participants' own experience. The presentation will describe preliminary results from the study and offer observations on the issue of engagement and non-engagement with services.

Real Life CBT For Psychosis: When It Doesn't Work

Convenors: Emmanuelle Peters, Institute of Psychiatry & Craig Steel, Institute of Psychiatry

Chair: Max Birchwood, University of Birmingham

The man who belonged to an evil race

Peters, E, Institute of Psychiatry

The case of a 36 year old man who believes he is evil will be presented. JH believes he is part of an evil race which is responsible for committing atrocities around the world. He believes this happened at his birth, after he suffered from anoxia and had to be resuscitated. The onset of this belief happened shortly after he was first diagnosed with epilepsy aged 23. Although his epilepsy is now well controlled, he has some specific neuropsychological deficits in the context of above average general cognitive ability. He hears and sees demons which corroborate his evil status. He is severely depressed and anxious, and reports having been depressed all of his life. He has attempted suicide on a number of previous occasions. His wish is to be locked up so that he may be prevented from carrying out evil deeds in the future. Although he has not done anything evil as of yet, he believes it is inevitable that he will do so at some stage. JH was seen for weekly CBT for a period of 18 months. His goal was to be less depressed. Although a number of gains were made in terms of increasing his activities and reducing his isolation, there were no clinically significant improvements either in terms of depression or his belief that he is evil. Some reflections on the lack of progress made will be proposed.

Learning to help people with psychosis with social recovery problems

David Fowler, School of Medicine, Health Policy and Practice UEA, Norwich

This paper reviews efforts (and many failures) over a period of 20 years trying to help young people with problems associated with social recovery and negative symptoms. The syndrome consists of people who, often, have recovered from the worst of positive symptoms but then present stuck and incapacitated in a restricted life style, depressed, amotivated with some low level paranoia and other psychosis. Such people are at high risk of suicide and for developing severe social disability in the long term. This can be a very frustrating presentation for therapists. Traditional approaches involving sitting and talking in therapy sessions can be demoralising and unproductive both for the therapist and client. Often the social predicament of such people is realistically highly adverse, associated with many real social losses and in such a context facilitating change solely from fostering understanding and therapeutic discussion is limited. The paper initially draws from experience with seven such clients who were part of an initial cohort referred for some of the preliminary single case studies of CBT for psychosis in the 1980s. Such work was clinic based, involved cognitive therapy approaches focused on attempting to develop shared formulations of amotivation. Good relationships were formed but the approach disappointingly showed little benefit. Later work continued on the same vein, but later experience in a new long stay inpatient unit suggested that behavioural work which focused on people engaging in meaningful activities could be a key. Our current work focuses on combining therapeutic attempts with social interventions which assist people to regain employment or continue in education or social activities. This may be a promising way forward and is consistent with growing evidence that

CBT may be effective with negative symptoms and depression. The paper is illustrated with case material throughout. In general keeping a focus on assisting people to achieve social gains despite ongoing problems can be a good way for therapists to continue persevering with difficult cases despite apparent lack of success with symptom change.

Is being difficult to engage sufficient reason for not referring?

David Kingdon and Holly Kirschen, University of Southampton

CBT for psychosis has been readily available in West Southampton over the past few years and so we have recently audited its use. Almost half of those identified with schizophrenia on community and rehabilitation team caseloads had been offered it. Those who hadn't been referred tended to be older and female rather than male. The reasons for not referring were varied but commonest was that the person was doing well anyway, a small number of refusals and that they were deemed too difficult to engage. One such patient is discussed who had a long history of symptoms commencing with chronic fatigue augmented by command hallucinations and passivity which at the time that CBT commenced meant the person had virtually stopped eating and would not sleep in her bed. CBT focused on engagement and work with the command hallucinations but, after some initial success, was eventually discontinued because of non-response after 8-10 sessions. And that's when it started to get really interesting.

The challenge of applying CBT in secure environments

Haddock, G, University of Manchester

This paper will describe an individual, cognitive-behaviourally oriented intervention with a young man living in a low secure, inpatient ward. The details of the case are heavily disguised to protect confidentiality. The young man was aged 25 at the time of the intervention and had been given a diagnosis of schizophrenia at age 15. He had been admitted to hospital with an extremely severe and distressing psychotic symptoms over 10 times during this time. At the time of contact, he had been living on a low secure ward for one year. This admission had occurred as a result of staff finding the young man increasingly difficult to manage in an usual acute ward setting. This was due to the young man's hostility and aggression towards ward nursing and medical staff, his disagreement with his diagnosis and his unwillingness to accept the treatment offered. There were a number of key issues that were important for him. Particularly, he was extremely angry at the treatment he had received from mental health services. He considered that his diagnosis was incorrect and that he had not been getting the treatment he felt he needed. He also wished to use illicit substances, believing that these were helpful to him in coping with his severe anxiety and was angry that he was not allowed to do so in hospital. This paper will describe the therapeutic work that was carried out with this client and highlight the difficulties that interfered with significant progress being achieved over the time of the intervention. Significant issues that will be highlighted relate to the difficulties in carrying out individual CBT in secure environments, issues relating to working collaboratively around treatment and substance use.

Psychological Processes in Early Psychosis

Convenors: Joanne Hodgekins & Corinna Hackmann, University of East Anglia

Chair: David Fowler, University of East Anglia

The structure of schizotypy and associated underlying mechanisms in clinical and non-clinical populations

Joanne Hodgekins, University of East Anglia

Schizotypal personality is a useful construct to measure in both clinical and non-clinical populations. Indeed, the presence of anomalies in experience, thinking and beliefs have been shown by previous research to be relatively common in the general population (e.g. McGorry et al, 1995; Verdoux & van Os, 2002). Thus, whereas schizotypal phenomena may once have been perceived as the prodromal symptoms of psychosis, their presence could now perhaps be argued to provide evidence for a psychotic continuum, a concept that can be utilised to conduct further research into the etiology of psychosis. However, somewhat less clear in the literature is the prevalence of the different sub-types of schizotypy in non-clinical populations and their relationship to various clinical, social, and cognitive variables (e.g. emotion, schema, social cognition, neuropsychological performance). In order to hypothesise about factors involved in the development of psychosis, it would also be useful to ascertain whether such relationships were comparable to findings from clinically psychotic samples. This study will attempt to highlight the distinction between the different types of schizotypal phenomena (i.e. positive,

negative, disorganised) in terms of their potential underlying mechanisms and also report their respective prevalence in a non-clinical population. The findings will then be compared to those from a clinical population and the theoretical implications of this discussed.

Psychological factors in people at risk of developing psychosis: Comparisons with non-patients and relationships to psychotic experiences

Anthony P. Morrison^{1,2,1} *Psychology Services, Bolton Salford & Trafford Mental Health Trust*² *Department of Psychology, University of Manchester*

There have been recent advances in the ability to identify people at high risk of developing psychosis using a combination of state and trait risk factors (Yung et al., 1998). This has led to interest in the possibility of preventing the development of psychosis; however, psychological factors in this population have yet to be studied in any detail. This study examines the role of cognitive factors in a high-risk population including dysfunctional assumptions, sociotropy and autonomy, metacognition, self-discrepancies and perceived stress. Data from 58 patients at ultra-high risk of developing a first episode of psychosis in a recent randomised controlled trial will be compared with a sample matched for age and occupational status. In addition, the relationships between these cognitive factors and the psychotic experiences of people at high-risk will be examined. The theoretical and clinical implications will be discussed.

Anomalous Interpersonal Schemata among First-Episode Psychotic People with Co-Morbid Social Anxiety

Maria Michail & Max Birchwood, School of Psychology, University of Birmingham

Background: Social anxiety disorder has been frequently identified as a co-morbid diagnosis in schizophrenia (17%; Cossof & Hafner, 1998). However, its pathogenesis still remains unclear and thus few effective therapeutic treatments are available. This research explores the notion that social anxiety may be a psychological response to psychosis. Shame cognitions arising from a diagnosis of mental illness are suggested to contaminate social interaction leading thus to social avoidance and withdrawal. Method: Four groups of participants, aged 17-35, will constitute the sample of this study: a) social anxiety group, b) first-episode psychotic group, c) first-episode psychotic group with co-morbid social anxiety d) control group. A clinical interview using the Schedules for Clinical Assessment in Neuropsychiatry is conducted to establish diagnoses of social anxiety and/or schizophrenia based on the ICD-10 criteria. A battery of measures is also administered to identify shame cognitions and the risk factors underlying their emergence. Adverse childhood experiences are identified using the Childhood Trauma Questionnaire whereas the Revised Adult Attachment Scale assesses interpersonal relations. Analysis: Analysis of Covariance will be used to compare two groups at a time, controlling for current psychotic symptoms while regression procedures will examine the link between childhood attachment and adult interpersonal functioning. Results: Recruitment of participants and data collection is still in progress. Preliminary findings report high levels of social anxiety in individuals with psychosis. Ten of the thirty-one people with psychosis recruited (32%) were also found to be socially anxious. Implications: Providing a pathway for the nature and origins of social anxiety in psychosis will have further implications for the understanding and treatment of emotional dysfunction in psychosis.

Trauma and Early Psychosis

Corinna Hackmann, University of East Anglia

The proposition that there is a relationship between trauma and psychosis is currently widely accepted. Early psychosis is ideal for the investigation of premorbid trauma and the nature of the relationship between this and later psychotic symptoms. Despite this, research into trauma in early psychosis is relatively uncommon. The current study of an early psychosis cohort of approximately 50 cases had two primary aims. Firstly, the prevalence of PTSD and lifetime exposure to traumatic events was investigated. Secondly, we conducted a thorough exploration of the relationships between psychotic symptoms and trauma history. This included an investigation into the phenomenology of positive psychotic symptoms in people with and without current PTSD. Two routes by which traumatic experience can impact on psychotic symptoms were explored. Evidence for a direct relationship between positive psychotic symptoms and re-experiencing symptoms typically associated with PTSD was investigated. A less direct route was also considered, whereby core schemata mediate the relationship between traumatic events and the development of psychotic symptoms.

Possible selves, schema, and beliefs about illness in recovery from first episode psychosis

Gavin Taylor & Freya Mellor, Norfolk Early Intervention Service, Norfolk and Waveney Mental Health Partnership

Recovery from an initial psychotic episode is often measured by the reduction of positive symptoms (e.g. hallucinations and delusions) that a person has experienced. However, social and behavioural adjustment is also vital for pre-morbid levels of functioning to be attained. Adjustment following an acute psychotic episode involves appraisal the illness and implications for self and future functioning. Negative personal beliefs about illness (e.g. entrapment, humiliation, self as illness, loss and stigma) and low status future possible selves have been linked to post-psychotic depression in chronic schizophrenia (Birchwood, 2000). Depression in schizophrenia is associated poorer social recovery including greater unemployment and increased hospitalisation (Sands and Harrow, 1999). There is no published research on the predictive value possible selves and personal beliefs about illness in first episode samples. Unpublished research (Plaistow, 2001) suggests that the pattern and importance of negative beliefs about illness as predictors of post psychotic depression may be different in the early stages of psychosis. An investigation by Day (1999, unpublished) has revealed associations between balance in possible selves and levels of depression, negative symptoms and current functioning. The present study aims to further understanding of associations between possible selves, beliefs about illness and social recovery in first episode psychosis. It is proposed that the recovery process may be linked to the motivational resources a person has, with more motivational resources reflecting better recovery. The possible selves model (Markus and Nurius, 1986) suggests that motivation can be assessed by looking at the type and importance of future images of the 'self' (possible selves). Oysterman and Markus (1990) have further suggested that motivation will be highest when an expected possible self in the future is balanced by a feared self in the same domain.

Finding Yourself In A Strange Situation: Applying Attachment Theory To Psychotic Experiences

Convenor and Chair: Matthias Schwannauer, University of Edinburgh

A Developmental Psychopathology of Psychosis

Schwannauer, M, University of Edinburgh; Gumley, AI, University of Glasgow; Taylor E, University of Edinburgh.

Using a small number of case studies we want to illustrate the role of specific attachment experiences in the developmental course of adolescent onset psychosis. In our investigation of the developmental pathways of psychosis we want to focus on the genesis of prodromal difficulties and their transition to psychotic experiences and distress. In the narratives of these developmental pathways we represent models of normal adolescent development and transition to understand a pathogenesis of psychotic symptomatology. At the heart of these developmental trajectories are concepts of belief formation and cognitive development, secondary individuation processes and interpersonal development. Particular attention will be placed on the processing and individual relevance of significant attachment experiences or early experience of loss and trauma. In the contributions we will discuss the impact of life-span developmental models on our understanding of the onset and course of psychosis and consider specific developmental treatment models of adolescent onset psychosis.

Using the Adult Attachment Interview in the context of psychosis: implications for psychotherapeutic discourse

Gumley, AI, University of Glasgow; Schwannauer, M, University of Edinburgh; Macbeth, A, University of Glasgow

The Adult Attachment Interview (AAI, Main, Kaplan & Cassidy, 1985) is an hour-long semi-structured interview consisting of 18 questions assessing adults' state of mind with respect to attachment. The interview asks respondents for descriptive adjectives of attachment figures during childhood alongside specific autobiographical memories supporting respondents' choice of adjectives. Specific questions are asked about what respondents did when emotionally upset, physically hurt or ill and how their attachment figures responded. Respondents are asked about experiences of separation, loss, rejection and abuse. Respondents are also invited to reflect on how their early experiences have affected their adult development. Importantly, the interviewer is required to be relatively non-directive. Hesse (1996) has defined the central task within the AAI as the challenge to generate and reflect upon memories related to attachment whilst simultaneously maintaining a coherent discourse. This paper will illustrate the use of the AAI with single cases of individuals with psychosis. In so doing the paper will show how early developmental experiences and individual's attachment organisation are relevant to the construction of narrative and discourse in psychotherapy with psychosis. Implications for research and clinical practice are reflected upon.

Attachment style and psychotic experiences in a non-clinical population: An analogue study

Macbeth, A, University of Glasgow; Gumley, AI, University of Glasgow; Schwannauer, M, University of Edinburgh

The redirection of emphasis towards a dimensional model of psychotic experiences has helped to foster research into the psychological mechanisms that may underpin development and maintenance of psychotic experiences. An enhanced understanding of the aetiology and maintenance of the interpersonal mechanisms in psychotic phenomena could be complemented by utilising a socio-developmental approach. One possibility would be the application of attachment theory, developed from the writings of John Bowlby (1969/1982, 1973, 1980). In particular, insecure attachment styles (dismissive, preoccupied and fearful) have been reported to associate with depression, personality disorders, and adolescent psychopathology. Insecure attachment has also been linked to a 'sealing-over' recovery style in psychosis (Tait et al 2004). However, there has as yet been little research directly addressing the nature of attachment in psychotic phenomenology. Here, preliminary results of an exploratory study of the relationship between attachment styles and psychotic phenomena are presented. An analogue group of non-clinical participants was used as a framework for further investigations with a clinical sample.

What Happens In CBT For Psychosis? Exploring Therapy Process Issues

Convenor: Rollinson, R., University of East Anglia and Norfolk and Waveney Mental Health Partnership NHS Trust and Fowler, D. University of East Anglia and Norfolk and Waveney Mental Health Partnership NHS Trust

Chair: Fowler, D. University of East Anglia and Norfolk and Waveney Mental Health Partnership NHS Trust

'What happens in CBT for psychosis? - An examination of session content in the PRP trial'

Rollinson, R., Fowler, D., Smith, B., Jolley, S., Onwumere, J., Steel, C., Garety, P., Kuipers, E., Bebbington, P., Freeman, D. Psychological Prevention of Relapse in Psychosis Trial (Wellcome Trust Funded).

This paper provides a detailed examination of the content of therapy sessions within a randomised controlled trial of CBT for psychosis. This should be of use to clinicians looking for detailed information about how therapy is actually provided in practice, and also for researchers looking for a means of monitoring therapy provision. The Psychological Prevention of Relapse in Psychosis (PRP) trial is a multi-centre randomised controlled trial exploring the efficacy of Family Intervention and CBT for Psychosis in reducing rates of relapse in people with psychosis. Trial participants were recruited at the point of relapse and if randomised to a therapy condition, received up to a year of therapeutic input. An existing adherence measure (the Cognitive Therapy for Psychosis Adherence Scale, Startup, Jackson and Pearce 2002) was further developed within the PRP trial. Therapy sessions were regularly rated on this measure to ensure equivalent levels of therapy adherence across the different therapists working on the trial. A sample of 180 therapy audiotapes have been rated on this adherence measure, providing a rich descriptive account of the content of therapy sessions. This paper presents: The revised version of this measure as a tool for developing and maintaining adherence and competence within similar trials or clinical practice. A detailed description of the actual content of sessions at different stages of therapy using the ratings from this measure. A comparison with Cognitive Therapy Scale ratings made of the same sessions. An exploration of any differences in the type and amount of therapy provided to different client presentations.

Recovery style, working alliance, and drop-out from CBT for acute schizophrenia

Startup, M. Wilding, N. Startup S, University of Newcastle, Australia and Jackson, M. University of Wales, Bangor, UK

Background: In the North Wales randomised controlled trial of cognitive behaviour therapy (CBT) for acute schizophrenia spectrum disorders, patients who received CBT as an adjunct to treatment-as-usual (TAU) had significantly better outcomes at 12 months than patients who received only TAU. However, patients who were offered CBT but dropped out of treatment early (mean = 4.5 sessions) had outcomes that were no worse than patients who stayed in (mean = 20.2 sessions) except that they had lost insight by 6-month follow-up before returning to their baseline level. The explanation for these curious findings might be that the drop-outs and the stay-ins had different but equally valid recovery styles. Method: Recordings of ten sessions were selected from a random sample of the drop-outs and these were matched by session number with a random sample of stay-ins. Ratings were then made, by two independent raters, using the Working Alliance Inventory and an abbreviated form of the Integration-Sealing-over Scale. Therapists' ratings of their patients' active engagement in therapy were also analysed. Results: The drop-outs (vs. stay-ins) showed a sealing-over recovery style before they dropped out and did not agree well with their therapists on the goals and tasks of therapy despite forming adequate bonds. Conclusions: Rather than try to alter patients' recovery styles, a more appropriate aim might be to match treatment to the patients' styles.

Treatment integrity, therapeutic alliance and outcome: an evaluation of the relationship in CBT and befriending for psychosis

Katherine Bateman, University of Southampton

Background: Outcome studies of CBT for psychosis have shown positive results from cognitive behaviour therapy and supportive treatments. It has been suggested that this results partly from the common, non-specific aspects of therapy. Although this is possible, in many studies, treatment integrity has not been adequately examined and it may be that the cross-contamination of treatments might account for some results obtained. This research examines treatment differences and relationships with outcome, for treatment integrity and working alliance, in early sessions of CBT and befriending for psychosis. Method: This study used outcome and therapy data from sixty dyads involved in a randomised controlled trial of CBT and befriending. Observer ratings of adherence, competence and alliance were made from early treatment sessions. Treatment differences in adherence, competence and alliance were examined and their relationship with global and negative symptom change was explored. Results: CBT was adherent to a cognitive model of psychosis and was characterised by competent administration of techniques. Befriending did not include specific cognitive therapy techniques. There were significant differences between CBT and befriending on measures of competence and adherence. Working alliance was high in both interventions with comparable levels of therapeutic 'bond' between treatments. Significant treatment differences were observed in 'task' and 'goal' rated alliance with higher levels observed in the CBT group. Higher levels of goal rated alliance, insight oriented techniques and competently administered specific and non-specific CBT techniques differentiated those individuals who improved and those who did not. Conclusion: Befriending and CBT were procedurally different interventions, with comparable levels of therapeutic bond. Higher task and goal alliance scores suggest that patients invested more in the CBT intervention. Factors that facilitate improvement may change over the course of therapy but in early therapy, aspects of working alliance and adherent and competent administration of techniques appear to be implicated in improvement. Further research in this area is required.

Comparison of befriending and CBT in terms of social support

*Milne, D., Wharton, S., Turkington, D. *, James, I. *, Samarasekera, N. All University of Newcastle upon Tyne * 3Ns Mental Health NHS Trust*

In an investigation into the efficacy of CBT in treatment of drug-refractory positive symptoms of schizophrenia, Sensky et al (2000) found CBT to be superior to 'befriending' (BF) at 9 months follow-up. However, there were no significant differences between the two interventions at the end of the treatment period. This result clearly begs the question, 'why was BF effective?' In attempting to answer this question, this presentation reports on a pilot study conducted to determine the nature of BF, and the similarities and differences with respect to CBT. In the pilot study, 20 participants' therapy tapes from the original Sensky et al study were sampled; ten from the BF and ten from the CBT treatment groups. The tapes were assessed on the Social Observation System (Milne and Netherwood, 1997), a scale assessing the degree to which therapist speech conforms to social support. The results revealed that BF and CBT were distinct forms of therapy. Also, BF, but not CBT, equated to social support.

Comparison of therapy in clinical and research settings and examination of dissemination issues

C. Haig (1,2), R. Rollinson (1,3), D. Fowler (1,3), R. Warner (4), B. Smith (3), C. Steel (3), S. Jolley (3), J. Onwumere (3), N. Coxhead (5) 1 University of East Anglia, UK 2 Norwich Primary Care Trust 3 Wellcome Trust Funded Psychological Prevention of Relapse in Psychosis Trial 4 Mental Health Centre of Boulder County 5 North Essex Mental Health Partnerships Trust

The similarities and differences in the application of cognitive behavioural therapy for psychosis between research and routine clinical settings were explored. In study 1, 40 audio-recordings of therapy sessions were collected: 20 from an ongoing research trial and 20 from routine mental health services. The Cognitive Therapy Scale for Psychosis-Revised (CTPAS-R, Rollinson and Fowler, 2002) was used to compare the content of sessions between these two experimental conditions. Within study 2, focus groups were conducted to explore the experiences of clinicians using CBT for psychosis. Three focus groups were completed, each with clinicians from a different organisational setting: i) generic community mental health teams, ii) an early intervention for psychosis service, and iii) an ongoing controlled efficacy study. There was no significant difference in the number of CTPAS-R non-adherent ratings between the research and routine groups. The research group used techniques of 'Schema Work' ($p < 0.05$), 'Formulation Intervention' ($p < 0.05$) and 'Relapse Formulation' ($p < 0.05$) significantly more frequently, while routine therapists used 'Assessment of Psychosis' significantly more frequently ($p < 0.05$). All focus groups commented upon increased engagement difficulties and resistance to change when working with clients with psychosis. There were similarities in the factors they felt were required to overcome these difficulties, including: increased flexibility of services, continued training and support, and specific therapist characteristics. The focus groups differed in the extent to which their organisational setting had provided the above requirements. These differences influenced therapists' confidence and sense of security in using this approach. The methodological problems and implications of the study are discussed.

Panel Debate

What Can Psychological Interventions Add To The Treatment Of First Episode Psychosis?

Convenor: Johns, LC, Institute of Psychiatry and Tabraham, P, Institute of Psychiatry

Chair: Birchwood, M, University of Birmingham

Providing Psychological Interventions for Patients with First Episode Psychosis

Johns, LC, Institute of Psychiatry

This presentation first outlines the range of intervention targets in first episode psychosis and the various psychological intervention approaches. It reviews briefly some of the evidence for these interventions, and describes some of the difficulties in providing these treatments in early intervention services. The presentation then describes a young man who developed a psychotic disorder one year after presenting to services with "prodromal" signs of psychosis. His psychotic symptoms included hearing voices and paranoid delusions. He was admitted to hospital, treated with medication, and discharged home. He lives with his parents and brother in a chaotic environment, and is quite socially isolated. This presentation sets the scene for the subsequent presenters, who will each describe a particular psychological intervention for first episode patients with reference to this particular case.

CBT for acute, psychotic symptoms

Haddock, G, University of Manchester

This paper will describe an overview of CBT interventions in acute, first episode psychosis. Key, clinical findings in relation to a randomised controlled trial of the approach will be described particularly in relation to affect and specific psychotic symptoms. In addition, differences in engagement and outcome according to the age of participants will be described. The implications for treatment on the basis of results from this trial and the clinical experience gained from this and other work will form the basis for the rest of the paper. The description will highlight the complexity of work that is required for people experiencing such a severe and distressing experience. Key areas that will be highlighted will be the need for flexibility in engagement and therapeutic strategies, developmental and familial issues, the commonality of substance use and the importance of social functioning and 'feeling normal'.

Staying Well After Psychosis: Psychological determinants of remission and emotional recovery.

Gumley, AI, University of Glasgow; Reilly, J, Greater Glasgow Mental Health Division; Macbeth, A, University of Glasgow; Power, KG, University of Stirling

Staying well after psychosis is an important priority shared by individuals with psychosis, their families and loved ones, and services. Despite this there is little evidence to show that Cognitive therapy is effective in the maintenance of recovery and the prevention of recurrence of psychosis. This paper will present data collected over a six-month follow-up period on 169 individuals diagnosed with schizophrenia. The paper presents two definitions of recovery after 6-months. The first definition is based on remission criteria developed by Andreasen and colleagues (American Journal of Psychiatry, March 2005, pp 441 - 449). This definition emphasises recovery in terms of positive symptoms, negative symptoms and disorganisation. The second definition of recovery emphasises emotional well-being in terms of anxiety, depression, guilt and social avoidance. These two outcomes are described and the cognitive appraisal factors linked to remission and emotional recovery are investigated. These psychological factors include autonomy and sociotrophy, dysfunctional attitudes, personal beliefs about illness, metacognitive beliefs, and positive and negative self esteem. The implications for understanding and facilitating staying well after psychosis are discussed.

Family Intervention in First Episode Psychosis

Onwumere, J, Institute of Psychiatry

The first episode of psychosis can present itself as a major trauma to the patient and their family. However, despite the increased interest and support for the provision of early intervention services in psychosis, the NICE Guidelines (2003) on psychological treatments for psychosis and the evidence base on the efficacy of Family intervention (FI) (Bustillo, 2001, Pharoah et al., 2001), very little is known beyond a handful of studies about the practice of FI within early psychosis populations. This case will be discussed with reference to the Family Intervention model of Kuipers, Leff & Lam (2002). Specific attention will be given to the role of psychoeducation, communication styles, problem solving and relapse prevention.

Open Papers

Psychosis

Chair: Mike Startup, University of Newcastle, Australia

Predisposition to hallucinatory experiences and delusional beliefs: the contribution of appraisals and unhelpful responses.

Michelle Campbell and Morrison, A. P. University of Manchester

Introduction: Evidence of non-pathological hallucinations and delusions has been discovered in the general population; the study of which aims to elucidate the nature and development of schizophrenia. The primary objective of the present study is to extend the current literature which examines these phenomena and apply the principles of the recently outlined cognitive models of psychosis (Morrison 2001, Garety et al 2001) to these experiences in non-patients. The present study takes a symptom-orientated approach in examining the role of unhelpful responses and appraisals in predicting predisposition and emotional responses to unusual experiences and beliefs in non-patients. Method: A survey was conducted via the Internet using a web-based questionnaire. Such a method allows the recruitment of a large number of participants. Furthermore, social desirability effects are minimised in web-based questionnaires, which is an important advantage when examining the sensitive area of mental health. All students from the University of Manchester were sent an e-mail inviting them to participate in the study and 544 students volunteered to take part. Results: The data was analysed using correlation and multiple regression and it was found that positive appraisals of psychotic-like phenomena and unhelpful responses were related to proneness to hallucinations and delusions. However, negative appraisals and unhelpful responses, which include punishment and worry -based thought control strategies and avoidant safety behaviours, were found to be related to distress. In addition, active (help-seeking type) safety behaviours were associated with lower levels of distress. Discussion: The present research findings strongly support the notion of a continuum of psychosis. Evidence of non-pathological hallucinations and delusions in a non-clinical population were discovered, indicating that there is no clear dividing line between schizophrenia and normal functioning. Furthermore, the recent cognitive models of psychosis have been supported as appraisals and unhelpful

responses have been found to be related to the occurrence of sub-clinical psychotic phenomena and distress. It is acknowledged that the clinical implications of the findings of this investigation must be considered cautiously as the participants were from a non-clinical population. However, these findings have implications for the treatment of those identified as being at ultra high risk of developing psychosis (Yung et al, 1998). Challenging negative appraisals of hallucinations and delusions may successfully reduce distress in this group. Similarly, if unhelpful responses are identified, for example avoidant safety behaviours or worry-based thought control strategies, attempts should be made to substitute these with functional responses. Such interventions may serve to delay, or prevent, the transition to psychosis. Conclusions: The study of pre-psychotic phenomena can aid our understanding of the development of schizophrenia. Future studies should examine the effectiveness of an intervention which is specifically targeted at reducing the use of unhelpful responses in those at high risk of developing psychosis

Childhood trauma and psychosis in the major mood disorders

Paul Hammersley, Manchester University

Over the last three years a number of researchers have identified a significant association between childhood abuse and subsequent adult psychotic symptoms in the schizophrenia spectrum disorders. This association appears to be particularly robust in terms of severe childhood abuse and auditory hallucinations of a critical nature. Research into childhood abuse has in the past focused on physical or sexual abuse, more recent studies strongly suggest that emotional abuse or neglect in childhood may be just as important. To date no one has yet fully investigated the possibility that the association between childhood abuse and adult psychotic symptoms could also occur in psychotic mood disorders. (Bipolar disorder, unipolar psychotic depression, PTSD with psychotic features or borderline personality disorder with psychotic features). Preliminary studies have been conducted by Hammersley et al (2003), Zimmerman (1999) and Garo (2005) Results from an investigation into the association between childhood trauma and psychotic symptoms in bipolar affective disorder will be presented. Evidence appears to be suggesting that the association is possibly, a 'cross-diagnostic' phenomena and that adult experience of critical / abusive hallucinations may often occur as a consequence of severe childhood abuse regardless of diagnosis. The most significant recent findings will be presented. Clinical implications for CBT therapists will be discussed

A comprehensive psychological treatment programme for people with a diagnosis of Schizophrenia.

Emma Williams, West London Mental Health NHS Trust

The paper describes the content and delivery of a comprehensive psychological treatment programme for people with a diagnosis of schizophrenia. The aims of the programme are to: minimise the risk of relapse; reduce residual psychotic symptoms; increase psychological 'insight'; promote adherence to medication; and improve psychological well being and self efficacy. The programme has a cognitive-behavioural framework and uses the 'Vulnerability-stress' model as its primary theoretical underpinning. The three main tenets of the approach are: The importance of the therapeutic alliance; responsiveness needs of individual clients and addressing multiple needs. The treatment programme is divided into five modules as follows: Module 1 focuses on engagement, treatment preparation, 'insight', self-efficacy, defining schizophrenia and agreeing the language. It has a strong educative component providing information about diagnosis and a working model of schizophrenia. Module 2 examines the individual's experiences and understanding of their diagnosis and how this has affected their life. Personal identification of the onset, course and consequences of the illness are examined. There is an emphasis on self-knowledge and coping. Module 3 focuses on positive symptoms; delusional beliefs, paranoid thoughts, hallucinatory and other experiences. The focus is on identification, understanding and coping with such experiences. Module 4 promotes the person's protective factors in order to improve their ability to cope with the problems associated with their diagnosis. This includes coping with stress, negative symptoms, improving interpersonal skills, medication adherence and self-efficacy. Module 5 brings together the main elements covered in the programme, personal relapse prevention plans are developed and future directions explored

Cost-effectiveness of CBT for acute schizophrenia under clinically representative conditions.

Startup, M., University of Newcastle, Australia; Jackson, M. C., University of Wales, Bangor; Bendix, S., University of Newcastle, Australia

Introduction: There is good evidence now that Cognitive Behavioral Therapy (CBT) for psychotic disorders is effective in alleviating symptoms and, perhaps, improving social functioning among stabilized individuals with residual psychotic symptoms. Now there is evidence that it is also effective (and cost-effective) for people suffering acute psychotic episodes. Method: In the North Wales randomized controlled trial of CBT for patients who had recently been admitted to psychiatric hospital as

a result of developing an acute psychotic episode (Startup, Jackson & Bendix, 2004), 43 patients were assigned at random to a treatment-as-usual (TAU) control group and 47 were assigned to TAU plus CBT. Weekly CBT sessions were begun as soon as possible after admission to hospital and continued without interruption following discharge, up to a maximum of 25 sessions. Results: It was found that the CBT group gained greater benefit than the TAU group in terms of reduced negative, psychotic and disorganization symptoms, and improved social functioning, with effect sizes in the range 0.63-0.80. A larger proportion of the CBT group (60%) than the TAU group (40%) had recovered by 12-month follow-up and none of them (vs. 17%) showed reliable deterioration compared with baseline. Most of the benefits were already apparent 6-7 months after admission to hospital and most of them persisted for at least two years. They were obtained under conditions which are broadly representative of routine clinical practice, they were no more nor less pronounced for people with a recent onset of illness than for others, and they did not cost significantly more (direct service costs) to the health delivery system. Discussion: The evidence for this form of treatment is now strong enough! to recommend that it should be widely available as a treatment option for people with psychotic disorders. The form of training required by mental health professionals in order to provide this treatment effectively, staffing levels, and the managerial arrangements needed to ensure that the treatment is delivered routinely, will be discussed.

Therapeutic and Clinical Applications

Keynote Addresss

Implications of the NICE Guidelines for Panic Disorder and GAD

Professor Paul Salkovskis, Institute of Psychiatry, King's College London and South London and Maudsley Centre for Anxiety Disorders and Trauma and Member, NICE Anxiety Guidelines Group

The NICE Guidelines for Panic and Generalised Anxiety Disorder recommend cognitive behavioural treatment (CBT) is the first treatment of choice. Antidepressant medication is also recommended, but not in combination with CBT at least in the first instance. Third in line is guided self-help within a CBT framework. The guidelines also recommend that treatment decisions be shared between clinician and patient and that CBT be offered promptly and locally by properly trained and supervised practitioners. The implications of these and the other recommendations are discussed in terms of developments in training, clinical practice and research. It is concluded that the CBT community is woefully ill prepared for the appearance of this and other guidelines, and we need to consider how best to proceed now.

Compassion, Evolution and Cognitive Therapy

Professor Paul Gilbert, University of Derby and Derbyshire Mental Health Services Trust

This talk will argue that all organisms, including humans, are orientated to distinguish between threat and safeness. Many psychological difficulties are related to the experience and perception of threat, which triggers safety/defensive behaviours. In addition some people (especially those from traumatic backgrounds) find it difficult to have sense of safeness or be self-soothing. This talk will consider new research on warmth and soothing systems and ways to help people who are high in shame and self-criticism learn to use a compassionate focus. Compassion training is multifaceted and seeks to promote the experience of safeness and acceptance, enabling people to disengage from systems threat-focused and self-attacking. Fears and problems in using a compassion focus will be discussed.

Schema Therapy: New Advances in Treating Resistant Personality Disorders

Dr Jeffrey Young, Schema Therapy Institute and Columbia University, New York, USA

As cognitive therapists struggle to expand standard CBT to treat resistant personality disorders, we encounter many obstacles. Because personality disorders are fundamentally different from Axis I disorders in many respects, we are faced with vital questions. Do the core assumptions of CBT apply to these clients? Is the conceptual model too narrow to explain the phenomena we observe? Are cognitive-behavioral techniques alone adequate for effective treatment? Can we understand these clients without a well-defined developmental theory? Can we treat resistant PD's successfully without a more central role for the therapy relationship? Is it possible to apply a short-term, structured therapy designed to treat "symptom disorders" to chronic PD's, in which there are often no clearly defined symptoms or targets? This keynote will address these questions by proposing a complete re-evaluation of CBT for difficult personality disorders. Dr. Young will describe new developments in schema therapy, including a revised, integrative theory that places major emphasis on the role of unmet childhood needs, and the resulting schema-driven, self-defeating life patterns, cognitions, interpersonal and emotional difficulties that underlie personality disorders. Research supporting the schema approach will be summarized. The presenter will propose major changes in the CBT treatment paradigm for challenging clients, such as those with Borderline Personality Disorder. These include schema *mode* work; "limited reparenting"; enhanced emotion-focused techniques; "empathic confrontation"; and the need for intermediate- to longer-term treatment for these clients. The keynote address will conclude with important research and clinical questions that still need to be studied in order to answer these controversial questions about CBT and schema therapy for resistant PD's.

Symposia

Mapping The Process Of Change: Self-Monitoring Using Hybrid Single Case Methodologies

Convenor: Dudley, R. University of Newcastle upon Tyne

Chair: Freeston, M. University of Newcastle upon Tyne

Introduction to hybrid single case methodologies

Freeston, M. H., University of Newcastle and Newcastle Cognitive and Behavioural Therapies Centre

Single-case or N=1 methodologies have historically been associated with experimental behavioural analysis and behaviour therapies. However, with the wide acceptance that a broad definition of behaviour can include internal events that observable by the participant alone, cognitive processes and interventions can be studied with these methodologies. Thus, single case methodologies can be adapted to studying both process and outcome of cognitive therapies. One of the great strengths of such designs is that through ideographic or idiosyncratic definition of target variables, great clinical relevance and exquisite sensitivity can be obtained. Further, such designs require that the participant be included in the design function by taking an active role in identifying and defining the targets to be measured. While this specificity of measurement is a strength for almost all purposes, the lack of comparability across subjects or benchmarking reduces the illustrative and persuasive nature that such designs may have. Fortunately the development of methodologies for clinically significant change (including reliable change) provide a means to apply standardised measures to single cases. While the combination of single-case design and ideographic definition and psychometrically developed measures in the same study would have been an anathema to many in the past, it is argued that combining these approaches into hybrid single case methodologies can provide a powerful tool to study both process and outcome in both observational and intervention designs. It is further argued that they can play a role in studying the rare, the comorbid, and the complex, in developing new interventions, and in understanding process. This symposium illustrates a range of applications of single-case design methodology

Cognitive change in first episode depression

Barton, S University of Newcastle and Newcastle Cognitive and Behavioural Therapies Centre

This presents a case of individual CBT for first episode depression in a 40 year old woman. The case was formulated around two maintenance cycles: firstly, over-investment in her marital relationship to the relative exclusion of other roles and goals, and secondly, strategic disengagement from the over-invested role in attempts to prevent a bad situation from worsening (including social avoidance, thought suppression and emotional avoidance). This woman had a long-standing pattern of maintaining a felt-sense of value through the approval and support of her husband, and this investment pattern continued after he became unsupportive and abusive towards her. Some years later she remained over-invested in obtaining his support and approval, even when they had separated and had only occasional contact. We formulated that her over-investment and disengagement were maintaining the depression, for example through an implicit false hope that he would support or approve of her in the future, or her belief that others (including him) had influence, power and agency, but she did not. We targeted specific thoughts and beliefs within this investment cycle, and activated new behaviours to counteract the disengagement. There was steady progress over the first 12 sessions, followed by a more pronounced trajectory towards remission at the point when she took a conscious decision to change what and whom she valued. Remission was achieved in a further 6 sessions, and treatment gains have been maintained at 6 and 9 months post-therapy. This case suggests the value of attending to precipitating events in first-episode depression because they can signal what is maintaining depression some time later. Models of over-investment within an individual's value system are highly relevant in first-episode depression, and associated cognitive changes need to be linked explicitly to patient agency and decision-making. The detail of change processes offered by single case analysis is greater than that usually associated with larger outcome studies, and a potentially influential source of evidence on which to base clinical practice.

Cognitive processes in relapse following medication withdrawal: a single case series

Cromarty, P, Dixon, J, Moorhead, S., Freeston, M. Newcastle Cognitive and Behavioural Therapies Centre

Research has clearly established the efficacy of pharmacotherapy and cognitive behaviour therapy (CBT) for depression and anxiety. In contrast there is a lack of literature addressing problems arising at cessation of treatment such as factors in relapse during withdrawal from medication. The current study uses an intensive single case AB style design to examine the role of psychological constructs such as interpretations, beliefs and attitudes that may influence relapse and lead to resumption of medication following successful CBT. Clear examples of these and associated safety behaviours that maintain disorders are seen in CBT models of Panic and Hypochondriasis. CBT proposes that these are present at the outset of treatment whether this is pharmacological or psychological. Therefore these processes may warrant investigation at cessation and could apply during medication withdrawal especially as using medication itself could function as safety seeking behaviour. The three participants, two female and one male had been treated with CBT and medication for depression and on discharge expressed a desire to withdraw from medication. The first part of the study naturalistically tracks their belief changes as medication decreases; the second examines changes in these for two cases when a planned CBT intervention is introduced due to possible relapse. The third case underwent an unproblematic withdrawal. All three cases had unsuccessfully attempted to withdraw from antidepressants at least once previously. Case-specific, daily self-monitoring diaries were used throughout all phases to measure target variables. Standardised questionnaires were used at baseline, mid-point and post treatment up to six months follow up. Results show a series of changes in symptoms, appraisal of symptoms and beliefs about medication over the course of the study. Therapeutic gains stabilised and the participant remained medication free at six months follow up. The pattern of change is discussed in terms of current approaches to medication cessation and the possible role of planned and focussed CBT during and immediately following withdrawal.

Traumatic psychosis

Pauline Callcott. Newcastle Cognitive and Behavioural Therapies Centre, UK

Acknowledgements, Sally Standart, Mark Freeston and Caroline Johnson Newcastle CBT Centre and Douglas Turkington University of Newcastle Upon Tyne.

Increasingly, the link between trauma and psychosis is recognised. The difference in PTSD psychosis presentations is that PTSD is often undiagnosed (Read et al 2001) and untreated and the individual and professionals involved do not always make a link between trauma and the presenting symptoms. (Morrison et al 2003). This suggests there is much to be learned about the relationship between the symptoms of PTSD and Psychosis and that formulating those links with the individual can lead to sustained therapeutic gains. In this case series Psychotic and PTSD symptoms were measured using standardised measures as well as individualised measures targeted carefully to the needs and problem list. At the end of treatment reduced distress associated with all symptoms, both psychotic and PTSD related, once PTSD was addressed using relevant CBT techniques.

Providing alternative explanations for delusions: single case examples

Robert Dudley: University of Newcastle and South of Tyne Early Intervention in Psychosis service

Inherent in the definition of delusions are two key features. The first is the unlikely or false nature of the belief that is usually held with a high degree of conviction. The second is concerned with the non acceptance of readily available, less distressing explanations. In CBT we often ask people to consider whether there are other explanations for their experiences. However, people with delusions may find it harder to generate or consider other explanations. In this case study, the belief in the original delusional explanation is recorded over time, along with key factors such as emotional reactions. Also we recorded the belief in alternative, less distressing, but non delusional explanations, over the course of treatment. As conviction in the delusional explanation reduces there is a steady increase in the belief in the alternative explanation. The theoretical and clinical implications of this case example will be considered.

Single case methods applied to supervision of CBT.

Peter Armstrong: Newcastle Cognitive and Behavioural Therapies Centre.

Explicit contracting of CT supervision enables participants to better define the key learning goals of the supervisee. Such definition facilitates measurement of a range of factors within the supervision (e.g. quality of supervisory relationship, clarity of roles, adequacy of supervisory methods) and of the supervisee's development. This development can be tracked in terms of both ideographic (e.g. personal learning targets) and more objectively-identifiable variables such as elements of competency as described by CTS-R. Such tracking of Supervision via single case methodology can in turn be used to

validate or revise the model of supervision (in this case 'The Newcastle Cakestand') applied to the 'case' studied.

Self-help: how does it work out in practice?

Convenor and Chair: Chris Williams, University of Glasgow

Uptake, preferences and outcomes for self-help guided by computer vs workbook in patients referred for therapist-guided CBT for depression

Mark Kenwright, John Burrowes, Karen Wilson, Kiran Sharma, Mark Barber. West London Mental Health NHS Trust

Self-help CBT packages are recommended as an effective intervention for anxiety and depression in primary care (NICE, 2004), but many experienced CBT therapists required to set up and manage such new service developments are currently based in secondary care services. In such services, long waiting times may pressurise CBT therapists to offer self-help packages to patients waiting for therapist treatment. This naturalistic study examined patient uptake, preferences and outcomes between two self-help packages for depression (workbook vs computer), when offered to patients on a waiting list for therapist-guided CBT in a routine secondary care CBT service. 191 patients referred to the Ealing CBT service with depression were pre-screened for suitability for self-help. Patients were offered their choice of package – a workbook from home with brief therapist support by phone or a standalone computer at the clinic with brief face-to-face therapist support. Rates of uptake and preferences for either package will be presented, along with outcomes for computer vs workbook up to one month follow up on self-report measures: Beck Depression Inventory, Beck Anxiety Inventory, Work and Social Adjustment Scale, single item depression scale, patient satisfaction scales. 30% of referred patients were suitable, and accepted self-help. Improvement was similar for workbook vs computer, but reasons behind preferences for either package were very different. The implications of the findings for service configuration will be discussed.

Can practitioners let go and let patient's help themselves?

Frances Cole, General Practitioner. Wendy Iredale, University of Huddersfield.

Nigel King, University of Huddersfield. Rod Sutcliffe, University of Leeds.

Chris Williams, Glasgow Institute of Psychosocial Interventions (GIPSI) and University of Glasgow.

Training primary care practitioners leads to improvements in using CBT self-help materials and in building therapeutic relationships but not enablement skills. The consequence some patients were less likely to be offered access to self-help materials, mainly determined by the practitioner's decisions. This presentation shares the results of the characteristics of practitioners who collaborate both successfully and unsuccessfully in engaging patients in self-materials and management of their psychological problems. This work suggests that further training may need to address these issues before recommendations such as those by NICE for the routine consideration of bibliotherapy can be widely used.

START: Self-help treatment in primary care.

Williams, C. University of Glasgow. Rafferty, L. Stuart Reid, Sheraz Ahmad, Jennifer Brodie, Robert Hinshelwood, Greater Glasgow NHS Primary Care Division.

Jill Morrison and John Norrie, University of Glasgow

Since October 2004 the START project has overseen the training and introduction of the 'Self help Support Worker' within four Primary Care Mental Health Teams (PCMHT's) in the Greater Glasgow area. This is part of a Scottish Executive Health Department initiative Doing Well by People with Depression - led by the Centre for Change and Innovation (<http://cci.scot.nhs.uk/>). The role of these Self-Help Support Worker's has been to deliver 'Overcoming Depression: A Five Areas Approach' - a series of Self Help workbooks or CD-Rom to patients with mild to moderate depression and to support them in their use of these materials. Six months from the introduction of the Self- Help service to PCMHT's in Glasgow there has been a total of 223 patients referred to the START project across the four sites. The number of patients referred to each of these Primary Care Mental Health Teams since the start of the project totals 813 thus the START project have received 27% of the total referrals to these teams. Patients received a mean of 3.75 sessions of treatment by the self-help support worker. All sessions are delivered using a structured protocol. The mean CORE score at first appointment was 1.64, dropping to 0.97 at the end of treatment ($p < 0.001$). 62.5% of patients who completed treatment had end of treatment CORE scores representing that of sub-clinical population. The CSQ-8 (Client

Satisfaction Questionnaire) has been used routinely with clients. This consists of 8 items rated 1-4. These are rated both individually and combined (score 0-32 with higher scores reflecting greater satisfaction; Larsen et al, 1979). The mean score has been 29.0 (92%). Conclusions: The early data has shown that the project is having a significant impact. Overall 4 self-help support workers who are only working for 3 days a week on the project have seen an average of 27% of all referrals to the primary mental health care teams. They have been able to work safely and manage risk well. Only one fifth of patients have needed additional interventions. The treatment has been remarkably effective and timely consisting with less than 4 sessions on average and only about 3 hours in total face to face time. Patient satisfaction has been high and clinical impact both clinically and statistically is very significant. Details of the project are described at www.fiveareas.com.

A Primary Care Based Mental Health Book Prescription Scheme

Frude, N.J. Cardiff and Vale NHS Trust

The majority of adults with mental health problems are treated exclusively in the primary care context. Resource limitations mean that treatment is usually pharmacological, despite the fact that psychological treatment would often be the treatment of choice. This paper presents an innovative book prescription scheme that provides a way of offering a form of psychological therapy to the majority of adults who present in primary care with mild or moderate mental health problems. This bibliotherapy scheme has been running in Cardiff since March 2003 and involves collaboration between secondary and primary care, and effective collaboration between the NHS and local government (via the library service). The strategy will shortly be employed in a national (all Wales) scheme 'Book Prescription Wales'. Similar schemes have now been implemented in over 40 regions of the UK, with many more in active development. It is argued that such schemes are not only highly cost-effective but can be cost-saving. In line with current enthusiasm for increased patient self-monitoring and self-management, schemes such as this could represent an important strategy for facilitating more effective patient self-care across many areas of mental and physical health.

A supported self help book prescription scheme within primary care: Development and early evaluation

Farrand, P, School of Clinical Psychology, Mental Health and Disability, University of Plymouth.

There has been a large increase in the number of self administered self help book prescription schemes for mild to moderate mental health problems across the UK. The Devon Book Prescription Scheme has evolved out of these schemes. Within the Devon scheme however support in the use of self help is also offered through specialist self help clinics run by graduate mental health workers. Such clinics are based upon the 2+1 model of support for self help, whereby clients receive an initial 30 minute assessment and information concerning self help, followed by two weekly/fortnightly 15 minute sessions to support the use of self help or offer motivation to continue usage. During the final 15 minute session twelve weeks later, the client is reassessed and signposted to other mental health or community based services when appropriate. Little however is known about the added effect that offering such support has over self administered self help schemes with respect to treatment efficacy or self help usage. This presentation will overview the development of the supported self help book scheme and present preliminary data on clinic usage and treatment efficacy.

Living Life to the Full: delivering CBT self-help in a Further Education College setting.

Wilson, A. NHS Greater Glasgow Mental Health Division. Ross, S. NHS Greater Glasgow Mental Health Division. Williams, C. University of Glasgow.

This new course is aimed at anyone who is interested in building key life skills that will help them to understand the causes and impact of depression and anxiety. The course is held within a community-based Further Education College and is advertised in the same ways as Digital Photography and car mechanic courses. The aim is to provide access to CBT self-help for anyone who wishes it. We present the initial impact of the course in addressing people's knowledge and self-perceived skills of managing their own mood. The Living Life to the Full course aims to increase access to information and skills of self-management of common mental health problems by people in the general community. This may include a wide range of people including those with current or past histories of contact with psychiatric services, carers, and health care practitioners wishing to learn these skills. The aim is to disseminate access to useful information and skills about anxiety and depression in a non stigmatising venue. 8 sessions of 2 hours are held weekly at Anniesland College of Further Education in Glasgow. It is planned that the course will expand into an additional 5 Colleges in the Glasgow area by the end of the year. An on-line version of the course will be available free of charge from August 2005 at www.livinglifetothefull.com and is supported by the Scottish Executive Health Department initiative "Doing Well by People with Depression" - led by the Centre for Change and Innovation (<http://cci.scot.nhs.uk/>). A variety of volunteer trainers offer the training in this series of evening. The

course is aimed at anyone who is interested in building key life skills that will help them to understand the causes and impact of depression and anxiety. Based on the Overcoming Depression and Anxiety Five Areas materials (www.fiveareas.com), the focus of the course is to teach key skills that can be used to help tackle problems that are commonly encountered. These include learning how to deal with practical problems, rebalancing relationships by becoming more assertive, learning how to overcome problems of reduced activity, how to improve sleep quality and finally how to begin to notice and then challenge extreme and unhelpful negative thoughts. These are the sorts of skills we all need in life, and they can be used by those attending or shared with others attendees know or work with. The course is advertised as being particularly useful for anyone who wishes to find out more about these common emotional difficulties and how to respond to help change things for the good. Feedback from the course has been good, and learning gains will be summarised, and learning points in developing the course discussed.

Doing clinically relevant research: "There is more than one way to skin a cat"

Convenor and Chair: P. M. Salkovskis, Institute of Psychiatry

"Under the Microscope": Experimental & Analogue Studies

Davey, G, University of Sussex

Clinical research on analogue populations is becoming increasingly accepted as a legitimate way of furthering our knowledge of psychological disorders. This paper will discuss the relevance of analogue studies and the way in which they can contribute to theory building in clinical psychology. Particularly important in this respect is the use of controlled experimental manipulations with analogue populations, and the light that such procedures can throw on the mechanisms underlying a range of psychopathologies.

"It's good to listen": Qualitative research from a phenomenological perspective

Pistrang, N., and Barker, C. University College London

This paper discusses ways in which practitioners can use qualitative research methods in their work. In particular, it looks at the theory and application of phenomenological approaches to qualitative research, which focus on an in-depth understanding of the participant's psychological world. Such approaches have much in common with the activity of careful listening and empathy in clinical work, and thus can be highly congenial to cognitive therapists. The paper highlights the similarities and differences in taking a phenomenological stance in clinical work and in research. It presents an overview of methods and good practice guidelines for qualitative research, illustrated with examples from published studies. We hope to demonstrate that studies using a phenomenological approach can be conducted in a systematic and rigorous way, and that they make a valuable contribution to the evidence base for clinical interventions.

At the coal face: turning good clinical practice into high quality research

Brown, J.S.L., Institute of Psychology, Kings College London

This presentation will describe two different kinds of research I have undertaken. I will first describe my experiences as a NHS psychologist, evaluating different kinds of clinical work, whether of the clinical service or of specific interventions I was involved in. This led to the evaluation of different kinds of large-scale mental health promotion workshops (each for up to 25 people), first focussing on Stress, then on Depression and then on Self-confidence. The presentation will then describe more recent developments when I have used a more experimental approach, examining the definitions of Self-confidence and Self-esteem more closely, with a view to applying the results back into the clinical setting.

"A foot in both camps": Collaboration between clinical and non-clinical scientists

Salkovskis, PM, Institute of Psychiatry, KCL and Tang, NKY, Institute of Psychiatry, KCL

It is an open secret that an individual requires an enormous amount of time, effort and expertise to realise the benefits promised by the scientist-practitioner model of clinical psychology. Whilst clinicians generally appreciate the value of doing clinically relevant research, many are deterred by the complexity involved in the actual integration of research and practice in their everyday work. In this presentation, we will consider a "win-win" collaboration between clinical and non-clinical scientists. We will examine the process of doing clinically relevant research from both perspectives, highlighting the potential gains that could be obtained from working with colleagues who have similar research interest but different training backgrounds. Through practical examples, we will illustrate how it is possible for academically-oriented and clinically-oriented researchers to work creatively together as a team.

NICE Guidelines For Depression: Do We Deliver Nice Services?

Convener: Chris Williams University of Glasgow

CBT and Depression

Paul Gilbert, Mental Health Research Unit, Kingsway Hospital, Derby

CBT has proved to be effective for a range of depressive disorders. However, the active ingredients remain somewhat elusive and new 'varieties' of CBT are appearing constantly. For example, cognitive behaviour analysis focuses on the consequences of the behaviour. What little evidence there is also suggests that there are differences between treatment centres which may relate to 'skillfulness' of therapists. This raises very major concerns as increasing numbers of training courses are appearing with little quality control. This talk will sound a word of caution in that the rush to provide more CBT could also be its undoing.

NICE antidepressants?

R. Hamish McAllister-Williams, School of Neurology, Neurobiology and Psychiatry, University of Newcastle

The NICE depression guidelines include recommendations for the use of both psychotherapies and medication in the management of depressed patients. However, many of the most contentious issues in the document relate to antidepressant usage. The publication of the depression (and anxiety) guidelines in December 2004 were delayed for some considerable time primarily due to a number of controversies regarding the use of antidepressants. These included concerns regarding whether some drugs are associated with suicide and possible cardiotoxicity of a widely used drug. Further, when the guidelines were published the most reported headline in the lay press related to the recommendation not to use antidepressants in mild depression. This presentation will discuss the use of antidepressants in depressive illness in the context of holistic management, as well as addressing the various contentious issues regarding their use. It will be argued that there is a legitimate place for their appropriate use alongside psychological therapies.

The compassionate focus for the cognitive-behaviour psychotherapies

Convener and chair: Paul Gilbert, Mental Health Research Unit, Kingsway Hospital Derby

Discussant: Ann Hackmann, Oxford Cognitive Therapy Centre

A group program for Compassionate Mind Training for people with long-term complex problem attending a day unit.

Paul Gilbert, Mental Health Research Unit, Kingsway Hospital Derby and Sue Procter, Cognitive Therapy Group Program Day Unit, Derby

This paper will give a brief outline of the basis of compassionate mind training. We will then outline how (9) patients with long term and complex problems, attending the day unit, volunteered for a 12 week research project on Compassionate Mind training. We will discuss the nature of their difficulties and reflect on the process of the therapy for these individuals. Data will be presented on various measures of change.

Compassionate Mind Training with individuals in the early stages of a Dementia Syndrome experiencing shame and self-attacking

Gwyn Higginson, Bradwell Hospital, Newcastle-under-Lyme

Compassionate Mind Training is a new adaptation to Cognitive therapy that focuses on developing a compassionate focus. My talk will discuss how these techniques can be offered to individuals in the early stages of a dementia syndrome who have self awareness of the impact of the effects of memory impairment in their daily life and who as a result are experiencing feelings of shame and self attacking. A case study will be presented to illustrate how autobiographical history of past skills and hobbies integrating client's strengths, memory assets and alternative senses can be used to facilitate a compassionate voice.

Compassionate mind training for people who hear malevolent voices

Sophie Mayhew, Derbyshire Mental Health Trust

Compassionate mind training aims to reduce shame, self-blame and condemnation and increase self-compassion. This therapy was developed for non-psychotic individuals with chronic self-attacking. Hence there is no data on how voice hearers would engage with and experience efforts to develop self-compassion. This study is a case series design that invited voice hearers to collaboratively explore compassionate mind training and provide feedback as to its value. In addition, data was gathered on individual change in voice hearing, self-compassion, depression and anxiety. Research findings, insightful voice hearer feedback and implications for future research and practice will be discussed.

The Use of Compassion imagery in PTSD.

Deborah Lee, Oxford Cognitive Therapy Centre

This paper will explore developments in compassionate mind training with a special focus on developing a person's concepts and images of the perfect nurturer. The way compassionate mind training can be applied to people suffering for various PTSD, especially in the context of high shame, will be discussed.

NICE Guidelines For PTSD: A Summary Of Key Recommendations

Convenor and Chair: Jonathan Bisson, Co-Chair, NICE Guideline Development Group and Cardiff University

Setting the scene

Johnston, SJ, Ashford Counselling Service

Much can be learnt from the experiences of individuals directly involved in traumatic events and their aftermath. The Herald Assistance Unit was set up by Kent County Council in 1987 and managed by Janet Johnston. This discreet service lasted for a year and four months following the capsizing of the Herald of Free Enterprise off Zebbrugge on 6th March and was based on recommendations from Bradford Social Services following their response to the Bradford football stadium fire in 1986. Since 1987 Janet has helped the Kent County Council Social Services and Emergency Planning Department to develop its Psychosocial services in readiness for critical incidents. This has involved annual training programmes for multi agency staff groups. Janet will describe what happens organisationally when disaster strikes, what it is like for the community and for individuals who may develop PTSD. She will also discuss issues raised by PTSD sufferers who committed themselves to the development of the NICE Guidelines? There is sometimes a mismatch between what society perceives as PTSD sufferers' needs and what they actually need. This must be addressed to provide effective interventions and will be considered with reference to testimonies from the NICE guidelines. Janet will also discuss why this is such an important document and consider whether it will lead to gold standards of care that can be implemented.

The NICE PTSD Guideline: Key Recommendations - International Comparisons and Challenges for Implementation

Stephen Pilling (Guideline Facilitator), The National Collaborating Centre for Mental Health

PTSD is a treatable condition for which trauma focused psychological interventions (CBT and EMDR) are the treatments of choice and so should be developed in the NHS. Other treatments such as single session de-briefing are unlikely to be of benefit and so should not be part of routine care in the NHS. This paper will summarise the key recommendations for pharmacological and psychological treatment in the recent NICE PTSD guidelines. It will also briefly compare these recommendations with other international guidelines for the treatment of PTSD, highlighting where appropriate differences in key recommendations. It will also consider the challenges this presents for implementation in the NHS.

Non-treatment recommendations

Jonathon Bisson, Cardiff University

In addition to treatment recommendations the NICE guidelines made many other recommendations that should improve the quality of care provided to PTSD sufferers. Appropriate assessment and high rates of detection are essential. There is no good evidence to support the routine use of general population screening for PTSD but it is recommended that targeted screening for high-risk populations be considered after traumatic events. Assessment must take into account individuals' cultural, religious and

other beliefs. It should also assess whether individuals are ready to undergo treatment with trauma focused psychological intervention or whether a phased approach is indicated with emotional stabilization and resolution of social/practical issues first. The impact on family members should also be addressed, supporting them may be vital to help the PTSD sufferer recover. The guideline also discusses the importance of disaster planning in a multiagency manner. Finally five key areas for future research have been identified - establishing effective trauma focused treatments for children; guided self help programmes; screening programmes; enhanced trauma focused psychological interventions; and the comparison of psychological and pharmacological interventions.

Practice-based evidence: Researching NHS delivery of CBP

Convenor and Chair: Tom Ricketts, Sheffield Care NHS Trust & University of Sheffield

Introduction

Tom Ricketts, Sheffield Care NHS Trust & University of Sheffield

The development of effective cognitive behavioural approaches has been described as involving the interplay between theory, psychological research and clinical evaluation. An important further stage in this process is evaluating the transfer of approaches from those centres where they have been developed to the wider health-care delivery arena. One approach to evaluate that transfer is termed 'practice-based evidence'. This symposium will provide a brief introduction to practice-based evidence research approaches followed by four presentations. Each of these presentations will focus on different settings in which a practice-based evidence approach has been taken within the NHS to address important clinical questions.

An evaluation of large group CBT psycho-education for anxiety disorders delivered in routine practice.

Houghton. S., Sheffield Care NHS Trust.

Cognitive behavioural therapy (CBT) has been shown to be an effective psychological therapy for a wide range of mental health problems (Dept. of Health 2001). However there are well documented limitations to the accessibility of CBT for patients attending NHS services (Lovell & Richards 2000). Typically CBT is provided by specialist secondary or tertiary services which suffer from high demand relative to availability. This problem has become more acute with the drive towards evidence-based mental health care and the increasing scope for the utility of CBT. Consequently waiting times for CBT have grown with many services reorganising their delivery systems to accommodate a rising tide of referrals.

Are routine clinical decisions regarding the allocation and suitability of patients within an integrated NHS psychotherapy service theoretically congruent?

Saxon. D. Specialist Psychotherapy Service, Sheffield Care NHS Trust

The Sheffield Specialist Psychotherapy Service is an integrated NHS psychotherapy service comprising of a Cognitive Behavioural Psychotherapy (CBP) team and a Psychoanalytic Psychotherapy (PAP) team. Referrals are received and managed centrally, with allocation to each of the teams according to clinical judgement regarding the likely effectiveness of the chosen approach for the individual. Using routinely collected demographic and diagnostic information and a standardised routine outcome measure, (CORE - Core System Group 1998), this study describes the patients referred to the Service, and contrasts those allocated to the PAP or CBP services. With obvious resource implications, it assesses whether 'routine' practice decisions are theoretically congruent to each modality and are consistent regarding who is accepted for therapy by which modality.

Influencing practice using routine outcome data in primary care.

David Ekers, County Durham & Darlington Priority Services NHS Trust.

With the ever-increasing demand for psychological interventions in primary care settings services are faced with an interesting dilemma. Primary care is expected to manage high volumes of patients with 'common mental health issues' whilst delivering high quality interventions recommended by NICE. The availability of adequately trained professionals to deliver such interventions remains inadequate. In this presentation the approach of self-help will be outlined in the context of this challenge and local stepped care developments. The content and evaluation of a training package aiming to equip practitioners with relevant skills will be outlined. We will also review the role and evolution of the use of implementation of routine outcome tools (Clinical Outcome in Routine Evaluation CORE), to inform service development. Outcome data (n=2500) will be presented with an aim to highlight the difficulties in the use of such

systems across a wide geographic area. Lessons learnt regarding the use of such systems in service governance will be discussed in relation to future planned developments.

Comparing efficacy and effectiveness outcomes in CBT and other therapies

Michael Barkham, Elspeth Twigg, Anne Rees, Chris Leach, Mike Lucock, Gillian Hardy, David Shapiro, Peter Bower.

Randomised controlled trials are often held as being the 'gold standard' for determining the credibility of interventions. How far the outcomes achieved in these efficacy studies are mirrored in clinical practice is an important question for practitioners and policy makers. In this study we compare the outcomes of cognitive-behavioural, psychodynamic-interpersonal, process-experiential and client centred therapies for the treatment of depression from a pool of published efficacy studies with a number of effectiveness studies that include outcome data from routine NHS practice across primary and secondary care settings. Differences and similarities between therapies and settings will be highlighted and discussed.

Issues in the safe delivery of computerised CBT

Convenor: Rob Waller, University of Leeds

Chair: Ann Garland, President, BABCP

Computerised CBT is increasingly common and has been the subject of two NICE reviews, the most recent in 2005. Whilst there is evidence to support its efficacy in randomised controlled trials, debate continues over its effectiveness in routine clinical practice and little work has looked at potential adverse consequences. If self-help is to be widely available then it needs to be directed to those most likely to choose it and benefit from it; and be safe for those who might use it inappropriately or unwisely. This symposium looks to review current evidence and the group discussion at the end of the presentation will be on the content of guidelines for the safe delivery of computerised CBT.

The Adverse Consequences of Computerised Cognitive Behavioural Therapy - A Systematic Review

Rob Waller, University of Leeds and Simon Gilbody, University of York.

Rob Waller and Simon Gilbody will present the results of a Systematic Review of potential adverse consequences associated with computerised CBT. It is based on the papers identified in the most recent NICE guidelines but examines them from a different point of view, seeking answer some of the following questions: Who does Computerised CBT NOT work for? To what extent are adverse consequences planned for? What risk assessments should be used? What happens to people who drop out of computerised therapy? How acceptable is it to clients?

Reasons for choosing or refusing self-help: who wants a computer and who wants a book? Results of a naturalistic study for depression

Mark Kenwright, John Burrowes, Karen Wilson, Kiran Sharma, Mark Barber. West London MH NHS Trust

This paper presents the qualitative data from a naturalistic study of self-help in a routine NHS specialist CBT service. Patients referred for depression were pre-screened and offered the choice of supported self-help by computer or workbook whilst they waited for therapist treatment. 58 patients, out of 134 screened as suitable, accepted the offer of self help. Reasons for accepting or refusing self-help, along with reasons behind preferences for computer vs workbook, and the patient characteristics involved, will be presented. The evidence reveals users choices regarding the timing, location and method of self-help. The implications for designing new service delivery strategies that may include computerised self-help packages will be discussed.

Uptake of, satisfaction with and further treatment required of completers and non completers of Computerised Cognitive Behavioural Therapy

Robert Dudley, University of Newcastle Upon Tyne, and Early Intervention in Psychosis Service South of Tyne and Wearside Mental Health NHS Trust

The Newcastle Cognitive and Behavioural Therapies Centre like many settings, experiences considerable demand for clinical services, resulting in long waiting times. As one of a number of waiting list initiatives we have undertaken an evaluation of Computerised Cognitive Behavioural Therapy (CCBT, Overcoming Depression CD Rom) for depression. Participants were interviewed by a clinician

prior to commencing and at the end of treatment. The treatment was self administered with an assistant psychologist available during the sessions to provide appropriate advice. Participants complete BDI, BAI, CORE, GAF, 5EQD as well as a measure of satisfaction. Despite reductions in symptoms for those completing treatment, most people did not accept the offer of treatment or dropped out prior to completion. Out of 61 people screened, only 12 completed treatment. In this presentation drop out rates at each stage of treatment, satisfaction data are reported. As the CCBT was offered as a 'while you wait' option the subsequent uptake of CBT from a therapist rather than in a self help setting, as well as the perceived outcome of this option will be reported.

CBT self-help for depression and anxiety: identifying hidden delivery issues

Macleod, M. and Williams, C. Psychological Medicine, University of Glasgow.

CBT self-help is recommended in the NICE guidelines for the treatment of anxiety and depression. However, little is known about how best to select patients for self-help, nor whether these approaches have adverse consequences. This project researched practitioner use and attitudes to self-help and focused on these two areas. The most recent definitive review of systematic reviews and meta-analyses of self-help which focuses on delivery in practice (Lewis et al., 2003) was examined in detail to identify any patient factors which may predict success with self-help and any adverse consequences already identified in the existing evidence based literature. Little information was identified and so this was supplemented by a survey of expert CBT practitioners accredited by BABCP (www.babcp.com). Self-help materials were looked upon positively by therapists and were used by 99.2%, mainly as an adjunct to individual therapy. Only 39.8 % had been trained in the use of self-help, with those trained being more likely to often recommend self-help than those untrained. Higher levels of patient motivation, patient belief that self-help can make a difference, likely adherence and self-efficacy were the four factors found by the literature review and by more than 68% of expert practitioners to predict a successful outcome with self-help. Limited evidence of adverse consequences was identified in the evidence base, and only three additional factors were identified as very important by more than 68% of practitioners. These were consequences of low compliance, lack of detection of worsening of patient clinical state, and the risk of the misinterpretation and poor application of self-help materials. The following step of this research is to incorporate these patient factors into a clinical checklist to check its predictive validity in selecting patients who can make good use of self-help. This will help clinicians screen for patients likely to succeed with self help and offer alternative options to those who may struggle to work in this way. A follow-up study will be carried out to assess the efficacy of the checklist and the likelihood of the identified adverse consequences.

Research on PTSD, a meta-analysis and development of the NICE guidelines

Convenor and Chair: Jonathon Bisson, Cardiff University

Meta-analysis of pharmacological and psychological interventions for PTSD: key stages and methodological approach

Matthews, R, M National Collaborating Centre for Mental Health

This presentation outlines the common methodological approach adopted by the following three papers to be presented at this symposium. The presentation outlines the stages of the review process from the systematic literature review undertaken to identify relevant studies of treatment interventions (both psychological and pharmacological), to study selection and synthesising the evidence. Further, this presentation will explain how critical a priori decisions such as inclusion, exclusion and quality criteria, classification of treatments and setting thresholds for clinically important change were arrived at.

Early Interventions for PTSD

Richards, David A. University of York, UK on behalf of the NICE PTSD Guideline Development Group

PTSD is a distressing and disabling condition with limited spontaneous recovery from diagnosis. There is great concern to ameliorate the impact of events by responding early following traumatic incidents. However, the prevalence of initial distress following a traumatic event is far greater than that of either acute stress disorder or PTSD and potentially we may deliver interventions to people whose problems would spontaneously remit. There is a debate between those who would provide some intervention for all survivors of traumatic incidents, and those who advocate waiting and targeting interventions at people likely to develop chronic PTSD. A systematic review of early interventions for PTSD, conducted as part of the NICE Guideline development process identified three groups of early interventions: treatment for all – studies that investigated treatments delivered to all traumatic incident survivors,

normally within the first month after the incident; early psychological interventions for acute PTSD and acute stress disorder – studies that investigated treatments delivered to people who were assessed as having a high risk of chronic PTSD, initiated within 3 months of the incident; early pharmacological interventions for acute PTSD and acute stress disorder – studies using drug treatments for people in the acute phase of the disorder. We found that trauma-focused CBT is the only treatment with a reasonable evidence base for early interventions in PTSD. It should be targeted to symptomatic individuals only and can be started within 1-3 months post-trauma. Non-trauma-focused treatments and individualised immediate interventions for all should be avoided.

Drug treatments of PTSD

Turner, Stuart, University College London (on behalf of the NICE Guideline Development Group).

There are important difficulties in comparing drug treatment trials with psychological therapy trials, such that drug trials are likely to produce lower effect sizes than comparable psychological treatment trials. This led to a lot of discussion in the Guideline Development Group. However, using our a priori criterion for a clinically important effect (Standardised Mean Difference less than -0.5), drug trials were disappointing in these meta-analyses. For paroxetine (one of the two licensed drugs for PTSD in the UK), there is a reliable, positive effect which is statistically significant but which failed to reach the target effect size for a clinically important effect. Including available data (we had to estimate SDs) from two large unpublished trials of sertraline, the other licensed drug treatment of PTSD, we were able to demonstrate neither clinically important nor clearly statistically significant effects. We did find single trials, meeting our quality criteria, supporting the use of the antidepressants mirtazapine, phenelzine and amitriptyline. They met our a priori threshold for a clinically important effect. However, caution is required in interpreting single trials and especially in comparing older trial and newer trial designs. We have also examined tolerability data and side-effect profiles. On this basis, we recommend that paroxetine and mirtazapine should be the drugs of choice for use in primary care (although the use of an unlicensed drug is the responsibility of the prescriber). The NICE guideline sets out recommendations for the appropriate use of drug therapies. Clinical services, especially in primary care, face a major challenge in shifting from widespread use of drug treatments to providing accessible trauma-focused psychological treatments with a more selective use of drug interventions.

Psychological treatments

Jonathon Bisson, Cardiff University

A systematic review and meta-analysis of all randomized controlled trials of psychological treatments for PTSD was undertaken. Thirty-eight RCTs were identified. Trauma focused cognitive behavioural therapy (TFCBT) and eye movement desensitization and reprocessing (EMDR) showed clinically important benefits over waitlist/usual care on measures of PTSD. The evidence base for EMDR was not as strong as that for TFCBT, both in terms of the number of RCTs available and the certainty with which clinical benefit was established. There was limited evidence that TFCBT and EMDR were superior to supportive/non-directive treatments, hence it is highly unlikely that their effectiveness is due to non-specific factors such as attention. There was limited evidence for stress management and group CBT but other therapies (supportive/non-directive therapy, psychodynamic therapies and hypnotherapies) that focus on current or past aspects of the patient's life other than the trauma or general support, did not show clinically important effects on PTSD symptoms. However, this may be due to the limited number of studies available and does not mean that these treatments were shown to be ineffective.

Money, Money, Money: How To Get Funding to Do Clinical Research

Chairs: Roz Shafran, University of Oxford University and Emily Holmes, MRC Cognition and Brain Science Unit, Cambridge

Funding opportunities provided by the MRC

Gillian Murphy, Neurosciences & Mental Health Board Medical Research Council, London

The Medical Research Council promotes research into all areas of medical and related science with the aims of improving the health and quality of life of the UK public. The MRC funds high quality research by supporting university researchers through a range of grant schemes designed to meet scientific needs and by personal awards for research training and career development. This presentation will give an overview of MRC's current funding schemes, with particular emphasis on funding for clinical research and trials, and training opportunities for clinicians, academics and members of allied health professions. The aim will be to provide guidance and tips for writing successful applications. In addition, information on new opportunities and new developments such as full economic costing will be highlighted.

Funding Opportunities From the Economic and Social Research Council

Michelle Dobson, The Economic and Social Research Council

The ESRC is the UK's largest funding agency for research and postgraduate training relating to social and economic issues. It provides independent, high quality, relevant research to business, the public sector and Government. The ESRC invests more than £93 million every year in social science and at any time is supporting 2,000 researchers in academic institutions and research policy institutes. It also funds postgraduate training within the social sciences to nurture the researchers of tomorrow. More at <http://www.esrc.ac.uk>

How to apply successfully for a research grant: a Chief Scientist Office view

P Craig, Chief Scientist Office, Scottish Executive Health Department

'All happy families are alike; each unhappy family is unhappy in its own way.' Leo Tolstoy, 'Anna Karenina'. Research grant applications are like families: there are more ways to write a bad one than a good one. Nevertheless, there are common problems that account for the majority of unsuccessful applications – and many of these are quite easily rectified. This paper will provide a brief guide to some of the key points clinical psychologists should bear in mind when they are seeking funding for applied health services research - including studies to develop screening and measurement tools for use in clinical settings, trials of psychological therapies and epidemiological studies of mental health problems. Using examples from real grant applications, successful or not, it will cover issues such as: getting started; defining research aims and questions; choosing a method; dissemination and implementation; and the importance of collaboration.

Funding opportunities provided by the Wellcome Trust

John Williams, The Wellcome Trust.

The mission of the Wellcome Trust is 'to foster and promote research with the aim of improving human and animal health.' To achieve our mission, we focus on four aims. First, to advance knowledge and understanding in the biomedical sciences and their impact on society - past, present and future. Second, to contribute to a long-term and vibrant research environment by supporting careers and equipping researchers. Third, to advance the translation of Trust-funded research into health benefits by promoting clinical research and encouraging its application. The fourth aim is to engage with the public through informed dialogue. To achieve our mission, we both award grants to other bodies and manage our own projects. Since 2000, we have awarded grants totalling £1.45 billion. The presentation will describe the work of the Wellcome Trust and the different funding schemes available.

Funding opportunities for CBT research.

David Veale, The Priory Hospital North London and Royal Free University College Medical School

One of the aims of the BABCP is to foster and promote research. Competition for grants is fierce and there are no grant giving bodies with a special interest in the theory or practice of cognitive behaviour therapy. The BABCP therefore started a research fund in 1999. There are two main current sources of income (a) conference registration fee (so that delegates can contribute something to research) (b) Gift Aid donations from Membership subscription. Ideas on further sources of funding would be gratefully received. Our policy is to offer one or more grants when we reach a target of about £25-30K (which we hope to do in 2006). No process has yet been agreed for applications for the first grant. It is envisaged that we will set up a small committee, invite applications from the membership and have a normal peer-review process.

Panel Debate

Key goals and techniques in the treatment of personality disorder

Speakers/Panellists: Kate Davidson, University of Glasgow & Greater Glasgow NHS, Scotland, Janet Feigenbaum, University College London, UK and Jeff Young, Schema Therapy Institute and Columbia University, New York, USA

Chair: Philip Tata Chair, BABCP Scientific Committee

There is a recognised need for Personality Disorder Services throughout the UK. Besides from 'traditional' CBT, Dialectical Behaviour Therapy and Schema-Focused Cognitive Therapy have developed in order to optimise the treatment of Personality Disorder. Each of these approaches has their own particular strengths and it is timely to consider what therapeutic goals and techniques best serve the treatment of this type of client. We have therefore gathered the following experts: Kate Davidson, University of Glasgow & Greater Glasgow NHS, Scotland, Janet Feigenbaum, University College London, UK and Jeff Young, Schema Therapy Institute and Columbia University, New York, USA, in the treatment of Personality Disorder who will: a) Provide a statement of their position on core goals and techniques of the CBT treatment of Personality Disorder b) Be available for questions and answers from the floor, following their position statements.

Open Papers

Service Delivery and Self-help

Chair Chris Williams, University of Glasgow

Is a 'Stepped Care' Service an Accessible, Acceptable and Effective Option for Those Experiencing Mild to Moderate Mental Health Problems?

Donna Gilroy, Greater Glasgow NHS Health Board

Introduction : STEPS provides specialist primary care services for those experiencing mild to moderate mental health problems (e.g., depression, anxiety, stress, panic). Primary Care interventions for common mental health problems are associated with high DNA and drop-out rates and 'gate-keeping', thus placing barriers to access for help. At present, services provide poor access, due to limited therapist resources, with only a minority of people seeking help able to receive therapy. 'Stepped Care' is increasingly being advocated as an efficient and effective way of delivering psycho-social interventions for a variety of different problems. (see Lovell and Richards, 2000; Bower & Gilbody, 2005 for further discussion). The STEPS team utilises a specialist 'stepped care' model of service delivery, which employs different modes, levels and intensities of psycho-social intervention, depending on the needs of the individual. STEPS offer a range of 'Rapid Access' Services in addition to offering brief CBT and Person-Centred Counselling. Bower & Gilbody (2005) highlighted the need to conduct evaluation of functioning stepped care models. As such, STEPS evaluated their service over the first six months of provision, looking at the following factors: 1) Level of accessibility of service to patients 2) Efficiency of the service 3) Acceptability of the stepped care model to patients and referrers 4) Type and level of severity of problems seen within the service " Effectiveness of the services offered in dealing with presenting problems .Method: Process and Clinical Outcome data have been systematically collated using a computer database, patient files, administration of clinical outcome and patient satisfaction measures. The following STEPS services were evaluated: 1) Individual Therapies (Cognitive Behavioural Therapy and Person-Centred Counselling). 2) Stress Control Courses 3) First Steps Support Group 4) Advice Clinic 5) Advice Line 6) Healthy Reading Book Prescription Scheme 6) 'Step Out Of Stress' Booklet Series (self help for a range of mental health problems) 7) Website: www.glasgowsteps.com. Results: Data from the first six months of provision is currently being collated and analysed. Preliminary results indicate a high volume, easy- to-access, flexible service that is running well in its early stages with significant capacity. Clinical measures indicate that the service is seeing problems well within the level of clinical 'caseness'; and not the 'worried well'. There was a relatively small pool of clinical outcome data at the 3 month stage. Results will be presented over the extended period of 6 months, allowing stronger conclusions to be made about accessibility, efficiency and effectiveness. Discussion: Discussion will centre round the patterns of uptake and throughput within the various steps, the nature and level of problems seen by the service, and the potential effectiveness of the services provided. Implications for service development will be highlighted.

Evaluating a multi-level, multi-option stepped care service presents unique challenges and these will also be discussed within the context of the results.

A Clydebuilt Multi-level/multi-purpose Service for Common Mental Health Problems.

White,J; Johnston,S; Joice,A; Petrie,S; Hutton,P; Gilroy,D. all STEPS primary care mental health team

While CBT approaches are strongly recommended for the treatment of common mental health problems (NICE guidelines, December 2004), the reality is that these services are scarce on the ground, relatively low volume, involve high drop-out and significantly poorer outcomes at the routine clinic level than at the research centre level. Long waiting lists are the rule in NHS services. Services, even at the primary care level, tend to focus on well-entrenched problems and little preventative or early intervention work is carried out. In addition, these approaches often fail to take into account the social realities experienced by service users. Other factors to be taken into account are the large number of people with these conditions who do not seek help (for a range of reasons), those missed at the primary care level, lack of relapse prevention approaches and the lack of user choice in most services. Most CBT approaches are based on a 'cure' model when, for many, keeping their heads above water may be a more realistic aim. Those with common mental health problems, at the primary care level, are more likely to be offered person-centred counselling or complementary therapy than CBT while there is growing concern at the amount of anti-depressant prescribing. In part, this is due to GPs having a lack of viable referral options. While additional resources would be welcome, we should be looking to better utilise existing resources. Stepped-care CBT models have the ability to greatly expand the options at the primary care level, not only to improve individual therapy but to develop more population-based approaches. STEPS is a primary care mental health team in a deprived area in Glasgow. We have developed a high volume multi-level / multi-purpose service that attempts to tackle the above problems. At the clinic level, we can offer individual therapy and a range of 'Rapid Access Services' (RAS) that offer a real alternative to prescribing and allow user choice. Individuals, not referrers, are responsible for choosing the RAS. Currently, these RAS include 'Stress Control' large group (100+) evening classes, Advice Clinics and Advice Lines, Mental health sections in public libraries, 'book prescribing' schemes, support groups run by an 'expert patient' ex-service user, self-help book series, website (www.glasgowsteps.com) and exercise options. At the community level, we are developing awareness raising approaches (Good Mood Week, DVD, 'StressMaster' days, etc) and working with a range of statutory and non-statutory groups. We are a Scottish Executive Exemplar site. This talk will look at the theoretical and practical rationales behind this approach

Healthy Reading: Book Prescription in Glasgow.

Simon Petrie, STEPS, NHS Greater Glasgow

Introduction: People attending NHS services with mental health problems are placing well documented pressures on the system, particularly on GPs as well as upon others within primary care settings. Recent statistics suggest 30% of all GP consultation time is taken up by patients reporting common mental health problems such as anxiety or depressive disorders (Corney et al., 1996). Anti-depressant medication tends to be the treatment of choice for such problems, with prescription rates having tripled within the past seven years (Scottish Executive data). The STEPS Primary Care Mental Health Team - recently formed in Glasgow, specialise in innovation in primary care, in attempting to address some of these pressures. The team are actively developing new and better means for people with common mental health problems to quickly gain access to high quality psychological help. One possible means of helping people with mental health problems is to recommend good self-help literature. It is from this basic premise that the ideas of the 'Healthy Reading' book prescription scheme was developed. It is based on the strategy of identifying high quality self-help books that GPs and other primary care professionals might confidently recommend to their patients. There is much evidence that demonstrates how effective the use of self-help books can be. Controlled clinical trials on books have generally indicated positive outcomes, with results often comparable to those achieved through drug therapy or psychotherapy. Bibliotherapy can provide substantial relief from mental health problems. One way of accessing self-help books is to issue paper prescriptions as a way of authorising and activating book borrowing via libraries. Through the use of such a scheme health professionals can write 'book prescriptions'. Following assessment, health professionals can consult a list of recommended books and issue a paper prescription for the book or books most relevant to the specific mental health needs of the individual patient. Librarians would then be able to 'dispense' the prescribed books, just as pharmacists dispense prescribed medication. There are several book prescription schemes running within the UK, with the scheme set up and running in Cardiff since 2003 proving particularly successful. The Glasgow book prescription project was launched in February 2005. Method: Evaluation of this project will involve answering the following questions. Over a set period of time (i.e. 12 months) :- 1) How many prescriptions have been written? 2) How many prescribed books are issued by the libraries? 3) How effective is bibliotherapy? 4) Are patients satisfied with bibliotherapy? 5) Are prescribers satisfied with bibliotherapy? 6) What are the effects of bibliotherapy on levels of medication prescribed for mental

health problems? 7) What are the effects of bibliotherapy on referral rates to other mental health services? 8) What are the effects of bibliotherapy on use of the libraries, membership levels, borrowing patterns etc.? Results: Preliminary results will be presented. Discussion: Discussion will centre round the uptake of this particular scheme, and projections of how effective, useful and popular bibliotherapy could prove to be. There will be discussion of the issues involved in the evaluation of book prescription projects, and also of the issues involved in setting up such schemes. Finally, there will be discussion of how well book prescription fits into a stepped care model of service delivery. Conclusions: Conclusions will be drawn, with a particular emphasis on ways of further developing this innovative means of delivering self-help psychological treatment.

A Controlled Trial of Assisted Bibliotherapy: An Assisted Self-help Package for Stress/mild to Moderate Anxiety.

Thomas Reeves, South of Tyne and Wearside Mental Health Trust

The majority of people who can potentially benefit from psychological treatments such as Cognitive Behavioural Psychotherapy (CBP) suffer from what are termed Common Mental Health Problems (CMHPs) of these Anxiety and Depression are the most common (Ekers et al 2004). Lewis et al (2003) observe that more recent mental health policy however has focused on people with severe mental health problems in secondary care services leaving primary care to deal with the rest. There are clearly not enough trained therapists to go round (Lovell and Richards 2000) and it is unlikely that there ever will be. There is increasing evidence however to suggest for a great many people with CMHPs formal therapy is unnecessary and short term treatments with limited therapist assistance can be just as effective (Lovell and Richards 2000), indeed NICE (2004) guidelines also suggest this. Assisted Bibliotherapy (AB) - a package designed by G Kupshik (1999) - is one such assisted self-help treatment which may offer a viable addition to existing services. It is an 8 week package of module handouts which are offered along with weekly 20 minute coaching sessions with a trained health professional. There is a strong CBP component to the literature as well as other tried and tested stress management techniques. The completion of weekly homework assignments encourages the practice of the strategies. It has undergone a previous controlled trial which indicated its effectiveness. This paper describes a controlled study of AB in two GP practices in Sunderland the effectiveness of AB was measured with The Clinical Outcome in Routine Evaluation Score (CORE) (CORE system Group 1998) and the Hospital Anxiety and Depression Score (Zigmond and Snaith 1983). Measures were administered to the treatment group pre treatment, post treatment and at 3 month follow up. The control group completed measures at initial assessment (pre) and after an 8 week period (post). Measures of satisfaction and compliance to the treatment were also completed. Early results indicate that both groups improved, however the treatment group improved significantly more than the control group. Measurement of clinically significant change will also be presented. The study indicates that AB offers an effective treatment which can be provided in primary care settings by non specialist health professionals it is brief and popular with both patients and GP's. It is not just seen as compromise or "cheaper" option, it is an additional treatment option within primary care which is less intrusive than formal therapy, more convenient for patients and less stigmatising

Balancing clinical effectiveness with clinical efficiency in Primary Care: Comparing group psychoeducational CBT, with individual CBT and individual psychodynamic-interpersonal psychotherapy.

Kellett, S (Barnsley PCT), Clarke, S. (Barnsley PCT) & Matthews, L. (Barnsley PCT)

Introduction: Psychological therapies in Primary Care are typically under resourced, whilst being asked to treat ever increasing numbers of patients. Due to typically extended wait-times for treatment in Primary Care, the investigation of alternative, more clinically efficient, types of psychological intervention are indicated. The aim of this study was to assess whether group psychoeducative cognitive-behavioural therapy (CBT) was equivalent in terms of clinical effectiveness in comparison to individual CBT and individual psychodynamic/interpersonal (P/I) psychotherapy. Group psychoeducative CBT has been previously illustrated to be a clinically efficacious and efficient intervention for the anxiety disorders in Primary Care (White, 2000). Methods: The psychoeducative CBT group accepted an eclectic diagnostic mix of patients referred from Primary Care, which is the norm for such service provision (White, 2000). Participants in the group completed four validated measures of mental health (BSI, IIP-32, BDI-II & GHQ-12) at assessment, start of group therapy, termination of group therapy and at three-month follow-up. 43 complete data sets were available for analysis. The intervention consisted of six two-hour group psychoeducative CBT sessions using the White (2004) 'stress control' approach, which has been recently redesigned to also encompass management of depressive, as well as anxious, psychopathology. The two individual treatment comparison groups were constructed from primary care treatment episode records taken from the local audit and evaluation system (Newman & Kellett, 2000). The individually treated patients were matched according to equality of therapy time input received in the psychoeducative group and contained a similar diagnostic mix. The individual CBT modality contained 68 patients and the psychodynamic-interpersonal psychotherapy 65 patients, with measures

completed only at initiation and termination of treatment in the individual modalities. Results: The psychoeducative group was effective in treating mental health problems across the diagnostic mix, with only 10 per cent of patients requiring further individual psychological intervention at three-month follow-up. Repeated measures ANOVAs indicate that the group members experienced reductions in depression, generalised and phobic anxiety and improvements in interpersonal functioning. Comparison of the outcome scores in an ANOVA between modalities, indicate that there were no statistical differences according to treatment type across the three forms of intervention. Analysis of clinically significant change, also recorded similar rates of clinical improvement in each of the treatment modalities. Conclusions: The results suggest parity and equivalence of outcome regardless of the mode of psychological intervention for clients in Primary Care; although the methodology can be criticised due the lack of randomisation, diagnostic mix and issue of parity of input

Behavioural Medicine

Keynote

**The best bridge between despair and hope is a good night's sleep'.
Psychological treatments for sleep disturbance and comorbid disorders.**

Professor Allison G. Harvey, University of California, Berkeley.

This talk has two broad aims. First, I will detail the current evidence base on the psychological approaches that are available for treating sleep disturbance. This will include the widely used cognitive behavior therapy for insomnia as well as a recently developed cognitive therapy treatment. A second emphasis of this talk will be on sleep disturbance that is comorbid with another psychological health problem. Everyone who engages in clinical practice knows that insomnia can occur as the sole presenting problem or as a condition that is comorbid with another psychological disorder. I will describe evidence suggesting that conceptualising sleep disturbance as epiphenomenal to the comorbid disorder is unwise because (1) sleep disturbance serves as a risk factor for, and can be causal in, the development and/or maintenance of the comorbid disorder and (2) substantial evidence is accruing to suggest that insomnia that is comorbid with another psychiatric or medical disorder does not reliably improve with the treatment of the so-called 'primary' disorder. The comorbid disorders that will be discussed include bipolar disorder, unipolar disorder, substance abuse, PTSD and chronic pain. In summary, unlocking the puzzles that the high rates of comorbidity between sleep disturbance and psychological disorders throw up is a burgeoning topic. In particular, the development of treatments with a dual focus are an exciting new domain for research and clinical practice.

Symposia

Overcoming Obstacles to return to work; The Prisma Programme

Convenor and Chair: Verina Wilde, Prisma Health Ltd

Discussant: Simon Darnley, Prisma Health

Managing Disability and Return to Work

Wilde V, Prisma Health Ltd

In 2003 British workers were off sick for 166 million days. The Confederation of British Industry estimates that sickness absence costs businesses in the United Kingdom 11 billion pounds per annum with over 3 billion pounds attributed to long term sickness (DWP 2004). Common health problems such as depression and anxiety, musculoskeletal and cardio-respiratory conditions now account for the majority of sickness absence, long term incapacity and early retirement, yet there is no absolute medical reason why this should be so (Waddell and Burton 2004). People in receipt of long term disability payments often see their situation as hopeless, believing that everything that could be done for them has already been tried and that any further attempt at rehabilitation is useless. Traditional healthcare systems are often unable to provide people with chronic disabilities with the comprehensive and intensive support that their situations require. This presentation will provide an overview of an interdisciplinary model of disability resolution (The Prisma Programme) which offers solutions that are often hard to access through other health care providers. Effective resolution of the disability is achieved by managing and coordinating input from various medical, psychological and other healthcare disciplines together with occupational and financial specialists within a cognitive behavioural framework. The importance of addressing the non clinical elements of disability (such as employment and financial issues) alongside the clinical issues such as depression, anxiety, pain or fatigue will be highlighted. Many people off work because of disability for a number of years are apprehensive about therapy, anticipating that it will not work for them when other approaches have failed. Prisma's approach to managing ambivalence and engaging the apprehensive client will be addressed, together with an exploration of common dysfunctional beliefs in this group of clients. The emphasis is on increasing function rather than eradication of symptoms. The focus from the start is on behavioural work related functional targets and work shaping and updating skills. Return to work is managed by either graded return to an existing employer or retraining and updating skills and liaison with Job Brokers or advice regarding self employment. Insurance companies and the Government are aware of the costs incurred when people are off work due to disability. A powerful indicator of the efficacy a disability resolution

programme is the cost savings it produces. Compelling data from a review by Watson Wyatt (Actuarial Consultants) will be presented to illustrate the savings that have been made for Insurance Companies on Income Protection claims when clients have completed the Prisma Programme. Implications for various stakeholders will be addressed.

'Not just CBT'

Darnley S. E. Prisma Health

Depression, anxiety and stress have now taken over back pain as the number one reason for long term work absence in the United Kingdom. If people are off sick for more than 6 months the current consensus is that they only have a 3% chance of returning to the work place. CBT is generally thought of as an effective treatment for depression and anxiety and yet when working with this specific client group many issues not traditionally associated with CBT become paramount. These include financial, family, insurance, lifestyle and employment issues. Using case examples we will discuss how these issues can be integrated into a CBT rational and framework. We will discuss practical solutions and demonstrate how this approach has had significant success in helping people return to work after long term absence.

Role of the Physiotherapist

Chaddock, CE Chartered Physiotherapist/Case Manager

The role of physiotherapists within interdisciplinary management of return to work will be examined. The difference between this and conventional physiotherapy with its emphasis on increasing function rather than symptom eradication will be explored. Methods of the 'hands off' physiotherapy approach to return to work will be explained including graded increases in function, identification of appropriate work shaping activities, including case examples. This will highlight the complementary roles of the physiotherapist and CBT practitioner which when combined enhance the return to work process.

The Medical Perspective on Sickness Absence and Return to Work

Alan Carson, Robert Fergusson Unit and Department of Clinical Neurosciences, Royal Edinburgh Hospital

Over the last 20 years there has been increasing evidence that patients' experience of symptoms correlates poorly with objective markers of pathology across a range of common medical conditions. Patients' illness beliefs and expectations, emotional state, and social circumstances will all contribute to the level of displayed disability. Many of these contributing factors are suitable for treatment with CBT. However, even allowing for an optimal therapeutic relationship and considerable change in the patient this is often not enough to facilitate a return to work. To return to meaningful employment often requires pragmatic solutions to practical problems, including financial negotiation over disability benefits and private health insurance. How these problems might be approached will be discussed. Sleep problems in adulthood. Co-occurring psychological problems and therapies

Sleep problems in adulthood. Co-occurring psychological problems and therapies

Convenor and Chair: Allison Harvey, University of California, Berkeley

Sleep and nocturnal panic

Craske, M.G. University of California, Los Angeles

Nocturnal panic, or waking from sleep in a state of panic, occurs relatively frequently among patients with panic disorder. This paper presents two sets of data. The first study addressed the role of attributions about physiological sensations that occur during sleep in nocturnal panic. Participants who were led to believe that physiological fluctuations were unexpected to occur were more likely to wake in a state of panic in response to false physiological feedback cues during sleep than participants who were led to believe that the same physiological fluctuations were expected and controls. In the second study, cognitive behavioral therapy, modified for nocturnal panic, was compared to a wait list control, for patients with frequent and regular nocturnal panic attacks. CBT was effective in reducing nocturnal panic attacks, and results were maintained over a nine-month follow-up. Clinical status changes were matched by changes in physiological and subjective reactivity to stressors relevant to nocturnal panic.

Sleep and chronic pain

Tang, NKY, Institute of Psychiatry, KCL

Sleep disturbance and chronic pain are closely related common health problems. It is conservatively estimated that 50% of patients with chronic pain have sleep disturbance that warrants clinical attention. Although these patients are usually prescribed sedative/hypnotics or antidepressants to improve sleep, many of these patients find the side effects of the drugs intolerable and continue to experience sleep disturbance as the pain persists. In this talk, I will consider the current theoretical perspectives on the mutual maintenance of pain and insomnia and examine the possibility of applying recent advances in the psychological understanding and treatment of primary insomnia to insomnia co-occurring with chronic pain. Two experiments will be presented that provide a test of the implicated cognitive-behavioural mechanisms underpinning insomnia in chronic pain as well as the effectiveness of psychological strategies for improving sleep in patients with chronic pain.

Sleep and PTSD

Hackmann, A. Department of Psychiatry, University of Oxford, and Institute of Psychiatry, London. Ehlers, A. Psychology Department, Institute of Psychiatry, London

Symptoms of posttraumatic stress disorder fall into three clusters: re-experiencing, avoidance and arousal. This paper examines what happens to two re-experiencing symptoms (intrusive memories and nightmares), and one arousal symptom (sleep disturbance), over the course of treatment.

The patients received an intensive programme of cognitive-behavioural treatment, delivered over one week, with three booster sessions. Treatment strategies used were derived from Ehlers and Clark's model of PTSD (Ehlers and Clark, 2000). Patients kept daily and weekly diaries recording frequency and other characteristics of intrusive memories, nightmares and sleep. The relationship between these variables over time will be examined. In addition several case studies will be presented, of cases where there were interesting simultaneous changes in intrusive memories and nightmares following a therapeutic intervention. Theoretical implications will be discussed.

Expecting to sleep badly: A self-fulfilling prophecy?

Kathleen Stinson¹, Allison G. Harvey^{1,2}, & Katriina Burnet¹. ¹ Department of Psychiatry, University of Oxford ² Department of Psychology, University of California, Berkeley

Published in Nature, Born et al. (1999) asked normal sleepers to spend three nights in the sleep laboratory. On one of the nights the participants expected to be woken at 6am. On the other two nights they expected to be woken at 9am. However, on one of these 'long sleep' nights the participants were actually woken, by surprise, at 6am. When the participants expected to be woken at 6am they exhibited an increase in their levels of adrenocorticotropin (a hormone that stimulates the adrenal cortex) from one hour before waking. But this was not observed when the participants were woken at the same time (6am) by surprise. These findings are important because they suggest that expectation pervades sleep and they raise the possibility that expecting to sleep poorly may compromise the quality of sleep. These findings may be relevant to a wide range of real world situations including (1) patients with PTSD who expect to be woken by nightmares, (2) patients who suffer from nocturnal panic attacks who expect to wake up in panic, (3) patients with sleep apnea or periodic limb movement disorder, and their bed partner, who expect to be woken, (4) 'on-call' workers, such as hospital workers and emergency services personnel, who expect to be woken, (5) parents of new infants who expect to be woken and, of course, (6) people with chronic insomnia who expect to sleep badly. The present study was conducted to begin the process of exploring the implications of the Born et al. study for chronic insomnia. A sample of 26 individuals with chronic insomnia was compared to 28 normal sleepers. All participants were asked to keep a sleep diary and wear an actiwatch (to provide an objective estimate of their sleep) for seven consecutive nights. The sleep diary was completed in the evening prior to going to sleep and immediately on waking. The nighttime diary asked the participant to record (1) how well they were expecting to sleep, (2) the basis of their expectation and (3) aspects of their 'current state' that were predicted to influence their expectation. The morning diary asked the participant to record how well they slept (SOL, WASO, TST etc). The results indicated that the insomnia group were more likely than the good sleeper group to expect that they would sleep badly. The insomnia group were also more likely to report sleeping badly. Expected sleep was highly correlated with reported sleep. The 'current state' variables most associated with expecting to sleep poorly were (1) concern and anxiety about sleeping badly, (2) negative affect and (3) state anxiety. It is concluded that cognitive models may need to be revised to incorporate the role of expectation in the development and maintenance of insomnia. Further, novel treatment approaches for ameliorating the effects of expectation may be required.

Hypnotics and sleep quality in older adults

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Chronic insomnia is both frequently reported and widely treated in UK primary care, where hypnotic drugs remain the treatment of choice. As a result, while hypnotic therapy beyond 3-4 weeks is widely regarded as clinically undesirable, long-term use remains common, particularly among older patients. This mismatch between the needs of patients with chronic sleep problems, and the short-term value of hypnotic drug therapy could be addressed by cognitive-behaviour therapy (CBT) for insomnia. While much of the research supporting the wider use of CBT for insomnia has been conducted by sleep specialists working in secondary care settings, recent evidence (Morgan et al, 2003) shows that CBT for insomnia can be effective when delivered by non sleep specialists working in primary care settings. In a Randomised Controlled Trial conducted in general practice, 101 patients (all chronic hypnotic drug users with insomnia) were offered a CBT 'package' delivered by specially trained primary care counsellors. Relative to the control group, CBT treated patients reported significantly improved sleep quality, significantly reduced hypnotic use, and significantly improved quality of life at 3, 6 and 12 month follow-ups. Using baseline and follow-up assessments from the 101 CBT treated patients and 108 control patients (total 209; age range: 31-92) included in the trial, this presentation examines: the clinical impact of chronic hypnotic drug use; the impact of CBT for insomnia on drug-use reduction and discontinuation; and the relationship between age and the clinical impact of CBT for insomnia. The results of these additional analyses indicate that long term hypnotic drug use is associated with generally poor sleep quality, while the clinical benefits of Cognitive Behaviour Therapy for insomnia appear to be age-independent.

Sleep-related cognitions and recovery from alcohol dependence

Smith, Neil T, Institute of Psychiatry. Hill, R. - South London and Maudsley NHS Trust. Wanigartane, S. South London and Maudsley NHS Trust / Institute of Psychiatry

The association between sleep problems and alcohol misuse is well-documented. Alcohol hastens sleep but the overall effect is one of sleep fragmentation, with sleep becoming shallow and shortened (Mendelson, 1987). The research on alcohol misuse disorders reveal that alcohol abuse and dependence have been linked to reductions in sleep latency, poor sleep efficiency and disrupted sleep patterns (e.g. Vitiello, 1997). Sleep problems have also been linked with the individual's propensity to relapse back into alcohol use once discharged (Foster and Peters, 2002). The cognitions central to insomnia have been examined in a variety of populations and a cognitive model of insomnia has been proposed (Harvey, 2002). The link between dysfunctional cognitions about sleep and actual sleep deficits has been shown to exist in those with a diagnosis of primary insomnia, but not in a population meeting criteria for alcohol dependence, or in a population recovering from alcohol dependence. In the present study the aim is establish the relationship between subjective and objective measures of sleep and a range of sleep-related cognition measures. The study aims to recruit 80 participants from a 4 week alcohol detoxification inpatient programme. Sleep difficulties prior to entering the unit and one month after discharge will also be assessed. Brief data on alcohol use post-discharge will also be collected. We hypothesise that A) there will be a relationship between higher dysfunctional cognitions and sleep difficulties, as found in the primary insomnia literature B) those with sleep difficulties prior to admission will show the strongest link with distorted cognitions and sleep difficulties whilst on the unit C) dysfunctional cognitions at end of stay will predict 1 month post-discharge sleep disturbance estimate and relapse to alcohol use. We also aim to test whether, as in Harvey's model, dysfunctional cognitions about sleep are related to distorted perceptions about sleep deficit, as measured by discrepancies between subjective and objective measures.

Psycho-Oncology

Convenor and Chair: Collier, S. Psychological Medicine Service, St James's Hospital Dublin

A cognitive behavioural therapy approach to cancer related fatigue.

Collier, S. Psychological Medicine Service, St James's Hospital Dublin. O'Dwyer, AM. Psychological Medicine Service, St James's Hospital Dublin.

Cancer related fatigue has been described as “the most important untreated symptom of cancer today” (Cella et al., 2000). It is acknowledged as being a nearly universal problem, which is consistently in the top three self-reported cancer related concerns of patients. It is defined as a subjective state of overwhelming sustained exhaustion and decreased capacity for work that is not relieved by rest. It is a multidimensional phenomenon with physiological, emotional, cognitive and behavioural manifestations. Many challenges exist in its assessment, diagnosis, and treatment. Recent guidelines (Portenoy & Ltri, 1999) show a pharmacological bias to treatment. However the definition of fatigue implies that it is a problem that may be amenable to cognitive behavioural therapy. Based on the work of Moorey and Greer (2002) the Psychological Medicine Service, St James's Hospital, Dublin, has developed a structured approach to working with various types of fatigue in cancer patients. It is our experience that cancer patients experience very different kinds of fatigue depending on their stage of treatment. Through the use of clinical case examples, this presentation will outline the content and methods of a cognitive behavioural therapy approach to fatigue, which is tailored to patients, based on individual difference and stage of treatment and / or recovery.

Cognitive behavioural therapy for cancer patients: A model of service development

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Deficiencies in the psychological care of cancer patients were eloquently summarized in a document produced by the Department of Health and Children in Ireland (1999). It noted that psychological problems in cancer patients, though common, are often undiagnosed and untreated; that psychological issues are often stigmatized and isolated; and that “counselling” and “self-help” groups are often unregulated and uncontrolled. More recently (2003) the UK NICE guidance highlighted similar concerns. Both documents have sought to suggest minimum standards of care, proposing that psychological morbidity should be regularly and routinely assessed throughout care, and that a wide spectrum of psychological and psychiatric interventions should be available for patients with cancer. Implementation of these guidelines will be difficult, however. The numbers of cancer patients are vast; trained mental health specialists few; and issues of isolation and stigmatization remain significant. The Psychological Medicine service at St James's Hospital, Dublin has been addressing these issues over the past 24 months. It has devised a multi-layered strategy aimed at integrating psychological care within the patient's overall care, providing a range of psychological interventions over the wide spectrum of psychological and psychiatric morbidity that these patients present. This paper will present the initial results of the implementation of this strategy focusing on the use of cognitive behavioural therapy within a multi-disciplinary, stratified model of psychological care for cancer patients.

Psychological characteristics of cancer patients who use complementary therapies

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McLaughlin, L., Queen's University of Belfast. Woodward, R., University of Ulster*

There has been considerable research on the prevalence and demographic profile of cancer patients who opt to supplement conventional therapies with the use of complementary therapy. There is rather less information on the personality and adjustment variables associated with the decision to use complementary therapy. The aim of the present study is to investigate the relationship between the use of complementary therapies by cancer patients and their mental adjustment to cancer, recovery locus of control, life orientation and psychopathology. Two groups were drawn from a regional centre which provides both conventional and complementary cancer treatments. Participants in Group 1 (n = 61) opted for complementary therapies in addition to conventional treatments for cancer, while participants in Group 2 (n = 56), chose conventional treatment only. All participants completed the Mental Adjustment to Cancer Scale (MAC), the Recovery Locus of Control Scale (RLOC), the Life Orientation Test (LOT), and the Hospital Anxiety and Depression Scale (HADS). Information regarding demographic details and patients' motivation for the use of complementary therapy was also collected. Those people who chose complementary therapy demonstrated a mental adjustment to cancer which is characterised by significantly higher levels of fighting spirit and anxious preoccupation. This group had also a higher internal recovery locus of control than those receiving conventional treatment alone. There were no significant differences between the groups on life orientation or psychopathology. The

findings of this study do not support the argument that the use of complementary therapy is associated with higher levels of psychopathology and distress. However, the data do indicate that for some patients the use of complementary therapy fulfills an important psychological need. The finding that psychosocial variables like fighting spirit and locus of control may impact on an individual's therapeutic choice can assist clinicians in tailoring interventions to personality and adjustment characteristics.

Psychological Approaches To Cancer Pain

Walsh, R. Department Of Pain Medicine, St. Vincent's University Hospital, Dublin

Pain in cancer is a complex clinical issue. Cancer pain syndromes can be disease and tumour-related or more frequently, pain related to treatment such as radiotherapy, surgery and chemotherapy. Psychological approaches to pain and cancer-related chronic benign pain conditions will be discussed. Cognitive-behavioural approaches to the assessment, understanding and treatment of pain will be illustrated. The role and experience of a Clinical Psychologist working in a multidisciplinary pain clinic will be outlined with reference to pre-surgical screening for advanced neuromodulation post-mastectomy neuropathic pain procedures. Cancer patients have similar reactions to pain to those of chronic pain patients (Turk, 1998) so basic techniques of CBT for pain can be applied. Cognitive and behavioural factors such as fear-avoidance, pain catastrophizing and pain behaviour are common therapeutic goals. The benefits of a Cognitive-Behavioural Therapy Pain Management Rehabilitation Programme for cancer patients will be highlighted.

Buddhist meditation in a cancer support centre

Ganey, S., Northern Ireland Cancer Centre/Potala Buddhist Centre. Davidson, R. and Holland, R., Northern Ireland Cancer Centre

"The purpose of meditation is to make our mind calm and peaceful. If our mind is peaceful we will be free from worries and mental discomfort, and so we will experience true happiness; but if our mind is not peaceful we will find it very difficult to be happy, even if we are living in the very best conditions." Geshe Kelsang Gyatso. This presentation describes an eight-week Buddhist meditation and mindfulness training course which was developed specifically for use in a Psycho-Social Support Centre for patients who have cancer and their relatives. The course was developed and piloted over a two year period. The resulting eight week programme now runs four times a year. The relationship with cognitive therapy and the implications for training and practice will be examined

Cognitive-Behaviour Therapy in the Treatment of Insomnia in Cancer Patients:Four Case Studies from the Republic of Ireland

Steggles, S. St Lukes Hospital Dublin, University College Dublin.

Four case studies are presented to illustrate the use of a cognitive-behavioural approach including hypnosis to treat insomnia for cancer in-patients who were undergoing 6-weeks of radiation treatment at St.Luke's Hospital, in Dublin, Ireland. Case study participants underwent an initial assessment involving a clinical interview and the administration of a questionnaire to assess their sleeping problems and related issues. Specifically, the Insomnia Symptom Questionnaire (ISQ) was administered before treatment began and two weeks after the completion of treatment. Participants also completed a sleep diary daily (SDD) before treatment began, during the treatment phase and for another two weeks after the completion of treatment. The clinical intervention involved six-sessions and included: a) Psycho-education (education about the cognitive-behavioural model of anxiety and its relationship with sleeping difficulties, with emphasis on learning self-help skills to cope with sleeping problems); b) hypnosis/self-hypnosis (participants were taught self-hypnosis,focusing on both relaxation and challenging their anxiety-producing and maladaptive sleep thoughts); and c) cognitive restructuring * participants were taught to recognize, challenge and replace maladaptive sleep cognitions, challenging their validity, and reframing them into more adaptive substitutes. On the two outcome measures, the ISQ and the SDD, all case study participants showed varying degrees of improvement. Findings suggest that the clinical interventions utilized were effective in ameliorating sleeping problems for the case study participants. Caution should be exercised in generalizing the efficacy of the clinical intervention based upon these case studies.

Cognitive Behaviour Therapy and Palliative Care

Convenor and Chair: Stirling Moorey, South London and Maudsley Trust

Promoting Fighting Spirit in People with Cancer

S Greer, St Raphael's Hospice, Surrey

The term 'Fighting Spirit', which denotes a specific coping response by some people who develop cancer, has not always been clearly understood. The present lecture provides a clinical description of 'Fighting Spirit': a) In patients with primary, potentially curable, cancers. b) In patients with advanced/terminal illness. 'Fighting Spirit', the opposite of helplessness/hopelessness, is correlated with low anxiety and depression scores. Cognitive behavioural techniques, which promote this positive coping response are described.

Systematic review of positive mental attitude in advanced illness

C Wettebot O'Brian & S Moorey, South London and Maudsley Trust

A "positive mental attitude" has been shown to be associated with improved psychological adjustment in patients with early stage cancer. This presentation reviews the evidence for such an association in advanced or terminal cancer. We carried out a systematic search of Medline and PsychINFO using the terms 'fighting spirit', 'positive attitude', 'sense of coherence', 'coping' and 'adjustment' paired in turn with 'cancer', 'palliative care', 'terminal illness' and 'terminal cancer'. A hand search was done of the last ten years of eight relevant journals. All relevant papers were examined and their conclusions discussed in the context of each study's merits and flaws. Eight papers were identified all of which looked at patients with cancer. Three papers used the Mental Adjustment to Cancer (MAC) scale. Four papers used scales measuring factors such as treatment-specific optimism, active coping and self-efficacy. One paper used qualitative techniques to look at psychological distress in ovarian cancer sufferers. The balance of evidence suggests that in advanced or terminal cancer a positive mental attitude is associated with less psychological distress. There is a need for larger studies looking at a broader range of illnesses and designed specifically to answer this question.

Review of outcomes of a cognitive therapy clinic in a palliative care setting

Mannix, Kathryn A, Marie Curie Hospice, Newcastle upon Tyne

Cognitive behaviour therapy (CBT) is a time-limited, problem-focussed, patient-centred psychological therapy that has been shown to improve coping and emotional distress in a variety of physical illnesses. Palliative care patients commonly suffer emotional distress, and interest in applying CBT in this setting is growing. Palliative care patients may be physically frail and have a short life expectancy; CBT may therefore need to be modified in this setting. Little is known about outcomes in palliative care. In a CBT Out-patient clinic established in a hospice, 42 referrals were seen over a 3 year period by a palliative medicine consultant who had additional specialist training in CBT. Most patients had advanced cancer. Predicted life expectancy at time of referral was short (median 6 months, range 1 - >12 months). Most patients were referred with a label of 'depression' or 'not coping.' On assessment, a variety of psychiatric diagnoses was found, anxiety being the most common. Half of referrals came from palliative care professionals, the remainder from GPs or hospital teams. Of the 42 referrals, one patient died before assessment and 2 were unsuitable for CBT (one with severe cancer-related cognitive impairment and one who was unable to think psychologically). Median number of sessions of CBT was 5 (range 1 - 16). In 39 patients who proceeded to CBT, 33 (85%) had improvement in their psychological symptoms and 6 failed to improve. Three patients who initially improved later had relapse of their psychological symptoms as their disease progressed (9%). However, 16 patients remained emotionally stable despite progressive disease, including 11 who died without relapse of their emotional symptoms. The remainder of patients were still alive and well at the time of data analysis. These early results suggest that CBT has a place in the management of emotional distress in a palliative care setting: patients are able to benefit and relapse-prevention strategies can be implemented. The details of therapy, conceptualisation and outcomes will be presented.

A randomized trial of CBT in palliative care

Stirling Moorey, South London and Maudsley Trust and Institute of Psychiatry. Marcia Kapari, St Christopher's Hospice. Matthew Hotopf, Institute of Psychiatry and St Christopher's Hospice. Barbara Monroe and Max Henderson, Institute of Psychiatry, St Christopher's Hospice.

This presentation will describe the design and implementation of the first randomized controlled trial of psychological therapy in palliative care. Considerable sensitivity is needed in engaging patients, carers and staff in research of this kind which has required some modifications to the randomization process. The study is in two phases. Phase one involved the random allocation of Home Care Nurses to receive CBT training or no extra training. Evidence for the effectiveness of this training has already been presented. In phase two all new patients seen by the nurses in the trial are screened using the HADS and those scoring > 8 on anxiety or depression invited to participate. Those still scoring as cases at a full assessment interview are entered into the trial and assessed at 6 weeks, 10 weeks and 16 weeks. Nurses use CBT techniques within their usual home consultation. Patients receive 4 weekly sessions and further sessions as required. The control group receive treatment as usual. Some of the practical and clinical challenges posed by research in this area will be highlighted and data on the progress of the trial so far will be reported.

Open Papers

Treatment Issues in Dissociative Problems and Chronic Disease

Chair: Hazel O' Dowd, North Bristol NHS Trust

Hypothesising CBT Treatment for Dissociative Seizures: A Single Case Study

Craig Chigwedere, South London and Maudsley NHS Trust, London

Dissociative seizures are defined as sudden and time limited disruptive changes in a person's behaviour, which are not due to any organic disturbance, including epilepsy (Goldstein et al. 2004; Betts and Boden, 1991). A CBT-based dissociative seizure treatment model does not currently exist and there are no published CBT based randomised-controlled treatment trials. The results of one CBT-based single-case study (Chalder, 1996) and one pilot group study have been published (Goldstein et al. 2004). There is therefore a relative paucity of CBT based, treatment-focused dissociative seizure literature and a clear treatment and/or explanatory model does not yet exist. However, literature indicates the possible role of trauma and co-morbid psychiatric disorders, such as anxiety and depression in seizure development and maintenance. Using an AB single case design, this paper will illustrate the treatment of dissociative seizures and highlight important factors that may point towards a possible treatment model. It will hypothesise that cognitions, lack of recognition of subjective emotional and autonomic arousal and use of safety behaviours are important maintenance factors. Consequently, to ameliorate the effects of these factors, CBT treatments would need to be adapted, taking into account the apparent heterogeneity of the semiology of dissociative seizures, which often includes loss of awareness. In this case, the participant was a 37-year-old woman with a 19-year history of dissociative seizures. The measures used were standardised self-report questionnaires, subjective units of distress and seizure frequency diaries, which were given at four time points, pre- and post-treatment and 1, 3 and 6-month follow-up. The active treatment phase was over 12 sessions! with three follow-up sessions. Specific to this case, four distinct treatment stages are highlighted, arousal recognition, reduction of avoidance, restructuring trauma related cognitions and relapse prevention. The gains identified on all measures were maintained at 6-month follow-up. The generalisability of these observations and hypotheses will need further research and may be clearer on completion of a current ongoing randomized controlled trial comparing CBT and Standard Care in the treatment of dissociative seizures.

Cognitive Behaviour Therapy for Depersonalization Disorder: An Open Study

E Hunter, D Baker, M Phillips, M Sierra, A David, Institute of Psychiatry, London

Depersonalisation (DP) and Derealisation (DR) are subjective experiences of unreality in, respectively, one's sense of self and the outside world. These experiences occur on a continuum from transient episodes that are frequently reported in healthy individuals to a chronic psychiatric disorder that causes considerable distress (Depersonalisation Disorder: DPD). Despite the relatively high rates of reporting these symptoms, little research has been conducted into psychological treatments for this disorder. We report on an open study where 21 patients with DPD were treated individually with Cognitive Behavioural Therapy (CBT). The therapy involved helping the patients re-interpret their symptoms in a non-threatening way as well as reducing avoidances, safety behaviors and symptom monitoring.

Significant improvements in patient-defined measures of DP/DR severity as well as standardised measures of dissociation, depression, anxiety and general functioning were found at post-treatment and six months follow-up. Moreover, there were significant reductions in clinician ratings on the Present State Examination, and 29% of participants no longer met criteria for DPD at the end of therapy. These initial results suggest that a CBT approach to DPD may be effective, but further trials with larger sample sizes and more rigorous research methodology are needed to determine the specificity of this approach

Patient Experiences of Cognitive Behaviour Therapy for Chronic Fatigue Syndrome (CFS/ME).

Stevenson, C.B., Barts and the London; Gannon, K., University of East London

Introduction: Cognitive Behaviour Therapy (CBT) has a considerable evidence base as an effective treatment for Chronic Fatigue Syndrome (CFS/ME). However CBT is a controversial treatment approach in some patient groups, who question its appropriateness for everyone with CFS/ME. This study explores patient experiences of non-trial CBT for CFS/ME, employing a qualitative methodology. The qualitative approach is appropriate to explore in detail, from the clients' perspective, the meaning and experience of therapy. **Method:** Ten patients, who had received regular, non-trial based psychological therapy incorporating CBT from clinical psychologists at a specialist CFS service, were interviewed about their experiences of living with CFS/ME and receiving treatment. Interpretative Phenomenological Analysis (IPA) was used to analyse the interview transcripts. **Results :** Participants all reported some aspects of the contact with psychologists to be helpful for a range of issues related to CFS/ME and recovery, both directly and indirectly, although there were mixed views about how useful the CBT specific ideas and 'techniques' were in treating the symptoms. The multi-factorial model of the illness was found to be useful. Participants did not use the language of CBT to describe their experiences; however several participants described helpful changes in their view of self, relationships with others and their understanding of the illness. These indicated shifts in beliefs and appraisals in relation to these aspects and an internalisation of a psychological perspective. For example, participants described a link between emotions and symptoms or the role of guilt in pushing themselves to over-activity. Non-specific factors including the relationship with the therapist and the timing of therapy were regarded as very important, so was the specialist knowledge of the therapist and the context of treatment as occurring alongside physiotherapy and medical treatment. Two participants did not find the content of CBT helpful in improving the symptoms, although valued the relationship with the therapist. Several found certain tasks of therapy challenging or impossible, some attributed this to the condition itself e.g. doing homework when fatigued, others to personality factors and others to the therapy as not appropriate. Living with CFS/ME involved experiencing stigma and invalidation for most participants, which provoked the perceived need to 'fight on' against charges of malingering. Given this context, some participants described therapy as validating and others described needing the psychologist to give them 'permission' to rest and stop fighting. However, one participant experienced the focus on thought challenging in CBT as invalidating and unhelpful. **Discussion :** For the participants in this study, the treatment received was mostly experienced as validating and helpful for a range of CFS management issues. A validating context was vital due to their experiences of stigmatisation and the struggle for explanation. There were mixed views about how useful CBT techniques were in reducing the symptoms. Limitations of the study, implications for service provision and suggestions for further research are discussed. It is suggested that qualitative methodology is appropriate for exploring patients' experiences of therapy and elucidating the complex processes involved in engagement and change.

Cognitive Behavioural Therapy in Chronic Fatigue Syndrome: A Randomised Controlled Trial of an Outpatient Group Programme.

O' Dowd, H, North Bristol NHS Trust. Gladwell, P, North Bristol NHS Trust. Rogers, C, Bristol University. Hollinghurst, S, Bath University. Gregory, A, North Bristol NHS Trust

Introduction: Chronic Fatigue Syndrome or Myalgic Encephalopathy (CFS/ME) describes a range of symptoms and clinical characteristics that cause substantial suffering and disability. As with any chronic illness, the patient suffers across physical, psychological and social domains. There are financial implications as a result, in terms of the demand on the Health Service, loss of time from work, social security and insurance claims. In the absence of compelling evidence for either the cause or the cure, attention has turned to management of the illness. Experience of rehabilitation and symptom management for other chronic conditions has informed the development of a Cognitive Behavioural Therapy treatment approach. This trial was undertaken to test the hypothesis that group CBT would produce an effective and cost-effective management strategy for patients in primary care with CFS/ME. It was hypothesised that treatment gains in these areas would be present even when the non-specific effects of therapist exposure were controlled for. **Method:** The participants were adults with a diagnosis of CFS/ME referred by their GP, seen in a Health Psychology Department for the Management of Chronic Illness in a General Hospital in Bristol. A double blind, randomised controlled trial was adopted with three arms: · Group Cognitive-Behavioural Therapy (CBT) · Education and Support Group (EAS) ·

Standard Medical Care (SMC) There are few disease specific outcome measures for this population and so a range of generic measures were included to cover: 1) Level of fatigue 2) Degree of emotional distress 3) Quality of life measures which include functional ability 4) Physical fitness · 5) Cognitive function 6) Resource use. Results: 153 patients met the criteria for the trial - 52 were randomised to receive CBT, 50 to EAS and 51 to SMC. The sample was found to be representative of the patient group and showed no significant differences at baseline, other than a much higher percentage of men in the CBT arm of the trial. Three of the key outcome measures, fatigability, physical fitness and functional ability showed a statistically significant change at six months post-intervention in the direction of the research hypothesis. All of the outcome measures showed a consistent trend in the direction of the research hypothesis. The cost-effectiveness of the intervention proved very difficult to assess and did not yield reliable conclusions. Discussion: The trial used a broad range of outcome measures. Unsurprisingly, some of these measures showed more change than others, with three demonstrating statistically significant change in the direction of the research hypothesis. All of the outcome measures showed a consistent trend in the same direction, and examination of the clinical significance was also consistently in favour of the hypothesis that group CBT is an effective intervention in CFS/ME. Conclusions: Group cognitive therapy is an effective treatment for CFS/ME. It was found to be as effective as trials using individual therapy. There was evidence of improvement in the EAS group, which indicates there is limited value in the non-specific effects of therapy.

Child and Adolescent

Keynote Address

I Think Therefore I Am: A Cognitive Genetic Approach To Anxiety And Depression In Children And Adolescents

Dr Thalia C Eley, Institute of Psychiatry, London

Background. Depression and anxiety often start early in life and show considerable continuity into adulthood. It is therefore important to understand their development in younger populations in the hope we can in future ameliorate or even prevent them. Genetic studies are now moving beyond simple examination of heritability to consider more complex patterns of risks such as interaction between genes and the environment (Eley et al., 2004a). Integrative models incorporate multiple levels of risk from genes through cognitive vulnerabilities to acute stressors. However, few studies examine more than one level of risk. The series of analyses presented in this paper combine multiple methods and include assessment of genetic risks, cognitive vulnerability and environmental stress with regard to the development of depression. Design. Data come from two samples: G1219, an unselected sample of 1,500 twin and sibling-pairs (Eley et al., 2004b), and ECHO, a study of 300 twin pairs selected for high anxiety. Methods. The cognitive measures include interpretation of ambiguous information, heart-beat awareness and attributional style. Measures of stress included social adversity, parental educational level, stressful life events, and parental discipline style. Symptom measures include both depression and anxiety. Results. Analyses reveal associations between threat interpretations, attributional style, environmental stress and depression, and between threat interpretations of ambiguity, heart-beat awareness and anxiety. All measures were genetically influenced, and there were interactions between differing levels of risk. Longitudinal analyses reveal the role of some of the vulnerability factors in the development and change of depression symptoms over time. Conclusions. These results highlight the importance of incorporating multiple levels of assessment into studies of the development of multifactorial traits such as depression and anxiety.

Symposia

Sleep Problems In Childhood: Therapies And Co-Occurring Behavioural/Emotional Problems

Convenor and Chair: Gregory, A.M., Institute of Psychiatry, University of London

Sleep, Depression, and Emotion-Regulation in Children and Adolescents

Ronald E. Dahl, University of Pittsburgh

This presentation will focus on the sleep, affect regulation, and affective disorders in children and adolescents. Data will be described from a series of studies in children and adolescents meeting DSM-IV criteria for MDD compared to age-matched control subjects free of any psychiatric disorder. The measures include two nights of EEG sleep, subjective reports of sleep at home and in the laboratory, and cortisol levels around the interval of sleep onset. Results show that depressed children demonstrate greater subjective than objective disturbances in sleep, while depressed adolescents reveal evidence of more objective sleep disturbances and tendency for greater evening cortisol levels. These sleep and cortisol changes are also predictive of a more negative clinical course when these adolescents were followed longitudinally into early adulthood. The clinical implications of these findings will be discussed. Finally, the presentation also will describe a brief overview of a clinical approach to treating sleep/wake schedule problems in depressed adolescents.

Sleep Problems And Their Treatment In Children With Developmental Disorders

Wiggs, L, Oxford Brookes University Dept of Psychology and Stores G, University of Oxford Dept of Psychiatry

The rate of sleep problems in children with a range of developmental disorders (DD) is reported to be significantly higher than for typically developing children (TDC). For example, overall, amongst children with DD prevalence rates of over 75%, even up to age 16 years, are typical whereas for TDC prevalence rates are about 30%. In DD samples the sleep disturbances described include: 1) physiological sleep abnormalities 2) sleep disorders which are more prevalent in particular groups of

children, arising as a result of their underlying condition (eg sleep related breathing problems in children with Down syndrome) 3) sleep problems (particularly difficulty settling to sleep and staying asleep) of unspecified origin which are common across a range of conditions. The last group deserves attention, not least because of the persistence and severity of the sleep problems, the additional stress that they place upon carers and the potential contribution that sleep disturbance might be making to the children's daytime behaviour and cognition problems. Behavioural interventions (BI) have a prominent role to play in the treatment of paediatric sleeplessness in TDC. Further, successful BI has repeatedly been associated with improvements in the daytime functioning of the children and the family as a whole. This paper will focus on the nature of sleeplessness in children with DD, and how it might be amenable to BI, with special reference to children with Attention Deficit Hyperactivity Disorder and Autism spectrum disorders, highlighting underlying causes of sleeplessness in these samples and associated child and family variables. Data from a randomised controlled trial of BI for sleeplessness in children with Autism spectrum disorders will be presented, suggesting that where sleeplessness is behaviourally maintained, or has a behavioural component, BI is an effective form of therapy even when the child has an underlying medical or developmental condition. The small, but increasing body of evidence to support the use of BI for sleeplessness in children with DD has implications for preventive approaches; instructing parents in ways to encourage the development of good sleep patterns may help prevent some of the long-standing and severe sleep disorders and their associated negative effects for the child and their family.

Preventing infant crying and sleeping problems

St James-

Roberts, I, Thomas Coram Research Unit, Institute of Education, University of London

Problems with their babies' persistent crying or night waking are common concerns for parents in Western societies and, consequently, costly complaints for health services. Baby books give parents conflicting advice, some recommending 'infant-demand' methods of care, which adapt to infant expressed needs, while others advise parents to use 'structured' care by imposing routines and schedules. Media reports have suggested that Western parents are increasingly employing 'controlled crying' forms of care which leave babies to cry for prolonged periods. This talk will present findings from two studies comparing 'infant-demand' with 'structured' approaches to parenting. The first, a randomized controlled trial, found that structured care helped infants to learn to remain settled at night (sometimes called 'sleeping through the night') at an early age. This was true in general, but particularly true where infants had a high number of feeds in the first postnatal week. The second, cross-cultural, study compared three groups of parents who elected to use different forms of care before their babies were born. Two groups were community samples, one in London and one in Copenhagen, with Copenhagen parents expected to provide more responsive care. The third, 'Proximal care' group included parents who adopted a highly 'infant demand' form of parenting, including co-sleeping, continuous holding and frequent feeding. Behaviour diaries and home observations were used to confirm the parenting differences and to measure infant crying and sleeping. London babies fussed and cried 50% more than both Copenhagen and Proximal Care babies at 10 days and 5 weeks of age. As expected, bouts of unsoothable 'colicky' crying were common in all three groups at five weeks of age and did not differ between the groups. At 12 weeks of age, infant waking and crying at night was more common in Proximal Care than other infants and this continued at older ages. The implications of the findings for a conceptual understanding of early infant behavioural development, and for health care policy and practice, will be discussed.

Clinical Perspectives On Children's Anxiety Disorders: Formulation, Prevention, And Treatment In Early And Middle Childhood

Convenor and Chair: Wilson, C E, Cambridge and Peterborough Mental Health Partnership Trust

Formulations for co-morbid aggression and anxiety in middle childhood: combining classical coercion models with anxiety risk factor models

Appleton, P, Family Consultation Clinic, Bedford

In this clinical paper I describe the co-morbid presentation of aggressive/anxious behaviour in middle childhood; discuss the limitations of sole use of coercion theory-based models to understand this pattern of difficulties; present interpretations of co-morbidity based on the developmental literature on two known risk factors for anxiety disorders: behavioural inhibition, and anxious/resistant child-parent attachment relationships; and finally outline interventions combining coercion models with models derived from the developmental anxiety risk factor literature.

Children's worry: Formulation and treatment

Wilson, C. E. Brookside Family Consultation Clinic, Cambridge

The literature suggests that children's worry is common from about the age of 7 (Muris et al, 1998; Orton, 1982), with age and gender contrasts in types and frequencies of worry (Hoffner & Cantor, 1991; Henker, Whalen, & O'Neil, 1995). However, little is known about why some children have problematic worry, and others do not. Weems et al. (2000) found that in clinic referred children the pattern of content of worry was similar to non-referred children, but clinic referred children had more worries and these were more intense. Children who fulfilled criteria for GAD did not differ from children who fulfilled criteria for phobia on frequency or content of worries. Perrin and Last (1997) found that children with anxiety disorders had more intense worries and Muris et al. (1998) found that children who fulfilled criteria for GAD had a main worry that was more frequent, interfering and less controllable than main worries of children who did not fulfil criteria for GAD. However, it is not clear how these differences arise and therefore why worry becomes problematic to some children and not to others. There are a number of models of adult worry that may or may not be helpful in conceptualising children's worry; for example, Wells' meta-cognitive model and Davy's 'mood-as-input' processes model. These may or may not be appropriate to use in the formulation and treatment of younger children. This paper outlines a number of clinical formulations of worry in younger children using these models. It goes on to describe the treatment of the child and family, and the specific treatment of the child's worry. The need for developmental considerations and the incorporation of family beliefs and the child's beliefs about the family in the formulation is highlighted.

FRIENDS: A universal preventative cognitive behavioural therapy programme for children in junior schools.

Stallard, P, University of Bath, Avon and Wiltshire Mental health Partnership NHS Trust

The need for evidence-based preventative programmes to promote emotional health in children has been highlighted as an important objective in recent Government documents (Every Child Matters 2004: The Children's NSF 2004). FRIENDS is a universal preventative programme designed to promote emotional resilience in children (Barrett & Turner 2001; Lowry-Webster, Barrett & Lock 2003). The 10-session CBT programme is delivered to whole classes of children with results from Australia indicating significant reductions in anxiety, which have been maintained up to one year later. This paper will describe the experience of running FRIENDS in Bath and North East Somerset. FRIENDS is delivered to whole classes of 9/10 year old children by trained school nurses in over 20 schools. The FRIENDS programme will be described, a video of the programme shown and the results of the preliminary evaluation presented. The initial results indicate that children enjoy FRIENDS and after the programme are significantly less anxious and have greater self-esteem. Problems of implementing and sustaining the programme will be discussed.

A New Cognitive-Behaviourally Based Parenting Intervention, for Families of Young Children with Anxiety Disorders

Cartwright-Hatton, S., Division of Clinical Psychology, University of Manchester

Anxiety disorders are the most common psychiatric problem of childhood, and are often persistent into adolescence and adulthood. Anxiety disorders of childhood have damaging consequences in a number of domains, particularly academic and interpersonal. Furthermore, it is now thought that many cases of depression and substance misuse are secondary to earlier anxiety disorders. Worryingly, we have no treatments for anxiety in young children, who are less able to benefit from CBT. This paper describes a new intervention for this under-served group. The literature suggested that a treatment combining good parenting skills and a basic cognitive-behavioural intervention would be most appropriate. Given the age of the children (under ten years), the intervention was delivered entirely to parents, who would use their new skills to help their children overcome their anxiety. Eleven families have now received the intervention, and have completed measures of children's symptoms before and after treatment. All families reported that their children's anxiety had improved as a result of the intervention. Satisfaction with the treatment was also very high. Analyses indicated that the effect size of the intervention was large and statistically significant, even within this small pilot study. This new parent-focussed intervention may represent an effective way of treating a worrying and under-served group.

Treatment of Child Anxiety Disorder in the Context of Maternal Anxiety

Creswell, C, Willetts, L & Cooper, P The Child Anxiety Disorders Research Clinic, University of Reading

Recent systematic reviews of outcome research indicate that the general CBT approach produces significant therapeutic benefit for children with anxiety disorders (e.g. Cartwright-Hatton et al, 2004). However, it is clear from these reviews and the individual trials that outcome is highly variable, with a significant proportion of patients experiencing little if any benefit. Previous research has suggested that the presence of anxiety disorder amongst the parents of anxious children is associated with a marked reduction in treatment efficacy, however the inclusion of parent anxiety management (PAM) significantly enhances treatment outcome (Cobham et al, 1998). The processes by which PAM affects child outcome remain unclear. Indeed, in so far as CBT treatments of child anxiety disorder commonly require the parent to put treatment regimes in to day-to-day practice, both the parent's own anxiety and an anxiogenic management style may militate against optimal treatment delivery for the child. A modified CBT programme will be described which targets both the direct influence of maternal anxiety and associated characteristics of the mother-child relationship. Pilot data (n=21 families) establishes the feasibility of the modified programme and provides initial support for its efficacy in the treatment of child anxiety in the context of maternal anxiety.

Anxiety Of Childhood And Adolescence: Current Issues

Convenor and Chair: Sam Cartwright-Hatton, University Of Manchester.

Epidemiology and Treatment of Anxiety in Younger Children – A Neglected Population.

Sam Cartwright-Hatton, University Of Manchester

It is widely believed that anxiety is the most common psychological disorder of childhood. The evidence for this proposition in pre-adolescent children is examined. Prevalence rates for various anxiety disorders are presented, along with factors that should be considered in interpreting these. Second, the evidence base for CBT for anxiety is outlined. Details of a systematic review will be reported, showing that there is very little evidence for the efficacy of CBT in a pre-adolescent population. Some future directions in addressing these lacunae will be presented.

Posttraumatic reactions in children Diagnosis, early intervention and treatment

Paul Stallard, University of Bath and Avon and Wiltshire Mental health Partnership NHS Trust

Children exposed to a wide range of traumatic events suffer significant post-traumatic reactions. Issues relating to the diagnosis of post treatment stress disorder and acute stress disorder in children and pre-school children will be reviewed. Randomised controlled trials assessing the effectiveness of interventions with traumatised children will be summarised and the limitations of the current literature base discussed.

Current issues in cognitive behavioural theory and therapy for childhood OCD

Cynthia Turner, Institute of Psychiatry and South London and Maudsley Trust.

Obsessive-compulsive disorder (OCD) is now recognised to be a relatively common disorder in childhood and adolescence, with prevalence estimates ranging from 1% to 4% in epidemiological studies. Increased awareness of the prevalence of this disorder has been associated with an increase in research and clinical attention, with the result being that best practice guidelines are now being developed. Indeed, UK clinicians and researchers are anticipating the release of the NICE guidelines for treating OCD in children and youth later this year. However, as with other childhood anxiety disorders, psychological treatments for OCD have been largely modelled on their adult counterparts, and the empirical support base has lagged behind. It is perhaps not surprising to find that cognitive-behaviour therapy (CBT) is the only psychological therapy recognised to be effective in the treatment of childhood OCD. This paper will briefly review the current status of CBT for children and adolescents with OCD, addressing both cognitive behavioural theory and therapy. Current issues in clinical practice will be identified and illustrated through the presentation of clinical data.

Is conditioning theory a useful framework for studying the development of phobias?

Andy Field, University of Sussex

Despite the prevalence of therapeutic interventions based on conditioning models of fear acquisition, conditioning has been seen by many as a poor explanation of how fears develop. This is partly because research on conditioning has become less mainstream, models of learning have become increasingly more complex. This article reviews some of what is now known about conditioning/associative learning and describes how these findings account for some early criticisms of conditioning models of fear acquisition. It also describes how pathways to fear such as vicarious learning and fear information can be conceptualised as forms of associative learning and obeying the same learning rules. Some popular models of conditioning are then described with a view to highlighting the important components in learning. Finally, these models are discussed with respect to how fears develop and especially whether conditioning theory can be used as a useful framework for prevention and intervention.

The development of information processing biases in childhood anxiety: A review and exploration of its origins in parenting

Gisela Perez-Olivas Julie A. Hadwin and Matt Garner, Developmental Brain-Behaviour Unit, University of Southampton.

Cognitive models propose that information processing biases for threat cause or maintain anxiety in adults (e.g., Beck, 1976; Eysenck, 1997). This paper reviews theoretical models and empirical research in adult anxiety. It considers how adult models have been applied and adapted to develop theoretical frameworks and investigate information processing biases for threat in childhood anxiety. The paper goes on to review evidence which has demonstrated an association between parenting style and anxiety in children. Specifically, it reviews evidence which highlights a relationship between parent-child interactions and the development of information processing biases and anxiety in children. The paper emphasises the need for a developmental perspective to understand both the significance of information biases in childhood anxiety and their origins in parenting.

Cognitive And Meta-Cognitive Development In Children At Risk Of And With Existing Mental Health Problems

Convenor and Chair: Wilson, C E, Cambridgeshire and Peterborough Mental Health Partnership Trust

Impact of mental health on young children's abilities relevant to engaging in CBT

Reynolds, S, Girling, E, Eastwood, L & Coker, S University of East Anglia

Previous research (e.g. Doherr et al., 2005, Quakley et al., 2004) has demonstrated that young children (aged 5 to 7 years) are able to successfully engage in a range of tasks which have been developed to reflect skills required to take part in cognitive behaviour therapy. However, the effect of mental health problems on this ability has not been examined. Children aged 6 and 7 years (N = 192) were recruited from primary schools in the East of England. Mental health problems were rated by parents and teachers on the Strengths and Difficulties Questionnaire (SDQ; Goodman et al., 1999) and on the basis of population norms, we identified children falling into 'high risk' (n = 31), 'borderline' (n = 39) and 'low risk' (n = 122) groups. All children completed 3 CBT tasks, distinguishing amongst thoughts feelings and behaviours, linking thoughts and feelings and generating post-event attributions. IQ was estimated using the WASI. Results indicated a small, significant effect of mental health problems on performance. Post-hoc analysis showed that this was due to poorer performance of children with externalising problems. There was no effect of emotional problems on performance. These results have implications for the development and delivery of CBT to young children and require replication in clinical samples and evidence of predictive validity.

Cognitive Behavioural Therapy (CBT) With Children. An Investigation into the Presence of Cognitive Behaviour Therapy Skills in Young Children Referred to CAMH Services

Quakley, S, Reynolds, S, & Coker, S University of East Anglia

There is a developing body of literature exploring the adaptation and use of cognitive therapy techniques with young children (Kendall, 1990, Ronen, 1997, Cobham, 2000, Barrett, Lowry-Webster & Turner, 2000, Stallard, 2002 and Stallard, 2003). This has led to emerging definitions of the 'core skills' which children may need to be able to engage in cognitive behaviour therapy and has been compared to existing knowledge of cognitive development in children (Stallard, 2003, Grave and Blissett, 2004 and

O'Connor and Cresswell, 2004). Young children (aged 4-7 years) from non-clinical populations perform well on tasks central to cognitive behavioural therapy, for example the ability to generate post event attributions to hypothetical scenarios (Doherr, 2000; Doherr, Reynolds, Wetherly & Evan, 2004) and to discriminate and link thoughts, feelings and behaviours (Quakley, Coker, Palmer & Reynolds, 2003; Quakley, Reynolds and Coker, 2004). However, emerging evidence suggests that children from a community sample screened as 'at risk' of developing mental health problems (Reynolds, Girling, Eastwood & Coker, submitted; Eastwood et al., submitted) are impaired in these specific skills and that this impairment is observed in children with externalising problems but not with internalising problems. The aim of the current study is to examine the performance of young children referred to CAMH services on a range of tasks relevant to participation in CBT, to compare this to normative data and to examine the specific impact of emotional and behavioural problems on performance (controlling for IQ). In an observational study 84 children, aged 6 to 11 years, referred to CAMHs will be assessed on 2 tasks related to participation in CBT. IQ will be assessed using the WASI (Wechsler, 1999) and mental health will be assessed on the Child Behaviour Checklist (Achenbach, 2001) and the Strengths and Difficulties Questionnaire (Goodman, Ford, Simmons & Meltzer, 2000). Preliminary findings for approximately 30 participants will be discussed within the theoretical context of children's cognitive development, the delivery of CBT, and the extent to which CBT may need adaptation for use with young children.

Cognition and Metacognition in Childhood and Adolescence

Cartwright-Hatton, S. University of Manchester Division of Clinical Psychology.

Introduction: There is currently only a limited understanding of the extent to which children experience the cognitive distortions that are thought to underlie mental health problems in adults. Indeed, it is often thought that childhood is characterised by limited cognitive awareness and that cognitive distortions are either not present in this age group, or are impossible to access, with obvious implications for cognitive-behavioural therapies. This paper describes recent research that sought to examine metacognitive processes in a young population. Study One: Adolescents aged 13 to 17 years completed a shortened and simplified version of the metacognitions questionnaire (MCQ-A: Cartwright-Hatton, Mather et al., 2004), together with measures of psychological wellbeing. The instrument was reliable and valid for this population, who demonstrated a wide range of scores. Scores on this instrument did not vary with age of respondent, indicating that the metacognitive awareness tapped by this instrument is near fully developed by the age of 13. It is likely, therefore, that younger children would also have access to these concepts. Adolescents' scores on the metacognitions questionnaire were highly correlated with measures of depression, anxiety and obsessive-compulsive symptoms. Study Two: Young adults were completed a battery of mental health measures, together with a measure of metacognition (MCQ) and a questionnaire reporting on parenting that they received as children. There were small but significant correlations between participants' scores on the MCQ, and certain types of parenting. It is hypothesised that metacognition may partially mediate the observed link between these types of parenting and anxiety.

Meta-cognition in children's worry

Wilson, C. E. Centre for Family Research, University of Cambridge

Wells has shown that adult worriers have both positive and negative beliefs, or meta-cognitions, about worry (Wells, 1995). These beliefs are important in formulation and treatment of pathological worry and have led to a meta-cognitive model of Generalised Anxiety Disorder (Wells, 2000). Cartwright-Hatton and colleagues have found that adolescents have a similar range of meta-cognitions, and that these are related to anxiety in the same way (see symposia paper). However, less is known about younger children's pathological worry and whether they hold similar beliefs. Developmentally this is important, as children appear to start worrying early in life, and yet their cognitive skills are not yet fully developed. If children develop beliefs about worry in a certain pattern we might discover that there are key developmental stages in which pathological worry in children can develop. This study aimed to: 1. Investigate whether younger children could identify positive and negative beliefs about worry in open ended questions 2. Describe the type and frequency of these beliefs 3. Explore how positive and negative beliefs about worry were associated with levels of worry and other anxiety symptoms in younger children. 50 children aged 7 –9 years old were recruited through schools. They completed the Penn State Worry Questionnaire for children, the Multi-dimensional Anxiety Symptom Checklist, and open ended questions about beliefs about worry. Preliminary findings will be discussed in relation to the conceptualisation and treatment of worry in young children.

Cognitive Vulnerability For Depression Across The Lifespan

Convenor and Chair: Barton, S, University of Newcastle & Newcastle CBT Centre

Discussant: Armstrong, P, Newcastle CBT Centre

Adolescents at risk for depression: Do rumination, thought suppression and over-general memory confer vulnerability?

Kuyken, W. University of Exeter

First onset of depression among people who suffer recurrent depression throughout their lives often occurs during adolescence. Moreover, adolescent onset of depression is associated with more life problems in adulthood and an increased risk of eventual suicide. This paper reports two studies of adolescents at risk for depression examining putative cognitive mechanisms that may be implicated in increasing vulnerability to depression onset. The first study examined a group of 326 14-18 year-olds to establish the extent to which cognitive processes thought to be implicated in first onset of depression are in fact observed in adolescents at risk for depression. The second study used a remission design to compare 32 formerly depressed and 31 never depressed adolescents to examine whether over-general memory is a trait marker in adolescents at risk for depression. Results across the two studies and implications for the developmental psychopathology of depression will be drawn out.

Reactivation of negative cognition in formerly depressed adults

Barton, S.B. (University of Newcastle) Todd, C. (University of Leeds) Morley, S.J. (University of Leeds) Clark, J. (University of Newcastle)

Teasdale's (1988) differential activation hypothesis (DAH) suggests that formerly depressed people often have cognitive vulnerabilities to recurrent depression, and these can be observed in the reactivation of negative cognition during sadness or dysphoric mood. This paper will present two linked studies that explore this hypothesis using mood induction methods to test for cognitive reactivation. Evidence for differential effects was found in both studies, that is, reactivation in former depression, but not in people who have never been depressed. The first study observed reactivation in formerly post-natally depressed women (PND). Sad mood reactivated dysfunctional attitudes concerning their maternal role, but not general dysfunctional attitudes, suggesting a specific cognitive vulnerability concerning maternal role investment in PND. The second study observed reactivation in formerly depressed adults (unipolar). Sad mood reactivated negative automatic thoughts but not general dysfunctional attitudes. Combined, the studies support the differential activation hypothesis (DAH), but increase doubt that general dysfunctional attitudes are the primary cognitive structures that are reactivated. Building on these findings, sad mood induction in clinical practice is presented as part of relapse prevention following successful CBT for depression. The aim is to measure reactivation post-remission, establish the patient's unique relapse signature, and build explicit CBT skills to compensate if and when reactivation occurs in the patient's later experience. The rationale is to expose patients to dysphoria, confront their fears about relapse, and increase their efficacy in combating future depression.

If Only: Regret and its relationship to cognitive therapy for depression in late life

Davies, S.P. School of Psychology University of Hertfordshire and Woods, R.T. School of Psychology University of Wales Bangor

The emergence of depression as a reaction to the many challenges of later life is a familiar scenario among older people and their carers and is now beginning to attract some attention from therapists. It is the central assertion of this paper that coping with regret plays a pivotal role in mental health and ageing as regret represents the intrusion of past events and actions upon the present. The nature and the content of regrets are usually age-related. This may represent a particular risk for depression in later life. Older people frequently have more difficulties with troublesome regret if they perceive the repairing or undoing of past actions or omissions as their responsibility. This process may generate plausible alternatives to the action, taken known as regret counterfactuals which may hinder adjustment to actions taken a long time ago. Because older people have less opportunity to put things right, their attitude to regret is a crucial part of their mental well-being. A cognitive model of regret highlighting the crucial role of regret counterfactual generation and maintenance will be presented to account for the clinical presentation of older clients with depression. Effective cognitive therapy for depression with older people should not focus solely on action oriented strategies, but should also aim at the adaptive modification of regret as an important cognitive tool. Some initial data about the psychological effects of regret counterfactuals ('If onlys') in a small sample of older people will be presented as will a plan of a more focused study in the area.

Eating and Impulse Control

Keynote Address

Evidence Based Decision Making In Adolescent Anorexia Nervosa

Professor Simon G Gowers, University of Liverpool

Clinical decisions should be based on best quality evidence, rather than the personal preferences of a treating clinician or service. Evidence-based treatment guidelines are increasingly available to inform health service professionals and the public about best practice. The National Institute for Clinical Excellence (NICE) published its guidance on the treatment of Eating Disorders in 2004 in an attempt to standardise treatment. It was however unable to find many good quality treatment trials for anorexia nervosa and based most of its recommendations on expert and consensus opinion. These recommendations will be reviewed, highlighting controversial areas such as when to admit to hospital, the role of compulsory treatment and the use of specialist services. The TOuCAN trial, currently running in North West England is a large study combining a randomised controlled trial and a naturalistic series in order to answer questions about the impact and acceptability of different treatment models and their cost-effectiveness. One treatment arm comprises a specialist out-patient programme combining CBT with motivational interviewing and parental counselling. Whilst the importance of involving family members in the treatment of adolescents is beyond dispute, the relative merits of a conjoint family therapy approach as against an individual CBT intervention supported by parental counselling will be examined. The one year outcomes of this series (n=215) will be presented and the implications for treatment discussed.

Symposia

Complex Problems in Eating Disorders

Convenor: Michelle Lee, Oxford University Department of Psychiatry

Chair & Discussant: Bob Palmer, University of Leicester

Co-occurrence of eating and anxiety disorder psychopathology

Roz Shafran, Oxford University Department of Psychiatry

Recent reports suggest that approximately two-thirds of the individuals with anorexia nervosa and bulimia nervosa meet diagnostic criteria for a lifetime anxiety disorder. There are several possible reasons for the co-occurrence of anxiety and eating disorders including (1) the presence of one disorder serves as a vulnerability and/or maintaining factor for the development of the other; (2) both disorders share common vulnerability and/or maintaining mechanisms e.g., low self-esteem, perfectionism; (3) the disorders are not connected but co-occur by chance (4) poor discriminant validity of the current classificatory scheme whereby the same symptoms can result in a diagnosis of both an anxiety and eating disorder. Treatment is likely to be guided by an analysis of the reasons for the co-occurrence. A case-example is presented in which it was considered that the anxiety and eating disorder were being maintained by "clinical perfectionism". The impact on the target anxiety and eating disorder of a treatment designed to address "clinical perfectionism" will be described. The presentation concludes by discussing other possible ways to tackle the co-occurrence of eating and anxiety disorder psychopathology.

Treatment of adolescents with severe anorexia nervosa

Simon G Gowers, University of Liverpool

Where a young person with anorexia nervosa fails to respond to routine out-patient management, a number of issues should be considered in planning the next stage of treatment. Concern about physical risks can deflect from attention to psychological aspects of the disorder, whilst 'failure' of out-patient management can lead to a belief that an in-patient approach will yield better outcomes. This

presentation will use case examples to demonstrate the importance of evaluating the potential benefits versus disadvantages of different treatment approaches. In particular, issues in in-patient management such as inconsistencies in the use of thresholds for admission and discharge will be explored, using research data from cohort and randomised trials. Co-morbid mood disorder and self-harm pose additional concerns. Balancing benefits and costs of different interventions has a parallel in the motivational treatment approach which it is argued, can be extremely useful in the treatment of adolescents.

The interpersonal aspects of eating disorders

Janet Treasure, Institute of Psychiatry, Kings College, London

One of the difficult tasks in the management of eating disorders in particular anorexia nervosa is to get an optimal balance between duty of care, patient autonomy and information sharing. Anorexia nervosa has a profound interpersonal impact. Furthermore the interpersonal environment has a marked effect on the outcome. Models of illness perception and the meanings attached to eating disorders can have a profound effect on the appraisals and behaviours in relation to the illness. Furthermore the mismatch between the readiness to change symptoms can have a deleterious effect on all parties. A model of carer coping will be presented in this talk and the preliminary results of two interventions which focus on carers will be given.

Making CBT happen when the eating-disordered patient is not committed to treatment

Glenn Waller, St. George's Eating Disorders Service & Institute of Psychiatry

Treatment for the eating disorders is dependent on the patient's commitment. Cases are often described as 'complex' because they fail to engage with services, drop out of treatment, or do not complete essential therapy tasks. These are commonly patients with comorbid Axis I or Axis II disorders. CBT with these patients is dependent on two clinical skills that have been adapted from other disorders: adopting a clinician stance where motivational analysis and enhancement are ongoing processes; and finding ways of coping with therapy-interfering behaviours. Both require that the patient should be engaged in making CBT work, rather than being the responsibility of an over-invested clinician. Research evidence will be used to demonstrate the motivational issues involved, and clinical examples will be used to exemplify these principles and methods.

NICE Guidelines For Eating Disorders

Convenor: Michelle Lee, Oxford University Department of Psychiatry

Chair: Simon Gowers, University of Liverpool

NICE eating disorder guidelines: service level issues

Bob Palmer, University of Leicester

The NICE guideline development group had three working sub-groups. One addressed service level interventions including the perspective of users and carers. The amount of good evidence relevant to these issues was small and was often of poor quality. Nevertheless many recommendations were produced mostly through clinical consensus and hence there were few surprises. Key recommendations will be presented briefly and discussed.

Physical Recommendations

Janet Treasure, Institute of Psychiatry, Kings College, London

Matching the intensity and type of treatment to need involves a careful risk assessment of medical, clinical and psychosocial factors. The UK NICE guidelines recommended that outpatient treatment should be the preferred initial approach unless a high level of risk is present {National Collaborating Centre for Mental Health, 2004 12072 /id}. The plan of management is thus tailored to risk which needs to be monitored as part of treatment. The guidelines have information about efficient methods to measure and manage risk within the Appendix. Recent legal cases and the high morbidity and mortality in eating disorders will make this section essential reading. The quality of evidence on physical treatments for the primary problems and co-morbidity (psychological and physical) was limited.

The NICE Guideline for Eating Disorders one Year on: Psychological Treatment Recommendations.

Ulrike Schmidt, Institute of Psychiatry, London

This paper will critically review the clinical, research and audit recommendations on psychological treatments of eating disorders made in the NICE eating disorder guideline (National Collaborating Centre for Mental health, 2004), in the context of emerging research. The following questions will be addressed from the perspective of a member of the guideline development group: Did we get it right? What do these recommendations mean for eating disorder services? How can we implement them? What are the challenges ahead?

The NICE-man cometh (back): Getting ready for the next evaluation of treatment for the eating disorders

Glenn Waller, St. George's Eating Disorders Service & Institute of Psychiatry, London

For a CBT practitioner, the National Institute for Clinical Excellence report on the treatment of the eating disorders (NICE, 2004) can be interpreted as indicating that we are doing well or as suggesting that we have a long way to go. The best evidence is that CBT works moderately well for pure cases of bulimia nervosa and binge eating disorder, but that its use is less well supported in anorexia nervosa. Of greater concern is the lack of evidence regarding treatment for the large number of atypical cases. The optimistic pessimist's view might be that the glass is a quarter full. This talk will consider how far CBT has to go if it is to maintain its perceived superiority over other therapies by the time of the first NICE update in a few years time. Existing treatment trials will be considered, outlining the need to widen the cognitive-behavioural (and related) targets that we address. Key themes will be: the importance of delivering the therapy appropriately, based on principles rather than rigid protocol; the central role of behavioural experiments; the need to address treatment process and therapeutic engagement; and the role of clinicians in developing case series data that drive innovations in practise. Systemic issues will also be considered.

Clinical Perfectionism, Psychopathology And Barriers To Change

Convenor: Caroline Riley & Roz Shafran, University of Oxford, Department of Psychiatry

Chair: Roz Shafran, University of Oxford, Department of Psychiatry

Clinical Perfectionism as a Barrier to Change

Riley, C., (Oxford University Department of Psychiatry) Shafran, R., (Oxford University Department of Psychiatry), Fletcher, J., (Warneford Hospital, Oxford), Harvey, A., (University of California, Berkeley, USA) Fairburn, C. G. (Oxford University Department of Psychiatry).

Background: Clinical perfectionism is a recently developed construct, arising from the need to clarify the nature of perfectionism that causes significant adverse consequences in its own right or interferes with the treatment of psychiatric disorders. The cognitive-behavioural model of clinical perfectionism proposes that clinical perfectionism will impede treatment for accompanying Axis I disorders when the domain in which the perfectionism is expressed (e.g. excessively high standards for social performance) overlaps with the domain of the disorder (e.g. social phobia) Aims: The primary goal of this study was to determine whether clinical perfectionism impedes treatment outcome in four clinical groups. The secondary goal was to investigate whether this effects occurs more when the domain in which the clinical perfectionism is expressed overlaps with the domain of the disorder. Methods: Seventy-four participants receiving standardised treatment for one of four psychological problems: depression (n=30), anxiety (n=13), insomnia (n=15) or OCD (n=16) completed the Clinical Perfectionism Questionnaire (CPQ, Fairburn, Cooper & Shafran, in prep.) and measures of depression, anxiety and their specific psychopathology before and after treatment for their Axis I disorder. The CPQ has a section assessing the domains of clinical perfectionism. Results: Treatment non-responders had a significantly higher pre-treatment CPQ score than responders ($p<.05$) suggesting that clinical perfectionism was associated with poorer outcome. Furthermore, participants for whom the domain of clinical perfectionism and their Axis I disorder overlapped showed a significantly smaller degree of change in relevant psychopathology compared to those who had clinical perfectionism in a domain other than their disorder ($p<.01$). These findings support Shafran et al.'s original hypothesis. Conclusions: Clinical perfectionism does appear to

be associated with poorer outcome following treatment, particularly when the domain of the perfectionism and their Axis I disorder overlaps. The implications of this study for treatment are discussed.

Behavioural expressions of clinical perfectionism

Lee, M., Riley, C., Shafran, R., & Fairburn, C. G. Oxford University Department of Psychiatry, UK

'Clinical perfectionism' is the type of perfectionism that interferes with functioning. Such perfectionism has been suggested to play an important role in the development and maintenance of disorders such as anorexia nervosa and OCD, and it has been reported to impede successful treatment of some Axis I disorders such as depression. A cognitive-behavioural analysis of clinical perfectionism postulates that it has clear behavioural features such as repeatedly checking, seeking reassurance and avoidance. The aim of the current study was to examine these behavioural expressions of clinical perfectionism using both self-report measures and behavioural tasks. Three behavioural tasks were used; a bead-sorting task, interpretation of homophones, and recall of ambiguous sentences. The presentation will describe the most common behavioural manifestations of clinical perfectionism in 20 participants selected for a randomised controlled trial of CBT for clinical perfectionism. The relationship between behavioural tasks and self-report measures in this clinical sample and healthy controls will be presented, and changes in the behavioural tasks before and after treatment will be described. Implications of these findings for the measurement of clinical perfectionism are considered.

Clinical perfectionism in obsessive compulsive disorder

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Clinical perfectionism is a common trait of patients with obsessive compulsive disorder (OCD). The aim of this study was to examine the prevalence of clinical perfectionism in patients with OCD, whether clinical perfectionism changes with cognitive behavioural therapy for OCD and whether it is associated with a worse treatment outcome. The study population consisted of 49 patients with OCD who were admitted to the Inpatient Cognitive Behavioural Therapy Unit of the South London and Maudsley NHS Trust between January 2004 and January 2005. The mean scores on a perfectionism questionnaire at admission were 11.6 (SD 6.6), which is higher than control subjects but lower than, for example, patients with eating disorders. Patients with OCD who were diagnosed with obsessive compulsive personality disorder had significantly higher scores on perfectionism than those who were not. Although obsessive compulsive symptoms, relationship problems and low self esteem significantly improved with treatment, perfectionism did not. Perfectionism was also predictive of a worse outcome, independent from severity of obsessive compulsive symptoms at baseline.

Extreme outcomes of social expectations: the role of social perfectionism, future thinking and goal adjustment in suicidality

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Objectives. There is a growing body of evidence to suggest that socially prescribed perfectionism is associated with suicidal behaviour. Within a self-regulatory framework, this paper aims to investigate this pathway (i.e., social perfectionism–hopelessness/suicidality) more closely, to determine whether other cognitions (e.g., goal adjustment) moderate the relations between relatively stable perfectionism and distress. Methods: Data from two prospective studies are reported. The first study assessed healthy participants (n=211) twice over a period of 5 weeks. Whereas the second study focused on deliberate self-harm patients (n=150) who were assessed at time 1 and, on average, six weeks later. Results. There was unequivocal evidence for the deleterious effects of social perfectionism in predicting changes in suicidal ideation in both groups of participants. There was also evidence of moderation for goal adjustment and future thinking. In other words, there was evidence to suggest that cognitions can buffer the relationship between relatively stable individual difference dimensions and suicidality. Conclusions. These findings point to the fruits of integrating personality, cognitive and social processes, to better understand hopelessness and suicidal risk. These studies support the self-regulatory framework and they suggest that positive and negative cognitions are mediated by different motivational systems. The implications for suicide prevention are considered.

Intellectual Disabilities

Symposia

Cognitive-Behavioural Therapy for People with Intellectual Disabilities and Complex Mental Health Problems

Convenor: John L Taylor, University of Northumbria, Newcastle upon Tyne

Chair: Bruce Gillmer, Northgate & Prudhoe NHS Trust, Northumberland

Discussant: Gillian Haddock, University of Manchester

CBT for People with Intellectual Disabilities: The Case Against Therapeutic Disdain.

John L. Taylor, University of Northumbria, Newcastle upon Tyne

People with intellectual disabilities have increased vulnerability of to mental health and emotional problems. Despite this we are unsure about the prevalence and course of these conditions in this population. There are a number of reasons for these gaps in our knowledge, including a general lack of interest in, or concern for the needs of people seen as different, and a paucity of instruments to help with the assessment and understanding of the emotional and mental health needs of people with intellectual disability. It has also been suggested that therapists are reluctant to offer individual therapy to people with intellectual disabilities as this would necessitate building close therapeutic relationships with people perceived as unattractive because of their disability. In this paper the evidence to support the effectiveness of cognitive-behavioural therapies for emotional and mental health problems amongst people with intellectual disabilities is selectively reviewed. Issues relating to the evaluation, delivery and sustainability of these therapeutic approaches in routine service settings are considered, and priority clinical research questions for future enquiry are discussed. There have now been several reviews and commentaries concerning psychotherapy for people with intellectual disabilities and mental health and emotional control problems. The existing reviews tend to be limited in scope, and patchy or inaccurate in their accounts of published outcome research studies in this field. These issues aside, the evidence to support the use of psychological therapies with this client group, particularly cognitive-behavioural therapy, is limited but promising. Further research into the applicability of these therapies with this client group across clinical problems and service settings is indicated.

Creative Collaboration: Making Sense of a Cognitive Behavioural Formulation.

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Cognitive Behaviour Therapy (CBT) is increasingly being used with people with intellectual disabilities. One of the challenges in working this way is effectively sharing a formulation of the problem with the client. It can be argued that without a shared understanding of the formulation the basis of CBT with the client is jeopardised. Whilst there are advances in CBT in both working with this client group generally, and specifically in applying CBT to complex mental health problems, such as psychosis, the clinician is faced with challenges in interpreting complex ideas to a client that makes these ideas meaningful. The clinician's creative skills are required in order to achieve this. There are a variety of creative approaches but, as a clinician, one can often feel the need to 'reinvent the wheel'. This presentation aims to describe some of the creative approaches that have proved clinically useful and share this with colleagues. It will draw on examples of clinical practice, including three case studies of clients referred for help with symptoms of psychosis, to illustrate ways of making the formulation make sense to the client.

Cognitive Therapy for Detained Women with a Learning Disability and Anti-social or Borderline Personality Disorders

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In addition to their anti-social and offending behaviour, women within forensic populations, both detained and convicted, also present with personality difficulties, which both challenge the system and staff caring for them. The most prevalent of these difficulties are labelled in DSM IV as Borderline or Anti-social personality disorder. Therapeutic interventions are not always routinely available for this group or the difficulties they pose. Recently however interventions have been developed to address these difficulties both within health and criminal justice settings. Additionally the Department of Health has recently published guidelines for the development of services for patients with personality disorders (DOH 2003). There is no reason to suppose that women with a learning disability in forensic services will be any different from women without a learning disability. Infact a needs analysis in a low secure forensic service for women with a learning disability identified this area as an area of unmet need. One of the

interventions being evaluated currently is an adapted form of cognitive therapy (Davidson & Tyrer 1996, Davidson 2003) for outpatients with either anti-social or borderline P.D. in an outpatient setting. This paper describes a project, which seeks to adapt this intervention for women with a learning disability detained in this low secure forensic setting. This paper will outline the methodology of the project and how the goals of, one successfully adapting the intervention for the client group, and two whether the adapted intervention is effective with the client group, will be evaluated. Some of the adaptations to the intervention will be described along with a presentation of case material.

Manual-guided Approaches

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The value of manual-based approaches to CBT for people with intellectual disabilities and complex needs is questioned and the associated issues of therapist training and supervision explored. There is an ambivalent disdain for manualised approaches. In this cost conscious climate of time-limited delivery there is a ready clamour for off the shelf approaches emerging from clinical trial. But these are readily set aside in the face of the 'self-evident truth' of individualised wizardry, personalised formulation, and a desire for flexibility of method, especially in more complex cases. Yet there is little evidence that the expert Lone Ranger is any better in terms of clinical outcome. What is true is that more experienced therapists make better use of manuals, probably because such approaches are widely misunderstood. They actually span a continuum of flexibility and required skill, which is variably suitable for a range of competencies. There is also an assumption that manualised intervention and individual formulation is mutually exclusive. It will be argued that, far from curtailing therapeutic flair and innovation, manualised therapeutic autonomy is a crucial step in the evolution of evidence-based therapy. In order for new evidence-based interventions to have enduring value there is a reciprocal requirement of training for competency and for expert supervision. A pyramidal supervisory structure is advocated, which draws on the available best practice for CBT. The vexed issue of treatment-gain maintenance for this intractable population is addressed using a systemic picture of practice. Finally, some practical advice is offered for supervisors in a consideration of anger treatment.

Anger Control Problems: Developments in Cognitive-Behaviour Therapy and Assessment

Convenor: John L Taylor, University of Northumbria, Newcastle upon Tyne

Chair: Stanley Renwick, Ministry of Defence, Catterick

Discussant: Raymond W. Novaco, University of California, Irvine, USA

Anger and Aggression in Older Persons.

Chris Fox, East Kent Nhs And Social Care Partnership Trust And Stan Renwick , Ministry Of Defence, Catterick, UK

It is increasingly acknowledged that difficulties with aggressive behaviour pose a significant challenge for practitioners and service providers addressing the needs of adults with mental health issues (e.g. psychotic disorders, cognitive impairment disorders). As such, the remediation and management of these problem behaviours has become an important clinical challenge in this field. Whilst a variety of bio psychosocial approaches to conceptualisation of these behaviours have been adapted, to-date, little interest has been evident in exploring the potential contribution of Anger (Fox et al, 1997, 2001,2002,2003). This is particularly surprising given that it has been seen to constitute a significant potentiater of aggression in other clinical and forensic populations (Ramm & Renwick, 2005). New interest has arisen as many of the formerly used medications have been restricted on the grounds of safety e.g. atypical antipsychotics and cost e.g. cholinesterase inhibitors. This paper explores the potential mediation of anger in the difficulties posed by older adults with mental health problems. Empirical evidence will be presented supporting this relationship in an in-patient population including patients with 'organic' and functional difficulties. In parallel, case vignettes will be presented indicating the wider role anger problems can play in out-patient populations and the importance of addressing this within therapeutic endeavours. This evidence will be used to propose that much greater attention should be paid by practitioners to anger in the presentations of their patients and the potential value of developing bespoke approaches to its remediation.

Anger Dyscontrol in Posttraumatic Stress Disorder.

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The significance of anger in posttraumatic stress disorder (PTSD) extends beyond its place as a diagnostic symptom. Anger is strongly associated with both civilian and combat-related PTSD, as demonstrated in both laboratory and field based research, and it is strongly predictive of the subsequent development and severity of PTSD and the response to treatment. However, there remains a general neglect of anger by PTSD researchers, in contrast with their near normative assessment of depression and anxiety. Attention to anger is lacking even in combat veteran studies that address violence as a focal topic. The presentation will present an overview of research on anger in PTSD, set forth a conception of anger dysregulation in PTSD, present new findings on anger and PTSD in a large US national sample of combat veterans, and refer to empirically validated cognitive behavioural treatment intervention with severe cases. It will be argued that there should be a substantial re-orientation to anger in the assessment and treatment of PTSD.

Using CAT to Address Anger Problems

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As their titles would suggest, there is a considerable overlap between Cognitive Behaviour Therapy (CBT) and Cognitive Analytic Therapy (CAT). Broadly speaking CBT involves an integration of cognitive and behavioural approaches while CAT involves an integration of cognitive, behavioural and analytic approaches. Both therapies involve a collaboration between the therapist and the client in order to come to an understanding of the client's difficulties and to find an effective way to address them. However, there are also some significant differences in theoretical focus and methodology. This paper will use case material to illustrate how some CAT understandings and therapeutic tools can often be particularly helpful to both therapists and clients in attempting to address anger problems.

Cognitive-Behavioural Anger Treatment for People with Intellectual Disabilities: A Review of the Research Evidence.

John L Taylor, Northumbria University and Northgate & Prudhoe NHS Trust

Aggression is the most prevalent type of challenging behaviour amongst people with intellectual disabilities. It is the main reason for people in this client group to be admitted and re-admitted to institutions and to be prescribed psychotropic medication. The application of cognitive behavioural treatments for emotional problems in clients with intellectual disabilities is still in its infancy. In recent years, however, there have been a number of clinical studies conducted that support the use of cognitive-behavioural interventions for anger problems experienced by people with intellectual disabilities. The majority of these studies are case and case series reports, but six studies included control group comparisons that yielded significant between group differences and moderate-large treatment effects. This evidence is reviewed in this paper. The effectiveness of a novel individual and formulation-based cognitive therapy approach to ameliorating deep-rooted anger control problems associated with aggression in clients with intellectual disabilities is described and illustrated with the results of a series of empirical treatment studies and case study material. Implications for future research and practice are discussed.

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