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Basic Processes

Keynote Addresses

Thinking About the Unthinkable: Cognitive Processing of Traumatic Experiences in Children and Adolescents

Professor Tim Dalgleish, Medical Research Council Cognition and Brain Sciences Unit, Cambridge

In the U.K. and across the world millions of children and young people have experienced psychological trauma. Countless of these suffer from trauma-related disorders such as PTSD. Despite this clinical need, research on the psychological reactions to trauma in young samples lags far behind such work in adults. Four key clinical questions merit urgent attention: How should we assess traumatic stress reactions in younger samples (particularly very young children)? What are the underlying psychological processes that contribute to traumatic stress disorders in youth? Following trauma, how can we predict which children and young people will be most severely affected? And, what are the optimal psychological treatments for stress disorders in the young? This talk presents data that speak to these four questions from studies grounded in the cognitive approach to traumatic stress disorders. The studies include experimental work on the cognitive processes involved in PTSD in children and adolescents, prospective-longitudinal data examining assessment issues and predictors of outcome in relatively large samples of young survivors of road accidents and violent assaults recruited from accident and emergency clinics, and details and results of a randomised controlled clinical trial of cognitive-behaviour therapy (CBT) for PTSD in children and adolescents that has recently been completed. Some possibilities for future research directions will also be put forward.

Exposure Therapy, Combined Treatment, and the Enhancement of Therapeutic Learning

Michael W. Otto, Ph.D, Boston University

The available evidence suggests that traditional approaches to combination treatment--e.g., the combination of antidepressant treatment and cognitive-behavior therapy (CBT)--have yielded disappointing results for the treatment of anxiety disorders. Recent advances in translational research provide a framework for understanding these limitations as well as encouraging a new approach for enhancing CBT effects. For example, results from the animal and human laboratories indicate that extinction of fear learning may be strongly dependent on context. Studies indicate that changes in internal state (such as anxiety reduction from a benzodiazepine) may be a powerful enough context such that adequate safety learning from exposure (extinction) is achieved only in that context. In this presentation, context effects and combination treatments are discussed in relation to the goal of helping patients re-establish a sense of safety in relation to the core fears. In addition, attention will be devoted to novel pharmacologic strategies, targeted not to anxiolysis but to the enhancement of therapeutic learning, for boosting treatment response to exposure-based CBT. Particular attention will be devoted to support from the animal and clinical-trial literature for the role of d-cyclsoserine (DCS), a partial NMDA agonist, in enhancing learning from exposure-based CBT. Because DCS is taken on single occasions prior to exposure sessions, is not taken during subsequent home practice of exposure assignments, and does not appear to have significant anxiolytic properties or side effects, this agent should be free of the drug-state context effects characterizing other combined treatment approaches.

Symposia

Remembering Trauma

Convenor: Tim Dalgleish MRC Cognition and Brain Sciences Unit, Cambridge

Recalling, reliving, or redundant? The nature of trauma memories in pre-schoolers, children, and adolescents?

Meiser-Stedman, R, Institute of Psychiatry, Kings College London

Cognitive models of post-traumatic stress disorder (PTSD) attribute great importance to memory processes in the onset and maintenance of this psychopathology (Brewin et al., 1996; Ehlers & Clark, 2000). In spite of clinical reports supporting the application of this theory to children and adolescents, very little empirical research has tested these models in youth (Meiser-Stedman, 2002; Salmon & Bryant, 2002). We conducted two prospective studies of children and adolescents exposed to single-event trauma where we have sought to examine the role of memory processes. The first comprised 10-16 year olds exposed to assaults or road traffic accidents (n=90), while the second comprised 2-10 year olds exposed to road traffic accidents (n=113). Our results will be discussed within the context of the developmental psychopathology of reactions to traumatic stressors.

Is emotional suppression a helpful or unhelpful form of affect regulation when processing traumatic material?

Dunn, B. MRC Cognition and Brain Sciences Unit, Brewin, C. Sub Department of Clinical Health Psychology, University College London

A commonly held belief across a range of therapies is that the suppression of felt and expressed emotions is unhelpful and may inadvertently exacerbate rather than reduce negative affect. For example, Acceptance and Commitment Therapy (ACT: Hayes et al., 2003) conceptualizes the maintenance of mental health difficulties as in part resulting from unhealthy attempts to escape and avoid emotion. Similarly, the recognition and willingness to experience previously avoided or denied emotion is also believed to be central to therapeutic progress in a range of third generation cognitive therapies, including Dialectical Behaviour Therapy (DBT: Linehan, 1993) and Mindfulness Based Cognitive Therapy (Segal, Williams & Teasdale, 2001). While there is reasonable empirical support for the negative 'rebound' consequences of thought suppression (Wegner, 1997) in healthy and clinical populations (for a review see Purdon, 1999), the assumption that emotional suppression is potentially counter-productive has yet to be empirically validated in detail. This presentation will describe recent studies from our laboratory examining the consequences of suppressing felt and expressed emotional responses to traumatic material. Our methodology involved asking healthy participants to watch a video trauma induction of the real life aftermath of road traffic accidents, either under emotional suppression, acceptance or control conditions. We examined the impact of these conditions on subsequent emotional responses and memory for the trauma material. In addition, the relationship between the trait tendency to use thought or emotional suppression and how individuals responded to the trauma video was examined in the control group. How well the findings from these studies support the commonly held therapist belief that it is helpful to discourage clients suppressing unwanted affect will be discussed and tentative clinical implications considered.

I don't want to go into the details: Over-general autobiographical remembering in trauma survivors as a form of affect regulation

Dalgleish T, MRC Cognition and Brain Sciences Hauer B, University of Maastricht Rolfe J, Dept of Experimental Psychology, University of Cambridge Golden A, MRC Cognition and Brain Sciences Wessel I, University of Groningen

Research has shown that individuals experiencing posttraumatic stress have difficulty accessing specific personal memories in response to mnemonic cues and that this difficulty correlates postively with the degree of distress. Some authors have argued that this represents a form of affect regulation whereby avoiding processing details of the emotional past is aimed at reducing stress levels. Other authors have argued that the over-general memory phenomenon is instead a function of the laboratory task used to examine it (i.e. memories on demand to word cues). In this analysis, over-general memory occurs because individuals with traumatic stress are poor on all executively demanding tasks. Consequently, when asked to come up with specific memories of the past they can't do this very well either. Proponents of this executive functioning hypothesis cite the fact that trauma-exposed individuals are plagued by specific recollections of their trauma as evidence that there is no fundamental problem in

accessing the specific past. Two hypotheses arising from this work are considered. First, if the over-general memory effect in trauma-survivors is about not performing well on executive tasks, then one would expect the relationship between over-general memory and traumatic stress to reverse on a memory tasks where individuals are actively encouraged to come up with general memories. In other words, the more distressed trauma survivors should now be less over-general. In contrast, if the effect is about affect regulation, changing the task instructions to encoruage general memories should make no difference and post-traumatic stress should still correlate positively with over-generality. We present data from a group of trauma-survivors who completed this reversed memory task. The second hypothesis is that perhaps intrusive specific trauma memories in the day-to-day and over-general memories to cue words in the lab depend on different processes of memory retrieval. It may be that intrusive memories are example of automatic activation of specific material; i.e. direct retrieval, whereas over-general memories are examples of a more effortful, generative retrieval process that breaks down. This was tested by using a lab task that actually promotes direct retrieval of memories, in a large group of survivors of childhood sexual abuse. The prediction here was that the usual over-general memory effect would disappear on this direct retrieval memory task if direct retrieval processes operate in a different way. The clinical implications of both sets of data for the way trauma-survivors remember their past are considered.

Past lives: Memories from the personal past and from the life of the deceased in sufferers of traumatic (complicated) grief

Golden, A MRC Cognition and Brain Sciences Unit. Dalgleish T MRC Cognition and Brain Sciences Unit. Mackintosh B University of East Anglia

Research has shown that individuals who have experienced significant trauma have difficulty accessing specific autobiographical memories when given memory cues. In theoretical terms it has been proposed that this over-generality might represent a form of affect regulation aimed at avoiding specific, distressing information. The fact that trauma survivors are over-general when cued about their past is somewhat paradoxical, as a core feature of psychological trauma is the experience of spontaneous intrusive and distressing recollection of very specific details of the personal past. One reasons for this contrast may be that memories for the source of the person's distress, i.e. of the trauma, are immune to the over-general effect. This may be because they are so emotionally laden that they override any such attempts at avoidance/regulation. Alternatively, spontaneous trauma memories may be retrieved in a different way to the types of retrieval invoked by memory cues. We examined this idea that memories for the source of distress are immune to the over-general effect by looking at autobiographical memories to cue words in individuals who have experienced traumatic bereavement and who have a diagnosis of complicated grief (CG) and comparing them to memories to cue words from the life of the deceased person. Our hypothesis was that the autobiographical memories should be over-general (relative to controls) in the usual way but that this over-generality effect would disappear for cued memories from the life of the deceased individual. Data are presented from groups of CG individuals and controls and the clinical implications are discussed.

Overgeneral Memory: From Marker to Mechanisms

Convenors: Thorsten Barnhofer and Catherine Crane, University of Oxford
Discussant and Chair: J. Mark G. Williams, University of Oxford

The endorsement of dysfunctional attitudes is associated with an impaired retrieval of specific autobiographical memories in response to matching cues

Spinhoven P Leiden University Claudi B Department of Psychiatry, Academic Medical Center, University of Amsterdam Ismay K Leiden University Aart S Department of Psychiatry, Academic Medical Center, University of Amsterdam Williams JMG Department of Psychiatry, Oxford University

It is noteworthy that in accounts of the retrieval of overgeneral memories relatively little attention is paid to the meaning of the specific words used in the cue-word task. Dalgleish et al. (2003) have recently proposed a theory which states that one of the reasons an individual may “fail” to retrieve a specific memory in response to a particular cue-word has less to do with whether it is positive or negative, than whether it maps closely onto the content of coherent, more generic, higher order mental representations Two studies investigated this hypothesis that overgeneral memory may arise from matching between task cues and dysfunctional attitudes or schemas. In the first study 111 euthymic patients with at least two previous major depressive episodes completed the Dysfunctional Attitude Scale: Form A (DAS-A) and the Autobiographical Memory Test (AMT). In the second study 82 patients with a borderline personality disorder completed the Young Schema Questionnaire (YSQ) and the same version of the AMT. In both studies, patients retrieved less specific autobiographical memories in response to cue

words that matched highly endorsed attitudes or schemas. These results suggest that overgeneral memories may be the result of certain cues activating generic, higher order mental representations. Further studies that match cue words with schematic models are needed and may help to throw light on the cognitive processes involved in the generation of overgeneral autobiographical memories.

Failures to Retrieve Specific Memories and Dysfunctional Schemata: An Investigation of the "Capture" Error Hypothesis

Barnhofer T University of Oxford, Spinhoven P, University of Leiden, Williams JMG. University of Oxford

Failures to retrieve specific memories occur more often under conditions of compromised executive control. This study investigated the hypothesis that, under such conditions, previously depressed individuals are more likely to fail in retrieving specific memories, the more the to-be-accessed content is dominated by dysfunctional attitudes. Sixteen previously depressed and 19 never-depressed participants were assessed for dysfunctional attitudes regarding "need for approval" and "performance evaluation". One week later, they were asked to generate specific memories following dependency- and achievement-related cue words, both under single and dual task conditions. In previously depressed participants, dysfunctional attitudes regarding "need for approval" significantly predicted specificity for dependency-related events under dual task conditions. The results suggest that failures to retrieve specific memories may occur as a form of "capture error".

A sentence completion procedure as an alternative to the Autobiographical Memory Test for assessing overgeneral memory in non-clinical populations

Rees, P University of Leuven, Belgium Dirk H, University of Leuven, Belgium. Williams, JMG University of Oxford, UK, Eelen P, University of Leuven, Belgium

Overgeneral memory (OGM) has been proposed as a vulnerability factor for depression (Williams, 2004). Traditionally, a cue-word procedure known as the Autobiographical Memory Test (AMT; Williams & Broadbent, 1986) is used to assess OGM. Although frequently and validly used in clinical populations, there is evidence suggesting that the AMT is insufficiently sensitive to measure OGM in non-clinical groups. We evaluated the usefulness of a sentence completion method to assess OGM in non-clinical groups, as an alternative to the AMT. Participants were 197 students who completed the AMT, the Sentence Completion for Events from the Past Test (SCEPT), a depression measure and visual analogue scales assessing ruminative thinking. Results showed that the mean proportion of overgeneral responses was markedly higher for the SCEPT than for the standard AMT. Also, overgeneral responding on the SCEPT was positively associated to depression scores and depressive rumination scores, whereas overgeneral responding on the AMT was not. Results suggest that the SCEPT, relative to the AMT, is a more sensitive instrument to measure OGM, at least in non-clinical populations.

Cue self-relevance and autobiographical memory specificity in individuals with a history of depression

Crane C, Department of Psychiatry, University of Oxford Barnhofer, T Department of Psychiatry, University of Oxford Williams, JMG Department of Psychiatry, University of Oxford

Previously depressed and never depressed individuals identified personal characteristics (self-guides) defining their ideal, ought and feared selves. One week later they completed the autobiographical memory test (AMT). For each participant the number of AMT cues that reflected self-guide content was determined to produce an index of AMT cue self-relevance. Individuals who had never been depressed showed no systematic relationship between cue self- relevance and specificity. In contrast, in previously depressed participants there was a highly significant negative correlation between cue self-relevance and specificity – the greater the number of AMT cues that reflected self-guide content, the fewer specific memories participants recalled. It is suggested that in individuals with a history of depression, cues reflecting self-guide content are more likely to prompt a shift to processing of information within the long-term self (Conway et al., 2004), increasing the likelihood that self-related semantic information will be provided in response to cues on the autobiographical memory test.

How recollecting states and events might contribute to overgeneral memory in depression

Barnard P MRC Cognition and Brain Sciences Unit, Cambridge Park, R Department of Psychiatry, University of Oxford, UK & Oxfordshire Mental Healthcare NHS Trust. Ramponi, C MRC Cognition and Brain Sciences Unit, Cambridge

Autobiographical recollection was sampled in adolescents with a diagnosis of first episode major depressive disorder and matched community controls. Rather than scoring the retrieved material as specific, extended or 'overgeneral,' the verbal protocols were analysed in some detail to examine the extent to which autobiographical dialogue referred to self and others in an agentful role or to states of self and others. This analysis also distinguished physical and mental (experiential) states, and whether or not the states referred to were restricted to the cued context (e.g. the last time they met up with friends) or applied more widely. A group with greater severity of current depression as indexed by the Hamilton rating scale for depression (Hamilton, 1967) typically referred to self and others in a different pattern form either those with low current Hamilton scores or community controls. Recollection with increased depression involved a lower proportion of utterances reference to self in an agentful role and a higher proportion utterances in which some state of self was assigned. The implications of these results for how recollection, self-representation and depression inter- relate will be discussed.

Social Cognition Across Psychological Disorders: Research Innovations and Clinical Implications

Convenor & Chair: Warren Mansell, University of Manchester

Face Processing Biases in Social Anxiety

Garner, M University of Southampton

Models of social phobia suggest the disorder is in part maintained by a range of processing biases that limit accurate processing of social feedback and correction of pre-existing social fears (e.g. Clark & Wells, 1995; Clark & McManus, 2002). This talk will present data from a series of studies examining face processing biases in social anxiety, with specific reference to biases in attention and interpretation of ambiguity. Findings from eye-tracking studies suggest social anxiety is characterized by reduced allocation of attention to social versus non-social material and by unstable (vigilant-avoidant) processing of facial expressions. Evidence from illusory correlation paradigms assessing contingency estimates between non-verbal social cues and emotional/valenced outcomes suggest socially anxious individuals lack the positive inferential biases that characterise non-anxious individuals, consistent with findings from lexical decision tasks. These findings will be discussed in relation to those from emotional expression discrimination paradigms that suggest socially anxious individuals interpret ambiguous (computer-manipulated) facial expressions in a negative fashion, and preliminary evidence of a selective deficit in emotional expression recognition. The cognitive and neuro-biological mechanisms thought to underlie these processing biases will be discussed

Selective attention and recognition memory for faces in body dysmorphic disorder

Anson M Institute of Psychiatry, King's Collge London Veale D Institute of Psychiatry, King's Collge London de Silva P Institute of Psychiatry, King's Collge London Santos I University of York Young AUniversity of York

Body dysmorphic disorder (BDD) is characterised by significant preoccupation and distress relating to perceived defect(s) in appearance, when objectively these are absent or minimal. In social and public situations, two of the most frequent symptoms reported by BDD sufferers are firstly, marked fear of negative evaluation of appearance by others and associated self-consciousness, (e.g. Buhlmann et al, 2002); and secondly, high levels of comparison of appearance to others (Phillips, 2005). It was hypothesised that both these factors would result in differences from healthy controls in the way BDD sufferers processed other people's faces. Data will be presented from three experimental studies exploring these factors amongst people with BDD and healthy controls. The first experiment involved a replication of the modified dot probe task designed by Mansell et al (1999) to investigate selective attention to social threat cues (emotional faces) in social anxiety. In the present study the anticipatory social threat induction used by Mansell et al was altered in order to relate to body dysmorphic concerns. Experiment two involved a modified dot probe task investigating selective attention to faces of varying levels of attractiveness. Participants were presented with a series same sex face pairs (half male, half female). Each face had been pre-rated for attractiveness, and the face pairs were divided into three pairing categories (attractive-moderate; attractive-unattractive; moderate-unattractive). Experiment three consisted of a recognition memory task for full and half-view faces. Participants were presented with a series of full view male and female faces. In the test phase, the faces were presented again along with a

set of distractor faces, with half the original faces and distractors being shown in full view, and half in part view (upper or lower face). The Warrington Recognition Memory Test was also administered. The results will be discussed in terms of current cognitive models of BDD (e.g. Veale, 2002) and social phobia (Clark and Wells, 1995), and the implications for cognitive-behavioural treatment approaches for BDD will be considered. It is suggested that increased attention to the appearance of others, particularly in terms of specific features and characteristics, contributes to selective focus on appearance, as well as preventing people with BDD from obtaining an accurate view of the appearance of others. This maintains the distorted internal image held by BDD sufferers, and exacerbates their negative comparative evaluations. At the same time, self- focused attention relating to social-evaluative anxiety is likely to maintain BDD through the following processes. Firstly it increases BDD sufferers' focus on an internal distorted image, and their erroneous inference that this is how they appear to others; secondly, it prevents accurate observations of others reactions; thirdly, it generates a negative reaction in others, which they interpret as a negative reaction to their appearance; and finally, it maintains selective focus on specific features, resulting in magnification of the perceived defect

Theory of Mind in schizophrenia: early work and recent developments

Corcoran R Senior Lecturer, School of Psychological Sciences, University of Manchester

This presentation will begin with a summary of the findings of the initial studies conducted by Corcoran, Frith and colleagues which explored theory of mind functioning in people with schizophrenia. Following this, evidence in support of the suggestion that theory of mind is achieved through a form of inductive reasoning will be reviewed with a particular focus on findings in people with schizophrenia. Finally, some more recent work examining inductive reasoning skills in people with persecutory delusions and exploring theory of mind skills across diagnostic groups will be presented.

Bipolar Disorder and Individuals with Hypomanic Personality

Mansell W University of Manchester, UK

The processing of social information is critical for effective functioning. It is proposed that individuals with a vulnerability to mania show a specific bias in their appraisal and use of social information during states of elevated or activated mood; their perception of personal success is disproportionately based on their own internal state rather than from other sources. In particular, it is proposed that they show reduced use of information from other people who are appraised in ways that allow their feedback to be discounted (e.g. untrustworthy, incompetent, jealous). Over repeated cycles, this bias leads their mood, thinking and behaviour to escalate and diverge from the social context. A series of experimental studies is described involving individuals with bipolar disorder and students scoring high on the Hypomanic Personality Scale (which predicts the development of mania). The studies explore appraisals and recall of information about the self and others, appraisals of the self and a partner during a co- operative task, and the degree to which individuals follow advice from other people during elevated mood states. The degree to which the findings support the model will be discussed, and implications for future research and treatment will be suggested.

Clinical cognition: new developments in our understanding of interpretation, at tention and working memory

Convenor & Chair: Colette Hirsch, Institute of Psychiatry, King's College London

Anxiety and the resolution of ambiguity

Richards A, Birkbeck College, University of London and Blanchette I University of Manchester

Research has shown that mood is influential in resolving ambiguous information. An anxious person is more likely than a non-anxious person to interpret a threat/neutral ambiguous stimulus in the threatening rather than neutral way, (i.e., a mood-congruent bias). This early research examined the resolution of ambiguity in isolation, whereas everyday processing always takes place within a context. We have demonstrated in earlier experiments that context influences the interpretation of ambiguity in high state anxiety individuals, and this bias overrides any mood-congruent bias. Threat/neutral homophones were presented simultaneously with context cues related to either the threat-related or neutral meaning. Individuals in the anxiety-provoking condition were more influenced by context cues then those in the control condition. We have demonstrated this effect using both naturally occurring (i.e. in people awaiting treatment at an orthodontic clinic) and experimentally-induced high state anxiety.In a series of experiments, we presented ambiguous facial images, which were created by morphing two exemplar emotional expressions into a composite face. We wanted to see if the effect observed with ambiguous verbal stimuli would generalise to ambiguous visual stimuli. In the first experiment, a series of morphed

faces (e.g., happy/neutral, angry/happy) were presented with a context word related to either the more positive or more negative emotion in the expression. The anxious group were filmed during the experiment in order to induce anxiety, whereas the control group were not. We found, as predicted, that although both groups made interpretations in line with the context, the anxiety manipulated group were more influenced by the context than the control group. In the second experiment, composite facial expressions were presented on a background context that was neutral or related to one or other of the emotions in the face. We also changed the mood manipulation to a demanding mental arithmetic test whereas the control condition performed a very simple arithmetic task. Again, the anxious manipulated group resolved the ambiguous emotional expression in line with the context, so that if the pictorial background context was positive the emotional expression was more likely to be classified as positive whereas when the background was negative, the expression was more likely to be classified as negative. When the data were analysed in relation to trait anxiety rather than manipulated mood, a mood-congruent effect was observed, with the high-trait anxious group interpreting the ambiguous expressions more negatively than the low-trait group. We have therefore demonstrated context-congruency effects associated with state anxiety but mood-congruency effects associated with trait anxiety. It appears that when people are in an anxiety-provoking situation, they are more receptive to contextual cues and engage in more bottom-up processing. Trait anxiety is associated with mood-congruency not context-congruency. It may be that people with high-trait anxiety have a general mood-congruent interpretative bias that has developed over time, and may involve more top-down processing. Different mechanisms may underlie the resolution of ambiguity in state and trait anxiety

Attentional and interpretive biases: Independent dimensions of individual difference or expressions of a common selective processing mechanism?

Raykos B Institute of Psychiatry, King's College London MacLeod C School of Psychology, University of Western Australia

Attentional and interpretive biases are important dimensions of individual difference that have been implicated in the etiology and maintenance of a range of clinical problems. Yet there has been no systematic investigation into the relationship between these dimensions of individual difference. The current research program tested predictions derived from two competing theoretical accounts of the relationship between attentional and interpretive biases. The Common Mechanism Account proposes that cognitive biases represent concurrent manifestations of a single underlying selective processing mechanism. The Independent Mechanism account proposes that independent mechanisms underlie each bias.The current research program revealed no reliable association between attentional and interpretive biases across participants and the relative capacity of each bias index to predict subsequent emotional reactions to a mildly aversive stressor task was not equivalent. These findings suggest that attentional and interpretive dimensions of selective processing are not the same. An apparent contradiction is that the manipulation of one bias served to also modify the other bias, despite the observation that the magnitude of the resulting change in both biases was uncorrelated. Neither the Common Mechanism nor the Independent Pathways accounts can adequately explain this pattern of results. A new account is proposed, in which attentional and interpretive biases are viewed as representing mechanisms that are causally related but dissociable

Why worry persists: A novel task to assess working memory capacity in worry

Hayes S Institute of Psychiatry, London Hirsch C Institute of Psychiatry, London Mathews A University of California, Davis

Background: Worry is characterised by the repeated experience of apparently uncontrollable thoughts regarding possible future negative events. While proneness to worry varies continuously across the normal population, high worriers are often distinguished from low worriers by their reported uncontrollability of negative thought intrusions once worrying is initiated. Indeed, chronic excessive worry is the defining feature of Generalised Anxiety Disorder (GAD), a common disabling disorder resulting in severe cognitive, occupational, and social dysfunction. Evidence has suggested that working memory (a limited capacity store needed to engage in different tasks and switch between tasks) is reduced in high worriers due to worry consuming limited capacity resources. As a result, high worriers may be less able to redirect thoughts away from worry and onto non-worry topics than low worriers, resulting in perseverance of worry. The current study is the first to assess how much working memory (WM) capacity is taken up when people worry. The task used to assess this was an established random key press task, in which more random performance indicates more residual WM capacity to be used on other tasks. This random key press task was performed whilst participants thought about a current worry, providing a measure of WM capacity available for other tasks whilst worrying. In order to assess specificity of any effects, a control, positive personally relevant thought condition was also included. Method: High worriers and low worriers performed a random key-press task whilst thinking about either a current worry topic or a positive personally relevant thought topic, in counterbalanced order. Results: High worriers were less random (indicating less residual WM capacity) when thinking about a worry

topic than when thinking about a positive topic. In contrast, low worriers did not differ in terms of randomness when thinking about a worry or a positive topic. Conclusions: As predicted, high worriers had more working memory capacity taken up by worry than a positive thought topic. In contrast, non-worriers had the same amount of working memory capacity taken up when thinking about a worry or a positive topic. Such findings suggest that high worriers have less working memory capacity available when engaging in worry and as such, have less working memory available to enable them to switch their thinking away from worry onto non-worry topics. These results may have important implications for models of worry persistence and GAD.

Working memory and PTSD in ambulance workers exposed to the London bombings of 7th July

Wild J Institute of Psychiatry, London Handley R Institute of Psychiatry, London Morris R Institute of Psychiatry, London

Intrusive memories of distressing incidents are common among ambulance workers and are a hallmark of Posttraumatic Stress Disorder (PTSD). In PTSD, attempts to suppress intrusive thoughts are ineffective and maintain the disorder. In non-clinical samples, high working memory capacity (WMC) is associated with the ability to suppress intrusive thoughts (Brewin & Beaton, 2001). It is unknown whether high working memory capacity protects individuals from high frequencies of intrusions and possibly PTSD after trauma. This study examined the relationship between intrusive memories, working memory capacity and traumatic stress in ambulance workers on duty at the time of the London bombings of 7th July. Forty ambulance workers were assessed for working memory capacity using the OSPAN (Turner & Engle, 1989) prior to the bombings. Intellectual functioning, PTSD, frequency of intrusions, responses to intrusions, depression, anxiety, trait dissociation, trauma exposure, length of time in service, and alcohol and drug use were also assessed. Three months following the bombings, participants were re-assessed for PTSD. Results found that working memory did not predict PTSD status after exposure to the bombings. Negative interpretation of intrusive memories and avoidance were related to poor outcome. The relationship between working memory capacity, cognitive appraisals and PTSD in ambulance workers will be discussed. The results have theoretical implications for existing models of PTSD and for pathways of prevention in the emergency services.

Influencing Emotional Vulnerability: 'Training' Interpretational Style

Convenor & Chair: Jenny Yiend, University of Oxford
Discussant: Jenny Yiend, University of Oxford

Facilitating a more benign interpretation bias in high worriers: Effects on worry persistence.

Hayes S Institute of Psychiatry, London Hirsch C Institute of Psychiatry, London Mathews A University of California, Davis

Background: High worriers are characterised by their reported uncontrollability of thoughts regarding possible future negative events once worry is initiated. In addition, high worriers and generalised anxiety disorder (GAD) clients commonly show a bias to interpret ambiguous information in a threatening manner. One plausible hypothesis is that negative interpretive bias plays a causal role in maintaining bouts of worry, with worry being perpetuated, in part, by difficulty accessing benign interpretations. In order to determine whether a given cognitive process has a causal role in maintaining a psychological state, the cognitive process needs to be manipulated and its impact assessed. Previous research has successfully demonstrated that it is possible to train a more benign interpretive bias in non-anxious people. Utilising a similar paradigm, it is possible to assess the causal role of interpretive bias in maintaining worry. Specifically, the aim of the current study was to determine whether training high worriers to adopt a more benign interpretive bias for emotionally ambiguous events would result in a subsequent decrease in worry persistence. A standard behavioural task for assessing worry persistence was used, which involves participants focussing on their breathing and assessing the number of negative thought intrusions at random points. Method: High worriers were randomly allocated to either positive or sham interpretation training. Using training paradigms developed by Grey & Mathews (2000) and Mathews & Mackintosh (2000), which have been shown to facilitate a more benign interpretive bias in non-anxious people, a positive interpretation bias was trained using a combination of homograph and sentence training. The positive training condition involved consistently accessing benign meanings of threat-related homographs and threateningly ambiguous sentences. In contrast, the sham training condition involved accessing half threat, half benign meanings of threat-related homographs and threateningly ambiguous sentences. Following training participants completed the worry task, which provided a measure of the number of negative thought intrusions. Results: Results indicated that high

worriers assigned to the positive interpretation training condition reported less negative thought intrusions (indicating reduced worry persistence) than the sham condition. These results demonstrate that it is possible to facilitate a more benign interpretive bias in high worriers, and moreover, that this may reduce the perseverance of worry. Conclusions: High worriers can be trained to develop a more benign interpretation bias. After benign interpretation training, participants had less negative thoughts than those in the sham condition. Hence, interpretive bias impacts on negative thoughts evident in worry. These data support the hypothesis that interpretive bias has a causal role in maintaining worry. Implications for both models and treatment of GAD will be discussed

Inducing Interpretative Biases: "Training" Clinical Perfectionism

Yiend J Oxford University Shafran R Oxford University Coughtrey A Oxford University

Introduction: Recent research demonstrates that cognitive biases, analogous to those reported in anxious patients, can be induced in healthy volunteers, providing strong evidence that cognitive processes play a causal role in anxiety disorders. Such biases are also implicated in other forms of psychopathology, including the newly defined construct of clinical perfectionism (Shafran, Cooper & Fairburn, 2002), which is thought to be associated with a variety of Axis I psychopathology, including eating disorders, depression and OCD. This study aimed to induce an interpretation bias in the clinically relevant domain of clinical perfectionism in healthy participants, using the text based training method developed by Mathews & Mackintosh (2000) and to examine the behavioural consequences of this procedure. Methods: A set of new materials relevant to perfectionism, based on those used by Mathews & Mackintosh, were developed and piloted. Thirty-nine selected non perfectionist students were trained to interpret ambiguous information in terms of self worth being dependent on success and failure. Their spontaneous interpretations of new material were then assessed using recognition ratings of sentences that disambiguated the novel ambiguous text. A number of questionnaire measures were administered to assess perfectionistic, anxious and depressed personality and mood, both before and after training, as well as a bead sorting task, known to assess checking behaviour. Results: Failure trained participants gave higher recognition ratings to failure targets than success trained participants, who rated the success targets significantly higher than failure trained participants, suggesting that the perfectionist training technique was successful in inducing congruent cognitive effects on novel ambiguous material. A significant behavioural result was found, suggesting that success trained participants who had previously chosen to check were less likely to do so post-test. No congruent effects of training on mood or trait measures of perfectionism were found. Conclusions: These findings validate the training paradigm and shows that it generalises to the clinically relevant domain of clinical perfectionism. The significant behavioural effect suggests that these findings are unlikely to be solely due to semantic priming effects. These data suggest further development of interpretative retraining, focussing on clinical populations, is warranted.

Modifying anxiety vulnerability by "training" an interpretive bias: success may depend on gender and active generation methods

Hoppitt L Open University and MRC Cognition and Brain Sciences Unit Mackintosh B Open University and MRC Cognition and Brain Sciences Unit Mathews A University of California, Davis Jenny Y Oxford University

Research has shown that it is possible to modify interpretive biases in non- anxious participants by "training" participants to select negative or more positive meanings from emotionally ambiguous words (Grey and Mathews, 2000). Importantly, it has been shown that inducing either a negative or more positive bias, modifies vulnerability to anxiety during a later "stress" task such that participants trained to interpret stimuli in a more positive way show less anxiety than participants in equivalent negative training groups (Wilson et al., 2006). Such findings confirm one of the fundamental assumptions underlying cognitive therapy that negative interpretive biases are causal in the development of anxiety, and by reducing or reversing such biases it is possible to reduce anxiety levels. However, it appears that not all procedures that modify an interpretive bias are equally effective in influencing anxiety vulnerability. In particular, participants must actively generate valenced meanings, rather than be passively exposed to valenced material, in order for an induced bias to have a beneficial effect. Furthermore, in our current experiments, gender plays a role in predicting training success: training methods were more effective for females, with males often yielding contrasting responses to our laboratory stress. Results from two studies will be presented and these issues discussed.

Validating the Cognitive Effects of Interpretation Bias Training

Yiend J Department of Psychiatry, University of Oxford Mathews A Department of Psychology, University of California Davison P Oxfordshire Mental Healthcare NHS Trust, Littlemore Hospital Introduction, Lester K, University of Oxford

Cognitive biases are widely documented in affective disorders and contribute to maintaining emotional distress and vulnerability by increasing exposure to negative information. Previous research on emotion congruent interpretational processing has successfully induced biases in unselected normals analogous to those naturally occurring in emotional disorders. Such induced biases have elicited congruent changes in emotional state and trait and in response to stressors. The therapeutic potential of experimental bias induction is currently being explored. However, one prominent method of interpretative bias induction, namely text based training pioneered by Mathews & Mackintosh (2000) awaits validation using interpretative bias tests that differ in form from the training procedure. It is critical to establish that the interpretation and mood effects observed are related to wider changes in the interpretation of emotional ambiguity rather than being restricted to task specific processes. The purpose of these studies was to test for wider cognitive transfer effects following training and to begin to elucidate the factors that may govern effective transfer. Method: During training, participants are forced to consistently disambiguate emotionally ambiguous social scenarios in either a positive/benign or negative direction. A battery of standard interpretative bias measures including homograph primed lexical decision and two ambiguous sentence tasks were administered to normal volunteers before and after a text based interpretation training procedure. Interpretation bias measures were chosen to be increasingly divergent in form from the training and standard recognition test, moving away from forced choice explicit interpretations to more implicit measures of interpretation bias. The PANAS, Spielberger State Anxiety (short-form) and visual analogue mood scales were used to measure state mood throughout the session. A negative mood induction challenge was given at the end of the session to examine any training effects on latent emotional vulnerability. A second study extended initial results by attempting to isolate the factors governing effective transfer. Results: Strong training congruent effects were evident on the standard recognition test with positively trained participants making more positive spontaneous interpretations whilst those negatively trained endorsed negative interpretations as more similar. Further analyses will be presented that examine i) the extent of cognitive transfer of induced bias and ii) the factors that appear important for effective transfer. Discussion and Conclusion: Interpretation bias training produces weak, but observable, effects on some tests of interpretation bias that differ in form from the training procedure. Baseline levels of interpretation bias can differ widely between unselected normals and should be measured routinely prior to induction techniques. Future work should attempt to develop induction methods that produce stronger cognitive transfer effects, as this is likely to impact upon the efficacy of inducing congruent mood change. Active processing at encoding appears to be important in governing effective transfer.

Testing Cognitive Models: 'Process Validity' and Advances in Self-Report Questionnaire Measurement

Convenor: Nick Hawkes, Barnet, Enfield and Haringey Mental Health NHS Trust
Chair: Gary Brown, Royal Holloway, University of London

Process Validity: An Empirical and Theoretical Investigation of Anxiety-Related Cognitive Behavioural Questionnaires

Hawkes N North East London Mental Health Trust Brown G Royal Holloway, University of London

Knowledge about basic processes in psychopathology often depends upon valid measurement using self-report questionnaires of cognitive behavioural phenomena such as thoughts, beliefs, behaviours, physiological sensations and emotions. Traditional quantitative psychometric criteria, though necessary, are not sufficient to establish that a questionnaire measures the intended construct. This paper introduces the concept of 'Process Validity', reviving Cronbach and Meehl's (1955) suggestion that 'studies of process' are also necessary to establish construct validity. Based on the cognitive model of questionnaire response (Tourangeau, 1984), an Item Wording Analysis method was developed and used to analyse sixty-two major anxiety-related questionnaires, identifying what cognitive beha! vioural constructs each is likely to measure and comparing these to their stated purposes. The IWA method showed good inter-rater reliability. The analysis suggested that questionnaire measures of cognitive behavioural constructs (eg thoughts, affect etc) often substantially measured other, unintended constructs, and that accuracy varied substantially between questionnaires (from 0-100%, mean 64.4%). The analysis also suggested that measures of anxiety symptoms and specific disorders were largely based on self-report of affect, physiological sensations, thoughts and behaviour, creating potential for

confounding in research which aims to relate these variables to psychopathology. In addition, the distinction between variability due to questionnaire content and variability due to the type of basic process measured offers a new perspective for understanding factorial instability of questionnaires

Development of a self-report measure to assess attitudes to planning for the future.

MacLeod A Royal Holloway, University of London Conway C Royal Holloway, University of London Batstone S Royal Holloway, University of London

A number of clinical groups, notably suicidal individuals, are known to find it relatively difficult to think of possible future positive experiences that they might have. This may, at least partly, be due to them not planning effectively for the future, as planning ability is linked to anticipating future positive experiences and suicidal individuals have been shown to perform poorly on tasks measuring ability to plan. However, limited ability is not the only factor that might impede planning for the future: attitudes towards the value of planning is likely to play an important role. Two studies will be reported. The first study uses an open-ended interview to elicit attitudes towards planning for the future within a group who have recently self-harmed. The second study builds on the responses to create a self-report measure of planning attitudes.

The Hypomanic Attitudes and Positive Predictions Inventory (HAPPI): The Development and Validation of a Scale to Aid in Cognitive Therapy for Bipolar Disorder

Mansell W University of Manchester, UK

The development in science and practice of cognitive therapy for psychological disorders has benefited from coherent models which specify the key cognitions that can be targeted in therapy. A scale is required to identify the cognitions that characterise bipolar disorder and that may contribute to the development of mania or hypomania. The Hypomanic Attitudes and Positive Predictions Inventory (HAPPI) was developed for this purpose. I will first describe the reasoning behind the development of the scale, including the choice of wording for the items, the choice of rating scale and the method of selecting initial items from a wide battery. A range of methods for controlling for confounds will be described, including the use of reverse items, filler items, and accounting for the degree of current and recent symptoms. The results of a factor analysis, test- retest reliability, and initial tests for the predictive validity of the scale will also be described. The development of a new scale requires consideration at the theoretical, empirical, clinical, statistical and practical levels; further work on the HAPPI will be required before it can be considered a fully reliable and valid measure of cognitions that contribute to the development and maintenance of manic symptoms

The development of a scale to assess beliefs about emotions

Tai, S University of Manchester

This presentation reports the development of a self-report measure that assesses beliefs about positive and negative emotions. The scale aims to test the hypothesis that the more unhelpful beliefs people hold about their emotions, the greater their predisposition to experiencing mental health problems. Emotion and metacognitive processes have long been implicated as causal and maintenance factors within anxiety disorders and depression, and more recent findings indicate that similar processes could underlie psychotic symptoms and bipolar disorders. The initial Beliefs about Emotions Scale (BES) is a 50-item questionnaire aimed at assessing a range of beliefs about emotions, including items related to perceived controllability of emotions, impact of emotions on self perception and perception of others, and perceived social acceptability of emotions. This presentation will first discuss the theoretical basis for the role of beliefs about emotions within severe mental health problems and the importance of such metacognitive processes within cognitive models. It will also describe the development of the BES, presenting analogue data from three preliminary studies including factor analysis, and examination of the association of beliefs about emotions with predisposition to bipolar symptoms and other psychotic symptoms.

Fear of Fear and Anxiety Sensitivity: Are they what you think they are?

Hawkes N North East London Mental Health Trust Brown G Royal Holloway, University of London

There are three current theories of 'fear of fear': interoceptive conditioning, catastrophic misinterpretation of body sensations, and anxiety sensitivity (AS; negative beliefs about anxiety). However, it remains unclear what existing AS and 'fear of fear' questionnaires actually measure, and whether they measure beliefs or anxiety symptoms. An Item Wording Analysis (IWA) was employed to determine what cognitive behavioural constructs people report when answering AS and 'fear of fear' questionnaires. Confirmatory Factor Analysis (N=275) of selected items found that the IWA predicted more accurately than their stated purposes how items would covary, suggesting that the IWA has validity. The Agoraphobic Cognitions Questionnaire measures catastrophic thoughts. The Body Sensations Questionnaire measures physiological sensations and affective reactions. The Agoraphobic Cognitions Scale measures affect, physiological sensations, and thoughts. Most Anxiety Sensitivity Index – Revised items measure physiological sensations and affect. Some also seemed to measure thoughts, but their loading on the 'thoughts' factor was insignificant. Only three ASI-R items measured beliefs. Because they measure the fact that a person tends to respond to somatic sensations with fear, BSQ and much ASI-R data are merely descriptive of 'fear of fear', would therefore be compatible with any of the theories, and so can provide clear evidence for no particular explanation for panic. Furthermore, and for the same reason, BSQ and ASI-R scores can be expected to be substantially confounded with measures of anxiety symptoms and with panic attack diagnostic criteria.

Open Papers

Mechanisms Mediating Psychological Disturbance across Disorders

Chair: Yvonne Linney, West London Mental Health Trust & Caroline Brett, Canterbury Christ Church University College

Introducing the Appraisals of Anomalous Experiences Interview

Brett, C Canterbury Christ Church University College

Introduction: This presentation aims to introduce the Appraisals of Anomalous Experiences interview. This novel semi-structured interview is designed to assess (a) anomalous experiences associated with psychotic illness, on a dimensional scale that incorporates the subclinical to clinical spectrum of severity; (b) psychological, behavioural and contextual variables relevant to an individual's appraisal of their anomalous experiences. The purpose of the measure is to collect data that could elucidate the role of multiple psychological factors posited to influence the clinical impact of psychotic-like anomalies (e.g. Garety et al., 2001; Morrison, 2001). Method: the instrument was developed during a pilot phase which involved: exploratory depth interviews, the construction of an interview schedule drawing on relevant existing measures, and pilot interviews. These initial interviews were carried out with a range of people endorsing psychotic-like anomalous experiences, including people with and without a diagnosis of psychotic disorder (n = 16). Preliminary analyses were carried out, comparing the responses of those with and without a diagnosis of psychotic disorder; the results suggested that the measure was acceptable and had good face validity. Analysis of inter-rater reliability was carried out, comparing the scorings of 3 independent raters. 90% of the variables (61/68) achieved weighed kappa scores >.4 . The finalised instrument was then used in a larger study comparing appraisals, responses and contextual variables related to anomalous experiences, between three groups of participants: 2 groups of those with (D) and without a diagnosis (UD) of a psychotic disorder (n = 37; 36 respectively) and a group of help-seeking individuals who met criteria for an 'at risk mental state' (ARMS: n = 20). Cross-sectional comparisons were made using ordinal logistic regression, to test the hypotheses that 'need for care' (indexed by D group membership), and anomaly-related distress (measured within the interview) would be predicted by the appraisal, response and contextual variables. For example, the psychological model of Garety et al. (2001) posits that externalising appraisals are pivotal in determining the clinical impact of anomalous experiences. All comparisons controlled for the types of anomalies being experienced. Results: 'Need for care' was predicted by appraisals of anomalies as being negative, dangerous, and caused by other people, and by anomaly-related distress. However, the externality of the appraisal did not predict 'need for care'. Anomaly-related distress was predicted by the presence of subjective cognitive deficits, lower perceived controllability of anomalies, and higher attempted control over anomalies, across the 3 groups. Appraising anomalies as 'spiritual' predicted lower distress.

Discussion: A range of psychological and contextual variables predict the clinical impact of anomalous experiences, confirming psychological models of the development of distressing psychotic symptoms at a fundamental level. These data also illustrate the value of assessing the presence and interpretation of anomalous experiences independently, in order to elucidate the nature of the continuum of psychosis across the population. Conclusion: The Appraisals of Anomalous Experiences interview provides a valid measure of the psychological and contextual variables relevant to the clinical impact of psychotic-like anomalies, and can be used with both clinical and non-clinical populations.

The psychological processes underlying symptoms of thought interference in psychosis

Linney Y West London Mental Health Trust Peters E Institute of Psychiatry

Morrison and his colleagues have proposed that positive psychotic symptoms, particularly auditory hallucinations, are the result of cognitive intrusions being attributed to an external source. He further suggests that the motivation for an external attribution arises from the reduction of cognitive dissonance, resulting from the occurrence of such intrusions conflicting with the person's beliefs about their own mental processes (metacognitions). This aim of this study was to investigate the applicability of this model to psychotic symptoms of thought interference, such as thought insertion or thought broadcast. Fifty psychotic patients with and without symptoms of thought interference were tested on (i) frequency of cognitive intrusions; (ii) metacognitive beliefs; and (iii) source monitoring. Beliefs that may be implicated in the development of symptoms of thought interference were also assessed by examining participant's appraisals of an unrelated anomalous event (a Card Trick task). Individuals with symptoms of thought interference had increased cognitive intrusions, more negative interpretations of cognitive intrusions, an external attribution bias, and were more likely to endorse appraisals regarding 'permeability' of the mind and conspiracy on the Card Trick task, in comparison to individuals without such symptoms. When the patient group was divided into those who currently experienced auditory hallucinations, and those who did not, almost all significant differences disappeared. These findings suggest that previous studies may have been confounded by the presence of thought interference, and that Morrison's model may be more appropriate for symptoms of thought interference, than for auditory hallucinations.

To what extent are checking and avoidance behaviours relating to body appearance concerns mediated by importance of attractiveness in self worth

Vale E Newcastle University and Newcastle, North Tyneside and Northumberland Mental Health NHS Trust Freeston M Newcastle University and Newcastle, North Tyneside and Northumberland Mental Health NHS Trust Southam L Newcastle, North Tyneside and Northumberland Mental Health NHS Trust

Among the clinical features of body dysmorphic disorder, avoidance and checking behaviour can be clinically disabling. Further, cognitive behavioural models of BDD postulate that these behaviours play an important maintaining role in the disorder. These behaviours are typically targeted in treatments for BDD (Vale, 2006). Existing models of BDD have not explicitly drawn on models of body image such as Cash & PruzinskyÆs 2002 model. This model purports that body satisfaction depends on the discrepancy or congruence between self-perceived physical characteristics and personally valued appearance ideals.Preliminary data (Southam 2002) indicated that whilst avoidance behaviour was directly related to distress concerning an appearance feature, checking behaviour was mediated by the importance of attractiveness as part of self-worth among a non-clinical sample who showed a range of concern about their appearance. This study is a prospective test of the hypothesis that the importance of attractiveness in self-worth mediates the relationship between checking behaviour and distress. As BDD can be conceptualised as one end of a continuum of concern about body or facial features, this study examined the proposed hypotheses among 192 young adults, who reported a range of distress. In fact, 54% reported greater than moderate distress associated with the part of the body that most concerned them. Drawing on the methodology used by Southam 2002 and the Body Dysmorphic Disorder Examination (BDDE; Rosen & Reiter, 1996), a measure was developed to test these specific hypotheses. The Appearance Schemas Inventory û Revised (ASI-R; Cash, Melnyk & Hrabosky, 2004) was also administered to measure the importance an individual places on attractiveness as part of their self-worth. Significant correlations were found between checking, avoidance, distress and the importance of attractiveness to self-worth. Additional analyses examine whether the importance of attractiveness to self-worth mediates the key relationship. Interactions between the variables, non-linear relationships and the moderating variables are also considered in constructing a multivariate prediction of distress. This study provides a basis for a more explicit integration of models of body image into our understanding of body dissatisfaction. It also starts to propose that avoidance and checking may have differential effects in the way that they contribute to the maintenance of body dissatisfaction. If these

findings can be extended to clinical samples, such enhanced understanding could lead to differences both in the formulation for a particular case, but also the types of intervention strategy that may prove to be effective

To what extent are religiosity and thought-action fusion associated with obsessive-compulsive symptoms?

Wright N Newcastle University and Newcastle, North Tyneside and Northumberland Mental Health Trust Freeston M Newcastle University and Newcastle, North Tyneside and Northumberland Mental Health Trust Sharon A Northumbria Healthcare NHS Trust

Although there have been a number of suggestions that religion may predispose toward OCD, the empirical evidence to date is weak (Wright, 2006). This is in part due to a lack of adequate measures to operationalise aspects of religious and spiritual beliefs and practices. From a cognitive-behavioural standpoint, it may be the rigidity of religious practice rather than the strength of religious belief that would create some of the necessary setting conditions for the development of OCD. Furthermore, it may not be religion per se, but rather the development of beliefs such as thought-action fusion (TAF), particularly moral TAF, that mediates any relationship between religious belief and practice on the one hand, and obsessive-compulsive symptoms on the other (Rassin & Koster, 2003). This study investigated the relationship between religiosity, TAF and obsessive-compulsive symptoms among 182 high school students (age 16-19) recruited from religious schools. Existing measures of religiosity and TAF were modified in order to address a number of shortcomings, namely their lack of specificity. Religiosity, for example, is often measured as a one-dimensional construct. Within this study, the measure of religiosity addresses religious beliefs, religious practices and spirituality as potentially separate constructs. The TAF measure selected items from existing scales to better delineate four separate components, namely, moral TAF, and three distinct types of likelihood TAF. Questionnaires were administered at school among psychology A-level students. Significant relationships exist between all three variables, in itself a replication and extension of earlier findings in the field. Additional analyses test alternative models of the link between OCD and religiosity and in particular whether components of TAF play a mediating or moderating role. The results extend previous findings by the improved measurement of all three constructs and enable a more fine-grained analysis of the separate contributions of different forms of TAF, along with the delineation of religious belief, religious practice, and spirituality. These findings can inform CBT models of OCD, particularly those with religious content and scrupulosity. Further, they can contribute to the ongoing debate as to whether religion may be pathogenic (i.e. a causal role) in the development of OCD or whether it is pathoplatsic (i.e. influences the expression of OCD) without having a direct causal role.

Vulnerability to depression and emotional processing

Chan S Department of Experimental Psychology, University of Oxford Goodwin G University Department of Psychiatry, University of Oxford Harmer C Department of Experimental Psychology, University of Oxford

Cognitive theories emphasise the role of negative biases in information processing in the maintenance and aetiology of depression. The existence of mood-congruent biases in attention, perception and memory is well documented in acutely depressed patients and to some extent recovered patients, suggesting that these abnormalities may be risk factors for depression. However, this research does not indicate whether these abnormalities precede the first depressive disorder or do they develop as a consequence of previous experience of depression. The present study therefore aimed to explore the relationship between emotional processing biases and vulnerability to depression. Specifically, it was hypothesised that negative biases would be shown in individuals who are never-depressed but are at high risk of developing depression. Neuroticism (N) is a well-known high risk factor for depression. The current study therefore recruited 33 high-N and 32 low-N never-depressed college students as the high-vulnerable and low-vulnerable (control) groups respectively. Their affective processing was assessed by a battery of tests, including emotional categorisation, emotional memory, facial expression recognition, attention to emotional information using the dot-probe task, and physiological reactivity to emotional stimuli using affective modulation of the startle reflex. In addition, key elements of cognitive function found to be impaired in depression were also assessed using the Rey Auditory Verbal Learning Task, Tower of London, and Autobiographical Memory Test. Group differences in task performance were examined by repeated measures ANOVAs. Results indicate that high-N volunteers were faster to classify negative versus positive self- referent personality characteristics, and produced less memory intrusions for positive words. Compared to the control group, they had a higher threshold in identifying happy facial expression and showed an elevated affect-modulated startle effect when viewing unpleasant pictures. These effects remained significant even after the scores of Beck Depression Inventory were statistically controlled for, suggesting that the biases appeared at least partially independent of low grade mood symptoms experienced by high-N volunteers. By contrast, there was no evidence for effects of neuroticism on attentional bias or over-general autobiographical memory.

High-N volunteers appeared to have enhanced verbal memory and executive function, but these effects were related to high levels of perfectionism These results suggest that negative processing biases constitute to the vulnerability of depression, and as such may precede depression rather than occurring as a result of depressive experience per se. Future longitudinal studies need to be conducted to investigate whether, and to what extent, such cognitive vulnerability predict subsequent depression. Moreover, as dysfunctional affective processing is detectable in non-clinical vulnerable sample, more research is required to explore the potential efficacy of early intervention targeting on the cognitive aspects of the high-risk population.

Impulsivity, Depersonalisation and Anxiety: Implications for CBT

Chair: Thorsten Barnhofer, University of Oxford

Cognitive and behavioural dimensions of impulsivity: Implications for cognitive behavioural psychotherapy

Sirous M, University of Sussex, Grant A University of Brighton Yeomans M University of Sussex

Impulsivity is a multidimensional psychological construct that had been defined in various ways. In the clinical field, impulsiveness has been used as a broad term that refers to problems in regulating, and especially in inhibiting, emotions, thoughts and behaviour. One of the operational definitions of impulsiveness is based on operant model that measures impulsiveness in terms of preference for immediate rewards over larger delayed rewards. According to this model, impulsivity is defined as ôthe selection of a small immediate reward in preference to a larger delayed rewardö. It has been shown that, in general, impulsive people score higher in a measure of cognitive distortion suggesting an underlying maladaptive cognitive component for impulsive behaviour (Mobini et al., 2006). Although, after subjective distress, impulsiveness may be the most common diagnostic criteria in the DSM-IV, it is not yet clear what behavioural and cognitive factors are involved in the initiation and maintenance of dysfunctional impulsive behaviour. The present study aims at examining behavioural and cognitive dimensions of dysfunctional/functional impulsivity. The participants were 118 undergraduate students from the University of Sussex. They completed a behavioural measure of impulsivity (delay discounting task) along with a battery of self-report questionnaires including the Cognitive Distortion Scale (CDS), Dickman Impulsivity (Dysfunctional/Functional) Inventory (DIS), Barratt Impulsiveness Scale (BIS-11), Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI). Ten participants with high scores on BDI and BAI were excluded from the data analysis. Discounting the value of delayed rewards was measured using computerized adjusting amount procedure (Mitchell, 1999) in the laboratory setting followed by the administration of the self-report questionnaires. The delay discounting procedure used in this study was designed to measure the ôsubjectiveö value of a 'standard' ú10 reward at several delay and an 'alternative' variable immediate monetary reward. Participants were divided into two high and low impulsive groups and compared on delay discounting measure. The median indifference points for monetary reward as a function of delaywere calculated for high and low impulsive individuals. The hyperbolic decay functions were fit to the median indifference points and k value was calculated. k is a free parameter representing delay (temporal) discounting obtained by slope-1/intercept. The CDS scores were compared between two groups, i.e. participants with Dysfunctional Impulsivity > Functional Impulsivity scores and participants with Functional Impulsivity > Dysfunctional Impulsivity scores. The behavioural findings showed that the subjective monetary value decreased more rapidly for high-impulsive group than for low impulsive group ($p > 0.01$). This was represented by higher discount rate (High k) for impulsive individuals as compared to low impulsive individuals. This result is in line with the findings that suggest impulsive individuals may have deficient tolerance of delay of gratification. Consistent with our previous finding, people with high scores on the BIS scored high on the CDS ($p>0.01$). However, further data analysis comparing two distinct groups (group with Dysfunctional Impulsivity > Functional Impulsivity vs group with Functional Impulsivity > Dysfunctional Impulsivity) showed that the dysfunctional cognitions are characteristics of dysfunctional impulsivity rather than functional impulsivity. The findings of this study suggest that the impulsive individuals have deficient tolerance of delay of gratification represented by high discount rates. Consistent with Beck's cognitive model (Beck et al., 1990) and findings from some other studies (e.g., Dench et al., 2005), our findings suggest that high impulsive individuals have dysfunctional interpretations of events around them that may contribute to their tendency to act rapidly with disregard to the consequences of behaviour. Lists of cognitive distortions can provide us with vital information in identifying themes to be addressed in the cognitive-behaviour therapy of impulse-control problems.

Cognitive biases in depersonalisation disorder

Hunter E South London and Maudsley NHS Trust & Institute of Psychiatry Salkovskis P Institute of Psychiatry David T Institute of Psychiatry

A recent cognitive-behavioural model of Depersonalisation Disorder (Hunter et al, 2003) suggests that cognitive biases are likely to precipitate, and perpetuate, symptomatology. This paper examines three aspects of potential cognitive biases in patients with depersonalization disorder (DPD). The first of these was to examine the phenomenology of catastrophic cognitions in patients with DPD, when compared to patients with anxiety disorders and healthy controls. The second aim was to investigate the role that attributional biases might play in the development of the disorder. Finally, the third aim was to experimentally manipulate parts of the model by a) activating catastrophic cognitions, and b) increasing the focus on symptoms. The research involved an experimental design that compared 68 participants in three groups: a) 25 participants with a diagnosis of DPD; b) a mixed anxiety disorder group of patients (16 with Obsessive-Compulsive Disorder and 5 with Panic Disorder); and c) 22 healthy, demographically matched, controls. All participants were interviewed using standardized, semi-structured psychiatric measures (SCID and SCID-D) to ensure they met criteria for their primary disorder, to assess co-morbidity, and to screen for the presence of psychiatric disorder in the healthy control group. The Catastrophic Cognitions Study employed a questionnaire measure designed specifically for this study to examine the frequency and percentage belief in a range of catastrophic cognitions. The Attributions Study was designed to investigate participant's attributions for a range of ambiguous symptoms that included symptoms of DPD, and was adapted from tasks used by previously by Sensky and colleagues (Sensky, MacLeod & Rigby, 1996; MacLeod, Haynes & Sensky, 1998). Thirdly, four experimental tasks aimed to manipulate symptom severity, by either activating catastrophic cognitions (Paired Associate Task), increasing the focus on DP/DR symptoms (Dot Staring Task), or inhibiting both these processes (Mental Arithmetic Task and Dichotic Listening Task). In the Catastrophic Cognitions Study, patients with DPD were found to have significantly more catastrophic cognitions regarding mental illness and brain dysfunction than controls. They were also shown to believe in these thoughts more than non-patients. In the Attributions Study, DPD patients were found to have an attributional bias when presented with ambiguous symptoms, and were less able to generate an initial normalising reason, in comparison to healthy controls. In both these cognitive biases, DPD patients were found to bear strikingly similarities to patients with Anxiety disorders. However, DPD patients displayed greater specificity, in that they did not demonstrate biases for catastrophic beliefs about physical illness, as did the Anxiety patients. Finally, the DPD patients showed a very different pattern of responding from the other two groups when experimental manipulations of aspects of the model were carried out. When processing of catastrophic cognitions and symptom monitoring were inhibited, DPD patients reported a reduction in symptoms, whereas Anxiety patients and controls continued to report an increase in symptoms. Although theoretical associations have been made between DPD and anxiety disorders, and in particular that deriving a model of DPD from the existing models of anxiety disorders, could assist clinicians in the understanding and treatment of DPD, no empirical research had been conducted and the theoretical model remained speculative. The findings from the current research validate three predictions that would be made from the DPD model by Hunter et al (2003), and are valuable in furthering our understanding of the psychological processes involved in DPD.

Using implementation intentions to modify attentional biases in social anxiety

Webb T University of Manchester Ononaiye M University of Sheffield Sheeran P University of Sheffield Reidy J Sheffield Hallam University

Cognitive models of social anxiety (e.g., Mogg & Bradley, 1998) suggest that selective attention to threatening stimuli plays an important role in the development and maintenance of anxiety. However, few therapeutic interventions to date directly target these attentional processes and those that do (e.g., Amir, Beard, Klumpp, & Elias, 2004) rely on time-consuming retraining. We investigated whether forming strategic, if-then plans (known as implementation intentions, Gollwitzer, 1999) that specify a good opportunity to control attention and a response to that anticipated opportunity can help to modify attentional biases in social anxiety. N = 48 participants were recruited on the basis of either high (> 9) or low (< 4) scores on the Social Avoidance and Distress Scale (Watson & Friend, 1969). Participants were invited to the laboratory and completed a forced choice variant of the Visual Dot Probe (VDP; MacLeod, Mathews, & Tata, 1986) task under conditions of social evaluative threat (all participants believed that they would have to give a speech). Following a fixation point (500ms), a word representing a somatic sensation (e.g., blushing) or a negative evaluation (e.g., stupid) was presented alongside a matched neutral word (e.g., cupboard) for 500ms. One of the words was then replaced by a probe (E or F) to which the participant responded. The instructions provided to participants prior to the VDP task differed by condition. Participants in the ægoal intention group were told that ôduring the computer task, it is important that you remain calm and do not worry about the speechö. Participants in the æimplementation intentionÆ condition were given the same instructions as participants in the goal

intention group, but were also asked to form a plan; ôIf I see a neutral word, then I will focus all my attention on it!ö Participants in the ækontrolÆ group were given no further instructions about what to do during the computer task. Thus, the experiment had a 2 (social anxiety: high vs. low) x 3 (instruction: none vs. goal intention vs. implementation intention) design. As expected, when participants were given no instructions (control condition) or were simply asked to remain calm (goal intention condition), socially anxious participants showed an attentional bias toward threatening words (Ms = 22.22 and 14.03, respectively) that was not observed amongst non-anxious participants (Ms = -2.63 and -6.38, respectively). However, consistent with the idea that implementation intentions can modify attentional processes, socially anxious participants who formed implementation intentions did not show an attentional bias toward threatening words (M = -1.70). The findings demonstrate the potential of implementation intentions for modifying attentional biases in social anxiety. If-then planning may complement existing therapeutic techniques, by providing a simple and effective way of preventing unwanted attentional responses

Cognitive behavioural therapy for generalised anxiety disorder following traumatic brain injury: a single case study

Terry G, Nottingham Traumatic Brain Injury Service

Traumatic Brain Injury (TBI) is, almost invariably, a catastrophic and life-changing experience. Damage to the brain can lead to a wide range of cognitive problems (e.g. impaired memory and concentration, poor problem solving skills, reduced ability to regulate emotions etc), and depression, anxiety and anger management problems are common within this client group. Psychological services for TBI client often focus on neuropsychological/psychometric assessment (McGrath and King, 2004). As brain injured clients are often excluded from mainstream mental health service, opportunities to access to psychotherapeutic intervention can be severely limited. Despite this there is a growing body of evidence that cognitive behavioural interventions can be effective in reducing psychological distress, and are an important adjunct to traditional rehabilitation services for TBI rehabilitation. This paper presents the cognitive behavioural treatment of a client presenting with Generalised Anxiety Disorder (GAD) co-morbid with cognitive impairment resulting from traumatic brain injury (TBI). A full assessment and detailed history was obtained and a collaborative case conceptualisation developed. The presenting problem was conceptualised using a hybrid of Wells (1995) cognitive model of GAD and the SPAARS (Schematic, Propositional, Analogical, Associative Representation Systems) (Power and Dalgliesh, 1997). These models were chosen because the former explains the clear theoretical distinction between worry and meta-worry. The latter model was useful in incorporating important factors at a schematic level that emerged during the formulation process. The impact of the TBI was particularly significant in the development and maintenance of the problem in that reduced cognitive ability:a) Reinforced existing core beliefs.b) Affected task performance through inattention.c) Affected accurate short term memory increasing doubt and uncertaintyd) Instigated the onset of worrying and checking behaviours, as mentally reviewing performance was taught as a coping strategy.Treatment (over 20 sessions) consisted of; socialisation to the conceptual model and normalisation ofworry, behavioural experiments, both in session and for homework, to test out beliefs about the consequences and controllability of worry, reattribution of negative beliefs about worry, and reduction of safety behaviours. The intervention was successful in reducing worrying and checking behaviours to a level that was acceptable to the client, given the additional problems associated with his cognitive impairment. Details of Problem/Target rating and self-report measures pre-, mid- and post- treatment will be presented. This case study demonstrates that cognitive behavioural interventions can produce good results with clients presenting with emotional disorders co-morbid with cognitive impairment. Despite problems of poor memory and attention, the client was able to understand a relatively complex case conceptualisation, provide accurate self-report through measures and diary sheets, and ultimately make significant treatment gains. The presentation will include details of the assessment and conceptualisation, a description of the course of therapy including modifications to take into account cognitive impairment, the treatment outcomes, and a brief critical discussion of the theory underpinning the process.

Cognitive behavioural therapy for torture survivors: The case for therapeutic pragmatism: three case reports

Regel S Traumatic Stress Service, Nottinghamshire Healthcare NHS Trust Berliner P Department of Psychology, University of Copenhagen, Denmark

Increasing numbers of refugees are presenting to mental health services and pose significant clinical challenges for practitioners. The most clinically challenging to engage in a psychotherapeutic context are survivors of torture and politically organised violence. Much of the literature on therapeutic work with torture survivors has tended to focus on psychodynamic approaches, with some attempts to study and describe cognitive behavioural approaches in torture survivors (Basoglu, 1998). It has been demonstrated that cognitive behavioural therapy is effective for PTSD, as recommended by the NICE

guidelines for the assessment and management of PTSD in primary and secondary care (NICE, 2005). This paper illustrates, through three case examples, the use of CBT as an effective treatment intervention for this group. It will be demonstrated that the model can have effective clinical outcomes and provide a practical, problem orientated approach to working with survivors of torture and political violence (Regel and Berliner, 2005) Cognitive behavioural therapy was used to treat three torture survivors presenting with PTSD and co-morbid depression. This paper describes the use of assessment and treatment approaches using CBT principles, demonstrates the flexibility and applicability of the model,. Therapy was multifaceted, with all three clients received a total of twelve hourly sessions of Cognitive Behavioural Therapy (CBT), over a period of six months. A key focus of early sessions was education regarding the development and maintenance of presenting problems, a combination of graded exposure to feared situations, simple anxiety management techniques and involvement with community resources. The use of Eye Movement Desensitisation and Reprocessing (EMDR) was also used to treat traumatic memories arising from the torture. Treatment strategies were adapted to include the use of interpreters. The interventions were successful; facilitating a range of clinical changes which were maintained at 1 year follow-up. Clinical change was also audited through the use of translated versions of the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist. These case examples illustrate the usefulness of CBT as a treatment intervention for torture survivors. It also demonstrates the utility of CBT in different cultural contexts, despite perceived cultural limitations. It calls for creativity and flexibility on the part of the therapist and a willingness to be less rigid with conventions of clinical practice, but yet stay true to the principles of the model. The presentation will include details of assessment, formulation, together with adaptations and modifications in treatment. Implications for assessment and practice in a cross cultural setting will be discussed.

Posters

Basic Processes

Reasons for Entrapment in Depression

Christodoulides T, South of Tyne and Wearside Mental Health NHS Trust and Barton S, University of Newcastle upon Tyne, Armstrong P, Newcastle North Tyneside and Northumberland Mental Health NHS Trust

Introduction: Entrapment is defined as ‘a perceived inability to escape from an undesirable current situation’ (Gilbert and Allan, 1998). Recent researchers have suggested that entrapment is a key concept in our understanding of depression (Gilbert and Allan, 1998; Leahy, 2000). The finding that entrapment and depression are positively correlated has now been replicated across various settings and populations (e.g. Gilbert, Gilbert and Irons, 2004). However, the nature of this relationship remains uncertain. We do not know the social roles or relationships in which people feel trapped or people’s perceived reasons that can lead people to feel trapped. In short, we understand how much people with depression feel trapped, but not where or why they feel trapped. This study aimed to address this by ! exploring and classifying depressed people’s reasons for becoming and remaining trapped in specific social roles, and by mapping these onto specific psychological processes. Method/Techniques: There was no available existing measure that examined reasons for entrapment. As such, this was an exploratory study in which a semi-structured interview tool was designed specifically from pilot work and a focus group of experienced clinicians working with depression. Reasons for entrapment were constructed from a number of aspects of the depression literature that were mapped onto underlying psychological processes. One clinical group of 16 participants with depression was recruited from a secondary care CBT specialist service. The sample consisted of 9 male and 7 female participants with a mean age of 39 and a mean BDI total of 27. Results/Outcomes: 15 of the 16 participants reported feeling trapped in one or more roles and these were heavily concentrated in the family domain (e.g. partner, parent). All participants who felt trapped were able to report specific reasons that mapped onto cognitive, behavioural and affective processes. Some reasons were reported by all participants e.g. that they had invested so much in the trapped role that it was too late to escape. Other specific reasons were strongly endorsed by some, but not all, participants e.g. a sense of duty or obligation to remain in the trapped role. An initial model of depressed entrapment was constructed from these findings. Discussion: The findings suggest that depressed entrapment is significantly more prevalent in familial relationships, than other social roles within the friendship, work or leisure domains. The reasons that were universally endorsed by all participants offered some support to Gilbert and others evolutionary theory of depression and Leahy’s investment model of depression. However, the finding that some specific reasons were strongly endorsed by some, but not all, participants suggests that some forms of entrapment are maintained through different psychological mechanisms. The proposed model of depressed entrapment provides multiple pathways to account for this. Given the exploratory nature of

the study and limitations of a small sample size this study requires replication and extension. It is! also recommended that future research focus upon testing the relationship between the components of the proposed model.

Confirmatory Factor Analysis of a 5 Factor Mindfulness Questionnaire

Duggan D, University of Oxford, Baer R A, University of Kentucky Williams JMG, University of Oxford

Introduction: There is growing evidence to suggest that treatments using mindfulness meditation techniques can lead to improved treatment of a variety of disorders, for example in the prevention of depression (Teasdale et al, 2000). In order both to explore the efficacy, and to get a clearer perspective of exactly what changes in patients undergoing these treatments, it has become apparent that it is necessary to measure mindfulness in a systematic way. This has led to the development of a number of self-report mindfulness questionnaires over recent years. Uncertainties regarding an operational definition of mindfulness have meant that existing mindfulness questionnaires measure mindfulness both as a uni-dimensional and multi-dimensional construct. Baer et al (2006) carried out an exploratory factor analysis on items pooled together from 5 existing mindfulness questionnaires. This produced a 5 factor solution which was subsequently confirmed as providing a good fit to data from another sample using confirmatory factor analysis (Baer et al, 2006). The 5 factors identified were nonreactivity, observing, acting with awareness, describing and nonjudging. This suggests that when using these compiled items, describing mindfulness as a multidimensional construct is more appropriate. However, both factor analysis techniques were performed on undergraduate samples in the USA, and before adopting a multidimensional approach to the measurement of mindfulness, this study was designed to test if the factor structure would be supported in! a British community sample. Method: A community sample of 313 people completed the mindfulness questionnaire items used by Baer et al (2006). A replication of the confirmatory factor analysis (CFA) was carried out in this sample using the SPSS add on package AMOS 6. Items were parcelled so that the CFA model specified contained 5 factors and 15 indicators (observed variables). The CFA model hypothesised that; (a) the 5 factors are correlated, (b) observed variables have non-zero loadings on the factor they are expected to measure but zero loadings on all other factors, and (c) errors of measurement associated with observed variables do not correlate. A further analysis was then carried out to test a 1 factor solution. Results: The five factor solution provided a reasonably good fit to the data when using goodness of fit indices (CFI = .975, RMSEA = .05, 90% confidence interval:04 to .07). The one factor solution did not provide a good fit to the data (CFI = .466, RMSEA = .24, 90% confidence interval:.23 to .25). Discussion: The five factor solution was supported as superior to a one factor solution in a British community sample. This suggests it may be useful to measure mindfulness as a multidimensional construct when evaluating treatments using general mindfulness techniques. Further work on defining the characteristics of mindfulness may be required to ensure that self-report questionnaires are able to record this construct adequately.

Psychological Predictors of Attitudinal and Psychophysiological Responses to Disfigurement. A Comparison of Sufferers of Visible Skin Conditions and Matched Controls

Grandfield T, University of Sheffield, Thompson A, and Turpin G, University of Sheffield

Introduction: It is widely established that individuals with a disfigurement can experience negative reactions from other people, in the form of staring and in some cases discrimination (e.g. Changing Faces, 2003).Although this tendency to avoid or discriminate against people with a disfigurement is well established, relatively little theoretical consideration has been given to account for this occurrence (Thompson & Kent, 2001). Research exploring the immediate attitudinal responses and psychophysiological reactions towards disfigurement would provide an important insight into the links between attitudes and discrimination. Methods: The main aim of the research was to explore the differences in reactions to photographs portraying skin conditions between people who suffer from a skin condition and controls. Thirty-nine participants were recruited from 2 dermatology departments and 39 controls were recruited via a volunteer database held at the University of Sheffield (age range 18-87). Clinical participants were selected according to the criteria that they have a chronic skin condition, were over 18 and speak English to a high standard. The control group were age and gender matched as closely as possible. Each participant came to the psychology department to take part, they completed a series of questionnaires (measuring motivation, skin stigma, disgust, appearance, external shame, skin shame, anxiety, depression, rating scales and demographic variables. They also completed a reaction time task (IAT) looking at differences between skin conditions and clear skin when paired with positive and negative attributes based on a previous design (Grandfield et al 2005). Then they were asked to view 15 images from the IAPS and 10 images depicting either clear skin or skin conditions. During viewing heart rate, skin conductance (SCR) and electromyograms (EMG) of three facial muscles (zygomatic, corrugator, levator labii) were measured. Each person was also asked to rate the pictures they had seen using the Self-Assessment mannequin. Results: The results of this study are ongoing, these include: The IAT is analysed initially using t-tests and then 2(control or dermatitis) x 2(gender) x 2

(picture set or duration of dermatitis) repeated measures ANOVA's. Psychophysiological responses are being examined to look at differences between stimuli as well as differences between participants. EMG is being looked at in detail to assess whether different facial muscles are activated with different stimuli groups. Analyses will also look at whether there is any relationship between the physiology and the IAT or other IV's. Differences in the questionnaire measures are being looked at between and within groups and with respect to the IAT and SAM. Main results will be reported within the poster

Do Females with Bulimia Nervosa and Eating Disorder Not Otherwise Specified Have Selective Memory Biases?

Griffith E and Kuyken, W University of Exeter, Jones, A Avon and Wiltshire Partnership NHS Trust

Introduction: Cognitive behavioural therapy (CBT) for eating disorders is informed by the cognitive model of eating disorders. The basic cognitive model suggests that beliefs concerning weight and shape, food and eating are involved in the maintenance of both anorexia nervosa and bulimia nervosa (Hunt & Cooper, 2001). Fairburn et al (2003) suggest that when taking a transdiagnostic approach, the cognitive model can be extended to include eating disorder not otherwise specified (EDNOS). This study focuses on one aspect of the cognitive models related to information processing; namely that memory biases exist that preferentially select for information from the individual's environment that is consistent with their weight, shape and food related beliefs (Hunt & Cooper, 2001). This study aims to extend the small amount of previous research conducted in this area (e.g. Hunt & Cooper, 2001); in an attempt to clarify the role that memory biases could play in the maintenance of eating disorders. The main hypothesis is that females with bulimia nervosa will recall more words related to weight, shape and food compared to neutral nouns, neutral body words and emotion words. On the basis of the transdiagnostic approach, it is also hypothesised that females with ENDOS will show a similar memory bias. Such a bias is not hypothesised for the control group. Method: The study design is experimental involving three independent groups; females with bulimia nervosa, females with EDNOS and a general population control female group. Females with bulimia nervosa and ENDOS were interviewed using the diagnostic items of the eating disorder examination (Fairburn & Cooper, 1987). As part of the research all participants listened to one hundred and thirty words. In line with the methodology utilised by Hunt and Cooper (2001) these were presented in a random fixed order as part of a self referential encoding task. Following a distraction task all participants were asked to recall as many words as possible. Results: The results of the study will be presented at the conference and the key theoretical and clinical implications will be highlighted.

The Relation Between Intolerance of Uncertainty and Attentional Biases

Heinecke N, Koerner, N, Dugas M Concordia University, Canada, Mogg K, University of Southampton

Introduction: Past studies of attentional bias have shown that individuals with generalized anxiety disorder (GAD) tend to focus their attention on stimuli that are denotative of physical threat and social evaluative threat (MacLeod, Mathews, & Tata, 1986). This has been interpreted as support for the notion that GAD-related threat cues are diffuse. Dugas and colleagues have suggested, however, that the diffuseness of the concerns reported by individuals with GAD might be explained by a core fear of uncertainty. In their cognitive model (see Koerner & Dugas, 2006), intolerance of uncertainty (IU) is a key process involved in excessive worry. It refers to a dispositional characteristic that arises from a set of fundamental beliefs about uncertainty and its implications (Koerner & Duga! s, 2006). IU is thought to influence information processing by promoting enhanced attention toward, and negative interpretations of, uncertain situations. Given that individuals who worry excessively are so sensitive to uncertainty, this study seeks to investigate the relation between IU and attentional processing of uncertainty-related stimuli. Method: In this ongoing study (n=50 thus far), non-clinical participants complete a probe classification task. In each of the 160 trials, two words are simultaneously presented for 500ms. One of the two paired words is neutral in valence, and the other is a word that refers to uncertainty (e.g., chance), physical threat (e.g., illness), social evaluative threat (e.g., inferior), positivity (e.g., adored), or neutrality (e.g., annual), thereby providing 5 possible word pairs. Following this, a probe (either the letter E or F) replaces the location occupied by one of the two words. Participants classify the probe by pressing a key marked either E or F (see Mansell, Clark, Ehlers, & Chen, 1999). Their response times are recorded in milliseconds. Participants also complete questionnaires a! ssessing intolerance of uncertainty, worry, symptoms of somatic anxiety and depression, trait anxiety, attentional control, and state levels of anxiety, sadness, irritability, happiness, and fatigue. Results: It is hypothesized that high levels of IU will be associated with quicker response times in trials in which the probe replaces an uncertainty-related, physical threat, or social threat word (congruent trials), as opposed to trials in which the probe replaces a neutral word (incongruent trials). Additionally, it is predicted that the results will remain unchanged after controlling for mood and attentional control. These hypotheses will be examined using the entire sample of this ongoing study; however, preliminary analyses have indicated that in high

IU individuals only, a greater severity of depressive symptoms is associated with slowed responses to trials involving uncertainty-related, physical threat and social threat words. Moreover, in high IU individuals, high trait anxiety and a greater severity of GAD symptoms are moderately associated with slowed responses to only those trials involving uncertainty-related words. Discussion: The findings will be discussed in terms of (1) the nature of attentional processing in individuals who are intolerant of uncertainty, (2) the possible role of mood in schematic information processing, and (3) implications for the cognitive model of GAD proposed by Dugas et al. (1998).

Analysis of Overgeneral and Contextual Thoughts and Memories of Never, Formerly and Currently Depressed Students

Jacoby N, Brewin, C, University College London Pennebaker J 125

Introduction: A contrast in the literature between autobiographical memory test (AMT) findings in depressed patients and predictions made by cognitive theories of depression was identified. Cognitive theories suggest that depression is likely to develop when people attribute negative, overgeneral explanations to past and present experiences, and unlikely to develop when positive explanations are given, even if they are overgeneral. AMT studies identify both a negative and positive overgeneral memory bias in depressed patients. This discrepancy may be due to the artificiality of the AMT procedure, with the types of memories primed by the task being different to those that would naturally occur. Alternatively, depressed patients may have reduced executive resources, such as working memory capacity, which decrease their ability to retrieve categoric memories on the AMT (Williams, 1996). The present study investigated this discrepancy by quantitatively analysing the naturally occurring thoughts of currently-, formerly- and never-depressed college students. Methods: Transcripts from Rude, Gortner and Pennebaker's (2004) study, which asked college students to write about their experiences of starting college, were analysed. The sample consisted of 66 never-depressed, 26 formerly-depressed, and 31 currently-depressed students (as identified by the Beck Depression Inventory). Transcripts were divided into phrases, and coded as either a thought or a memory, as having a contextual or general theme, and having a positive or negative valence. Percentages of each phrase type were compared between the groups. Results: As predicted, the currently-depressed group produced more negative utterances overall than the formerly- and never-depressed groups, and produced more negative general utterances than the formerly- and never-depressed groups. The formerly- and never- depressed groups produced more positive general utterances than the currently-depressed group, also as predicted. The never- and formerly-depressed groups did not differ from each other in the number of utterances produced in any of the categories. Interestingly, the currently-depressed group were also found to produce significantly more negative contextual utterances than the never- and formerly-depressed groups. Conclusion: The findings imply that overgeneral thinking in depressed patients is biased to negative recollections, and not positive. This contradicts AMT studies that have found negative and positive overgeneralisations in depressed patients, but supports cognitive theories of depression. This, in addition to the unexpected finding that the currently-depressed group produced more negative contextual thoughts than the formerly- and never-depressed groups, suggests that the AMT is not a reliable measure of memory specificity. Recent findings by Dalgleish et al., (submitted for publication) suggest that AMT findings are a result of working memory capacity limitations. The more naturalistic task in the present study places few demands on working memory capacity, which may account for the findings. However, as a negative bias towards contextual thoughts remained, it suggests that negative thinking could be a stronger trait marker of depression than overgeneral thinking, as depressed participants were still able to think contextually. Further research and analysis of currently-, never- and formerly-depressed participants' thoughts is needed to support and extend these findings, and to elaborate on the inconsistencies between AMT data and cognitive theory.

Latent Structure of Dieting Among Japanese High School Adolescent Girls: A Latent Class Analysis

Kachi Y, The University of Tokyo, Japan

Introduction: Although studies have evaluated the degree of each dieting behavior, no research has examined whether dieting behavior patterns are harmful or beneficial. Dieting refers to an intentional effort to achieve or maintain a desired weight through reduced caloric intake (Stice, Mazotti, Krebs, & Martin, 1998). The present study investigated whether adolescent girls having particular dieting behavior patterns can be classified, whether classes were predicted by body dissatisfaction and body mass index, and whether classes differed in binge eating and negative affect. Method: Two investigations were conducted. The first one that included four validated measures, which assess dieting behaviors, body dissatisfaction, binge eating, and depressive mood respectively was conducted in the period from July 2005 to August 2005. After this, the second cross-validation investigation that included one measure, which assesses dieting behavior, was conducted in September 2005. The first sample consisted of 441 female participants from five high schools in Gifu Prefecture, Japan. The second

sample for the cross-validation study was based on the responses of 138 girls from two high schools. Results: Latent class analysis revealed an unhealthy dieting class (27%), a healthy dieting class (39%), and a non-dieter class (34%). The cross-validation study also confirmed the reliability of this three-class structure. In addition, body dissatisfaction was able to significantly predict the unhealthy dieter class but not the other classes, while BMI could not predict any of the classes. Furthermore, the unhealthy dieter class had a greater frequency of binge eating than the other classes, while there was no difference with respect to depressive mood. Conclusion: Results suggest that unlike healthy dieting behaviour patterns, unhealthy ones are harmful

Assessing Implicit Self-esteem in Sub-clinical Depression and the Effects of Subliminal Evaluative Conditioning

Rawal A, University of Oxford

Introduction: Negative self-concepts have been postulated to be associated with depressive states. Recent theoretical and empirical work has alluded to the importance of assessing implicit self-esteem (ISE) in predicting outcome of depression. In contrast to intentional/reflective self-evaluations (e.g., explicit self esteem), ISE is thought to represent the automatic activation of self-evaluative associations (Strack & Deutsch, 2004). A recent study showed a relationship between ISE and levels of depressive symptoms in university students (Logel et al., 2005). The present study aimed to further elucidate the association between ISE and depression and to examine the effects of a subliminal evaluative conditioning procedure on a measure of ISE, thereby exploring the potential for changing imp! licit self-associations through this technique. Method: High and low depressive groups were recruited from a student population. The evaluative conditioning procedure was part of a lexical decision task, where participants were subliminally exposed to repeated pairings of the word 'I' followed by a positive adjective or a neutral noun (the former in the experimental, latter in the control condition). ISE was measured with the Implicit Association Test (IAT; Greenwald & Farnham, 2000) and by measuring participants' signature size before and after the conditioning procedure. Results showed that individuals in the high depressive group had significantly lower IAT scores than those in the low depressive group, indicating lower implicit self esteem. Following the lexical decision task participants exposed to positive subliminal evaluative conditioning showed a significant increase in signature size, whereas participants in the control condition showed no change. No effects of conditioning on explicit self-esteem, state anxiety or mood were found. An awareness check revealed that none of the participants were aware of the words being shown. Discussion: The study showed that low ISE is associated with subclinical depression, suggesting that negative automatic self-associations are a feature of this state. Specific effects of subliminal evaluative conditioning on ISE were shown by the large increase in signature size in absence of effects on explicit self-evaluations or mood. Thus, subliminal conditioning may have the potential to modulate implicit aspects of the self-concept. Signature size could be a valuable non-reactive/intuitive measure to reflect changes in emotional states. More research is required to elucidate the functionality of low ISE in depressive states and its relationship to processes such as rumination.

An Investigation into Illness Perceptions of Breast Cancer Patients and Their Spouses: Do Their Perceptions, and the Congruence Within Couples, Effect Psychological Adjustment?

Rivers Z and Wearden A, University of Liverpool

Introduction: Recent medical advances have produced an encouraging increased rate of survival in breast cancer patients. Research has demonstrated that patients' adjustment to the illness is influenced by risk factors, coping strategies and significant others (Berkman et al, 1992). Illness perception research in the area of breast cancer has shown significant relationships between patients' illness beliefs and their psychological adjustment to diagnosis and treatment (Buick, 1997). Recent work investigating the effects of incongruence of illness perceptions within couples has shown that dissimilarity is significantly related to psychological well-being in both patients and spouses (Richards, 2004). The current study aimed to examine the illness perceptions of breast cancer patients & their ! partners, and the effect of dissimilarity of perceptions on their psychological and marital adjustment. Method: 53 patients at Christie Hospital NHS Trust under 66 years of age, who had recently received their first diagnosis of breast cancer, and were married or co-habiting consented to take part in the study. 35 couples of those approached completed the full set of questionnaires measuring: Illness perceptions (IPQ-R), Psychological adjustment (HADS / GHQ-28) and coping (Brief COPE). Dissimilarity scores of illness perceptions within couples were calculated and analysis primarily examined relationships between dissimilarity and psychological functioning. Results: The study showed that patient and partners groups held very similar beliefs about breast cancer. Significant psychological distress in patients was found to be associated with low perceived personal control ($r=-.466$, $p<0.01$)), and high perceived consequences ($r=.332$, $p<0.05$) & emotional representation ($r=.682$, $p<0.01$). Partner psychological distress was also associated with high perceived treatment control ($r=.351$, $p<0.05$). Analysis of patient and partner dyads showed that when partners minimised the consequences ($F=4.112$, $p<0.05$,$df=2$) and emotional representations of the illness ($F=3.398$, $p<0.05$, $df=2$), and maximised the patient's personal control of the illness ($F=5.592$, $p<0.01$, $df=2$), patients were more

psychologically distressed. There were no signifi! cant relationships found between partners psychological functioning and dissimilarity in perceptions of the breast cancer. Conclusion: Results indicated that dissimilarity in certain breast cancer beliefs within couples were associated with poorer psychological functioning. It appeared that when aspects of the illness were not recognised by the partner it produced significant levels of distress for the patient. Overall, the study highlights the importance of concordance within couple's models of illness for adjustment to diagnosis and treatment of breast cancer, and brings to light the importance of collaborative intervention with both patients and spouses in dealing with the psychological effects of this difficult illness experience.

Factor structure, Reliability and Validity of the Meta-cognitions Questionnaire-30 in a Turkish Sample

Yilmaz E A, Abant Izzet Baysal University, Turkey and T Gençöz,
Middle East Technical University,Turkey and Wells, A University of Manchester

Introduction: In recent theorizing of emotional disorders (Wells, 1997; 2000; Wells & Matthews, 1994), metacognition is proposed as a generic factor in vulnerability to and maintenance of emotional disorders. Meta-Cognitions Qustionnaire-30 (MCQ-30; Wells & Cartwright-Hatton, 2004), which has been designed to measure a range of metacognitive beliefs and processes, is a widely used assessment device in metacognition research. The aim of the present study was to investigate the psychometric properties of MCQ-30 in a Turkish sample. It is hypothesized that the Turkish version of the MCQ-30 will be found to have a similar factor structure, and the reliability and validity as the English version. Method: Five-hundred and sixty one subjects comprising 457 (81.5%) students and 104 (18.5%) non-students participated in the study. Other instruments administered together with MCQ-30 were Penn State Worry Questionnaire (PSWQ), the trait-anxiety subscale of the State-Trait Anxiety Inventory (STAI-T), Padua Inventory Washington State University Revision (PI-WSUR), Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI), and Symptom Check List-90-Revised (SCL-90-R). Results: Consistent with the original MCQ-30, the Turkish version of the scale revealed five correlated but conceptually distinct factors as positive beliefs about worry, negative beliefs about uncontrollability of thoughts and danger, cognitive confidence, beliefs about need to control thoughts, and cognitive self-consciousness. Reliability analyses showed that MCQ-30 had adequate internal consistency and test-retest reliability coefficients. Considering the concurrent validity, the MCQ-30 was found to be significantly and positively correlated with pathological worry, trait anxiety, obsessive-compulsive symptomatology, anxiety and depression symptoms, and general psychological distress. With regard to the criterion validity of MCQ-30, the result of the between-subjects multivariate analys! is of variance (MANOVA) demonstrated that the high worry group significantly differed from the low worry group in all of the MCQ-30 subscales. Conclusion: The findings of the present study indicated that the MCQ-30 had adequate psychometric properties in a Turkish sample. In particular, the results revealed preliminary evidences with respect to the cross-cultural validity of the metacognitive theory. Future research investigating the cross-cultural aspects of metacognitive beliefs in emotional disorders is strongly warranted

Adult Mental Health

Keynote Addresses

Psychological Processes and Suicidal Depression

Professor Mark Williams, University of Oxford

Despite advances in understanding and treatment of depression and suicide risk, the evidence base for available treatments is very small. For many people at risk for suicidal behaviour, the issue is that of recurrence. We can learn much from the *differential activation* model that has helped us understand recurrence in major depression. This model hypothesizes that people differ in their risk because they differ (i) in the patterns of thinking that come to mind following small shifts in mood, and (ii) in how they habitually react to these patterns (e.g. by attempting to suppress the thoughts). Our research findings are consistent with this hypothesis: (a) suicidal ideas recur from one episode of depression to the next with more consistency than any other symptom; (b) even when well, a history of suicidal feelings makes a person more likely to react to mood challenge with larger increases in dysfunctional attitudes and impaired problem solving, especially in those with over-general memory; (c) there is preliminary evidence that Mindfulness-based Cognitive Therapy, specifically designed for at-risk patients who are currently well, can change important aspects of underlying vulnerability.

A Cognitive Model of Posttraumatic Stress Disorder: Theory and Therapy

Professor Anke Ehlers, Institute of Psychiatry, Kings College London, London

The cognitive model of posttraumatic stress disorder (PTSD) presented by Ehlers and Clark (2000) suggests that chronic PTSD develops if trauma survivors process the traumatic event in a way that poses a serious *current* threat. The perceived threat has two sources: First, people with chronic PTSD show excessively negative appraisals of the trauma and / or its sequelae. Second, the nature of the trauma memory leads to easy cue-driven trauma memories that lack the awareness of the self in the past. Furthermore, the patients' appraisals motivate a series of dysfunctional behaviours and cognitive strategies that are intended to reduce the sense of current threat, but maintain the disorder. A series of prospective longitudinal studies of trauma survivors and laboratory experiments supported the role of the three maintaining factors suggested in the model. The model has led to the development of a novel form of CBT, Cognitive Therapy for PTSD (Ehlers & Clark, 2000). Two randomised controlled trials showed that the treatment is highly acceptable to patients, and more effective than wait list or self-help instructions (Ehlers et al., 2003; 2005). Comparable effect sizes for the treatment were achieved by trained clinicians in a community setting (Gillespie et al., 2002). Further studies showed that the treatment is also effective when given as a 1-week intensive treatment, and that is effective in very chronic PTSD following terrorist violence.

Psychosocial factors in bipolar disorder: Recent findings and implications for therapy

Dr Steven Jones, University of Manchester

Bipolar disorder has long been seen as a primarily determined by biological-genetic factors. This has until recently inhibited research into the psychology of this important disorder. Recent evidence indicates that psychosocial factors play important roles in the onset and recurrence of bipolar episodes. Furthermore, research into psychological treatment indicates that relapse risk can be reduced by enhancing coping skills, stabilising sleep and behaviour patterns and addressing dysfunctional beliefs. However, further developments in therapy are likely to benefit from models that include a more detailed psychological understanding of the disorder. This talk will consider evidence for a multilevel model of bipolar disorder, in which the nature of attributions made for mood relevant experiences are proposed to be relevant to risk of pathological responses to initial mood fluctuations. A series of studies will be described concerning activity and sleep patterns in bipolar disorder and high-risk groups. Evidence for instability of affect and self-esteem in parallel with behavioural disruption will be presented and the development of two measures intended to tap appraisals for hypomania and depression relevant

experiences will be described. Finally the implications of this developing model for the improvement of psychological treatment of bipolar disorder will be considered.

Psychological Management of Bipolar Disorder and Recurrent Depression- Service Delivery and Integration with Psychiatric Care

Professor Richard Morriss, University of Nottingham, UK

The rates of recurrence in bipolar disorder and recurrent unipolar depression are around 50 per cent in the first year after an episode. Psychological treatments such as cognitive behaviour therapy, group and family psychoeducation and early warning sign interventions are effective in preventing recurrence and improving function in both bipolar disorder and recurrent unipolar depression, especially if they are used in addition to routine psychiatric care. Routine psychiatric care not only provides medication but also attends to physical health issues and ensures continuity of care before, during and after psychological treatment. However, only a small proportion of patients currently ever receive psychological treatments despite the recommendations of NICE Guidelines and other similar guidelines around the world. These treatments consume a lot of time form experienced therapists and it seems unlikely that these patient groups will receive psychological treatments unless services are reconfigured in such a way as to provide them systematically and efficiently. I will review research evidence for stepped care and other service models involving the delivery of psychological treatments for these disorders. I will also discuss my experience in NHS practice with using some of these approaches over the last six years.

Symposia

Current Directions in the Theoretical Developments of the Psychology of Bipolar Disorder

Convenor & Chair: Matthias Schwannauer, University of Edinburgh

Bipolar Disorders: A Critique of Psychological Theories

Power, M Edinburgh University

An overview will be presented of four key psychological approaches to the bipolar disorders, including the BAS/BIS, Cognitive Therapy, Interpersonal Therapy, and SPAARS models. Strengths and weaknesses of each will be considered in terms of how they do or don't account for main features of the bipolar disorders such as periodicity, mixed affective states, shifts in the self-concept, and patterns of recovery and relapse. Clinical material will be used to enliven what might otherwise be an off-putting and overly-theoretical presentation. The possibility will also be examined that the relationship between love and mania has theoretical interest and a study of love and mania will be briefly considered.

A Cognitive Self-Regulatory Model of the Ascent into Mania

Mansell, W University of Manchester

A comprehensive psychological account of the development of manic symptoms is needed to improve interventions for bipolar disorder. A review of studies of the multiple symptoms of mania, the prodromes of mania, and the psychological factors associated with bipolar disorder leads to specific findings that must be consistent with a theoretical account. A cognitive self-regulatory model of the ascent into mania is then described to explain the findings. It proposes two elements: first, a primary vicious cycle of increasing feelings of activation, appraisals of extreme personal success, and change in behavior that is shared across all instances of mania and contributes to the core symptoms of activation (e.g. racing thoughts, distractibility); second, a set of secondary processes involving appraisals of other people, catastrophic consequences, and culturally unacceptable content that determines the specific symptom clusters (e.g. hedonic, aggressive, dysphoric, psychotic) and influences the degree of dysfunction (e.g. hypomania versus mania). Empirical studies testing hypotheses generated by the model are reviewed and found to be supportive although further evaluation of the model and its clinical implications will be necessary. A complementary model of bipolar depression (Mansell, Colom, & Scott, 2005) and an overarching model of bipolar disorder to guide cognitive formulation and treatment will also be introduced (Mansell, Morrison, Reid, Lowens, & Tai, submitted).

Cognitive Processing in Bipolar Disorder

Lomax C St Marys Hospital, London

There are few theoretical proposals that attempt to account for the variation in affective processing across different affective states of bipolar disorder (BD). Barnard, Palmer, Scott and Knightley (2005, submitted) recently extended the Interacting Cognitive Subsystems (ICS) framework to account for manic states. Within the framework, positive mood state is hypothesised to tap into an implicational level of processing, which is proposed to be more extreme in states of mania. Thirty individuals with BD and thirty normal controls were tested in euthymic mood state and then in induced positive mood state using the Question-Answer task (Barnard et al., 2005) to examine the mode of processing of schemas. Although the present study did not support the hypothesis that the groups differ in their ability to detect discrepancies within schemas, it did find that the BD group was significantly more likely than the control group to answer questions that were consistent with the prevailing schema, both before and after mood induction. This may reflect a general cognitive bias, that individuals with BD have a tendency to operate at a more abstract level of representation. This may leave an individual prone to affective disturbance, although further research is required to replicate this finding.

Modular Treatments for Depression: Process and Outcomes

Convenors: Chris Brewin, University College London and Adrian Wells, University of Manchester
Chair: Chris Brewin, University College London
Discussant: Adrian Wells, University of Manchester

Rumination, metacognition and mood: Change Patterns in Major Depressive Disorder

Myers S The University of Manchester Wells A The University of Manchester

The metacognitive model of emotional disorders (Wells & Matthews, 1994; Wells, 2000) proposes that a style of thinking called the Cognitive Attentional Syndrome (CAS) leads to a prolongation and worsening of negative emotions. A feature of the CAS is difficult to control worry/rumination, and the activation of metacognitive beliefs. If these factors are important in depression they should vary as severity of depressive symptoms vary. This study examined the pattern of variation in depression, rumination time, uncontrollability of rumination, and metacognitive beliefs. 21 patients with a diagnosis of DSM-IV major depressive disorder completed weekly ratings of rumination, and depression (BDI). There were 3-7 data points for each participant corresponding to 3-7 weeks of monitoring, yielding 103 continuous data-points in total. Participants also completed measures of metacognitive beliefs on two occasions at the beginning and end of their monitoring period. Data were subjected to chain P-factor analysis to identify a pattern of within-person change across cases.The overall mean amount of time spent ruminating was 67.78 per cent, ranging from 10-100 per cent of the time each week. Factor analysis revealed 2 factors representing the correlates of mood change. The first was a rumination/negative metacognitive belief factor, and the second was a positive metacognitive belief factor. Change in depression loaded on both factors but predominantly on factor 1. In summary, variation in severity of depression was associated with fluctuations in the time spent ruminating, uncontrollability of rumination and negative metacognitive beliefs about rumination. Depression also varied as positive beliefs about rumination varied. These results support the metacognitive model, provide new information about the structure of change processes, and offer implications for treatment

Metacognitive Therapy for Major Depressive Disorder: Does it work?

Fisher P The University of Manchester

Metacognitive therapy for depression (Wells and Papageorgiou, 2004) offers a new, brief, and potentially effective treatment approach targeted at the factors involved in the occurrence and persistence of ruminative thinking. In an extensive consecutive controlled case series, patients meeting study criteria first entered a baseline monitoring period yielding a minimum of three pre-treatment data points. Treatment was delivered in 6-8 sessions, and all patients were assessed at post-treatment and follow-up. In this paper the content of individual treatment sessions will be illustrated and outcome data will be reported. The treatment appears to work well with Effect-sizes on self-report and assessor rated measures of depressive symptoms appearing to surpass those typical of standard cognitive-behavioural treatment

Intrusive memories and images in Major Depressive Disorder: Background and phenomenology

Patel, T University College London Brewin C University College London Wheatley J University College London Wells A University of Manchester Fisher P University of Manchester Myers S University of Manchester

Recent studies have found patients with major depressive disorder experience repetitive intrusive memories/images as often as patients with posttraumatic stress disorder (Brewin et al., 1999). These intrusive memories/images are thought to play a significant role in maintaining depressive mood. However, relatively little is known about their phenomenology. In the present study an Intrusions Interview was designed to help identify the characteristics and content of both intrusive memories and images (i.e. a 'snapshot' from the original memory, with no contextual detail e.g. an attacker's face). The details of the two most frequent and distressing memories and/or images were recorded. Patients who met SCID (Structured Clinical Interview for DSM-IV, 1996) criteria for current or recent major depressive episode were interviewed. Twenty-four out of forty seven patients reported experiencing one or more intrusive memory; four of those patients also reported experiencing spontaneous intrusive images. Despite intrusive images not being experienced as commonly as intrusive memories they were just as frequent, distressing and uncontrollable when they did intrude. The thematic component of the intrusions was similar to that found in previous depression studies e.g. illness/death, interpersonal crises and personal injury/assault. As a result the majority of these intrusions were strongly associated with a range of negative emotions e.g. sadness, anger and helplessness. Both the memories and images were experienced as being very vivid, with the memories involving a sense of reliving. The intrusive memories were usually only minutes in duration, although could be a trigger for rumination lasting hours. The intrusive memories/images clearly appear to have a negative impact on affect, suggesting an intervention aimed at targeting these intrusions could potentially result in a shift in mood.

Re-scripting Intrusive sensory memories in depression: process and outcome

Wheatley J University College London Brewin C University College London

Intrusive sensory memories have been found to be almost as common in depression as they are in post-traumatic stress disorder (Brewin et al., 1999). The themes of these memories are often related to key defining moments in autobiographical memory: loss of loved ones, interpersonal crises, illness, personal assault or injury. Imagery re-scripting is a core component of CBT for PTSD but has been little used for depression. This study describes the treatment of 8 patients meeting DSM-IV criteria for major depressive episode who received an average of 8 sessions of individual imagery-based therapy. Their memories were of extremely distressing events such as childhood sexual abuse, witnessing parental conflict, illness and death of a parent, experience of domestic violence and terminations of pregnancy. Treatment involved imaginal re-scripting (Hackmann, 1998) of these events rather than the traditional CBT techniques of verbal challenging or behavioural experiments that are more commonly used with depression. Preliminary results indicate that imaginal reliving resulted in lower levels of depressive symptoms and reduction in ruminative thought processes, with gains maintained at 3 and 6 months. Possible mechanisms of change are considered. Updating, elaborating and contextualising of key defining negative moments so that they are given new meaning and seen as the exception rather than the rule (Ehlers and Clark, 2000). Development of metacognitive insight û these are just images that can be manipulated (Teasdale, 1999). Developing a strong competitor for the toxic image reduces that images retrieval and accessibility (Brewin, in press). Whilst the mechanisms of change remain as yet unclear it seems that imagery re-scripting might be promising in the treatment of depression. This is an experiential technique that seemed to result in belief change even though these beliefs were not directly challenged either verbally or evidentially. Could it be that rather than getting stuck in discussion of the content of depressive cognitions we can guide patients to use their imagination to help them see beyond their depressive beliefs?

Recovery Processes and Relapse Prevention in Bipolar Affective Disorder

Convenor & Chair: Anna Swift, Norfolk & Waveney Mental Health Partnership NHS Trust

Discussant: Anne Palmer, Norfolk & Waveney Mental Health Partnership NHS Trust

Process and Outcome in Recent Onset Bipolar Disorder

Jones, S University of Manchester

Introduction: Bipolar disorder is a chronic recurrent illness with a severe impact on the individual and their family. Recent studies suggest that psychological intervention have benefits in reducing relapse risk in individuals with an established course of bipolar disorder. For both clinical and theoretical reasons

it is important to assess whether delivery of CBT adapted for delivery after first diagnosis of bipolar disorder is feasible and acceptable. Method: Seven participants received a six-month CBT intervention following initial diagnosis with bipolar disorder. A single case experimental design was used in each case, with randomly chosen baseline duration of 4-8 weeks. Each participant received six months of therapy, with a six-month follow-up period. Results: Data will be presented illustrating both individuals' outcomes and the process of change. All participants completed the intervention and provided positive feedback about the therapy process. Initial indications of clinical effectiveness will be presented. Discussion: The results of the current study will be discussed in the context of the ongoing need to refine and develop psychological approaches to the treatment of this neglected group. Such developments however need to be driven by both clinical need and coherent theoretical rationales if progress is to be made in a systematic manner.

Relapse and Recovery in Bipolar Disorders a 18 month follow up

Schwannauer M University of Edinburgh Fegan S Primary Care Organisation, NHS Lothian Baird S University of Edinburgh Power M University of Edinburgh

The paper will present up to date issues regarding the psychological intervention and relapse in bipolar disorders. Considerations are given to emotional, cognitive and psychosocial factors highlighting vulnerability and recovery in the course of bipolar disorders. The results for 180 patients that have completed the treatment and one year and 18 months follow-up assessments will be presented in this paper. In our analysis of the core findings we were particularly interested in the main mediating factors for the established therapeutic effects in this group of bipolar patients. The results of this study illustrate systematic differences in cognitive and psychosocial vulnerabilities in the comparison between high and low relapse groups within the sample. A path model illustrates the relative predictive values of key cognitive and psychosocial factors in these significant group differences. Implications for the model of psychological interventions and service delivery for these groups are discussed before the background of these results

An integrative cognitive approach to working with bipolar symptoms

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

In this paper, an integrative cognitive approach to the understanding of bipolar symptoms is outlined (Mansell, Morrison, Reid, Lowens & Tai, submitted). This approach focuses on the interpretation of changes in internal state as having extreme personal meaning. 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, and beliefs about the self and interpersonal relationships. The clinical implications of this approach will be discussed with a view to facilitating recovery and the prevention of relapse.

Mindfulness-based Cognitive Therapy (MBCT) in the Real World

Kuyken, W & White, K Mood Disorders Centre, University of Exeter

A recently developed approach, Mindfulness-based Cognitive Therapy (MBCT), draws on age-old mindfulness practices, cognitive science and established CBT approaches (Segal, Williams, & Teasdale 2002). MBCT is a brief group programme in which people learn to use mindfulness to aid their sustained recovery from depression. Two randomized controlled trials (RCT) led by the developers of MBCT have shown that it halves rates of depression recurring compared to normal treatment (Ma & Teasdale 2004;Teasdale et al. 2000). This presentation is concerned with the translation of MBCT to “real world” health care settings and draws on the Exeter Mood Disorders Centre’s experience to date. We will present pilot data from MBCT groups run in a range of NHS settings (Bowen, 2005), relate clinical experience of working with particular co-morbidities (bipolar, hypochondriasis, dissociative states and panic), review our MBCT instructor training programme, overview models of service delivery and outline the design of an MRC-funded RCT in progress in Exeter.

Advances in the Prediction and Treatment of PTSD: Applications of a Cognitive Model

Convenor & Chair: Anke Ehlers, Institute of Psychiatry, Kings College London

Who develops PTSD following assault? A prospective investigation into cognitive predictors and mechanisms

Kleim B Institute of Psychiatry, Kings College London Ehlers A Institute of Psychiatry, Kings College London Glucksman E Accident and Emergency Department, Kings College Hospital, London

Little is known about specific characteristics that may determine whether assault survivors develop PTSD. In a longitudinal study of 220 assault survivors we aimed to (1) identify the best combination of cognitive and demographic predictors of PTSD at 6 months, and (2) investigate a subset of the mechanisms leading to PTSD proposed by Ehlers and Clark's cognitive model. Participants were interviewed at about 2 weeks after their assault-related admission to the A&E department and predictors were assessed; PTSD severity was reassessed at 6 months. A logistic regression analysis showed that a combination of high mental defeat, high rumination, and a history of anxiety and depression predicted PTSD diagnosis best, and better than a diagnosis of Acute Stress Disorder at 2 weeks. A structural equation model provided evidence for cognitive mechanisms proposed by Ehlers and Clark. Our findings stress the clinical importance of cognitive assessment after an assault, which can contribute to an early identification of individuals at risk for PTSD, as well as of cognitive factors and mechanisms involved in the maintenance of PTSD.

Who develops PTSD and who is resilient? Early predictors in ambulance workers

Wild J Institute of Psychiatry, London Heims H Institute of Psychiatry, London Ehlers A Institute of Psychiatry

London Ambulance workers encounter daily traumatic events. Many suffer from Posttraumatic Stress Disorder. However, a high proportion do not suffer from psychological problems in response to trauma: they appear resilient. Resilience is defined as the ability to rebound from setbacks that occur in life. It consists of seven factors: emotional regulation, optimism, self-efficacy, reaching out, impulse control, causal analysis and empathy. This study investigated key thoughts and behaviours that support resilience in ambulance workers. The study also assessed cognitive factors that are thought to lead to PTSD according to the Ehlers and Clark (2000) model. London ambulance workers (N=84) completed measures of PTSD, depression, resilience, social support, alcohol and drug use, responses to intrusive memories, trauma cognitions, trauma history and trauma exposure at Time I. At Time II, six months later, participants completed measures of PTSD, trauma exposure and use of social support. The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID) was administered to confirm a diagnosis of PTSD. Results found that components of resilience significantly predicted PTSD severity. These were pre-trauma beliefs and behaviours reflecting problems with emotional regulation, optimism, self- efficacy and use of social support. Correlations and interactions with other cognitive predictors of PTSD will be presented. The results have implications for prevention and intervention planning in the emergency services.

A Pilot Study of Intensive Cognitive Therapy for Posttraumatic Stress Disorder

Grey N Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Trust, and Institute of Psychiatry, Kings College London Ehlers A Institute of Psychiatry, Kings College London Clark D M Institute of Psychiatry, Kings College London Hackmann A Warneford Hospital, Oxford, and Institute of Psychiatry, Kings College London

The Cognitive Therapy treatment derived from the Ehlers & Clark (2000) model of PTSD has been shown to be effective in both randomized controlled trials (Ehlers et al, 2003, Ehlers et al, 2005) and a dissemination study (Gillespie et al, 2002). This treatment has been applied in the traditional weekly therapy session format over 12 weeks, with three monthly follow-up sessions. This study presents the results of a pilot series of 14 people with PTSD who received an intensive version of the treatment: daily therapy sessions for one week, followed by one session a week later and three monthly follow-up sessions, resulting in the same total therapy hours as the weekly treatment. The intensive treatment was highly successful, with very rapid improvement in PTSD symptoms observed. The effect size of the treatment was the same as for the weekly treatment in previous trials. The potential advantages of this treatment will be discussed, together with an outline of a typical course of treatment and the nature of it for both the client and therapist.

Intrusive memories, nightmares and quality of sleep in PTSD: patterns and rates of improvement in weekly or intensive Cognitive Therapy for PTSD

Hackmann A Institute of Psychiatry, London Grey N Institute of Psychiatry, London Wild J Institute of Psychiatry, London Ehlers A Institute of Psychiatry, London

Previous research has demonstrated that during a course of Cognitive Therapy for PTSD, delivered once a week for twelve weeks, intrusive memories decline gradually in frequency and associated distress (Hackmann, Ehlers, Speckens & Clark, 2005). Preliminary results of a further study showed that during an intensive version of the same treatment, nightmares decreased and sleep duration improved parallel to the decline in intrusive memories, despite the fact that little or no attention was given to them during therapy (Hackmann, 2005). In the present study, nightmares, sleep and intrusive memories were measured before, during and after weekly or intensive Cognitive Therapy for PTSD. The paper will present to what extent nightmares and sleep quality change with treatment, and examining the relationships between the changes in intrusive memories and sleep measures. The results will be discussed in the context of theoretical models of emotional processing, and in relation to other studies in which nightmares were directly targeted.

The experience of OCD and its treatment

Convenors: Victoria Bream and Paul Salkovskis, Institute of Psychiatry, Kings College London

Intensive (5 day) CBT for OCD

Bream V Institute of Psychiatry Salkovskis P Institute of Psychiatry

CBT is the treatment of choice for OCD- this is established and enshrined in the NICE guidelines. Convention dictates weekly one-hour sessions of CBT. However, there is a growing interest in modifying the delivery of treatment for pragmatic and theoretical reasons. This is of potential relevance across the spectrum of severity of OCD, from early interventions with those with a recent onset of problem, through to those labelled as 'treatment resistant' with a long history of OCD. Intensive CBT is recommended in the NICE guidelines as a later stage in stepped care; findings on ultra-intensive 5-day treatment are presented. The participants in the study were those referred to a national specialist clinic, the Centre for Anxiety Disorders and Trauma, at the Maudsley Hospital London. Those referred were offered the choice between intensive or standard treatment. Those that chose the intensive format were matched with weekly cases for the purposes of comparison.The relative advantages and disadvantages of an intensive treatment (12-18 hours of CBT delivered over 5 days) compared to 12 standard weekly one-hour sessions will be explored. Similarities and differences between the outcomes of standard and intensive formats will be discussed, and questions raised about how to select the optimal format for the individual patient.

Client perspectives on intensive and standard CBT for OCD

Anna Bevan, Institute of Psychiatry, Kings College London, Bream V Institute of Psychiatry Salkovskis P Institute of Psychiatry

Involving service users in research and service development has become an NHS priority, and it is clear that incorporating client perspectives can enrich traditional methods of treatment evaluation. Although quantitative methods provide reliable measures of symptom change over time, and hence of treatment effectiveness, qualitative methods offer uniquely useful insights into factors affecting change, such as clients' engagement with treatment, or motivation to undertake difficult homework tasks. A better understanding of client perspectives may assist the development of highly acceptable services, and in turn, impact on service effectiveness. This study provides a detailed comparative qualitative analysis of client perspectives on two different formats (intensive and weekly) of a course of CBT for OCD. 6 treatment completers in each group (matched for age, gender, and symptom change over the course of treatment) were asked to reflect on what had been helpful and unhelpful about their treatment, and to consider the differences between treatment formats. The interviews were transcribed and analysed in detail using Interpretative Phenomenological Analysis. Results indicated that contrary to the beliefs of clients who had completed weekly treatment, those who undertook intensive treatment valued the high pressure and pace and felt that it improved motivation, engagement and eventual outcome. Although there may be individual differences in preference for OCD treatment format, clients who choose an intensive format perceive important benefits from it.

Mothers with OCD

Challacombe F Institute of Psychiatry Salkovskis P Institute of Psychiatry

OCD can be a hugely debilitating disorder for individuals and often has considerable impact on the whole family system. Parents suffering from this disorder may be compromised in their ability to meet both the physical and emotional needs of their children and are frequently very concerned about this. Research indicates that anxious parents have been found to be less warm and less promoting of psychological autonomy than controls in their interactions with their children, and frequently show high expressed emotion, whilst the children themselves show a greater preponderance of anxiety disorders. However, past studies have tended to examine anxiety disorders as a whole in comparison with healthy controls. This presentation focuses on mothers suffering from OCD and aims to explore the impact on children and on parenting style, discussing preliminary findings from an ongoing research project which has used a number of different methods to examine this topic

Therapist's Bag of Tricks for Paediatric OCD

Atkinson, L Institute of Psychiatry, Kings College London

Paediatric OCD treatment trial team Cognitive models of OCD (e.g., Salkovskis, 1985) have been shown to be effective in both the understanding and the treatment of adult obsessive- compulsive disorder. Cognitive models of OCD also appear promising with younger people (Williams et al., 2002; paediatric OCD treatment trial in progress at the Institute of Psychiatry); however, developmental adaptations need to be considered and actively incorporated into any treatment programme. Examples of creative adaptations of the cognitive model for paediatric OCD will be discussed and presented along with some video footage of a treatment case.

Client experiences of therapy for treatment resistant OCD

Stobie, B Centre for Anxiety Disorders & Trauma, The Maudsley Hospital

Obsessive Compulsive Disorder (OCD) is frequently described as a chronic condition, in which a significant proportion of patients do not respond to treatment. The National Institute for Clinical Excellence in the UK (November 2005) recommends that mental healthcare trusts should have access to specialist OCD treatment teams, to which these 'treatment resistant' patients can be referred when local treatments fail. The purpose of this study is to examine the treatments that patients with treatment-resistant OCD recall having experienced, and to contrast this with patient recollections of the therapy offered at a national cognitive behavioural therapy Centre that specialises in the treatment of resistant OCD. In an earlier study (Stobie, Taylor, Quigley, Ewing and Salkovskis, submitted) 57 respondents with treatment resistant OCD were administered self-report questionnaires examining the previous treatment which they recalled being offered. Respondent recollections of therapy were then contrasted with cognitive and behavioural treatment principles for OCD. A significant proportion of the 'previous treatments' group had never received CBT. Of those who stated that they had received CBT, based on their recollections of what was done in the sessions, 60% did not meet the researchers criteria for 'basic CBT'. The present study contrasts these results with those of a sample of treatment resistant patients who attended a specialist cognitive behavioural treatment centre. Participants were ad! ministered a modified version of the original self-report questionnaire; their responses were compared with the centre's treatment protocol. The specific therapeutic techniques and strategies respondents reported having engaged in during the sessions, as well as the perceived helpfulness and unhelpfulness of the interventions, were analysed, and contrasted with the results from the original study. The results from the 'specialist treatment' group differed substantially from the 'previous treatment' results, with a few notable exceptions. This research has clear implications for quality control and the setting of minimum standards of CBT delivery, the labelling patients as 'treatment resistant', and the provision of therapy to this population

Beyond the NICE guidelines: where and what next?

Salkovskis P Institute of Psychiatry

The nice guidelines reflect how much progress has been made in the treatment of OCD. However this symposium clearly indicates that much remains to be done. This presentation will seek to draw together the issues raised in the symposium and identify where clinical and research efforts may need to be concentrated.

Models and Treatments for Depression Across the Lifespan

Convenor & Chair: Stephen Barton, Newcastle University

Early intervention with treatment-resistant depression

Barton S Newcastle University & Newcastle CBT Centre Armstrong P Newcastle CBT Centre Freeston M Newcastle University & Newcastle CBT Centre Twaddle V Newcastle CBT Centre

This presentation describes a theoretical framework and early intervention case- series for a cognitive behavioural model of treatment-resistant depression. This population is at high risk of recurrent and chronic depression and early intervention has potential long-term health benefits. The model draws on the precipitation of first or second episodes when severe life stress is very common. Depression is precipitated by adverse events interacting with core self- representations or dominant goals. This disrupts personal identity and the self is devalued. Dysfunctional strategies to protect or re-establish personal identity maintain depressed mood, specifically engagement with unattainable or low value goals, and disengagement from high value attainable goals. The aim of treatment is to differentiate and diversify the self, promote engagement with attainable goals, disengagement from unattainable goals, and re-appraisal of goals that are under or over-valued. Clinical outcomes are reported for five consecutive patients, with good therapist adherence to the prescribed CBT targets. Three of the four treatment completers showed clinically reliable changes post-CBT, all sustained at 1-year follow-up. A case example is used to illustrate the model and specific targets for change.

Improving outcomes in CBT for depression: Process-outcome research

Kuyken, W Mood Disorders Centre, University of Exeter

CBT for depression is an evidence-based and widely used therapy for depression. Process-outcome research asks the question “What works for whom?” Answers to this question enable CBT to be better targeted in the service of improving CBT’s acceptability, dissemination, efficacy and effectiveness. This paper reports on three studies examining client factors (inflexible beliefs), therapist factors (competency) and their interaction (Kuyken, Kurzer, DeRubeis, Beck, & Brown, 2001; Kuyken, 2004; Kuyken & Tsivrikos, 2006). Implications for therapy, supervision and training are discussed.

Depression in older adults

Laidlaw, K University of Edinburgh

Depression in later life is often thought of as being a ‘natural’ reaction to the challenges and deficits that ageing brings in its wake. This common myth often results in underdiagnosis and under-treatment of older people. Using psychotherapy with older people can be challenging as in many cases depression overlaps with anxiety problems and there are high levels of physical comorbidities. In this presentation there follows a brief description of the basic elements of cognitive behaviour therapy (CBT) with older people is reviewed and discussed. By reference to published outcome research and meta-analytic evaluations it is asserted that CBT is an efficacious treatment for depression and anxiety in later life. An important debate amongst therapists working with older people is whether and how to adapt CBT for use with older people, therefore a comprehensive conceptualisation of CBT with older people is presented. While it is accepted that psychotherapy with older people can differ from psychotherapy with younger people in a number of ways, too often adaptations or modifications are made on an ad hoc basis leading to a dilution of the specificity and effectiveness of CBT. This new conceptualisation framework takes account of gerontological concepts in its development and suggests that CBT therapists may wish to consider elements such as cohort beliefs, intergenerational linkages, socio-cultural beliefs, role transitions and health status when working with older people. The conceptualisation framework provides a coherent means of modifying CBT while simultaneously retaining the structural elements and techniques of cognitive behaviour therapy.

Factors Associated with Successful Treatment of Borderline Personality Disorder: Spin-offs of the Dutch Multicentre Trial Comparing Schema Therapy with Transference-Focused Psychotherapy

Convenor: Arnoud Arntz, University of Maastricht, The Netherlands

Information processing changes and treatment effects in BPD.

Sieswerda S Maastricht University Arntz A Maastricht University

At least two biased information-processing characteristics seem to be prominent in Borderline Personality Disorder (BPD): attentional bias to threat cues and dichotomous thinking. Attentional bias in BPD is thought to be caused by the ever-present state of hypervigilance in BPD hypothesized by cognitive theories of BPD. It is assumed that BPD patients are always on the guard because they experience others and the world in general as dangerous and experience themselves as weak and vulnerable. This hypervigilance causes attentional bias to threat cues, especially signals of abuse, rejection and abandonment. A second bias hypothesized by cognitive theories of BPD is dichotomous thinking, the tendency to view others and the self in extreme, polarized ways. During the clinical trial comparing SFT and TFP for BPD, attentional bias was measured by the emotional STROOP task, and dichotomous thinking by having BPD patients evaluate film characters from short emotional movie fragments. It was tested whether reduction of BPD characteristics as defined by the DSM-IV was related to reduction of attentional bias and dichotomous thinking. Preliminary results indeed suggest that successful treatment is not only apparent from recovery from DSM-IV BPD traits, but also from changes in BPD-related information processing biases.

Cost-effectiveness of SFT and TFP for BPD

Arntz A University Maastricht, dept. of Medical, Clinical and Experimental Psychology
Severens H University Hospital Maastricht, dept. Clinical Epidemiology and Medical Technology Assessment

Besides assessing the effectiveness of Schema Focused Therapy and Transference Focused Psychotherapy, it is important to look into the cost- effectiveness of these two therapies. For instance: suppose that both therapies are equally effective, is one of them less costly? Or when one of the therapies is significantly more effective, are they comparable with regard to the cost-aspect? In the present project, cost-effectiveness has been determined by administering a three-monthly cost-interview with all included persons, in which they were asked about all possible relevant cost-items. Also costs outside the health care sector, such as absence from work and burden of the disease to the family, were taken into account. Mean costs per patient can be related to the proportion of recovered patients per treatment condition, to obtain the mean costs per recovered patient. In addition, every three months the Quality of Life was measured, in order to be able to calculate the cost per Quality Adjusted Life Year (QALY), in other words; the total costs that need to be invested to gain one extra QALY. The main results of the cost-effectiveness analysis will be presented

The implementation of schema focused therapy for the borderline personality disorder in regular psychiatry

Nadort, M Free University of Amsterdam, the Netherlands

An introduction will be given of the research study 'The implementation of Schema Focused Therapy for Borderline Personality Disorder in regular Psychiatry'. Prior to the implementation study, a pilot implementation was carried out. For this purpose a training programme was written and a DVD set of schema therapy techniques was developed. A demonstration of a compilation of these DVD fragments with schema therapy techniques will be given at the end of the lecture. The fragments are of course in Dutch, but are subtitled in English. Background: Since Schema focused Therapy was more effective and cost-effective than Transference focused Psychotherapy for Borderline Personality Disorder in the Dutch Multicentre trial, an implementation study was initiated for schema focused therapy. In this study we want to research the implementation of SFT for the Borderline Personality Disorder in regular psychiatry. Our research questions are:-Can SFT be implemented effectively in regular psychiatry (not only academic settings) and which are the problems we've come across?-How do the results of the implementation study of SFT compare with the results of the Dutch multicentre trial?-Is crisis support in the form of extra telephone accessibility outside office hours essential for the success of SFT? Extra telephone accessibility will be randomly allocated to half of the therapists. An introduction will be given about the research questions, the design, outcome measures, training programme of the therapists and the state of things. Prior to the implementation study, a pilot implementation study was carried out in 2004/2005. The pilot implementation study consisted of the following components: -development and evaluation of a schema therapy programme (50 hours/8 days)-creating a DVD set, containing six hours

of SFT therapy elements and techniques (also in English)-building a website linked to the SFT-course and DVD set: www.schematherapie.nl (also in English). Information will be given about the training programme and the contents of the DVD set. At the end of the lecture a compilation of three fragments will be shown.

Central and peripheral emotional responses in BPD and changes due to treatment: a fMRI study.

Arntz A Maastricht University van der Veen F Erasmus Medical Center Rotterdam van der Heijden P Maastricht University Gielen D Maastricht University

Borderline Personality Disorder is known as a disorder characterized by hyperemotionality. Brain imaging studies have indeed indicated that brain regions related to processing of (negative) emotions are hyperactive in BPD (notably the amygdala). Remarkably, the evidence from studies using peripheral psychophysiological measures is inconclusive, as studies found normal or even subnormal psychophysiological responses to emotional stimuli in BPD. We studied within the same session central (notably amygdala), peripheral (skin conductance responses and heart rate), and subjective responses (valence ratings) to emotionally negative, positive and neutral slides. BPD patients were compared to Cluster-C patients and nonpatients to investigate the specificity of previously reported effects. Next, to study whether or not successful treatment leads to normalizing of emotional processing, we compared BPD patients before and after successful treatment. The first results of this study will be presented.

The Therapeutic Alliance in Schema Focused Therapy and Transference Focused Psychotherapy for Borderline Personality Disorder

Van Dyck R Vrije Universiteit, Amsterdam, The Netherlands Kooiman K Leiden University Medical Centre, Leiden, The Netheralnds Arntz A University Maastricht, The Netherlands

The quality of the therapeutic alliance proves to be consistently associated with a positive outcome across different forms of psychotherapy. Up till now, no longitudinal research is available into different alliance qualities between psychodynamic-oriented versus cognitive-behavioural therapy in the treatment of personality-disordered individuals. This study tries to advance earlier comparative research of the therapeutic alliance (a) by investigating a homogeneous group of patients with a borderline personality disorder (BPD), (b) by using two well- defined forms of therapy with dissimilar therapeutic alliance qualities, and (c) by studying the development of the therapeutic alliance during treatment. This study investigated the quality and development of the therapeutic alliance as a mediator of change in Schema Focused Therapy (SFT) and Transference Focused Psychotherapy (TFP) for borderline personality disorder. More specifically, the present study aimed to investigate the following predictions: (a) the quality of the therapeutic alliance is rated higher in SFT than in TFP; (b) a lower quality of the therapeutic alliance at early treatment predicts premature treatment termination and clinical outcome; (c) growth of the therapeutic alliance during the first year of therapy facilitates later clinical improvement; (d) dissimilarity in pathological personality characteristics between therapists and patients facilitates the development of the therapeutic alliance and indirectly affects therapy outcome. 86 Patients were randomly allocated to 3-years bi- weekly SFT or TFP. Outcome was measured with the Borderline Personality Disorder Severity Index (BPDSI-IV). The therapeutic alliance was measured with the Working Alliance Inventory (WAI) (therapist and patient version) and Difficult Doctor-Patient Relationship Questionnaire (DDPRQ-10). For 78 of the included 86 patients measurements of the therapeutic alliance were available. As predicted it was found that scores for the therapeutic alliance were higher in SFT than in TFP. Moreover, negative ratings of therapists and patients at early treatment were predictive of dropout, while increasingly positive ratings of the therapeutic alliance by patients in the first half of treatment predicted subsequent symptom reduction in the second half of treatment. Dissimilarity between therapist and patients in pathological personality characteristics had a direct effect on the growth of the therapeutic alliance, but was unrelated to outcome. Results provide support for the assertion that type of treatment differentially affects the quality and development of the therapeutic alliance and that dropout rate and clinical outcome can be partly accounted for by the quality of the therapeutic alliance. These results suggest that the therapeutic alliance is one of the factors producing change in the treatment of BPD patients and that adapting the type of treatment may be an important avenue in trying to enhance the quality of the therapeutic alliance and clinical outcome. It is concluded that the therapeutic alliance is an important common therapy factor critically affected by type of treatment.

Interpersonal Processes in Cognitive Therapy for Depression

Convenor & Chair: Gillian Hardy, University of Sheffield
Discussant: Steven Jones, University of Manchester

Predicting Premature Termination and Poor Outcome

Saatsi S University of Manchester Hardy G University of Sheffield Cahill J University of Leeds

The aims of this paper were to explore the associations of client interpersonal styles and alliance with therapy completion and outcome. Of 97 clients who entered therapy, 24 clients dropped out of therapy. This latter group's final session Beck Depression Inventory scores were significantly lower than those clients who completed therapy. Analyses of BDI trajectories indicated a slower rate of progress in the non-completer group than the completer group, which may have contributed to their decision to end therapy. Clients who completed therapy had significantly higher alliance scores, and alliance was strongly associated with outcome. Clients who had an overinvolved interpersonal style were more likely to drop out of therapy and, with underinvolved clients, made fewer improvements in therapy.

Ruptures and rupture repair in CBT

Warham S University of Oxford Thomas N University of Oxford , Llewelyn S, University of Oxford

This paper reports on a series of three process investigations of ruptures occurring in CBT. The first study used Task Analysis to examine key sessions where ruptures and resolutions occurred. Results indicated that ruptures happened when therapists appeared to privilege theory over the concerns of the client and pursued their own, not the client's agenda. Ruptures were resolved only when the therapist either overtly valued the client's contribution or more clearly addressed client concerns. The second study examined therapists' accounts of ruptures using Interpretive Phenomenological Analysis. Therapists described ruptures as representing a notable breakdown in the collaborative relationship with their client, although they were not always recognised and at times presented unexpectedly. Reasons reported for ruptures included client fear, distrust and differing client and therapist agendas. Therapists reported a variety of strategies of resolving ruptures but also a range of negative impacts, suggesting the skills and difficulty with which therapists manage negative process. The final study compared the characteristics of ruptures and repair sequences between CBT and psychodynamic interpersonal therapy, in terms of the sequence followed and the fit with Safran and Muran's (1996) rupture resolution model.

Therapeutic alliance and cognitive change

Barton S University of Newcastle, Newcastle CBT Centre Hewitt S University of Newcastle Gillian H University of Sheffield Morley S University of Leeds

This study reports a test of the mediating effects of the therapeutic alliance and cognitive change in a naturalistic study of cognitive therapy for unipolar major depression. Sixty five patients received 12-sessions of individual cognitive therapy as part of the Leeds Depression Project. A cross-lagged panel analysis was conducted to test alliance and cognitive mediation of treatment outcome, testing changes in process variables from pre to mid treatment, and mid to post treatment. The effect of process variables on outcome was indexed by residualised change scores on the Beck Depression Inventory. Within the same time frame, there were stronger relationships between cognitive change and mood change than alliance strengthening and mood change. Across different time frames, specific cognitive changes in the first half of treatment were significantly related to alliance strengthening in the second half of treatment. The findings support the hypothesis that strengthened alliance is a product of cognitive change and mood enhancement, but also highlight the need for richer models of the inter-dependence and interaction of alliance and cognitive change across a course of therapy, rather than viewing these as conceptually or clinically distinct constructs. Theoretical implications are discussed for the common factors / treatment specificity debate, and clinical implications for structuring therapy and monitoring interpersonal processes.

Older Adults: Theoretical Developments and Improvements in Clinical Practice

Convenor: Gwyn Higginson, Northstaffordshire Combined Healthcare NHS Trust. Co-facilitator BABCP special interest group older adults

Chair: Grainne Sheridan, Nottingham NHS Trust. Co facilitator BABCP special interest group older adults

Exploring the issue of focality in cognitive-behaviour therapy with older people

Clarke, C Humber Mental Health Teaching NHS Trust & University of Hull

Focality is one of the suitability criteria for short-term cognitive therapy originally proposed by Safran & Segal (1990) and refers to the client's ability to keep focused on distinct and relevant topics in the discourse of therapy. Problems in focality can hamper cognitive-behavioural interventions and there is some evidence that focality is lower amongst older people even when other signs of suitability are present (Bizzini, Rouget, Zanello, Zinetti & Eisele. 1997). However, it will be suggested here that excessive talkativeness is not a straightforward signal that a client will not benefit from CBT. Where older clients do have problems focusing on relevant and distinct topics, this should not preclude the use of CBT but is an issue that should be balanced against other indicators of suitability. Focality problems in CBT with older people may manifest in different ways and could be subject to a complex interaction of cognitive, emotional, interpersonal and neuropsychological factors that need to be understood in the context of ageing. These factors will be explored in this presentation and case material will be used to illustrate the potential interaction between them as focality problems emerge in therapy. Useful procedural modifications to CBT aimed at tackling excessive talkativeness in the older client have been suggested by Laidlaw, Thompson, Dick-Siskin and Gallagher-Thompson (2003) but these may not often be based on a formulation of the 'storytelling' being exhibited. The conceptual material discussed in this presentation will be used to add context to such interventions and suggest additional methods for working collaboratively with focality problems that link to the factors underpinning them. There is currently a dearth of empirical research in this specific area despite its implications for the effectiveness of CBT with older people and areas of potential future research will therefore be outlined.

An investigation of the phenomenon of worry in a clinical sample of older adults, using a semi-structured interview

Bowie G Clinical Psychologist James I Consultant Clinical Psychologist Freeston M, University of Newcastle and NCBTC

Introduction: In later life anxiety is one of the most prevalent psychiatric disorders, with GAD being the most chronic and prevalent of all anxiety disorders. As worry is the cardinal feature of GAD, gaining a greater understanding of worry in older adults is likely to produce clinical implications in the recognition and treatment of GAD within this age group. However, the majority of past research examining worry in older adults used questionnaires, which restrict the content and amount of detailed information that can be described. Instead, this study utilised a semi-structured interview format, to obtain a more detailed and deeper account of worry in older adults. The primary aim of this study was to systematically describe specific features of worry amongst a clinical sample of older adults. Worry content and patterns of worry were the main areas explored. Other areas investigated included the possible function of worry e.g., individuals beliefs about worry. A secondary objective was to examine the relationship of key characteristics of worry and other clinical features. Method: Twenty-five older adults participated in the study, recruited from the caseloads of local clinical psychologists and identified as being worriers, (scoring above clinical cut off on the PSWQ). The primary measure used in the study was the semi-structured interview, which included a combination of open questions, probe questions, and ratings. Secondary measures included the GDS, BAI and PSWQ. Results: The study found similarity in patterns of worry content reported during free recall and those later endorsed. Overall, the content of worry reported was consistent with age related developmental changes occurring in later life, e.g., health (of self and others). Older adults with poorer health status were also found to be more likely to worry and also specifically worried more about their health. Conclusions: This study provides useful information surrounding the characterization of worry amongst older adults, an area that has received little attention in the past. Improving the recognition of excessive worry is important within this client group, since older adults themselves will rarely present to medical settings reporting such difficulties.

Training multi-disciplinary staff to run group CBT for Older Adults

Vivien, I

This presentation is about a project newly undertaken in Southampton within Hampshire Partnership NHS Trust to introduce change in one Psychiatric Day Hospital. The development is on-going and the discussion is about how staff are being trained in small groups to be able to facilitate open group therapy for either Managing Depression or Managing Anxiety using a Cognitive Behavioural approach. None of the staff trained had previous training in Cognitive Behaviour Therapy, nor were they familiar with the models used. Some details will be given of the content of the training, staff reactions to it, and learning arising from the project, with tentative implications for the trainer! There will be some details given of typical group content, along with our experience of ways to 'stream' patients into different styles of group, according to their apparent levels of ability as well as degree of difficulty. This has had implications for how staff running the groups have been delivering the therapy approach, whilst staying with the guidelines taught. We will also present some initial clinical outcomes of both types of groups, and describe whatever plans there may be to develop the project further by that stage. Staff were taken in groups of 3 or 4 and trained full-time over 10 days. They were introduced to a structured format for Cognitive Behavioural assessment, formulation and taught a relevant model for depression and several anxiety disorders. As part of their training weeks, they treated the trainer for two mild phobias (!) and were also introduced to audio taping their work with clients for supervision. Their competency was measured in selected areas only on the Cognitive Therapy Rating Scale Revised (CTS-R) and they were expected to function at a minimum of 3 on all areas rated following a post initial training period of observing the trainer, who is a BABCP accredited Cognitive Behavioural Therapist, run the requisite groups. During this period, they took greater part in the therapy, and the first group is now functioning at an independent level, and acting as a model for the second group trained. Group supervision is provided weekly by the trainer. Patients were given well-researched and validated measures prior to attending the groups, after completing the course of therapy, and will be given them again after follow-up is complete. Models and Treatments for Depression Across the Lifespan S B Barton Depression in Older Adults Depression in later life is often thought of as being a 'natural' reaction to the challenges and deficits that ageing brings in its wake. This common myth often results in underdiagnosis and under-treatment of older people. Using psychotherapy with older people can be challenging as in many cases depression overlaps with anxiety problems and there are high levels of physical comorbidities. In this presentation there follows a brief description of the basic elements of cognitive behaviour therapy (CBT) with older people is reviewed and discussed. By reference to published outcome research and meta-analytic evaluations it is asserted that CBT is an efficacious treatment for depression and anxiety in later life. An important debate amongst therapists working with older people is whether and how to adapt CBT for use with older people, therefore a comprehensive conceptualisation of CBT with older people is presented. While it is accepted that psychotherapy with older people can differ from psychotherapy with younger people in a number of ways, too often adaptations or modifications are made on an ad hoc basis leading to a dilution of the specificity and effectiveness of CBT. This new conceptualisation framework takes account of gerontological concepts in its development and suggests that CBT therapists may wish to consider elements such as cohort beliefs, intergenerational linkages, socio-cultural beliefs, role transitions and health status when working with older people. The conceptualisation framework provides a coherent means of modifying CBT while simultaneously retaining the structural elements and techniques of cognitive behaviour therapy

Regret as a focus for cognitive therapy with older people

Davies S University of Hertfordshire

Issues of shame and guilt have been identified as representing significant long- term risks for the perpetuation of psychological distress. However, regret is the more common experience of late life. Regret may play a pivotal role in psychological adjustment to late life events as this may cause an unhelpful, 're- hashing' of long-past events. Older people have less opportunity to act on the external world to put things that they regret right. Thus, their proficiency in dealing with regretful thinking may be crucial to their mental well-being. Effective cognitive therapy for older people may need to aim at adaptive modification of regret as an important part of psychological intervention with this group.

Applying CBT formulations in nursing care settings

James I, Centre for the Health of the Elderly, Newcastle General Hospital

This paper provides an overview of a CBT derived model developed for the treatment of challenging behaviour in nursing care settings. The approach, which is currently used in a number of areas in the UK and Ireland, involves working collaboratively with care staff to develop formulation-led interventions. The model is currently used to treat episodes of aggression, shouting, wandering, soiling, etc. The talk will provide empirical evidence regarding the efficacy of the model, and present case material

demonstrating some of the rather innovative treatment strategies employed (e.g. dolls; use of therapeutic lies).

Disseminating Cognitive Therapy for Anxiety and Related Disorders

Convenor: David M. Clark, Institute of Psychiatry, Kings College London

Disseminating Cognitive Therapy for Panic Disorder in Primary Care

Grey N Centre for Anxiety Disorders & Trauma, South London and Maudsley NHS Mental Health Trust Salkovskis P Institute of Psychiatry, Kings College London Quigley A Centre for Anxiety Disorders & Trauma, South London and Maudsley NHS Mental Health Trust Clark D M Institute of Psychiatry, Kings College London Ehlers A Institute of Psychiatry, Kings College London

Cognitive Therapy for Panic Disorder (Clark et al, 1994) is highly effective and has recently been recommended as an NHS treatment of choice for people with Panic Disorder (NICE, 2005). This study assessed the outcomes of patients treated by counsellors and therapists working in primary care before, during and after training and supervision in Cognitive Therapy for Panic Disorder. While clinically experienced, the therapists had little or no training in CBT prior to this project. During the baseline phase therapists provided treatment-as-usual to patients with Panic Disorder. They were then given a training workshop, ongoing supervision of further cases and a follow-up workshop. Outcomes of their patients were assessed throughout the baseline, training and post-training phases. Preliminary results of this ongoing project will be presented. In addition, the lessons learned from establishing and running this study will be discussed, with implications for the further dissemination of cognitive therapy within the NHS.

A Danish Evaluation of Cognitive Therapy for Hypochondriasis.

Salkovskis P Institute of Psychiatry, Kings College London Sorosen P Copenhagen Wattar U Copenhagen Birket-Smith M Copenhagen

Cognitive-behaviour therapy has been shown to be an effective treatment for hypochondriasis in the hands of the team that developed the programme (Clark, Salkovskis, Hackmann et al, 1999). The present study investigates the dissemination of the treatment to a Danish healthcare setting. Patients suffering from health anxiety (DSM IV defined Hypochondrisasis) were randomly allocated to Cognitive-behaviour therapy (n=20), Psychodynamic counselling (n=19) or a waiting list control (n=29). Waitinglist patients were subsequently randomized to one of the two treatments. In terms of health anxiety, patients receiving CBT improved significantly more than both waiting list and psychodynamic counselling, which were not significantly different on any measure. The CBT group also improved more than the waitlist group on measures of anxiety and depression. Psychodynamic counselling was not different from the waiting list on depression measures

A Swedish study of Individual Cognitive Therapy for Social Phobia.

Mortberg E Karolinska Institute, Stockholm, Sweden.Clark D M Institute of Psychiatry, Kings College London Sundin O Karolinska Institute, Stockholm, Sweden. Asberg W Anna Karolinska Institute, Stockholm, Sweden.

Randomised controlled trials have demonstrated that individual Cognitive Therapy is a highly effective treatment for social phobia (Clark et al, 2003; in press). The present study investigated whether it can be successfully disseminated in Sweden. One hundred patients meeting DSM-IV criteria for social phobia were randomised to Individual Cognitive Therapy, a locally developed Intensive Group Cognitive Therapy programme, or treatment-as-usual, (mainly SSRIs). Training in Individual Cognitive Therapy consisted of a two-day workshop in English, followed by supervision in Swedish. At post-treatment and one-year follow-up, Individual Cognitive Therapy was superior to both the Intensive Group Cognitive Therapy programme and treatment-as-usual. The intensive group cognitive therapy lasted only 3 weeks and was at least as effective as the more protracted, medication-based treatment as usual.

Cognitive therapy for Post-traumatic Stress Disorder in the context of terrorism and other civil conflict in Northern Ireland.

Duffy M NI Centre for Trauma and Transformation & University of Ulster Gillespie K Northern Ireland Centre for Trauma and Transformation, Omagh, Northern Ireland Clark D M Institute of Psychiatry, Kings College London.

Cognitive Therapy has been shown to be an effective treatment for PTSD resulting from non-terrorist related traumatic events (Ehlers et al. 2003, 2005). In order to assess whether it is also effective as a treatment of terrorist-related PTSD, patients (n = 58) who were referred to the Northern Ireland Centre for Trauma and Transformation following traumas that occurred in the context of terrorism and other civil conflict were randomised to immediate Cognitive Therapy or Cognitive Therapy after a 12 week wait. Cognitive Therapy was associated with substantial reductions in the symptoms of PTSD and depression and with marked improvements in work, family and social adjustment. No improvement was observed during the wait period

Psychosis

Keynote Addresses

The Politics of 'Schizophrenia': Understanding and Overcoming the Barriers to a Genuinely Integrated Socio-Psycho-Biological Model of Madness

Dr John Read, The University of Auckland, New Zealand

The President of the American Psychiatric Association, in a discussion of the pervasive influence of the pharmaceutical industry, recently stated: “We must examine the fact that as a profession, we have allowed the bio-psycho-social model to become the bio-bio-bio model.” This lecture will a) Summarise the research showing that the public rejects biological explanations of mental health problems, including schizophrenia, and espouses psycho-social explanations such as poverty, family stressors, child abuse etc b) Discuss the futility of biological psychiatry spending large amounts of money trying to persuade us we are wrong, given that bio-genetic causal beliefs have been demonstrated to exacerbate prejudice and fear c) Summarise recent studies demonstrating that the public are right, i.e. that there is indeed a strong causal link between a range of social factors (including childhood abuse) and a range of mental health problems (including schizophrenia) d) Discuss the role of the drug industry, and biological psychiatry, in promulgating a simplistic, pessimistic, largely unsubstantiated and overly biological model of mental health e) Suggest that these power differentials must be named and challenged in order to develop genuine, equal and effective partnerships between models, between disciplines, and between staff and service users.

Paranoia and the status of the attributional model

Professor Richard Bentall, University of Manchester

Ideally, our models of psychopathology should be open to direct empirical test. However, a hazard of proposing a model of this kind is that the tests, when carried out, may show that it is wanting. In the face of negative evidence, the researcher must decide whether to modify the model, in which case it must still be amenable to further tests, or to abandon it altogether. Over more than a decade and a half, evidence on the attributional model of paranoia has produced a mixed bag of results. The main problem for the model is that attributional abnormalities in paranoid patients seem to have a "now you see them, now you don't" quality, with some studies supporting the model and others apparently refuting it. However, examining the data provides new insights into the role of attributions in psychopathology in general, and also suggests new avenues for exploring the psychology of paranoid thinking. These studies show that: (i) the psychometrics of most attributional trait measures are inadequate for scientific purposes and existing scales, such as the ASQ, make erroneous assumptions about what happens when individuals make attributional judgements; (ii) attributions are highly context-specific, vary over time and are closely associated with actual paranoid thinking (they are state-like rather than trait-like); (iii) attributional abnormalities are present only in actively psychotic patients and not, for example, healthy paranoid samples; and (iv) abnormal attributions seem to be restricted to patients with 'poor-me' rather than 'bad me' beliefs (although patients often switch between these two types of paranoia over time). These findings suggest that attributions play a much less direct role in paranoia than previously thought. However, the idea that self-esteem related issues are important in the genesis of paranoia remains plausible. Furthermore, the latest data suggests interesting possibilities for integrating the psychological and biological data on paranoid thinking.

Symposia

Real Life CBT for Psychosis: When it Doesn't Work

Convenors: Emmanuelle Peters & Craig Steel, Institute of Psychiatry, Kings College London
Chair: Max Birchwood, University of Birmingham

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. Thee 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 signficant 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.

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 engag! ement 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.

A case of episodic paranoia

Kinderman, P University of Liverpool

CBT is characterised by an exploration of the relationship between thoughts, affect and behaviour, combined with techniques designed to alter cognition - thus altering belief systems, interpretative frameworks, emotional responses and behaviours. This case illustrates systematic failure to develop such a model - but also how psychologists may nevertheless contribute. The case is that of a 38 year-old woman with a history of episodic paranoia, referred for help with on-going stress and to reduce the likelihood of future relapses. In CBT therapy, no substantial progress was made in elucidating any clear links between thoughts, affect and behaviour. Subsequent attempts to use generic - "off-the-shelf" - schemas and responses were laughably inadequate. Further work, using generic relapse prevention approaches, were seen as irrelevant. A resultant formulation, focussing on stress, psychomotor agitation, perceptual abnormalities from a neuro-genetic perspective was developed by the client (not the therapist) and led to highly effective socio-medical interventions.

New Directions in Cognitive Remediation Therapy

Convenor: Clare Reeder, Institute of Psychiatry, King's College, London
Chair & Discussant: Til Wykes, Institute of Psychiatry, King's College London

The impact of executive and memory improvements following Cognitive Remediation Therapy (CRT) on social functioning and symptoms: a role for metacognition.

Reeder C Institute of Psychiatry, Kings College, London Wykes T Institute of Psychiatry, Kings College, London

Cross-sectional associations between cognition and both social functioning and symptoms have been used to identify appropriate cognitive targets for CRT. However, cognitive improvements rarely lead to functional changes, except within the context of receiving CRT, which suggests an indirect link between them. This study investigates the association between executive/memory improvements and improvements in functioning and symptoms, and the moderating role of CRT. 85 people with schizophrenia and cognitive inefficiency were assessed on executive and memory measures, the PANSS and the Social Behaviour Schedule. They were randomised to receive 40 sessions of individual CRT or treatment-as-usual and re-assessed immediately post-therapy. Cognitive change was assessed using three executive/working memory factors, (i) 'verbal working memory', (ii) 'response inhibition' and (iii) 'schema generation'; and composite verbal and visuo-spatial long-term memory measures. Consistent baseline cross-sectional associations were apparent between all cognitive scores (with the exception of 'schema generation') and both social functioning and symptoms. However, improvements in only the 'schema generation' scores were predictive of improved social functioning and negative and disorganised symptoms, regardless of treatment group. This suggests that cross-sectional associations do not make good cognitive targets for treatment to benefit functional outcomes, since longitudinal findings suggest no direct link. There was no evidence for a moderating effect of CRT. However, the improved ability to generate new schemas, which relies on metacognitive functioning, does lead to improved functioning and symptoms. A new model will be presented in which metacognition plays a key role in the relationship between cognition and functional behaviour.

Cognitive Remediation Therapy and Cognitive Behavioural Therapy in chronic schizophrenia

Penades R Institute of Neuroscience, Department of Clinical Psychology, Hospital Clinic, Barcelona

Introduction: Cognitive Remediation Therapy (CRT) is a novel rehabilitation approach designed to improve neurocognitive abilities such as attention, memory and executive functioning. It is also designed to improve functioning by using compensatory strategies to bypass cognitive deficits. The aim of the present study is to evaluate the effect of CRT on neurocognition, and secondarily on symptomatology and psychosocial functioning. Cognitive Behavioural Therapy (CBT) was used as a control condition because it aims to improve emotional problems and positive symptoms, focusing on modification of maladaptive beliefs and schemas, but neurocognition is not targeted. Method: A total of 40 chronic patients with DSM-IV schizophrenia disorder were randomly assigned for 4 months to one of two treatment groups: CRT or CBT. Repeated assessments were conducted before and after the treatments and at the end of a follow-up period of 6 months. Additionally, a method to establish reliable change was calculated from a separate sample of 20 schizophrenic patients who were under standard medication without any kind of psychological treatment. Results: CRT produced an overall improvement on neurocognition (Mean effect size = 0.5), particularly in verbal and non-verbal memory, and executive function. CBT showed the expected treatment effect on general psychopathology (anxiety and depression) but produced only a slight non-specific improvement in neurocognition (working memory). Furthermore, patients receiving CRT showed improvement in social functioning, demonstrating that cognitive improvements are clinically meaningful. These gains were still present at the 6-month follow-up. Conclusion: These results support the efficacy of CRT as it increased neurocognitive functioning to a degree not achievable from non-specific stimulation. This study adds to the growing evidence of the efficacy of cognitive remediation treatments in schizophrenia.

Cognitive remediation therapy for anorexia nervosa

Tchanturia K, Institute of Psychiatry, King's College London

Anorexia Nervosa (AN) is a complex and multi-factorial illness with high levels of disability, mortality and hence cost to the individual and society. An estimated 0.5 to 3.7% of females suffer from AN in their lifetime. It has the highest mortality rate of all mental illnesses (Treasure et al 2005). With this fact in mind, it is concerning that the NICE guidelines (2004) highlight the lack of research into the treatment of AN - in general, pharmacological treatments are not effective and, to date, there are no first choice

psychological treatments available for adult AN patients. Studies by our group (Tchanturia et al 2001, 2002, 2004a,b, 2005, Treasure et al 2005) focusing on cognitive flexibility experiments have contributed to develop an AN neurocognitive model. From these studies we have gathered robust evidence demonstrating cognitive rigidity in the AN clinical group in comparison to healthy female and bulimia nervosa groups. This data was recently replicated by other international groups (e.g. Steinglass in press, Fassino 2002).At this stage we aim to bridge our research findings to clinical practice. Research has shown that when similar cognitive problems are identified in other mental health conditions, cognitive training exercises are a helpful intervention. For example cognitive training has been used successfully with patients with brain lesion (Powell, 2003) psychosis (Wykes, 2002, 2005) age related problems (Goldberg, 2005) and learning disabilities (Stevenson, 2002). To date cognitive exercise strategies have not been used in AN treatment. At present AN treatment comprises physiological education, nutritional education, addressing emotional problems and motivational difficulties. The importance of cognitive "fitness" as a key to accepting and benefiting from other more complex psychological interventions has previously not been explored. We propose to introduce cognitive flexibility training as a starting block for further treatment to ensure that patients have confidence, motivation and cognitive robustness to receive further psychological treatment. Our initial clinical observations with this intervention based on a series of case studies (Davies & Tchanturia 2005, Tchanturia et al in press) have been successfully received and show promising results, thus driving us to conduct a larger investigation.

Facilitating more benign cognitive biases and the amelioration of anxiety and worry

Hirsch, C Institute of Psychiatry, King's College London

It is well established that psychological disorders are associated with negative biases in information processing such as attention, interpretation and imagery. These information-processing biases are central to many cognitive-behavioral models of psychological disorders. Whilst establishing that biases exist is important, it may be the case that the biases are incidental or a secondary consequence of the emotional problem; if so, then they would not have a causal role in maintaining a disorder. In recent years new paradigms have been developed to manipulate a particular cognitive process by training and then assessing its impact. The development of cognitive training paradigms is an exciting advance in research into information processing in psychological disorders that enables one to test out the causal role of a cognitive process in the development and maintenance of a disorder. The information gained from such research will help refine cognitive behavioural treatments. In this talk the utility of training methods to facilitate more benign interpretive biases will be examined in two studies looking at interpretation bias in social anxiety and one looking at persistence of worry in high worriers. In the first the ability to facilitate a benign interpretation bias in socially anxious people was assessed and its impact on anticipated anxiety. In the second study a training paradigm was used to assess the combined cognitive biases hypothesis that interpretive bias influences imagery. A third study investigated the causal role of interpretive biases in the persistence of worry. Implications of the utility of training paradigms to help answer a number of research questions and contribute to the refinement of CBT treatments will be discussed.

Exploring Users' Experiences of Psychosis and Recovery: Qualitative Approaches

Convenor: Heather Laithwaite, The State Hospital
Chair: Andrew Gumley, The University of Glasgow
Discussant: Matthias Schwannauer, The University of Edinburgh

The Interpersonal Self in Early-Onset Psychosis: A grounded theory analysis

Taylor, E University of Edinburgh

The prodromal phase has been conceptualised as a discrete phase in the disease process relevant for its 'warning' status. Recent psychological and medical research has suggested that intervention during this period may be beneficial. However, the phase is not well understood and definitions of it are both vague, referring to non-specific changes in interpersonal and intrapersonal functioning, and symptom led. The aim of this study was to explore how young people construct this period and how this may contribute to our understanding. Using a social constructivist approach and grounded theory methodology, eight people aged between 18 and 23 who had experienced a first episode of psychosis were interviewed sequentially.Analysis suggested that in this sample the self was described in interpersonal terms. The experience of developing psychosis was not considered by the sample as a series of discrete phases but as a process of survival over adversity. Two strategies emerged for this

survival process, defined by the relationship between psychosis and self. Self-concept appeared to be a mediating factor and individuals vacillated between these two strategies. Survival and recovery was defined as re-establishment of interpersonal relationships, mainly with peers.The research suggests that psychosis may best be understood as a struggle for self. The interpersonal nature of self may be a feature of developmental stage and/or predisposition to psychosis

An experiential perspective on persecutory paranoia: a grounded theory construction

Boyd, T University of Glasgow

Recently there has been a large volume of research on persecutory paranoia. Evidence has emerged for the role of social factors in the development of paranoia. There have however been no studies that have collaborated with users to develop an experiential perspective on paranoia. This study used a social constructionist version of grounded theory to construct an experiential perspective on persecutory paranoia. Ten individuals who had experience of persecutory paranoia were interviewed. The interviews were transcribed and analysed using the grounded theory method. A core process of fear and vulnerability was constructed. Sub categories of confusion and uncertainty, and self under attack contributed to the core process. These processes led to an engaging of the safety systems. Sub themes of these categories were identified. Many of these factors interacted to create the complex and dynamic experience of paranoia. Participants were often responding to genuinely frightening experiences but were also attacking themselves. Paranoia evolved as a mechanism of keeping oneself safe in dangerous situations. The need to negotiate a shared meaning of paranoia with users was emphasised. Direction for future research was discussed.

Sense of self, adaptation and recovery in patients with psychosis in high security NHS settings

Laithwaite, H The State Hospital, Carstairs, Scotland

Sense of self, adaptation and recovery in patients with psychosis in high security NHS settings. Qualitative methodology has enabled users' experiences and perceptions of recovery to be investigated, with studies demonstrating factors such as hope, and redefining sense of self as important factors in this process. To date, there have been no studies that have collaborated with users in high security forensic settings, to develop an experiential perspective of recovery in psychosis. This study used a social constructionist version of grounded theory to construct an experiential perspective on recovery in psychosis. Thirteen individuals who had experience of psychosis and were residing in a high secure setting were interviewed. The interviews were transcribed and analysed using the grounded theory method. The narratives produced by participants to describe their experiences were analysed. Some narratives contained rich and reflective accounts of their past experiences. In contrast to this, there were narratives that were short and abbreviated, with a blocking of meaning and sense of "sealing over" in responses. Implications of this for recovery are discussed. Participants spoke about past experiences and how these influenced the tasks involved in recovery. Developing relationships with staff and family were important factors in all participant's accounts of recovery. The development of relationships influenced how participants redefined themselves. Implications for clinical practice and further research are reviewed.

Researching Recovery from Psychosis - A User Led Project

Pitt, L Psychology services at Bolton, Salford and Trafford Mental Health

Involvement of service users in the research process and examination of recovery from psychosis are two topics that have generated recent interest within the research community. This user-led study examines the subjective experience of recovery in people with experience of psychosis. Seven interviews were analysed using Interpretative Phenomenological Analysis (IPA) and several themes to the recovery process emerged from the data. Recovery from psychosis was found to be a complex and individual process which meant different things to different people. It involved rebuilding self (increasing understanding of the self and empowerment), rebuilding life (rebuilding social support and active participation in life) and hope for a better future (a process of change and desire for change). The implications of these findings for mental health services will be briefly outlined.

Cognitive Therapy for Individuals at Ultra-High Risk for Psychosis: Keeping it Real

Convenor: Paul Tabraham, Institute of Psychiatry, Kings College London
Chair: Max Birchwood, University of Birmingham

Potential Pitfalls in The Provision of CBT to Individuals at Ultra High Risk of Psychosis

Tabraham P King's College London, Institute of Psychiatry Johns L King's College London, Institute of Psychiatry Valmaggia L King's College London, Institute of Psychiatry Kuipers E King's College London, Institute of Psychiatry

The use of CBT to treat psychotic disorders is now well established. More recently, CBT has been offered to individuals at "ultra high risk" (UHR) of developing a psychotic disorder. The UHR paradigm was developed by the PACE clinic in Melbourne and it was PACE that published the first study of CBT (in combination with antipsychotic medication) for UHR individuals (McGorry et al., 2002).Since then, further studies of CBT for UHR individuals have been published by research groups in Manchester (Morrison et al., 2004) and Cologne (Bechdolf et al., 2005). French and Morrison have also published a book, describing CBT for UHR individuals. In the UK there are currently services for UHR individuals in Manchester, Birmingham and London. All of these provide CBT. By the end of 2006, services in Glasgow and Cambridge will start to provide CBT in the context of treatment trial.Between August 2001 and March 2006, the service in London, OASIS, received 368 referrals. One hundred and three met criteria for an "at risk mental state" (ARMS) indicating UHR for psychosis and were offered treatment. The use of CBT to improve outcomes in this group has raised a number of issues which will be illustrated in the presentation. Therapists in OASIS begin CBT by asking patients to generate a list of problems and goals. Problems frequently include anxiety and mood problems that are not directly related to their UHR status. Comorbid anxiety and mood disorders are treated according to models and treatment protocols supported by research literature. Cognitive behavioural models of anxiety disorders usually include safety behaviours and treatment usually requires the elimination of these. Cognitive behavioural models of psychosis often include coping strategies and treatment may include coping strategy enhancement. The presentation will include case material in which behaviours can be conceptualised as coping strategies or safety behaviours and the implication for intervention varies depending on this conceptualisation. This leads to questions about whether UHR (and psychotic) individuals respond to anxiety differently to individuals with anxiety and mood disorders.CBT in OASIS is provided by therapists who also have case management responsibilities for the patients. The presentation will use case material to illustrate the conflicts that arise when CBT and case management are provided by the same professional. CBT is most effective when patients learn new skills which allow them to solve practical and emotional problems independently. In contrast, case management often requires a high level of intervention from mental health professionals. Switching between the roles of case manager and therapist can interfere with the working alliance required for successful CBT.Collaboration between therapists will help then to negotiate the potential pitfalls of providing CBT to UHR individuals.

Early Detection: The Misnomer of the False Positive

Skeate A Early Detection & Intervention Team (ED:IT) Birmingham UK Patterson P Early Detection & Intervention Team (ED:IT) Birmingham UK Birchwood M Early Detection & Intervention Team (ED:IT) Birmingham UK

The experience of the Birmingham Early Detection & Intervention Team (ED:IT) confirms that large numbers of young people who would not normally be offered a specialised service are currently in emotional distress and at high risk of increasing psychopathology without appropriate intervention. Depression, anxiety disorders, PTSD, dissociative disorders and other expressions of emotional distress are often subsumed under the impact of a psychotic presentation, yet are clearly linked to negative outcomes including suicide (Birchwood et al., 2000). It would therefore seem both clinically and theoreticallyimportant to re- evaluate diagnostic approaches to client assessment with an understanding that, aetiologically and symptomatically, many of the presentations of distress may beinterrelated. For both epidemiological and clinical reasons, co-morbidity holds valuableinformation that needs to be understood.The clinical relevance of co-morbidity (where an individual has symptoms that meet morethan one diagnostic category) to mental health has been well established in several large-scalestudies (Bijl & Ravelli, 2000; Kessler et al., 1994). Comorbidity has been associatedwith greater functional disability, longer illness duration, more severe symptoms and rapidonset (Andrade, Eaton & Chilcoat, 1994; Bijl & Ravelli, 2000; de Graaf, Bijl, Ten Have,Beekman & Vollebergh, 2004; Kessler et al., 1994; Kessler & Frank, 1997; Roy-Byrneet al., 2000; Vollrath & Angst, 1989). Although it is rare for psychotic symptoms to be experienced independently from a rangeof co-morbid affective disorders, when psychosis is suspected the focus of assessment is usually on positive symptoms. Especially for a client in the early stages of psychosis, thismay mean that other symptoms that are distressing and

burdensome are overlooked.Birchwood (2003) has suggested several ways in which emotional dysfunction can developin parallel with psychotic symptoms, thus causing uncertainty for a therapeutic focus.It is clear from the levels of psychopathology observed in the initial cohort of UHR clientsinto ED:IT that interventions aimed at alleviating emotional distress are warranted with treatment acceptance very high and case management often a useful engagement tool as well as being a vital support for clients. Individually tailored CBT forms the core of the treatment offered by ED:IT with the focus being on the emotional distress of these young people thought to be at risk of developing psychosis.Overall, much of the evidence base would seem to suggest an urgent re-evaluationof current assessment and diagnostic approaches to ensure that the effectiveness of clinicalinterventions with UHR individuals are optimised, and to allow the real possibility of applying preventative treatments to this young, vulnerable and highly distressed group of clients.

Targeting Safety Behaviours in Cognitive Therapy For Individuals at Ultra-High Risk of Psychosis

Bowe S, Bolton, Salford and Trafford Mental Health Trust

As is the case with anxiety disorders, the use of safety behaviours to prevent feared events is common in psychosis. Consequently, safety behaviours are identified as a maintaining factor in cognitive models of psychosis (e.g. Morrison, 2001; Freeman & Garety, 2002). Safety behaviours are also used by individuals at ultra-high risk of developing psychosis and are therefore important targets within cognitive therapy. In this presentation, safety behaviours in the at-risk population will be outlined along with case material to illustrate how targeting them in therapy can be effective at reducing attenuated (sub-threshold) psychotic symptoms.

Panel Debate

Panel Debate: The Ethics and Politics of CBT for Psychosis

Convenors: Craig Steel, Institute of Psychiatry, Kings College London and Robert Dudley, Newcastle University
Chair: Nick Tarrier, University of Manchester
Speakers: Max Birchwood, University of Birmingham, Rufus May, University of Bradford, John Read, University of Auckland, New Zealand, Richard Bentall, University of Manchester, Peter Kinderman, University of Liverpool

NICE recommends that CBT should be a standard part of treatment for people with psychosis. This goal necessitates a major growth in training in this area. Given this, it is timely to reflect on what has been learnt so far in order to help address the major challenges that will be faced. Speakers will comment on issues such as:
How 'cheaply' can we provide CBT for psychosis, in terms of level of training and number of sessions?
Given the varied models of CBT for psychosis, are there some core values underlying the aims which should be adhered to? Are there some approaches which may be unhelpful? In what way is CBT compatible with the biological view of psychosis and medication adherence therapy? Does our evidence base reflect what we are trying to achieve in CBT for psychosis? Speakers will provide a brief overview of the key issues as they see them, and then emergent themes will be discussed by the panel and audience.

Posters

Psychosis

Psychosis Attachment Measure: An Investigation of Attachment Styles, Interpersonal Functioning and Psychosis

Berry K, University of Manchester and Bolton, Salford and Trafford Mental Health Trust, Barrowclough C, and Wearden A, University of Manchester

Introduction: There is a growing body of evidence to suggest that adult attachment styles are important determinants of interpersonal functioning and the quality of interpersonal relationships, including therapeutic relationships (Mallinckrodt, 2000). Attachment theory therefore provides a potentially useful framework for understanding interpersonal difficulties and the quality of staff and patient relationships in psychosis. There is limited research investigating attachment styles in clinical samples and difficulties assessing attachment styles in psychosis with available measures (Dozier et al, 1999). The paper describes the development and validation of the 'psychosis attachment measure' (PAM). The PAM is based on Bartholomew's (1990) model of adult attachment. It has two subscales which m! easure anxiety and avoidance in attachment relationships. Parallel self- and informant-report versions have been developed. Method: Associations between self- and informant-reported attachment style, self-esteem, interpersonal functioning, therapeutic relationships and symptoms were investigated in a sample of patients with psychosis and their key workers. A second study used the PAM to explore associations between attachment and schizotypal characteristics in students. Results: Findings from clinical (n = 66) and student (n = 323) samples suggest the PAM has good psychometric properties with high internal consistency and test re-test reliability. In both samples, insecure attachment styles were associated with interpersonal problems and low self-esteem. In the clinical sample, avoidant attachment was associated with poorer therapeutic relationships. There were specific associations between positive symptoms and attachment anxiety and negative symptoms and attachment avoidance. Conclusion: The PAM is a valid instrument which can be used to explore attachment styles in samples with psychosis. Applying attachment theory to the understanding of interpersonal difficulties in psychosis will have significant clinical implications, as the theory generates hypotheses about approaches for maximising engagement and outcomes with individuals with different attachment styles (Mallinckrodt, 2000).

Self-esteem in Schizophrenia

Cater, J Clinical Psychology Course, University of Manchester, Barrowclough C, Tarrier N, University of Manchester

Introduction: Low self-esteem, or evaluation of self-worth, is common among individuals suffering from a wide range of mental health conditions and has recently become an area of research interest in schizophrenia, although as yet there have been relatively few empirical studies. The few available studies suggest that self-esteem is influential in many aspects of schizophrenia, including symptomatology, experience of illness, quality of life, and recovery (Barrowclough, et al, 2003; Freeman, et al, 1998). However, this field of study has been limited by a number of factors including a lack of longitudinal research, difficulties in interpreting the construct, and problematic measurement techniques (Andrews & Brown 19903). Barrowclough et al. (2003) used an interview-based method of self-estee! m assessment (SESS-sv), which was found to be superior to past measures of the construct. Using this measure, Barrowclough and colleagues (2003) found a relationship between negative self-evaluation and positive symptom severity and an inverse relationship between positive self-evaluation and negative symptoms. The general aim of the current research is to investigate the relationship of self-esteem to aspects of psychopathology in a clinical and a non-clinical sample, using new measures that address past inconsistencies in the self-esteem literature. Method: The relationship between self-esteem and psychopathology was assessed in three ways: (1) A follow-up investigation of Barrowclough and colleagues (2003) study was conducted to address the stability of self-esteem and its effect on symptoms, relapse, and suicidality over time. (2) A new self-report measure of self-esteem was developed based on an established interview to see if the benefits of the SESS-sv are due to its interview format or to its specific conceptualization of the construct. The psychometric properties of the measure and its relationship to positive and negative symptoms of psychosis were tested in a clinical sample. (3) A web-based study was conducted to further assess the psychometric properties of the new self-report measure and to examine the relationship of self-esteem with positive and negative psychosis-like symptoms in a non-clinical sample. Results: To date, recruitment numbers are as follows: (1) Follow-up study: 29 participants have been available for follow-up and 60 sets of casenotes have been reviewed. (2) Measure Development: 150 clinical participants have completed the new questionnaire. A symptom interview has also been completed with 65 participants to date. 35 participants have completed a 3-month follow-up assessment. (3) Online study: 330 university students and staff completed web-based questionnaires, with 110 participants completing the questionnaires at 3-month follow-up. Follow-up and online recruitment has been concluded and analysis has begun, due to be

completed by May 2006. Recruitment for the measure development study will end in May, with results due to be completed by June 2006. Conclusion: The goals of this research are to emphasize the multi-dimensional nature of self-esteem and its long-term impact on symptom profiles and outcomes, as well as produce a useful new measure that will be appropriate for use in both research and practice settings. Results and their clinical implications will be discussed

Positive and Negative Experiences of Voice Hearing in People with First Episode Psychosis, Treatment Resistant Psychosis and in People With Spiritual Beliefs

Dudley, R University of Newcastle Osborne, H Early Intervention in Psychosis Service, Northumberland, Tyne and Wear NHS Mental Health Trust, Gatiss E, Northumbria Health Care Trust Carlsson-Mitchell P, Northumberland, Tyne and Wear NHS Mental Health Trust, Freeston M, University of Newcastle Upon Tyne

Introduction: Voice hearing was traditionally regarded as one of the hallmarks of madness. However, within cognitive approaches the mere presence of a voice per se is not considered problematic, rather it is the individual appraisal of the voice that is important. In support of this assumption, studies have indicated that the experience of hearing voices can be perceived as a positive experience in both evangelical Christians and people with psychosis. Cognitive models have been developed to enhance understanding and treatment of distressing auditory hallucinations. However, there is a lack of research into what are the positive aspects of voice hearing. We know little about what leads a person to perceive a voice as a positive experience, and in what way does it differ from a negativ! e voice experience. Method: A recent study by Gatiss et al. (2005) examined differences in the cognitive-behavioural characteristics of positive and negative experiences of voices. 14 participants who hear voices in the context of a long psychotic illness, were interviewed regarding their positive and negative experiences of hearing voices (within-subjects design), using a specifically developed semi structured interview. Individual experiences were shown to vary along a number of predetermined dimensions, including beliefs about voices (such as the perceived impact, intent and control). We have subsequently extended the research to examine beliefs and appraisals of voice hearing in people who are experiencing their first episode of psychosis (n= 6 data collection is ongoing) and in people who hear voices! in the context of spritual beliefs but have not contacted psychiatric services (N= 8 data collection ongoing). Results: Differences were reported between and within groups not only in the beliefs about voices but also the emotional, physiological and behavioural responses to the voice experiences. Groups differed in beliefs about intent, and ability to control voices, as well as in their emotional reactions. Discussion: Voice hearing is associated with both positive and negative consequences. Beliefs about and apprasial of voices are important in understanding distress. We can learn from people without mental health problems who experience voice like phenomena in helping to address these beliefs about voices and improve coping through CBT.

Reasons for Substance Use in Schizophrenia: A Q Methodological Investigation

Gregg L, Barrowclough C and Haddock G University of Manchester

Introduction: Large numbers of patients with schizophrenia abuse drugs and alcohol. These 'dually diagnosed' patients are at increased risk of poorer symptomatic and functional outcomes than their non substance using counterparts. Substance use is associated with more positive symptoms (Pencer and Addington, 2003) and with more relapses and hospitalisations (Swofford et al, 1996). There is a clear need to reduce levels of substance use in this population but for treatments to be successful, we must have a better understanding of the reasons for this use. This study used Q methodology (Stephenson, 1935) to examine the reasons that patients with schizophrenia give for their own alcohol and drug use. Method: Forty five patients with schizophrenia or schizoaffective disorder who also met DSM criteria for a substance use disorder were instructed to sort a set of 58 statements describing situations in which people drink alcohol or use drugs. Statements were placed into a grid according to the extent to which they applied to the sorter (from +5 'applies most' to -5 'applies least'). The resultant sorts ('Q sorts') were analysed using an inverted form of factor analysis in which each person's sort is correlated with all of the other sorts in order that prototypical viewpoints can be extracted. Results: Factor analysis resulted in a 3 factor solution on which 41 of the sorts loaded. Factor 1 'chill out and have a good time' consisted of people who primarily used drugs or alcohol to chill out, to have a laugh and to have a good time with others. They endorsed the intoxicating effects of alcohol and drugs and used substances when they wanted to feel creative, energetic or more confident. Factor 2 'bored and anxious' consisted of those who used substances when they were feeling bored, depressed, anxious or tense; people who wanted to escape from their problems and worries. People loading on this factor also used substances when they were hearing voices or when they were feeling suspicious or paranoid. Factor 3 'fit in and feel good' was a mix of factors 1 and 2. The people who loaded on this factor used substances to escape unpleasant thoughts and feelings and to feel good and more confident. Unlike the people who loaded on factors 1 and 2 they also reported using substances because of social pressure: to 'fit in' with other people and to avoid feeling awkward about refusing drugs/alcohol. Conclusion: The present study is the first to use Q methodology to examine reasons for substance use in this population. The results show

that people with schizophrenia use substances for many of the same reasons that the general population do (to relax, to feel good, to alleviate negative emotional states and to fit in with others). For some however, substance use is also a method of either reducing or coping with the negative and positive symptoms of schizophrenia. Further research is necessary to explore the relationship of these different profiles to patient symptomatology and patterns of substance use.

The Effects of PTSD on Suicidal Ideation, Plans and Behaviour in Individuals with Schizophrenia and Co-Morbid Substance Use Disorder

Picken A, University of Manchester

Introduction: Suicide has a strong association with mental disorder and contributes to the excess mortality of the mentally ill. This association has been assessed by psychological autopsy of consecutive series of suicides and by studying the suicide mortality of particular disorders. Schizophrenia in suicide is the subject of much research as in addition to high suicide rates there are many difficulties for clinicians in identifying and predicting those most at risk of suicide. This is due to a number of risk factors being identified but few with predictive ability. This study focuses on a common co-morbid disorder, PTSD, whose impact on the individual may account for differences in risk across the population. It is hypothesised that individuals with a dual diagnosis and co-morbid PTSD will have significantly greater levels of suicidal ideation, more suicide plans and a greater history of suicide attempts than those with dual diagnosis alone. Method: Participants will complete assessments regarding suicidal ideation, plans and behaviour (Beck Scale for Suicide Ideation - BSS) in addition to a screen for PTSD. Those individuals who screen positively for PTSD will be further investigated regarding severity of their symptoms. Results: At present there are 42 individuals in the study, of 100 that we aim to recruit. Early analysis shows a significant difference in levels of suicidality, as measured by the BSS, between individuals whoe meet criteria for PTSD and those who do not. Also this difference seems to be associated with higher levels of depression and hopelessness in the PTSD group. Conclusions: Indiviudals with PTSD experience greater levels of hopelessness associated with their symptoms and impaired functioning and this in turn impacts on levels of suicidal ideation, plans and behaviour. The study needs further participants in order to assess the independent impact of other possible factors, such as demographics, levels of substance use and symptom severity of their schizophrenia. Preliminary results suggest that the presence of PTSD should be assessed when producing risk assessments

The Brain And Interpersonal Behaviour In Schizophrenia: A Functional MRI Study of the Effect Of Relatives' Criticism: A Preliminary Study

Deakin B, Elliot R and Rylands A, University of Manchester

Introduction: This study aims to determine whether a fMRI study can detect the different reactions to verbal criticism and neutral remarks made by the patient's relative (familiar source) and a matched stranger (unfamiliar source). Past research has revealed neuronal abnormalities associated with emotion and speech in schizophrenia. The body of psychosocial research on "expressed emotion" (EE) also indicates implications of a high EE environment on relapse and positive symptoms in schizophrenia. This prelininary study aims to investigate whether the effect of critical comments on brain mechanisms through a cross-sectional functional MRI (brain imaging) reveals responses to high EE of relative and strangers. This would reveal primary neural dysfuntions of schizophrenia that underpin !vulnerability to poor outcome. The study is hoped to establish a platform from which future research into the effect of relatives' EE can be tested in a larger study. Method: The study will compare fMRI responses evoked by speech in schizophrenic patients in remission who have become stabilised after an illness episode. In this pilot study 6 patients of schizophrenia will initially be tested. Auditory stimuli from an pre-recorded interviews are presented to patients whilst in the fMRI scan, in a 2x2 factorial design contrasting critical comments with neutral coments (matched for length) made either by their key relative or a stranger (age and sex-matched with their relative). Subjects will be presented with prerecorded segments (4 types: relative-critical, relative-neutral, stranger-critical, stranger-neutral) in a randomised order. Each segment is followed by a 20 second silence. The BOLD responses to the 4 different types of speech segments will be analysed. The scans will take place at the Wellcome Trust Research facility in Manchester. Results: It is predicted that for all subjects there will be i.) a main effect of recognition to their key relative compared to the stranger, ii.) a main effect of affect / threat elicited from criticism compared to neutral comment, iii.) an interaction between the type of comment (criticism / neutral) and whether it was given by the relative or stranger. Conclusion: If the predictions are confirmed then the results will indicate abnormalities in brain mechanisms arising from environmental factors. This will allow us to carry out a larger study to determine whether EE is related to brain activity and in the medium term to determine whether such abnormalities predict later relapse. This can be achieved by investigation of administrative outcomes (hospitalisation) from hospital notes of patients in the study. In the long term assessment of persistent vulnerability could be developed through scanning and refined psychosiocal interventions can be developed which will impact by reducing such vulnerabilities. Understanding brain-environment interactions will help develop and refine pscyhosocial treatments.

Core Beliefs and Recovery from Psychosis: An Exploration of the Role of Schemas

Taylor C, Harper S F University of Edinburgh & NHS Lothian Primary & Community Division

Introduction: Cognitive schemata are increasingly being recognised as having an important function in the vulnerability to and maintaining of psychological difficulties in adult life. Attitudes and beliefs have been highlighted as the conscious elements that the concept of schemas might apply to. Garety, Kuipers, Fowler, Freeman and Bebbington (2001) have suggested that early trauma, experiencing loss in childhood and stress could create dysfunctional schemas which may in turn produce an enduring cognitive vulnerability to psychosis, represented by negative schematic models of the self and world. This study seeks to explore the role of schemas in the ongoing functioning of individuals who experience psychosis. It would be clinically useful, therefore, to develop an understanding of the role of s! chemas between individuals who are currently unwell and currently in remission, potentially identifying relationships that might lead to improved treatments. Methods: Participants will be asked to complete the Young Schema Questionnaire Short Version (YSQ-S; Young, 1998), the Childhood Trauma Questionnaire (CTQ; Bernstein & Finch, 1997) and additional self-report measures of psychopathology and emotional dysfunction. Three groups of participants will be compared: a currently unwell group, individuals in remission group and a non-patient control group. Results: Recruitment of participants and data collection is shortly due to commence and aims to be completed by late June 2006, thus preliminary analysis of findings will be complete and ready to be presented to conference. Discussion: The findings will be discussed in relation to cognitive models of psychosis and the potential clinical implications of the findings of this exploratory study

Therapeutic and Clinical Applications

Keynote Addresses

Schema-Focused vs. Transference-Focused Psychotherapy for Borderline Personality Disorder: Results of a Multicenter Trial.

Professor Arnoud Arntz, University of Maastricht, The Netherlands

Although there is general consensus that only prolonged and intensive psychotherapy can provide real recovery from Borderline Personality Disorder (BPD), almost nothing is known about the relative effectiveness of different approaches. The present study compared the (cost-)effectiveness of two psychotherapies for BPD aiming at a fundamental change: a modern psychodynamic approach (Transference-Focused Psychotherapy, TFP) and a schema-focused cognitive approach (SFT). In a multicenter trial 88 patients were randomised to either TFP or SFT and treated for max. 3 years. Results indicate a differential dropout, with TFP having more (early) drop-outs than SFT. Results indicate positive effects of treatment on all BPD criteria, on indices of psychopathology, on personality, as well as on quality of life. Significant differences between the two approaches as to treatment effects will be presented, focusing on number of recovered patients, symptoms, personality, quality of life, and cost-effectiveness. The results indicate that it is possible to successfully treat these difficult patients by prolonged psychotherapeutic treatment. Assessment of attentional bias to threat cues indicates that 'symptomatic' cure is accompanied by normalizing of these automatic information processing characteristic, suggesting a deep and fundamental change. Moreover, results of a 1-year follow-up indicate that recovery continues.

The Role of Emotion in Cognitive Therapy

Professor Robert Leahy, Weill-Cornell Medical School and President of the International Association for Cognitive Psychotherapy

Cognitive therapy has often been criticized for giving inadequate attention to the role of emotion in psychotherapy. Although this criticism may be overly general, there is a need to expand the importance of emotion in understanding psychopathology within the cognitive therapy tradition. Painful emotions may be an inevitable part of a meaningful life---contrary to the goal of simply "feeling good"--- a meaningful life is based on the capacity to "feel everything". I will propose a model of the role of emotional schemas that delineates how people differ in their response to painful emotions--in themselves and in relationships. I will also review several studies on emotional schemas showing how this model helps us understand why validation is helpful, how emotional schemas are expressed in intimate relationships, and how these schemas are related to worry, personality disorders, substance abuse and post-traumatic stress. Furthermore, both the private and the interpersonal nature of crying---and its mutual interpretation---will be described. Finally, I will suggest how compassion for painful emotions can help transform suffering into meaning, help establish a sense of community based on the needs of strangers, and help in the appreciation of a life that is limited by mortality.

Acceptance and Commitment Therapy: Current State of the Evidence

Professor Steven C. Hayes, University of Nevada

Late edition abstract to be posted on BABCP website (www.babcp.com)

Symposia

Using Self-help: Setting up and Delivering Services in Practice

Convenor & Chair: Chris Williams, University of Glasgow
Discussant: Paul Farrand, University of Plymouth

Am I Depressed? Doing Well by People with Depression in Scotland

Smith M NHS Greater Glasgow & Clyde, Scotland

"Doing Well" (DW) is an innovative system of care that has been developed for people with depression in Renfrewshire, Scotland. The system is founded on a CBT/Self- help model, using the principles of "stepped collaborative care".Central to the DW approach is the use of the 'Personal Health Questionnaire' (PHQ), a self- rating instrument which allows clinicians and service users to share an assessment of depression severity. All referrals are made electronically, and all referrals include a PHQ score. This assessment is used as a guide to the initial intervention offered by the service. People with "mild" depression on the PHQ (scoring <15) are initially offered a guided self-help approach to care. People with "clinical" depression on the PHQ (scores equal to or greater than 15) also use a self-help approach, but this is supplemented by brief therapy (using a CBT or IPT model) and/or antidepressant medicines. The PHQ is used to monitor response to treatment, and people who are not recovering are "stepped up" to more intensive interventions. Service users are encouraged to take an active part in their own treatment, and the service has evolved in response to service user feedback (for example, to offer a one-hour initial appointment; to be seen in local GP practices; to make flexible use of contact by telephone and email as well as face-to-face appointments). 5 clinicians from different backgrounds have the capacity to see up to 100 new patients per month. 0.2 WTE consultant psychiatrist input is used for group clinical supervision and clinical review of complex cases or people who are not responding to usual treatment. Clinical staff spend an average of one day a week in continuing professional development. A DW website offers service users and carers the opportunity to monitor their PHQ online (www.doingwell.org.uk). Since July 2004 the DW programme has seen 750 patients. Average wait time for an appointment is 10 days. The average treatment time is 136 minutes over 4.4 clinical sessions. Average fall in PHQ during treatment is from 16 (indicating clinical depression) to 4 (indicating recovery). Service user satisfaction ratings are how high on CSQ?. The use of antidepressants has been reduced to 36% of all people with depression, with 20% of people with mild depression receiving these drugs compared with 69% of people with clinical depression. DW has established that it is possible to implement a clinically effective collaboration between secondary and primary care in the management of depression. Careful allocation of patients to self-help, CBT/IPT and/or antidepressant treatment requires close service user involvement and the use of the PHQ to determine depression severity and the response to treatment. A relatively small clinical team is able to make effective use of "talking therapies" despite a high volume of referrals from primary care.

START: Self-help Treatment Access Resource Team: take-up and outcomes

Rafferty L NHS Greater Glasgow Ahmed S NHS Greater Glasgow Fernon L NHS Greater Glasgow Hay L NHS Greater Glasgow Brodie J NHS Greater Glasgow Reid S NHS Greater Glasgow Day I Depression Alliance Scotland

The Self-help Treatment Access Resource Team (START) team has been funded to introduce the concept of a dedicated 'Self help Support Worker' within five Primary Care Mental Health Teams (PCMHT's) in the Greater Glasgow area. This is part of a Scottish Executive Health Department initiative called Doing Well by People with Depression - led by the Centre for Change and Innovation (http://cci.scot.nhs.uk/). The aim of the START Project is to provide multiple ways of accessing CBT self-help for those facing mild to moderate depression and anxiety. The team have achieved this as a joint project with Depression Alliance Scotland and local Primary Care Mental Health Teams. The Self-Help Support Workers are attached to local primary care mental health teams and work to provide initial screening for treatment using the 'Overcoming Depression: A Five Areas Approach' workbooks of CD Rom. Right at the centre of the service are two main concepts: 1) Stepped care assessment - where the Patient Health Questionnaire (PHQ-9) is used together with key items from the BDI-II questionnaire to allocate patients to the appropriate level of treatment. People with mild to moderate depression and no risk factors on the BDI-II (defined as a score of less than 2 on the BDI-II suicide item) - who wish to and are able to use the treatment approach (as defined by a score of less than 7 on the combined items for energy, concentration and motivation on the BDI-II) are offered the approach. Stepped care assessment means that only people scoring higher on the PHQ (>15) are offered a full clinical assessment by a qualified health care practitioner. Otherwise all patients are routinely offered the CBT self-help option described below.2). Patient choice is the other main driver for the self-help service - offering people their choice of working using individually-supported written or computerised self-help, or via a group in the

health service or Further Education College setting (the Living Life to the Full course). A free website (www.lvinglifetothefull.com) provides support for those using the written workbooks or attending the group courses. Baseline and outcome measures use the PHQ-9, BDI II, WASAS, EQ5D, CORE, CSQ. Outcomes and satisfaction Eighteen months from the introduction of the service there has been a total of 436 patients referred to the project. The number of patients referred to local primary care teams totals 2208 - and the START project has taken on 20% of the total referrals for treatment. Patients received a mean of 3.7 sessions of treatment by the self-help support worker. The mean PHQ-9 scores at baseline were 15 and were 7 at discharge representing a drop from moderate to severe depression to mild depression. The CSQ-8 (Client Satisfaction Questionnaire) 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 is 29.0 (92%). The mean CORE score at first appointment was 1.85, dropping to 1.04 at the end of treatment ($p < 0.001$) (the cut-offs for caseness are 1.19 for men and 1.29 for women on the CORE). The total clinical caseness on CORE domains for treatment completers at baseline was 82.3%, falling to 33.6% at discharge. Finally, the www.livinglifetothefull.com website has proved successful with 1.8 million hits since July 2005, over 8000 hits a day, 200+ visits a day and 6000 members/users in total and appears to be becoming a useful source of support for patients/clients as well as practitioners.

Using self-help: setting up and delivering services in practice

Day I National Co-ordinator Depression Alliance Scotland

Over the past three years the Scottish Executive has funded a major project throughout Scotland on the management and treatment of depressive disorders concentrating particularly on depressive disorders in the community and primary care. Ten of the thirteen Health Boards in Scotland are now project sites in this "Doing Well by People with Depression" initiative. Each project site has focused on ways of increasing the capacity of services to provide intervention for mild to moderate depression in primary and community care settings. Site interventions have focused upon the delivery of stepped care CBT treatments and have also involved significant NHS and voluntary sector collaboration.

What are users views as regards the acceptability and usefulness of "Overcoming Depression" CDRom

Kent C University of Glasgow Crawford G NHS Greater Glasgow Campsie L NHS Greater Glasgow Williams C University of Glasgow

A recent meta-synthesis (Lovell et al, 2006) has identified some key themes in the use of CBT self-help. These include participants' personal experience in a trajectory of depression, control and helplessness in engagement with treatment. Other important themes include patient help-seeking and how participants became engaged with mental health services. Building on this work, and focusing specifically on patient attitudes towards and use of a CD Rom based CBT package, 19 people who had completed at least 2 sessions of the "Overcoming Depression" CBT-based CDRom were asked to participate in focus group discussions of their experience. They had all participated in a Randomised Control Trial of the effectiveness of Overcoming Depression CDRom for patients on a clinical psychology waiting list. If patients declined participation in a focus group they were offered an alternative of telephone or face-to-face interviews as a method of gathering this data. A topic guide was devised after a search of the relevant literature and in conjunction with the researchers of the RCT. A grounded theory approach was utilised to modify the Topic Guide at each of the subsequent focus groups and interviews. All sessions were facilitated and recorded on a digital voice recorder and fully transcribed to aid thematic analysis. Overall, 14 participants will have shared their views and experiences as part of this qualitative analysis which completes in May 2006. Some participants have valued the anonymity provided by a CDRom based approach and felt it a useful adjunct to individual therapy. One participant described using the CDRom as a means of "beginning treatment whilst being in waiting list limbo". Other participants who felt that their own personal experience of depression developed from particular life events perceived this approach as being less useful. The conclusions will be discussed in full when a thematic analysis has been performed from all the data gathered.

The Therapeutic Relationship in Complex Cases

Convenor: Paul Gilbert, Mental Health Research Unit Kingsway Hospital, Derby
Chair Mary Welford, Consultant Clinical Psychologist for Manchester and Salford

Emotional Schemas and the Therapeutic Relationship

Leahy, R Weill-Cornell Medical School and President of the International Association for Cognitive Psychotherapy

Patients and therapists each come to the therapeutic relationship with their own conceptualization of what an effective relationship will be and how emotions are to be handled. Patients' schemas may focus on threats of abandonment, humiliation, or loss of autonomy, while therapists may have schemas reflecting demanding standards, need for control, and approval seeking. Moreover, both patients and therapists may have "emotional schemas" where emotions may be viewed as threatening, overwhelming, needing "regulation" or incomprehensible. These "schema mismatches" may lead the therapist to view emotions as a waste of time, "complaining" or a sign of "rumination" and make it difficult for the therapy to elicit emotionally significant material or to allow for important experiential exposure. The therapist can identify and modify mutually self-fulfilling "interpersonal strategies"---where personal and emotional schemas are continually confirmed (or never disconfirmed).

From safety to exploration: the working alliance in cognitive therapy for people with psychosis

Lowens, I University of Manchester

There is good evidence to suggest that the quality of the therapeutic relationship or working alliance, as experienced by the client, is one key factor affecting outcomes for all therapeutic schools, and all client groups. Therapists attempting to build a working alliance with people who are distressed by psychotic experiences are likely to face specific challenges. Paul Gilbert's Social Mentalities Theory provides a useful map to aid this process. This presentation will focus upon using the Social Mentalities framework to review the various factors that may either help or hinder alliance formation. The implications of these factors to the progress of therapy, and overcoming alliance ruptures will then be discussed.

Shame (and Guilt) in Psychotherapy – The Therapist's Tale

Schroder, T University of Nottingham

The self-conscious emotions of shame, humiliation and guilt, activated within a therapist, can play a significant role in therapeutic ruptures and difficulties. This talk will report on the first stage of a study which uses over 1000 narratives, taken from an International study, that explores therapeutic experiences of self-conscious emotions. The talk will consider definitions of shame and guilt, give prototypic examples and discuss the emergence of scoring systems for identifying these emotions in therapeutic transcripts. The implications of focusing on self-conscious emotions in the therapeutic encounter will be explored.

Therapeutic Compassion

Gilbert, P Mental Health Research Unit Kingsway Hospital, Derby

The facilitative components of the therapeutic relationship are commonly regarded as involving genuineness, empathy and positive regard with good evidence that these qualities affect the outcome. This talk will suggest that we can identify further components of facilitating and healing therapeutic relationships by focusing on research on interpersonal relations, and also compassionate abilities and processes. This talk will also explore the key elements of compassion and how and why these can have potentially major impact on therapeutic outcome, especially with complex cases.

Developments in the Provision of Low-intensity, High-volume Psychological Treatments

Convenor & Chair: David Richards, University of York

Introduction to the role of low-intensity, high-volume treatments in the management of depression

Richards, D University of York

This brief presentation will set the scene for the remaining papers in the symposium by outlining the role of low-intensity, high-volume treatments in the management of depression and describing some of their characteristics.

Models of Stepped Care: evidence from the first UK trials of collaborative care for depression and stepped care for common mental health problems

Richards, D University of York

This presentation will report the results of the first RCT of collaborative care for depression in the UK. Collaborative care is an organisational intervention which involves a) the introduction of a new case manager role into primary care, b) liaison and educational mechanisms between primary care clinicians and mental health specialists and c) mechanisms to collect and share information on individual patients. Although there is now evidence from 12,000 patients treated in 34 randomised controlled trials of collaborative care internationally, most of these have been conducted in the USA, intervention content is diverse and it has been by no means clear what the effect of such reorganisations will be in other health systems. In the present UK trial, conducted within the MRC's framework for complex interventions, collaborative care for people with depression had a large effect size compared to usual care. The protocol included educational support, medication management and a low-intensity psychological intervention. The essential components, the acceptability to patients and clinicians and the role of collaborative care in stepped approaches to psychological treatment access will be discussed. Acknowledgements: Michael Barkham, Peter Bower, Linda Gask, Simon Gilbody, Karina Lovell, Anne Rogers, David Torgerson, Annette Lankshear, Angela Simpson, Diane Escott, Janine Fletcher, Sue Hennessy.

Guided Self-Help – Empirical and Consensus Developments of a protocol for a MRC Complex Interventions Platform Trial

Lovell, K University of Manchester

The prevalence of mild/moderate depression is high and is a significant cause of distress and disability resulting in serious economic consequences for patients, families and the wider society. Despite evidence based psychological treatments being available, access to such interventions is problematic. To overcome such problems NICE guidelines have proposed the adoption of a 'stepped care' model, where patients receive effective low intensity treatments (such as books and computer programmes) at lower steps, and only access more intensive treatments where they fail to benefit. Step 2 of the NICE model includes the use of guided self-help (GSH). Although there is preliminary evidence that GSH is more effective than no treatment or usual care, there is insufficient high quality evidence from UK primary care settings. In addition, there is little known about the critical components of GSH e.g. which professional groups should deliver GSH, what level of guidance is required, and what is the appropriate health technology i.e. books, leaflets, computers etc. This project uses the MRC Complex Interventions Framework to identify and understand the critical components of this complex intervention, in order to design an effective and feasible protocol for testing in a large scale definitive trial: phase 1 (modelling) - to develop a protocol for the delivery of feasible and effective guided self-help for mild/moderate depression in a primary care stepped care system; phase 2 (exploratory trial) - to test the application of the GSH protocol and to provide estimates to assist in planning a definitive trial. The results of phase 1 will be examined in this presentation. Acknowledgements: Peter Bower, David Richards, Bonnie Sibbald, Michael Barkham, Anne Rogers, Linda Davies, Chris Roberts, Simon Gilbody, Judith Gellatly, Sue Hennessy.

Behavioural orientated treatments for depression. A systematic review

Ekers, D University of York

Depression has a point prevalence of between 15-30% in the United Kingdom. The condition is a major contributor to the global burden of disease, and will be second only to ischemic heart disease by 2020. The majority of depression treatment is via primary care in the UK. It is recommended by NICE that

psychological therapies be delivered in a stepped care system with recommended psychological treatment being CBT or interpersonal therapy. Problems exist, however, as there are too few therapists with sufficient qualifications to deliver full CBT treatment to even a small proportion of those with conditions for which it is recommended. Primary research evidence has suggested that single strand delivery may be as beneficial as multi strand with a large proportion of patients. These approaches, being less therapist intensive, may be suitable for delivery by a range of professionals beyond traditional psychological therapists, therefore increasing access if applied in such stepped care systems. Narrative but not systematic reviews of research into behaviourally orientated treatments of depression have proved informative regarding this question. In this presentation results from a systematic review carried out between December 2005-May 2006 will be reported. The review will appraise and summarise all randomised controlled trials with comparisons between behavioural orientated treatments and other psychological interventions or placebo control in the treatment of depression. The process of identifying relevant papers will be presented alongside results of a meta analysis, where possible, to explore the statistical effectiveness measured in terms of reduction of depression symptoms and functioning. Results will be presented with estimates of effect considering potential bias identified in the process. Development of further primary research to increase access in NHS settings will be considered in light of results.

Using the Telephone to Increase Access to Psychological Interventions in Primary Care

Horn, R University of York

Access to psychological therapies is a key government agenda. The increasing use of guided self-help in primary care and progress towards a stepped care model of treatment as advocated by NICE for many common mental health problems is certainly a step towards increasing the provision of low intensity high volume psychological treatments. However, access is more than a service simply being available and in a reasonable time scale. Access is also about services being appropriate to the needs of a patient population so that they can utilise it. In primary care, offering guided self-help in a face-to-face clinic setting does not necessarily meet the access demands of this patient group many of whom may still be working and find it difficult to regularly attend scheduled appointments in a clinic setting. There is increasing evidence that the telephone is an effective method of delivering psychological interventions and combined interventions such as case management for depression. It will be argued that the use of the telephone in primary care could further increase access to psychological interventions. In Craven, Harrogate and Rural District Primary Care Mental Health Service, there has been a pilot telephone clinic run by a Graduate Primary Care Mental Health Worker. Guided self-help has been delivered over the telephone along with a local 'stepped care model' where the telephone has enabled patients to receive a 'step up' and a 'step down' from usual care. This pilot has led to a current pilot RCT comparing telephone and face-to-face guided self-help for depression in primary care. Both the telephone clinic and the current pilot RCT will be discussed.

Measuring Competence in Cognitive Therapy

Convenor & Chair: Mark Freeston, Newcastle Cognitive and Behavioural Therapies Centre

Chair: Mary Shinner, Salford Cognitive Therapy Training Centre

Measuring competence in cognitive therapy: Background, context and issues

Shinner M Salford Cognitive Therapy Training Centre Freeston M Newcastle Cognitive Therapy Centre and University of Newcastle

The holy grail of CBT trainers would be to show convincingly that training and supervision increases therapist competence and that increased competence leads to better outcomes for patients and services. Likewise, the Holy Grail for those responsible for accreditation of CBT would be to show that accreditation ensures (and perhaps increases) competence and that therapy by accredited therapists leads to safer and better outcomes than therapy by non-accredited therapists. There is some evidence for the effects of training and supervision, first showing that training and supervision increases competence (e.g. Keen et al., 2006; Milne et al, 1999; Sholomkas et al., 2005) and then showing that therapist competence does indeed influence outcome (e.g. Davidson et al., 2004; Trepka et al., 2004). There is less, if any, good evidence for the link between accreditation, competence and outcome. The links between training, competency, accreditation and outcome are critical issues in the context of the rapidly developing demand for CBT and the current expansion of CBT training and services in the UK. Although CBT currently has a good reputation and is much in demand, the danger of "watering down"

training and therapy is a serious possibility. Insufficient training and supervision of sufficient quality may result in less than desirable levels of competence, in turn leading to unsatisfactory patient and service outcomes, which could then erode support for the development of CBT training and services within the UK. The ability to demonstrate the key relationships described above depends on the ability to measure competence in a valid and reliable way. Thus, the definition and measurement of competence has an importance that goes beyond its original use, which was to ensure one aspect of treatment delivery in randomized control trials. It also goes beyond its current common use within cognitive therapy training where it is used to check progress and to make assessment decisions in an academic context. Demonstrated competence is not yet part of BABCP accreditation, although a strong case could be made. It could be argued that the valid and reliable measurement of competence is in fact an essential part of the further development of CBT training and services in the UK.

A Fair Deal? Inter-rater reliability for assessments of clinical competence on the York CBT course

Latham, M University of York

The York CBT course uses two 'homegrown' scales to measure the clinical competency of students. One is designed to assess the initial contact (or screening) when a decision is made regarding suitability of CBT for the client. The other is for a mid-treatment CBT session. Each student is assessed once on each of the scales, which are double-marked by two of three available assessors. The scales will be described briefly and then data will be presented showing the degree of inter-rater reliability attained on each one. Comparisons will be made with inter-rater reliability obtained for more traditional academic assessments, such as essays and case studies. Potential means of improving inter-rater reliability will be suggested, and some of the hazards involved in assessing complex behaviours such as clinical skills will be highlighted.

Assessing the competence of cognitive therapy trainees: the influence of measurement error and its effect on reliability

Keen A School of Psychology, University of Aberdeen Freeston M Newcastle Cognitive and Behavioural Therapies Centre and University of Newcastle

Generalisability theory can be used to determine the magnitude of the sources of variation in, and the reliability of, all examinations. Unlike classical test theory, it allows one to calculate reliability over a number of different aspects of measurement simultaneously. Essentially, generalisability theory (rather than classical test theory) is thus suitable in those situations wherein the goal is to identify and quantify errors of measurement and in doing so find effective methods for reducing their influence. This study examines the assessment of competency in a naturalistic study conducted at Newcastle Cognitive and Behavioural Therapies Centre. It uses data from tape assessments from two cohorts of trainee therapists at two time points. It examines the reliability of the Cognitive Therapy Scale - Revised from the standpoint of generalisability theory and compares the reliability of these assessments and those from traditional written assignments (essays and case studies) on the same course. This study highlights a number of the measurement issues that are associated with the assessment of complex behaviours.

Reliability of assessment of therapist competency: A prospective study

Freeston M Newcastle Cognitive and Behavioural Therapies Centre and University of Newcastle Keen A School of Psychology, University of Aberdeen

Although naturalistic studies of reliability can inform about some sources of variability and error, they cannot manipulate factors in a way that allows important sources of variability and error to be determined at an optimal level of detail. In particular, separating contributions due to different patients for a given therapist or different sessions for the same patient cannot be identified. Likewise, an important source is variability due to differences between teams of raters associated with different courses has implications for standardisation and benchmarking. Finally, method variance is of great interest as there are a number of possible different assessment strategies such as global vs. dimensional ratings. This presentation considers some of the research questions, design issues, and practical problems in a prospective multicoated study that is in the design stage. It is hoped that this study will advance the measurement of competency in CBT both through its contribution to the evidence base but also through the effects of the concerted efforts of groups from different centres working together toward a common goal.

Experience and Reflection in Cognitive Therapy Training and Consultancy

Convenors: James Bennett-Levy, Oxford Cognitive Therapy Centre and Mark Freeston, Newcastle Cognitive Therapy Centre
Chair: James Bennett-Levy, Oxford Cognitive Therapy Centre

What can therapists learn about other people's anxieties from their own?

Freeston M Newcastle Cognitive Therapy Centre and University of Newcastle Richards J Newcastle Cognitive Therapy Centre Cromarty P Newcastle Cognitive Therapy Centre and St Martin's College

Although the cognitive models for anxiety disorders such as Panic Disorder are among the best known even among relatively inexperienced cognitive therapists, without an experiential understanding of anxiety, conceptual knowledge may be difficult to apply. As part of the first term teaching, 23 trainees enrolled in the Diploma in Cognitive Therapy took part in a five-week block of teaching on anxiety disorders. Rather than work directly from patient material, participants were invited to reflect on an example of their own experience of phobic-like anxiety. They were informed about what they would be asked to do and instructed to choose a phobic-like anxiety experience that they would be willing to talk about in these terms. They were clearly informed that at any point they could choose not to reveal specific features. Most work was to be conducted in the same pair or small group of three. All participants were willing to reflect on and to discuss a phobic-like anxiety experience from a wide range of specific phobias and social phobias. A range of age of onset, type of onset, and degree of interference was reported. Feedback on the block of training was predominantly extremely positive, indicating the acceptability of this approach when delivered in this context by experienced trainers. Participants rated their perceived empathy, understanding, and ability to treat effectively with people with anxiety disorders on nine items before and after the five-week training block. They were also asked to re-rate their baseline level on each of these variables at the end of training to see whether the type of training had caused them to revise their initial ratings. Based on the second set of ratings, participants indicated that they had overestimated their initial ratings of their empathy, understanding, and most aspects of their ability to treat people effectively. Importantly, the training did increase their perceptions of their understanding and abilities. There are three important implications of these results. First, this type of training may lead to a sense of deskilling that would need to be normalized and otherwise addressed. Second, reflecting on experience may lead potentially to more accurate perceptions of a therapist's own understanding and skill. Third, this type of training may ultimately increase confidence through a greater felt sense of connection to the patient's experience and greater awareness of the potential pitfalls and possible solutions when conducting therapy with anxious patients.

Learning CBT from the perspective of another model

Wills, F University of Wales, Newport

It seems likely that as more CBT trainees come forward, some of them will be learning CBT from other therapeutic positions. Studies into learning CBT from other perspectives (Persons et al, 1996; Freiheit & Overholser, 1997) have been optimistic, that reservations can be overcome. The effects of reservations on competency development have not, however, been studied. This study addressed two questions: Do differences in therapeutic attitudes affect competency development in CBT training, and, how can negative effect s of differences be overcome?. Method: This longitudinal study followed 3 cohorts of trainees (n=55) before, and after CBT training and at one-year follow-up. Therapeutic attitudes were tracked using a questionnaire, including a scale recording responses to core CBT principles as a repeated measure. A competency measure, an adapted version of the Cognitive Therapy Scale (Young & Beck, 1988) monitored trainees' skill development throughout training. Trainees were invited to reflect on their training experiences in interviews at follow-up. Results: Previously most trainees had trained to Diploma in Counselling level. Half had quite strong allegiance to person-centred therapy, and the others divided between CBT, Psychodynamic and Integrative/Eclectic therapy. Trainees with person-centred and psychodynamic preferences had quite strong reservations about CBT theory and practice. Psychodynamic trainees tended to have theoretical reservations that did not impact on their CBT practice. Person-centred trainees, however, often had reservations about implementing therapy structure, which they saw as 'dictating' to clients. These attitudes did impact on their practice and were associated with more failed items in assessments and consequently needing longer periods of time to achieve overall competency in CBT. Qualitative analysis of the post-training interviews revealed that trainees often approached assessment with elevated levels of anxiety and this sometimes lead them to apply the model in overly rigid ways. Help with these difficulties often resulted from opportunities to express reservations and to reflect on their changing attitudes and practice. These opportunities often resulted in a feeling that they could experiment, even 'play,' with the model, helping them to reach a more personally owned synthesis of values and practice. Conclusion: The study shows that previously held therapeutic attitudes can influence the learning of CBT practice. It appears congruent with CBT

theory and practice to acknowledge these attitudes and to allow 'training space' for trainees to reflect on and 'play' with them. This does not imply that trainers should adopt a highly permissive stance. It may be that a positive tension is created when trainers strive to keep trainees on the CBT highway whilst trainees may need for their own and their trainers' sakes to wander off undetected at times.

Evaluation of an Experiential Learning Model of CBT Based Consultancy To Teams

Balleny H Great Yarmouth & Waveney Assertive Outreach Team Norfolk and Waveney Mental Health Partnership NHS Trust Flack H University of East Anglia Clinical Psychology Training Course

Service users with complex needs, significant interpersonal difficulties and mental health problems, including those with diagnoses of borderline personality disorder, often have difficult relationships with mental health services, and the staff that work within them, that can interfere with access to appropriate services and interventions (Norton & Hinshelwood, 1996). One role of psychological services within secondary mental health services is to develop the approach of idiosyncratic conceptualisation and individualised care, using consultancy approaches, with the aim of improving staff and service understanding and treatment of, and attitudes to, people with serious mental illness and complex needs, in order that service users achieve greater levels of health (Coursey et al,1997). This study had two main questions: What impact does the use of an experiential learning model of consultancy (Kolb, 1984) and, within it, CBT models to inform conceptualisation, have on members of multi-disciplinary teams, and, does it make any difference to the problems experienced by teams working with service users with complex needs in the context of secondary mental health services? Method: This study involved 9 members of staff working within discrete teams with 4 service users with significant interpersonal difficulties within an adult mental health service. Outcome was measured in 2 ways; quantitatively by comparing staff ratings of problems experienced by the team, the service user, and the participating member of staff, before an initial consultation session and after 3 months; and, qualitatively using a semi-structured interview after the initial consultation session in which the whole team had reflected together on their experience of working with the service user and CBT models were used to inform conceptualisation. Template analysis was used to process qualitative data. Results: There were significant changes in problem ratings by staff in three of the four cases with changes being attributed at least partly to the consultancy process. Qualitatively, team members reported a number of positive outcomes of the process including development of; understanding of the service user, their own role in the interpersonal relationship, change in emotional reactions, new approaches to work with the service user and a sense of 'teamness'. Conclusion: The study shows that whole team consultancy using an experiential learning model of reflection on experience and conceptualisation using CBT models can contribute to significant change in problems experienced by teams working with complex cases, and improvement in interpersonal relationships between team members and service users. This implies that it is an intervention worthy of consideration in relation to idiosyncratic formulation, and, that further research and evaluation are indicated.

Enhancing CBT training and skills utilization through reflection

Bennett-Levy J Oxford Cognitive Therapy Centre, Oxford Padesky C Centre for Cognitive Therapy, Huntingdon Beach, CA, USA

Although there is increasing evidence that cognitive therapy training courses can have a positive impact on trainees' skills (Milne et al., 1999), we are only just starting to acquire empirical evidence for which specific training strategies may be maximally effective (Bennett-Levy, 2006). In the field of adult education, the seminal theory of Schön (1983) suggested that reflective practice might play a key role in the development of professional skills. The present study addresses the question: Does reflection during and after a therapy skills training workshop make a difference to therapists' awareness of new learning, and therapists' behaviour? It was predicted from Schön's theory and Bennett-Levy's (2006) model of therapist skill development that reflective processing should enhance therapists' learning and procedural skills. Method: Two groups of cognitive therapy trainees were compared who attended the same two-day cognitive therapy skills workshop in successive years: Group 1 'Training-as-usual' group; and Group 2 'Reflection' group which additionally completed reflection sheets at the end of each day's workshop and were instructed to complete follow-up reflection sheets at one, four and eight weeks post-workshop. At 10 weeks post- workshop, participants completed a questionnaire, enquiring whether there had been change in their (1) Awareness of the 16 target skills and (2) Behaviour/Use of these skills. Results: The Reflection group reported greater change than the Training-as-usual group, particularly in their behaviour/use of these skills with clients. Further analysis revealed that whether or not participants completed the reflection sheets at follow-up had a huge impact. Those participants in the Reflection group who used the post-workshop follow-up reflection sheets reported using the newly learned skills to a far greater extent than the Training-as-usual group. Non-users of reflection sheets showed little or no difference in reported utilization. Reflection sheet users also reported greater changes in awareness of new learning, and greater use and variety of reflective strategies post-

workshop. Email reminders facilitated the use of reflection sheets. Conclusion: Structured reflection during and particularly after a cognitive therapy training workshop has a significant effect on participants' awareness and reported utilization of newly learned skills in clinical practice (procedural skills). This study provides strong support for theories, which place the process of reflection at the heart of therapist skill development. Since several previous studies have shown that one major barrier to skill acquisition in novice therapists is reluctance to utilize newly learned skills with clients, this study is important in suggesting one way in which this problem may be addressed. However, provision of reflection sheets, and instructions to use them post-workshop, is not enough; participants must actually use the reflection sheets for this procedure to be effective. Email reminders help in this respect.

Panel Debate

Panel Debate: Implementing the NICE Guideline for OCD and BDD: Increasing the Availability and Quality of Cognitive Behaviour Therapy

Convenor & Chair: Mark Freeston, University of Newcastle and NCBTC

Panelists:
Jo Derisley, Norfolk & Waveney Mental Health Partnership NHS Trust
Karina Lovell, University of Manchester
David Veale, North London and the South London and Maudsley Trust
Gillian Leng, National Institute of Health and Clinical Excellence

The NICE Clinical Guideline, "Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder", was released in November 2005. As with other NICE guidelines for mental health problems, CBT is clearly indicated for the psychological treatment among both children and adults. In fact, CBT is the only psychological treatment for OCD and BDD for which there is currently any convincing evidence of efficacy. Although the treatment of OCD is among the longest established treatments within the cognitive behavioural therapies, there are still relatively few therapists who are competent, confident and experienced in providing this treatment when compared to the potential demand, and even fewer have experience in the treatment of BDD. The Guideline places a strong emphasis on better dissemination of information as well as earlier identification and diagnosis of OCD. These should, over time, lead to more people with these conditions to seek treatment. If the guideline is to have the desired impact in improving patients' experience of care, choice of interventions, clinical outcomes, and quality of life, there is a need for increased provision of effective therapy. This represents a significant challenge for CBT practitioners and for the services and organisations in which they work. Four members of the Guideline Development Group will be joined by a representative from NICE for this panel discussion that will address key issues in implementation of the guideline with particular emphasis on cognitive and behavioural therapies. Mark Freeston will chair the panel and provide a brief introduction to implementation issues that the Guideline Development Group faced. Jo Derisley will discuss the provision of CBT for children and young people. David Veale will consider both the treatment of BDD and the role of specialist treatment centres. Karina Lovell will discuss the provision of CBT to adults with particular emphasis on treatment delivery formats. Gillian Leng, Director of Implementation Systems for NICE, will provide a broader perspective on the implementation of NICE guidance. Following a short statement by each panel member, the panel will take questions from the floor.

Open Papers

Issues in Enhancing Treatment Delivery

Chair: Jim White, STEPS primary care mental health team, Glasgow NHS

Using CBT in routine general practice

Huey D North Tyneside PCT; University of Newcastle Fowles K North Tyneside PCT Scott J North Tyneside PCT

Common mental health problems and the psychological components of physical health problems form substantiate parts of a General Practitioners workload. Despite recognition of need, and increased interest and investment in the use of CBT based self-help materials, there is currently some debate regarding the effectiveness and utility of training GPs to use aspects of CBT in their routine practice. This study aims to evaluate whether a brief training package, aimed at socialisation to the key principles of CBT, was (a) perceived as acceptable and relevant and was (b) able to improve GP's recognition and understanding of psychological mediators of distress. A brief training package (3 x 1.5 hours; variable gap) was delivered to four small groupsof GPs (total n=28). Pre-training, brief ratings of background and experience were takenas well as a rating of a video role-play showing a GP consultation with a patient describing a common mental health problem. This rating was adapted from a measure ofclinical reasoning, used to assess the effects of problem-based learning. Two raters, blind to participant identity or time, scored the responses according to the presence of 'Five Areas' variables offered as explaining the patients distress (Kappa = .86). The rating scale had previously been piloted on a group of clinical psychologists (n=7). Post-training, participants re-completed the 'Five Areas' rating scale and the Training Acceptability Rating Scale (TARS). The TARS indicated high levels of acceptability, relevance and subjective change. The æFive Areas rating provided more objective evidence of change. Pre-training 12% of the variables listed as explaining a patientÆs distress were cognitive, compared to 23% post-training (Z = 3.42, p<.001, n=21). Pre-training 37% of the variables listed were environmental, compared to 27% post-training (Z = 2.76, p<.01, n=21). The relationship between these variables, the perceived adequacy of mental health education, and knowledge and confidence regarding mental health problems will also be presented. The Five Areas rating method provided a brief and reliable method for assessing CBT specific change following training. The brief training package produced observational evidence compatible with a change in the way participants understand patients' presenting problems. It will be argued that increased recognition of psychological mediators of distress is central to accurate problem definition, clinically useful decision making, and the facilitation of hope and change. The learning methods required to consolidate such change and facilitate skill development will be discussed.

Healthy reading: the experience of book prescription within a stepped care system of service delivery

Petrie S STEPS PCMHT - NHS Greater Glasgow

The STEPS Primary Care Mental Health Team - based in South Glasgow - specialise in innovation in primary care mental health. 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. It is from this basic premise that the idea of the 'Healthy Reading' project was developed. It is based on the strategy of identifying high quality self-help materials, making them accessible, and helping GP's and other primary care professionals 'signpost' the patients they see towards these materials. Part of this strategy has involved the use of 'book prescription', where health professionals can issue paper prescriptions to patients as a way of authorising and activating book borrowing via libraries. The STEPS Healthy Reading project has been evaluated over a 12 month time period, using descriptive statistics as well as questionnaire data from service users and professionals who have used the project, to thoroughly assess use, impact, and satisfaction Preliminary results suggest that there is a huge demand for self-help materials for mental health. Use of book prescription has been less widespread. Results for impact and satisfaction amongst service users and professionals will be presented Conclusions are that provided self-help materials for mental health are made readily available and people are effectively signposted towards them, uptake will be very high. Book prescription, whilst useful for some, need not form a central part of a stepped care system of service delivery. Discussion will centre round the way forward for this type of project.

CBT supervision of psychiatric trainees. Can a little knowledge be a therapeutic thing? Critical review of experience in a large Dublin training centre

McDonough M St Patrick's Hospital Tone Y St Patrick's Hospital Kearns C St Patrick's Hospital McGoldrick, M St Patrick's Hospital Delmonte M St Edmundsbury Hospital Richardson A St Patrick's Hospital

Much attention has been paid to the organisational aspects of psychotherapy training of psychiatry SHOs but little to the quality of psychotherapy delivered by trainees under supervision and their receptiveness to such training. Here we review our data and experience providing CBT supervision to trainees in a busy general psychiatry service. Two years after formal structures for psychotherapy supervision of trainees were introduced CBT supervisor and trainee 6monthly feedback questionnaires and patient clinical outcome scales were collated and analysed statistically. Supervisors provided additional qualitative feedback on their experience and where available audio taped sessions were rated using the Cognitive Therapy Checklist (CTC). 27 trainees (>6 months in psychiatry) were allocated to one of 4 CBT supervisors (1 psychiatrist, 3 nurse therapists) after 3 introductory seminars in basic psychotherapy and CBT skills. Data was available on 24 (3 never made contact with their supervisor citing work pressures and membership exams). Per 6 months trainees attended a mean of 5.8 supervision sessions taking on an average of 1.3 cases each (in order of frequency depression, social anxiety, low self-esteem, panic, phobia and paranoid psychosis). Likert scale ratings by supervisors of the trainees ability to establish and maintain a therapeutic relationship, their grasp and application of the relevant CBT model and their use of supervision varied considerably but averaged between acceptable and good. Patient outcome ratings will also be presented. Audio taped sessions were available in 7 cases (usually more enthusiastic trainees) and generally demonstrated acceptable levels of competence with some trainees quickly reaching good skill levels based on their CTC score. Difficulty maintaining a collaborative and non-didactic stance was the most usual area weakness. Unstructured feedback from supervisors raised concerns over lack of protected time for therapy sessions and supervision, scheduling difficulties, difficulty adopting a psychological model for some trainees and a fear apparent with many trainees of appearing unskilled or being exposed in supervision. Feedback by trainees û generally positive though often citing conflicting time demands and difficulty finding suitable cases - will also be presented. A minority of our psychiatry trainees could rapidly adopt and apply a CBT model competently under supervision but the majority find the experience challenging and require considerable support and close supervision in a non-threatening atmosphere. The least psychologically minded trainees are most in need of this training and require particularly careful engagement. For these trainees the focus should be less on racking up training cases and more on the interpersonal processes of therapy.

Patients in charge: A naturalistic investigation of a patient-led approach to treatment in primary care

Carey T Department of Clinical Psychology, Fife Primary Care Trust, NHS Mullan R Department of Clinical Psychology, Fife Primary Care Trust, NHS

In an earlier paper (Carey, 2005) an approach to treatment delivery was examined in which patients scheduled the duration and frequency of appointments. Results of this approach were encouraging but the generalisability of the findings was constrained because only one clinician trialled the approach and no standardised assessment measures were used. The aim of the present was to trial the same approach with two, rather than one clinicians involved and using the Depression Anxiety Stress Scale (DASS). The study is a naturalistic investigation which seeks to replicate and extend earlier results. Different types of data from a variety of sources was collected to investigate the effectiveness of this approach as it is conducted in the field. The approach was introduced at one GP practice and data were collected over a six-month period. Quantitative and qualitative data were collected including DASS scores, GP and patient reports, and pharmacological information. Results were similar to results from the first study. The approach was regarded favourably by GPs and patients and was generally effective in reducing depression, anxiety, and stress scores. Antidepressant prescriptions showed a slower rate of increase compared with the rate of increase across the region. This approach might be an effective way of promoting patient access to and involvement in service delivery as well as reducing waiting times. Also, development of this approach might assist in the improvement of patient responsibility and attitudes of self-care. The limitations as well as the implications of the study are discussed and directions for future development and evaluation are suggested.

The challenge of designing a cognitive behavioural focused group and engaging people who don't want to know!

Smith N St Andrews Hospital Fulton B St Andrews Hospital

An evaluation of a psycho-educational and exploratory programmewhich encourages disclosure, identification and mangement of psychosis. This programme has been designed to assist those people who are within the pre-contemplative and contemplative stages of change to increase thier motivation to find out more about their illness and the treatments that they can access.In secure settings it is widely acknowledged that many people who suffer with psychosis, who have been hospitalised for a number of years, have particular difficulty with high levels of negative symptoms. Thes may include lack of insight , motivation and loss of hope for the future. Combined these experiences over time often lead to increasing demoralisation (Fowler, Garety & Kuipers, 1995 and Johns et al , 2002).A consequence of increasing demoralisation, can be the presence of negative attitudes and beliefs about engagement in treatments offered which have been shown can help in alleviating negative symptoms (Heinssen, Liberman & Kopelowicz, 2000). These include individual cognitive behavioural therapy, relapse management and psychosocial treatment programmes. not applicable not applicable In this presentation we will outline:1) The factors & subsequent process that led to the design of the programme. These were:- identification of unmet needs within the patient population.- needs analysis-analysis of patient population characteristics.- evaluated current available programmes for suitability.2) The creative adaptations that were made to the content and delivery style in order to increase the likelihood of engagement and acceptability of the programme to this patient group.3) Adaptations that were made, which were designed to increase programme acceptability to patient population and maintain programme integrity.4) A summary of the content of the programme will be presented which was designed to increase participants' understanding of their experience of illness, current treatments available and to increase hopefulness.5) Presentation of encouraging findings will be discussed and further developments that have taken place as a result of this work.

Evaluating Innovative Applications of CBT

Chair: Ricardo Dalle Grave, MD, Department of Eating and Weight Disorder Villa Garda Hospital, Italy

A randomised controlled trial of cognitive behavioural therapy for perfectionism

Riley C Oxford University Department of Psychiatry Lee M Oxford University Department of Psychiatry Cooper Z Oxford University Department of Psychiatry Fairburn C Oxford University Department of Psychiatry Shafran R Oxford University Department of Psychiatry

Perfectionism can be either functional or dysfunctional (e.g. Hamachek, 1978). Dysfunctional perfectionism can be a debilitating problem in its own right that warrants treatment and there is some indication that such perfectionism can impede the treatment of co-existing Axis I disorders. Despite the clinical problems associated with dysfunctional perfectionism, there is little agreement as to the nature of this construct and a lack of clearly specified theory about its maintaining mechanisms. As a result, there has been little by way of direct treatment interventions. 'Clinical perfectionism' is a new, highly specified, cognitive-behavioural construct designed to capture the type of self-focused perfectionism that poses a clinical problem. This model has direct implications for treatment (Shafran et al., 2002). The current study reports on a preliminary randomised controlled trial of cognitive-behaviour therapy (CBT) for clinical perfectionism. Twenty participants with clinical perfectionism (as determined by a clinical psychologist familiar with the criteria) were randomly assigned to receive either immediate treatment (n=10) or a waitlist condition (n=10). After the initial eight-week delay, all those in the waiting list group who still had clinical perfectionism received the active intervention. Treatment consisted of ten sessions of CBT over eight weeks, targeted specifically at the individual's clinical perfectionism. This treatment was manualised, and the protocol consisted of four elements developed originally by Fairburn and colleagues (Fairburn et al., 2003). Research assessments were conducted blind to randomization at pre-treatment, post-treatment, and on two follow-up occasions (eight weeks and sixteen weeks after treatment). Participants in the waitlist condition had an extra assessment at the beginning of the waitlist period. Severity of clinical perfectionism was determined using the Clinical Perfectionism Examination (Riley, et al., in prep.) and the Clinical Perfectionism Questionnaire (Fairburn et al., in prep.). Participants also completed Frost et al.'s Multidimensional Perfectionism Scale, Hewitt and Flett's Multidimensional Perfectionism Scale, the BDI, the BAI, and the BSI and they were interviewed using the SCID. Two participants did not complete all follow-up assessments (10%).

Fifteen of the original 20 participants (75%) were clinically significantly improved after treatment and the effect size was large (1.8). Treatment gains were maintained at 8-week and 16-week follow-up. Ten participants met criteria for an anxiety disorder or major depressive episode immediately prior to treatment, reducing to four participants at 16-week follow up. This study provides preliminary evidence that a brief, cognitive-behavioural intervention is effective in reducing clinical perfectionism, and is superior to an allocation to an eight-week waitlist condition on measures of clinical perfectionism. The number of participants meeting diagnostic criteria for an anxiety disorder or major depressive episode halved after treatment, indicating that the intervention had a clinically significant impact on co-occurring psychopathology. This is the first randomized controlled trial, to our knowledge, to address perfectionism. The results are promising and further research using larger samples is warranted to establish the specificity of the intervention and its impact on a broad range of Axis I and II psychopathology.

A preliminary randomised controlled trial or a cognitive behavioural group intervention versus waitlist control for women with mayer-rokitansky-kuster-hauser syndrome

Heller-Boersma J G. The National Centre for Adolescent and Adult Women with Congenital Abnormalities of the Genital Tract, Queen Charlotte's & Chelsea Hospital & City University, London, UK Schmidt U Section of Eating Disorder Unit, Institute of Psychiatry, London, UK Edmonds K The National Centre for Adolescent and Adult Women with Congenital Abnormalities of the Genital Tract, Queen Charlotte's and Chelsea Hospital, London, UK

The Mayer-Rokitansky-Knster-Hauser Syndrome (MRKH) is a congenital abnormality of the female genital tract, manifesting in a non-formation of the vagina and the uterus, with normal ovaries. It is a common cause of primary amenorrhea, is typically diagnosed in mid- adolescence, and is just one example of a gynaecological condition that effects young women. Little is known about the psychological impact and management of this condition. We followed the Medical Research CouncilÆs Framework for Complex Interventions and developed a cognitive-behavioural model and group treatment of the impact of MRKH on these women, based on a systematic review of the literature on the psychological aspects of the disorder and clinical experience working with this client group. The aim of the present study was to carry out a preliminary test of the efficacy of this intervention compared to waiting-list control. 39 women with MRKH were randomized to the psychological intervention (N=19) or to waiting- list (N=20). Outcomes were assessed at post treatment (7 weeks) and 3 monthÆs follow-up. The main outcome measure was the Symptom Check-list (SCL-90-R) assessing psychological well-being. Other outcomes were self-esteem and interpersonal functioning. Participants who were allocated to the cognitive-behavioural group intervention had reduced psychological symptoms on the SCL-90-R and improved self-esteem and interpersonal functioning at end of treatment and at follow-up, whereas those on the waiting list remained unchanged. This study shows that a specific psychological intervention can ameliorate the psychological impact of MRKH. This model of treatment may also be applicable to women with other congenital or acquired gynaecological conditions impacting on their sense of self and femininity.

How can we improve outcomes for people with obesity? A combination of cognitive-behavioural, dietetic and physiotherapy interventions; the healthy living project

Cohen-Tovee E Newcastle, North Tyneside & Northumberland Mental Health Trust Geddes A Northumbria Healthcare Trust Gordon S Northumberland Care Trust Gray C Newcastle, North Tyneside & Northumberland Mental Health Trust Harrison L Newcastle, North Tyneside & Northumberland Mental Health Trust

Obesity is regarded as a chronic condition, requiring long term treatment (Rossner, 1995). While short-term successful weight loss may be achieved through a calorie restricted diet, behaviour modification and exercise, most people on these programmes regain the weight lost after treatment. Typically 95% of participants regain their weight within 5 years (Leibbrand & Fichter, 2002). The Healthy Living Projectö (HLP) was commissioned to provide a group intervention for adults with obesity & associated health risks (e.g. CHD, diabetes). The 12-week CBT-based group & follow-up sessions are provided by a clinical psychologist, dietitian and physiotherapist. The CBT component aims to maximise participants' motivation for change, introduces realistic goal setting, helps people to identify barriers to success and introduces strategies to help overcome negative thinking and improve low self-esteem. The group also addresses healthy eating, food groups and nutrition, portion sizes and food labelling, and safely increasing activity and exercise. HLP participantsÆ weight, height, blood pressure, waist circumference, self esteem (Rosenberg Self Esteem Scale), and depressed mood (Beck Depression Inventory) were measured at assessment, at the end of the group intervention, at 6 months, 1year and 2 year follow up. Sit-to stand, step-up and walking tests were also carried out pre and post-group. 93 participants have completed the HLP, 54 have provided 6 month follow-up data and 34 and 22 have

provided 1 year and 2 year follow-up data respectively. In order to investigate the factors associated with successful outcomes, semi-structured interviews were conducted with 7 participants. The interviews were analysed using a content analysis. Despite the focus of the group not being dietary restriction, 68% of participants had lost weight at post-group assessment; an average decrease of 1.4 kg was observed (n= 92, t=4.36, p<0.001) with 22% of participants losing between 3kg and 14kg. At six-month follow up 54% of participants had maintained a lower weight than pre-group, 50% had maintained this at two-year follow up. Decreases in waist circumference followed a similar pattern. Modest improvements in BP were found.Psychological measures revealed significant improvements in mood and self esteem both at post-group assessment and 6-month follow up sessions. At one-year follow up 70% of participants had sustained this mood improvement while 59% of participants still showed enhanced levels of self esteem.An average of 87% of participants showed an improvement in fitness levels at post-group assessment; e.g. the distance participants were able to walk in 5 minutes increased by an average of 67 metres (n=61, t=-6.43, p<0.001). Interviews with the 7 most successful participants (as measured at 2 year follow-up) indicated that attitudinal shifts, breaking the binge-diet cycle, practical behavioural strategies, advanced planning and support from the HLP Group / family were the most important factors in sustaining lifestyle changes. The combination of CBT with dietetic advice and increasing exercise, provided in a supportive group format, and with longer-term follow up, is a promising approach to improving outcomes in obesity.

Effectiveness and efficiency in a stepped care primary care service: comparing CBT and person centred counselling

White J STEPS Henry Sarah STEPS Gilroy D Edinburgh University

STEPS is a primary care mental health team working in a socially deprived area of Glasgow. We have, in our first year, established a radical stepped-care approach to the common mental health problems (CMHPs) ranging from individual therapy to population level approaches. The team comprises 4 CBT therapists (clinical psychologists and OTs), 2-3 assistant psychologists and 5 person centred counsellors. This talk centres on the individual therapy component of the service and compares CBT and counselling in terms of effectiveness and efficiency and looks at some of the challenges in routine evaluation in NHS settings. Using CORE and WSAS, we looked at clinical outcome of short term interventions. We looked at referral patterns to the two parts of the service, along with waiting times, opt-in, first appointment DNA and subsequent drop-out rates. We will discuss referrers perceptions of both CBT and PCT. We compared outcomes with other primary care studies and with other sections of our stepped-care service, e.g. the Stress Control evening class and the Advice Clinic. In general terms, results for individual therapy are disappointing but in line with many NHS outcome studies of common mental health problems. There appear to be some clear differences between CBT and PCT. The effects of social deprivation on both effectiveness and efficiency are clear We conclude that perhaps the main weakness in stepped care models is at the individual therapy level and not at the less intense intervention levels. We conclude that the idea of 'stepping up' to individual therapy, is ill founded and may help maintain a service model that has rarely served service users well. We conclude by looking at what combination of skills are necessary to ensure stepped care approaches function at optimal levels and how well placed CBT and PCT are to meet these needs.

Co-therapist role in therapy of panic disorder

Zepinic V, The Psychology Clinic, New South Wales, Australia

Panic disorder as an individual experience is an extreme form of anxiety or ‘terror’ that tends to occur in a life-threatening situation, especially when it is unclear whether awareness of any escape is available. The described concept of panic disorder in DSM-IV shows recognition of cognitive, psychological, and behavioural dimensions. As fear is a leading problem in panic disorder, clinical experience found that systematic exposure to frightening stimuli reduces pathological fear markedly. The exposure in vivo became a central ingredient in the treatment. However, the patients quite often are unable to do exposure without support. Subjects: The study was conducted with 26 outpatients diagnosed with panic disorder divided into two groups: 13 patients who had been treated without involvement of a co-therapist (control group), and 13 patients had been treated with a help of co-therapist (experimental group). Assessment: All patients were screened with the following instruments: BAI, DAQ, HPI, and BDI. Each treatment started with the pre-treatment session when the therapist and patient made acquaintance, the Daily Panic Record form was introduced, and co-therapist was instructed. All patients that participated in this study were re-assessed after three and six months of treatment. Co-therapist: Was chosen by a patient presumably that he/she is a person trusted and encouraging to the patient. Every co-therapist received brief instructions how they can help and what should do if the patient avoids the recommended exposition. The key co-therapist role was to reduce patient’s avoidance and rationalize the therapy. Results: Test results after three and six months of treatment confirmed significantly better progress in resolving panic disorder with patients who did treatment with co-therapist. The test results supported our hypothesis that in treating panic disorder

using a help from co-therapist the patients could achieved benefits in two areas: (1) they could tolerate exposure to the phobic target situations or object in more confident manner, and (2) they have complete control over the amount of time during which they exposed themselves to the dreaded targets.

Posters

CBT Training, Delivery and Acceptability

Power and Therapy: Does it matter?

Cole M, The Retreat, York

Introduction: The therapeutic working alliance is the cornerstone of effective therapy regardless of pan theoretical orientation. With this quantitative research project I have examined the therapeutic working alliance using the Working Alliance Inventory (WAI) questionnaires to ascertain if the therapeutic alliance is adversely affected by military rank differences between therapist and client within the Royal Navy working environment. The working alliance is a pan theoretical construct proposed by Bordin, which focuses upon the bond, task and goals in relation to client/therapist interactions. The WAI questionnaire scores were compared against the military rank of the therapist and client to ascertain if a relationship exists. Testing the hypothesis that military rank differences have a potential negative impact on the working alliance, and that this may be related to structural power. I then critically examined and discussed the data produced from the research process from my research indicated that there is a possible correlation between rank and therapeutic alliance and that this could have a negative impact on the therapeutic alliance and this is potentially proportional to the rank difference between the mental health nurse and client. However their was insufficient data to be certain. Method: Quantitive Research. Results: research indicated that there is a possible correlation between rank and therapeutic alliance and that this could have a negative impact on the therapeutic alliance and this is potentially proportional to the rank difference between the mental health nurse and client. However their was insufficient data to be certain. Conclusion: The therapuetic allience can be affected by many variables, structural power imbalances appear to be one of them, especially within the military enviroment. The nature of the organistion reinforces this power imbalance with a 'them' and 'us' attitude plus the use of overt symbols of power.

A Report on SPIRIT (Structured Psychosocial Interventions in Teams): Training Practitioners in the Use of Self-help Workshops to Treat Common Mental Health Problems

Crawford G and McVicar S, NHS Greater Glasgow and Williams C, University of Glasgow

Introduction: The SPIRIT course uses a jargon-free CBT model to deliver skills-based training in core psychosocial interventions, supported by written self-help materials (Williams, 2001). The course has been continually evaluated, indicating that trainee knowledge and clinical skills, measured subjectively and objectively, has increased across all of the topics covered in training (Williams, McAlindon, Ronald and Harrow, 2005). It has recently been suggested that para-professionals are more able to deliver CBT self-help than qualified mental health staff. This study examines some of the attitudinal impacts of professional group, time qualified and previous CBT training on self-rated perception recommendation and use of CBT self-help materials. Method: To date, 401 practitioners have been trained within Greater Glasgow Primary Care Division. Training is delivered by eight members of the Trust. The course consists of 8 main workshops each lasting 3.5 hours. In addition 6 hours of clinical supervision are provided. The content is based on the ten CBT self-help workbooks contained in the manual Overcoming Depression: A Five Areas Approach (Williams, 2001). Questionnaires are distributed at pre, post and follow-up intervals of the course. The questionnaires measure knowledge and skills gains of trainees, their use of the CBT self-help approach and the acceptability of training. Results: Training was completed by the following professionals - nursing (278), medicine (36), social work (20), pharmacy (1), occupational therapy (47), physiotherapy (1) and clinical psychology (10). Analysis using mixed between-within subjects ANOVA showed that significant differences between professional groups exist according to self-rated ability to use self-help with patients. Practitioners levels of expertise in using CBT, knowledge of key components of CBT and individuals ability to identify clear targets for intervention, at pre and post stages of the training varied between groups. All professional groups gained significantly from the training in these areas. Overall 94.8% of trainees would recommend training to other teams. Independent-samples t-test showed it was those who fell into the category ‘qualified five years or over’ were significantly less likely to recommend the training, and those who had previous CBT training found the course significantly more useful than those who hadn’t had any formal training. Conclusion: Differences between professional groups require more exploration however it is interesting to note the level of engagement and learning from occupational therapy. Prior training in CBT had an impact on recommendation of the course. Similarly, the seniority of the practitioner predicted the likelihood of recommending the course

Challenges and Issues Related to Providing CBT Training in Multi/diverse Professions

Foran K, Armstrong P Newcastle Cognitive and Behavioural Therapies Centre and Freeston M, Newcastle Cognitive and Behavioural Therapies Centre; University of Durham

Introduction: The Newcastle centre has been at the forefront of CBT training for over a decade. The Postgraduate Diploma in Cognitive Therapy is a highly regarded multi-disciplinary course has been one of the 'flagships' of CBT training in the British Isles since its inception in the early 1990s. Validated by the University of Durham, the course provides both academic and clinical challenges to trainees, and prides itself on also providing the support required to ensure their successful completion. The centre offers training from an ever-widening range of backgrounds and of all levels of experience. This diversity in professional backgrounds posses a number of challenges and issues for the training provided on this course. The aim of this paper was to look at the diversity of professional backgrounds that have attended the course and their areas of clinical interest, as expressed by their dissertation topics. Methods: The professional backgrounds of trainees from the Postgraduate Diploma in Cognitive Therapy course were investigated. Trainee's profession, work setting (including groups they work with) and area of clinical interest (as expressed by their dissertation topic) were compiled from routine data held by the course. Results: Trainee's professions were divided into 29 professional areas. Settings in which they work were also broken down into 19 different areas, which were further broken down by groups they normally work with. Dissertations addressing similar topics were complied together, which resulted in 14 separate areas. Dissertation topic compared by profession and settings were then examined. The results show that while a significant number continue to come from the main mental health professions and work in traditional mental health care services, increasing numbers are working in primary care, education, general hospital settings, palliative care, and the prison service. The areas of clinical interest are equally diverse and in a proportion of cases represent groundbreaking applications of CBT to new populations and settings. Conclusions: Due to the number of different professions that have been attending the course over the past number of years and the various areas of clinical interests, certain challenges and issues need to be addressed. Some of these challenges/issues concern; the wide range of previous experiences of CBT specifically and the psychotherapies in general, the fact that the different educational cultures/learning styles of the diverse professions can led to different responses to the 'house' style of teaching, and that different clinical cultures across professions tend to drive different goals from their CBT training

CBT Based Self-help Clinic in a Primary Care Setting: Who Benefits? Preliminary Findings of a Six Month Pilot Study

Kearley K, University of Oxford, Jericho Health Centre Martinelli, M and Croft A Oxfordshire Mental Healthcare NHS Trust

Introduction: The Department of Health has pointed out that users of mental health services consistently prioritise greater access to psychological therapies but, although some psychological services are available in primary care, the demand exceeds supply and it is drugs which have been the mainstay of treatment (Hollinghurst, et al. 2005). This report describes the preliminary findings of a self-help clinic based on an approach described by Karina Lovell (2003), which was set up by a GP at an Oxford practice to overcome the lengthy waiting list for psychological services. It was run by an accredited psychologist and CBT therapist who provided assisted self-help CBT to a wide range of patients, through brief 30-minute initial assessment appointments followed by 15-minute follow up sessions. This poster presents an evaluation of the initial six months of running of the clinic both in terms of patient outcomes and acceptability to the GPs and therapist. Method: Patients were referred to the clinic by their GP or practice nurse by asking them to book an appointment at their convenience. The clinic was run every Monday from 2pm to 6pm. Patients were invited to attend 10 minutes before their initial assessment appointment to complete a set of questionnaires; all participants completed the Beck's Depression Inventory, Beck's Anxiety Inventory and CORE. Participants were contacted by post three months after initial assessment and asked to complete follow up measures and a satisfaction questionnaire. GPs satisfaction with the service was evaluated by self-administered questionnaire six months after the project was started. Results: 54 patients were seen at the advice clinic during the 6 month period. Follow up measures are currently being analysed and will be available by July 2006. Initial results suggest that participants were generally satisfied with the clinic and found the approach helpful. Initial outcome measures for those patients who had guided self-help show large and statistically significant gains in their mental health, consistent with the results from two previous similar pilots run elsewhere in the UK (Lovell, et al., 2003; Cowan & Westbrook, 2004). There were also benefits associated with the new approach for both the therapist and GPs, which included a reduction in prescribing of psychotropic medication. Conclusion: Based on the initial data, the self-help clinic seems to offer an effective and economical way of helping people with common mental health problems in primary care which, in addition, has benefits for the practitioners involved. The implications of this finding and suggestions for further research are discussed.

A Systematic Review of Self-help for Anxiety

Mayo-Wilson E, and Montgomery P, University of Oxford

Introduction: Despite their prevalence and severity, few people with anxiety disorders ever obtain treatment. Inexpensive, effective, and widely-available interventions are needed to meet this unmet clinical need. Computer programs, videotapes, books, and other forms of self-help are widely available. There is some evidence that some of these interventions may be effective, but results have been inconsistent and inconclusive. This systematic review investigated the efficacy of media-delivered therapy alone for anxiety with no more than an hour of contact with a therapist, doctor, paraprofessional, or experimenter. Methods: A systematic review was conducted within the Cochrane Collaboration. All randomised controlled trials (RCTs) of media-delivered cognitive behavioural therapy (CBT) and behavioural therapy (BT) for adults with an anxiety disorder (other than PTSD and acute stress disorder) compared to another intervention or a no-treatment control and analysed using intention-to-treat analysis were eligible. Results: Only two studies met the inclusion criteria and only outcomes measured immediately post-treatment could be included in the review. These suggest that therapist-delivered treatment is more efficacious than booklet-delivered therapy for spider phobia in the short-term. No analyses of other delivery packages were possible. No analyses of long-term harms and benefits were possible. No known studies of social phobia, agoraphobia, panic disorder, OCD, or GAD met the inclusion criteria for the review. The negative effects in this review contrast previous meta-analyses, which reported positive effect sizes of 1.1 (self-help for fear reduction) (Gould 1993a), .91 (bibliotherapy for anxiety) (Marrs 1995), and .86 (self-administered treatment for phobias compared to therapist-administered controls) (Scogin 1990). Conclusions: Few media-delivered therapies have been properly tested without the addition of drugs or significant professional contact and this review did not address the efficacy of media-delivered therapy as part of a treatment programme. To date, researchers have tested combinations of media-delivered therapy, therapist-delivered treatment, drug therapy, and support services. More research concerning the effectiveness of media-delivered therapy alone'as it is used when purchase when purchased by consumers' is required to determine if media-delivered therapy works in isolation and how it compares to other therapies for anxiety. Media-delivered therapy is a promising tool for combating anxiety; vast unmet clinical need and the costs of mental health care (including the costs of not treating people with anxiety) demand that inexpensive and widely available interventions receive further attention. Included studies provide no evidence to support the use of media-delivered CBT and BT alone for anxiety, but studies that were excluded for a variety reasons suggest that it might have some benefits. In general, the authors of excluded studies examining media-delivered therapy in conjunction with other services argue that media-delivered therapy is more efficacious than no-treatment for anxiety disorders. Minimal clinician contact may be important in achieving positive outcomes. Media-delivered therapies are not all the same. Until a better system has been developed to help users identify evidence-based materials, the reviewers suggest that potential users consult practitioners for advice about the use of media-delivered therapy

Service User Satisfaction with CBT for Psychosis

Miles P, Peters E, Kuipers E Institute of Psychiatry, Kings College London and South London & Maudsley NHS Trust

Introduction: Research has now accumulated demonstrating the efficacy of Cognitive Behavioural Therapy (CBT) for psychosis (Zimmermann et al, 2005), culminating in the UK 2003 National Institute of Clinical Excellence: NICE guidelines recommending the wide-spread availability of CBT. Initial evaluations of service user satisfaction with CBT for psychosis appear favourable (e.g. Kuipers et al, 1997) although the factors underlying service user satisfaction remain unclear. This study examines service users' satisfaction with CBT for psychosis, in a NHS national specialist service; Psychological Intervention Clinical for oUpatients with Psychosis (PICuP) based at the Maudsley Hospital, South London & Maudsley NHS Trust. Methods: Service user satisfaction with CBT for psychosis was examined with the Satisfaction with Therapy Questionnaire (STQ; Beck et al, 1993). Of the 107 service users who completed therapy, 65 (61%) service users completed the STQ at the end of therapy and 40 (37%) at follow-up. Individual items were grouped to form five areas for further analysis: 'expectations of and perception of actual progress in therapy', 'belief in the extent to which they gained CBT skills and knowledge', 'beliefs about the usefulness of homework(s)', 'ratings of therapist attributes', and 'overall satisfaction with therapy'. Results: The majority of service users were satisfied with CBT for psychosis. At the end of therapy 77% were satisfied or very satisfied, rising to 80% by 3-months follow-up. The highest ratings were for therapist attributes, the lowest for CBT skills and knowledge. There were no significant differences in satisfaction by any service user demographics (e.g. age, sex, ethnicity) or service context issues (e.g. referral location; local NHS trust or national, waiting list or not, research trial or regular service). There was also no significant decrease in satisfaction from the end of therapy to 3-months follow-up. Binomial logistic regression analyses were performed to identify which areas

predicted service users' overall satisfaction with therapy. At the end of therapy (n=52) the logistic regression equation was significantly different from zero [X2(1)=15.024, p<0.001], and accounted for 54% of the variance. However, the only significant predictor of overall satisfaction was the 'belief in the extent to which they gained CBT skills and knowledge' [Wald(1)=6.186, b=0.580, p=0.013]. At 3-months follow-up (n=34) the logistic regression equation was significantly different from zero [X2(1)=5.457, p=0.019], and accounted for 41% of the variance. However, the only near significant predictor of overall satisfaction was the 'beliefs about the usefulness of homework(s)' [Wald(1)=3.670, b=2.760, p=0.055]. Conclusions: There are some limitations to the study, in that it is based on self-report, has a small possibly self-selecting sample and the results are based on a national specialist service, which may limit the generalisability of the findings somewhat. Nevertheless, these results suggest that (i) CBT for psychosis is an acceptable intervention to service users, regardless of their demographic characteristics or service context issues; (ii) the specific aspects of CBT, not the non-specific attributes of therapy, predict overall satisfaction and (iii) that homework setting may be important in ensuring ongoing satisfaction post-therapy.

Possible Causes of Early Termination of Cognitive Behaviour Interventions in Treating Depression

Salmoiraghi A, University of Liverpool

Introduction: The evidence of the efficacy of cognitive-behavioural interventions for depression is wide and well established. The efficacy and effectiveness of CBT is supported by numerous meta-analysis and literature reviews. Recent guidelines released by the National Institute for Clinical Excellence of the United Kingdom suggest that the combination of cognitive-behavioural interventions and pharmaco-therapy may be a particularly effective treatment for more severe cases and in chronic and refractory depression. Despite this, many clinicians often face a consistent number of cancelled and not attended appointments, or dropout rate after only few sessions, without a consolidation of the results.This paper speculates on the possible causes of early termination of cognitive-behavioural interventions for the treatment of depression. Methods: Literature concerning the topic has been reviewed. The literature search was electronically conducted using Medline, Psychlit and Embase. Results: Amongst the reasons mentioned are the stigmata of mental illness or attending psychiatric services, the difficulties of changing from the sick-role, the costs in terms of time and money, the psychological impact of self-esteem and Negative Automatic Thoughts, and the different rates of improvement of the patients. The author concludes that during the initial phase of the assessment the clinicians should consider other alternatives to CBT, such as the use of self-help materials, behavioural therapy, Interpersonal Therapy or counselling, in view to tailor the interventions to the individual's needs.

A Pilot Evaluation of CBT Formulation Workshops for Mental Health Teams

Schuller S, Oxford Doctoral Course in Clinical Psychology

Introduction: Multidisciplinary mental health teams frequently lack a shared perspective for conceptualising patient difficulties and for planning care (BPS/DCP, 2000). The present pilot study explores the possibility of teaching entire teams basic CBT formulation skills in relation to people with psychosis. The study also aimed to replicate studies suggesting that descriptive formulation elements are more reliably and validly formulated than inferential ones, and to investigate staff ability to formulate symptom maintenance cycles. Methods: Benchmark formulations were obtained from two Clinical Psychologists working in a UK Early Intervention team, based on two videotaped simulated assessment interviews with clients with recent onset psychosis. One-day workshops were run with 5 teams (3 CMHTs, 2 inpatient) comprising 33 qualified staff in total. Thirty participants (91%) had previously undergone less than 5 days of CBT training. During the workshop one case was formulated jointly and later participants formulated the second case by themselves, using a semi-structured response format. Background vulnerability factors ('Why me?') and proximal episode triggers ('Why now'?) were elicited using an open ended response format. Overt problems were elicited with a modified CANSAS scale and underlying belief ratings, with a modified Young belief taxonomy Symptom maintenance cycles were elicited in a diagrammatic fashion in relation to two problem scenarios depicted in the videos. Results: Both benchmark raters and workshop participants formulated long-standing vulnerability factors more reliably than proximal life events. Overt problem ratings correlated highly within teams and with external raters. Twenty-one staff (63%) returned underlying belief ratings that correlated significantly with both benchmark ratings. In addition, 21 staff (63%) formulated at least one 'good enough' symptom maintenance cycle, using adapted Kuyken et al. (2005) criteria. Thirty (91%) participants stated they would definitely seek further CBT training. Conclusions: Encouraging levels of formulation skill were identified in a highly structured context. However, considerable training, ongoing supervision as well as organisational and ideological changes will be required before presence of skill can translate into situated, collaborative and reflective use of skill in routine practice. Participants overwhelmingly endorsed a psychosocial view of psychosis in a self report measure, yet they formulated longer-standing / dispositional attributions for client presentations more reliably than situational ones, replicating Persons et al's (1995; p.29) findings. Staff training implications are discussed. The absence of baseline data on participants' pre-workshop CBT formulation ability limits the conclusions that can be drawn regarding the

incremental benefit of the workshops. The chief immediate value of whole-team workshops may lie in motivating previously hard-to-reach staff (e.g. mid-career nurses) to seek further CBT training.

The Challenge of a Psychological Therapies Service in an Acute Inpatient Setting

Wilson H and Clarke I, Hampshire Partnership NHS Trust

Introduction: The poster describes the provision of general psychological therapies services for a new acute psychiatric inpatient unit. The aim of this service is to combine brief CBT individual client work with input to the psychological thinking of the team, in the form of consultation, supervision, reflective practice and a DBT service. The pilot evaluation of the brief form of CBT, especially devised to meet the challenges of the in-patient setting is presented. The intervention is informed by the ICS split between the emotional and logical systems, as described in Clarke (1999). This approach gives prominence to management of arousal, mindfulness and techniques of meeting, expressing and letting go of emotion as opposed to the previous avoidance, thus drawing on Linehan's (1993) DBT approach and Emotion Focused Therapy (Greenberg 2002). The audit was designed to accommodate the particular conditions of inpatient admission, where measurement of symptom change was not useful for e! valuation because of concurrent interventions (medication etc.) and was designed to measure the specific aims of the intervention, namely increase in self efficacy, taking responsibility for symptoms and management of emotion. Methods: The intervention comprised: simple formulation, management of arousal, emotional coping techniques and discussion of general lifestyle management. Number of therapy intervention sessions ranged from 1 to 6. Data is presented on 14 clients. Pre and post therapy measurement concentrated on self efficacy and management of emotions, and goal achievement. Measures employed were: CORE (1988), The Mental Health Confidence Scale (Carpinello, Knight, Markowitz & Pease, 2000), Locus of Control of Behaviour Scale, (Craig, Franklin & Andrews, 1984), A specially devised scale for measuring emotional coping, An individual goal setting measure. Results: Differences in the pre and post therapy scores suggest that service users felt: more able to cope with emotions after intervention, had a greater internal sense of control, felt more confident in dealing with their emotions as well as more confident in employing strategies to deal with strong emotions. Conclusions: The evaluation data on a small number of cases suggests the effectiveness of the approach, the usefulness of the specially devised scale, and the need for wider testing of the model. Psychological services can contribute to developing a therapeutic milieu in an in-patient acute setting in a number of ways: staff support and training, reflective practice, on-going supervision, group and individual therapy.

CBT Innovations

Implementing Cognitive Behavioural Therapy in Vocational Rehabilitation with the Severely Mentally Ill

Binnie J, South London & Maudsley NHS Trust, Kings College London

Introduction: Individuals with a severe mental illness (SMI) have unemployment rates of 85% or higher (Rutman, 1994). Marrone and Golowka state that 'If people with psychiatric rehabilitation can work then &. people with mental illness should work' (1999, p.187). No clinical research studies have found the ill effects of employment on the mental health of people with SMI (Marrone and Golowka, 1999). How can clients find paid work and increase their time in employment? It is suggested here that cognitive behavioural therapy (CBT) is a possible benefit to clients with SMI. This project seeks to develop a new CBT treatment protocol to help clients with SMI utilise a local supported employment initiative (supported employment was preferable due to the Crowther, Marshall, Bond and Huxley (2005) systematic review findings). Case study methodology will be used with interventions and outcomes discussed. Finally, service design considerations and future developments will be presented. Methods: An extensive literature review has been undertaken to help create a CBT treatment guideline for working with the client group. A local supported employment project (Status Employment) has been approached and appropriate clients have been offered the treatment programme. Measures have been taken pre CBT sessions and will be taken again post sessions. Completed case studies will then be presented. Results: The literature review revealed that there has been only one study incorporating CBT into supported employment with clients with SMI (Davis, Lysaker, Lancaster, Bryson and Bell, 2005). Related studies were found that developed CBT interventions in pre-vocational training with SMI clients (Rose and Perz, 2005). Less recent studies have shown the benefit of CBT with the unemployed (no SMI) (Proudfoot, Guest, Carson, Dunn and Gray, 1997). Following the literature closely, CBT interventions were developed into a treatment manual to be implemented with clients from Status Employment. To date (07/03/06), clients have been identified, approached and treatment has started. Interventions will be complete by the end of May. The outcomes of the interventions will be discussed, with areas of further research highlighted. In addition, a service development plan will be recommended

Group Behavioural Activation for Depression

Curran J Houghton S and Saxon D, Sheffield Care Trust

Introduction: Behavioural Activation is a contextual approach to depression that focusses on helping clients make changes in their environment in order to reintroduce more positively reinforcing events and to reduce the frequency of negatively reinforced behaviours that are associated with maintenance of depression. Behavioural Activation has demonstrated equivalent outcomes to cognitive therapy packages (e.g. Jacobson et al 1996), and may exert its effect through different mechanisms. Recently, detailed therapist materials that elaborate the philosophical background and practical application of the approach (Martell, Addis, Jacobson 2001) and self-help materials (Martell & Addis 2004) that give clients the opportunity to work through the materials in a structured way have been developed. Th! is poster reports a practice-based development that utilises a treatment group format combined with some of the published self-help material for clients with self-reported depression. Method: Following assessment, participants with self-reported problems of depression/ persistent low mood were offered a place in the group. Treatment was delivered in a group format, meeting for one-and-a-half hours for 10-12 weeks. Sessions were structured around the content of the Martell et al. (2004) workbook and typically involved homework review, incorporating paired and whole group discussion, followed by a presentation of the new material to be covered and some time spent discussing it's practical implications and an opportunity for practice. Homework generally involved reading specific material from the workbooks and completing some or all of the exercises therein. Based on work evolving in other contextual psychotherapies additional sessions on values and acceptance were added t! o the programe at the planning stage. Results: Data will be presented on the pre- and post treatment measures on the Beck Depression Inventory and the CORE-OM for up to three groups, involving up to 30 clients. At the time of writing two groups have been completed (n = 19), with broadly positive results in terms of client feedback, client engagement and self-reported symptoms, although as symptom reduction in and of itself is not one of the primary goals of Behavioural Activation we are cautious over expressing that as an indicator of success. Conclusion: The potential strengths of the project, in terms of delivery, its potential applicability in primary and secondary health care settings, the relative ease of implementation, and some of its methodological limitations in the areas of assessment, selection, process and outcome will be examined and explored. The potential implications for practice, research and training will also be outlined.

The Use of Danger Ideation Reduction Therapy (DIRT) in Severe, Chronic, Resistant Obsessive Compulsive Disorder

Drummond L, St George's, University of London Kolb, P and Turner J SW London and St George's Mental Health NHS Trust

Introduction: DIRT has been researched in Australia. However, there have been limited trials in other countries. Indeed, a recent publication recorded the first reported case of DIRT used to treat OCD outside Australia (Govender, Drummond and Menzies, Behavioural and Cognitive Psychotherapy, in press). The Behavioural Cognitive Psychotherapy Unit (BCPU) based in SW London is the only fully staffed NHS facility for inpatient treatment of severe, chronic, resistant OCD. We decided to investigate the use of DIRT with these severely disabled individuals. Methods: The study is a randomised controlled trial of DIRT and traditional graded exposure with self-imposed response prevention (E+rp). All patients with severe OCD and contamination fears who are admitted to the BCPU are asked to join the study. People who agree to participate are randomly assigned to either DIRT or E+rp. A blind rater assesses them pre-treatment, at 3 months, 6 months and in follow-up. The instruments used include the Yale-Brown rating scale (YBOCS); Padua Inventory and Beck Depression Inventory. At 3 months, if the participant has not improved by at least 25% from admission ratings of OCD, they are changed onto the alternative treatment. Results: This study is still in the early stages and the data have not been fully analysed. However, a number of interesting and unusual case vignettes will be presented on the poster which demonstrate the use and versatility of DIRT for these most severely ill patients. Conclusions: The presentation will discuss the use of DIRT as a possible adjunct to traditional therapies in the most severely handicapped OCD patients

A Naturalistic Study of Specialised Inpatient Treatment for Severe, Chronic, Resistant Obsessive Compulsive Disorder (ODC).

Drummond L, Kolb P, Pillay A, Shashi R St George's, University of London

Introduction: The NICE guidelines for OCD (www.nice.org.uk) proposed a 6 stage model for OCD with level 6 representing the most severely ill patients. The guidelines suggest that these patients should receive specialised treatment including inpatient treatment in dedicated units for the most severly ill people. There have been previous studies examining inpatient treatment of this group (Drummond, 1993) but papers such as these were before the development of newer refinements in the management

of OCD. Methods: All patients with a diagnosis of OCD was included in the study. A number of instuments were applied to examine severity of OCD and depressive symptoms. These were repeated at discharge. These data along with demographic and information about previous treatment were analysed. Results: All patients had received at least one trial of a serotonin reupttake inhibiting drug in recommended doses and amny patients had received several drugs including augmentation therapy. All patients had recieved at least one course of treatment wiusing CBT from an accredited therapist. The patients had a high level of comorbidity with some patients also being diagnosed as suffering from schizophrenia; eating disorders as well as depression. The patients scored an average of 29 (severe OCD) on the Yale-Brown Obsessive Scale. 5 patients dropped out before any therapy was started. Of those who remained, all except 2 patients received treatment including graded exposure and self-imposed response prevention. The other 2 patients received danger ideation reduction therapy alone. Overall the obsessive-compulsive symptoms reduced by 56% on the Padua Inventory and the depression reduced by 70% on the Beck Depression Inventory. Conclusions: This study demonstrates that even the most severely ill patients can show clinically relevant improvements following treatment in a specialist inpatient unit. The number of patient that require such a facility is inevitably small but it appears important that such facilities are kept available on a national basis

Group CBT for Heterogeneous Anxiety Disorders

Erickson D, Janeck A, Tallman K Royal Columbian Hospital, , British Columbia, Canada

Introduction: CBT protocols for each of the anxiety disorders are robust and effective, but are best-suited for specialty clinics. In this study, we explore a format more suitable for general clinics: a single protocol, based on standard CBT techniques, designed to treat patients with different anxiety disorders in the same group. Method: Using a randomized, wait-list control design, in the context of an 'effectiveness' paradigm, we offered a novel 11-week Mixed Anxiety Group protocol to 152 patients with any of the six major anxiety disorders. The protocol included standard cognitive and behavioural components common to many CBT strategies, as well as diagnosis-specific techniques implemented with subsets of our patients. Results: The results indicate that participants in the immediate-treatment groups reported greater reductions in BAI scores, compared to those who were waiting for treatment. Patients with Panic Disorder in particular appeared to benefit. The reductions in BAI scores continued to be present six months later. Overall, the effect size was modest (Cohen's d = 0.50), compared to those usually seen with diagnosis-specific CBT protocols. Conclusions: The diagnosis-specific nature of CBT for anxiety is a considerable limitation, at least in Canada, for the dissemination and broad use of these robust treatment techniques. This study shows that significant, modest improvements in anxiety can be achieved when patients with various anxiety diagnoses are treated in the same group. That the effect size was less than anticipated may reflect the use of the effectiveness paradigm, e.g. overly broad inclusion criteria, and a treatment protocol that was too complex. A refinement in the protocol, and narrowing of the inclusion criteria, may increase the effect size. If a larger effect can be demonstrated, then the mixed anxiety group strategy may make good treatment more widely available.

Holistic Approach to Bipolar Affective Disorder: Using CBT to Achieve This!

Schultewolter K D, North Warwickshire Primary Care Trust

Introduction: Bipolar affective disorder is one of the most limiting psychiatric conditions and ranks at number six of the WHO list of disabling diseases. It is widely acknowledged by now that at the core of the treatment the biological element has to be tackled. However without using essential complimentary therapy in form of CBT the overall management seems to be ignoring that an estimated 50% of sufferer of Bipolar affective disorder continue to experience some psychopathology and don't achieve full functional recovery. It therefore seems to be necessary to not only compliment but truly complete the management of Bipolar Affective Disorder with the use of CBT in order to achieve full symptom relief and regain premorbid level of functioning. Method: This is a review of psychiatric clinical cases. Adult female and male patients with an established diagnosis after ICD-10 (International classification of Disorders, 10th version) who presented for treatment to the General Adult Psychiatric services received recommended and recognised treatment for Bipolar affective disorder in form of psychotropic medication. They further received input in form of CBT by an accredited and experienced C.B. Psychotherapist. The number of sessions was tailored to individual response and averaged around six sessions. The main target for CBT was achieving "ownership" for this possible "enduring mental illness". Whilst a fair bit of effort was put into behavioural modification (so-called life style adjustment) an equally significant effort was put into psychoeducation, which was illustrated by using techniques of "mindfulness". The process of improvement, rehabiliation and final remission was measured by assessing mental state and functional level compared to premorbid level. The CBT intervention was compared to the same outcome measures for the same patient's when they were treated in the past without CBT. Results: The results from these clinical cases are promising since the input of a relatively low number of CBT sessions as a complimentary treatment tool brought about quite significant progress in terms of improvement of psychopathology to full remission, regaining premorbid level of functioning and subjective quality of life experience. Conclusion: With regards to patients who suffer from classical

bipolar affective disorder the use of CBT as a complimentary form of treatment in order to achieve ownership for the illness has proven to be effective in clinical psychiatric practice. The improvement was measured by assessing mental state, functional recovery and subjective quality of life. The introduction of a control group, which is treated concomitantly without CBT can offer additional insight as opposed to comparing it with the patient's own treatment in the past without CBT. Obviously different confounders would be found in that case. The psychotropic medication complimenting use of CBT in psychiatric practice though can still be a practical problem, which can only be overcome if CBT by an experienced therapist is available! at the time of it being necessary. With the long waiting list for psychotherapy within the NHS this might currently be difficult to achieve. Although the understanding of CBT and the use of it in psychiatry is more promoted now than it had been much more active promotion and training within psychiatry seems to be needed. Further operational changes within the service would have to take place to account for the usefulness of this intervention

Developing a Cognitive-behavioural Conceptual Model to Explain the Development of Post-traumatic Stress Disorder (PTSD).

Swinden D, Nottinghamshire Healthcare NHS Trust

Introduction: As part of the MSc Cognitive Behavioural Psychotherapy course at the University of Derby, students were required to work together as a group to develop their own unique cognitive behavioural model to explain the development of PTSD. Although several models exist, none fully address the requirements of a comprehensive model, as described by Dalgliesh: Dalgliesh (1999) proposes that an effective model of PTSD needs to address several preconditions: The three central constellations of symptoms according to DSM IV re-experiencing, avoidance, and hyperarousal; The range of individual reactions to trauma including delayed-onset PTSD, acute PTSD, chronic PTSD, and no obvious emotional consequences; Premorbid psychological history, effects of event variables, social support, attributional style, and attitudes to emotional expression; Efficacy of exposure-based treatments for PTSD; A coherent model of mind within which the above can be realised. Method: The group adopted a problem-solving approach, beginning with examination of definitions and diagnosis of PTSD. Individual group members were allocated specific literature review tasks, feedback was vigorously critiqued as a group, and solution focussed steps were taken to move the process on. Each stage of the developing model was represented diagrammatically and refined as new ideas were considered. Results: The group initially developed a linear model, but after critical review of multilevel theories as well as other models, they integrated the Vulnerability-Stress model of Nuechterlein and Dawson (1984) with Teasdale□s (1999) model of Interactive Cognitive Subsystems (ICS). In the group's model, the traumatic event is central and interacts with incoming information obtained from the combination of vulnerability and protective factors. This interaction of information then feeds into the processing component of the model – ICS. Conclusion: The model explains how traumatic information can be processed by ICS to produce PTSD symptoms. However, it also allows for alternative routes. If individuals have enough protective factors to counteract fears of horror, hopelessness and helplessness at the time of trauma, the emotional and cognitive information can be processed smoothly leading to immediate recovery. If the trauma is so intense that it overwhelms the protective factors temporarily, it may lead to system overload and Acute Stress Reaction (ASR) for up to four weeks prior to recovery. Interventions during ASR are one possibility for prevention of subsequent PTSD, and provide an indication for therapy. However, if ASR does not resolve, it results in acute PTSD, which can then lead to chronic PTSD. If, despite acute PTSD, an individual is able to function well (when a good social support system and other protective factors can play an important role), this can feed back into the ICS to improve further processing of information and thus resolve acute PTSD. However, if an individual has negative functioning (loss of job, no social support system), this will feed back into ICS, further inhibiting processing and therefore leading to chronic PTSD. The consequences of chronic PTSD (comorbidity, unemployment, loss of social support) then feedback into the whole model system, leading to increased vulnerability, decreased protective factors, and higher risk of further trauma. This group assignment is an example of problem-based learning, is a process that can be used by other students, and the model produced can be adapted to explain other disorders and indicate therapeutic approaches.

The Complexity of Treating PTSD Symptoms

Zepinic V, The Psychology Clinic, New South Wales, Australia

Introduction: PTSD is a psychiatric disorder consisting of physiological and psychological responses resulting from exposure to an event or events involving death, serious injury, or a threat to physical integrity. Clinical evaluation for PTSD requires assessment of symptoms within each of the following three symptoms clusters: re-experiencing, hyperarousal, and avoidance/numbing. Due to complexity it is quite often difficult to understand the pathophysiology of PTSD and to develop an effective treatment. This complexity extends over the entire range of PTSD abnormalities: the deregulation of many neurobiological systems, the distortion of the patient's appraisal process, the disruption or learning and memory, and alterations of both tonic and phasic mechanisms, and the difficulties caused by the neurobiological shift from homeostasis to allostasis. This is particularly caused by severity and duration of trauma exposition, developed trauma memories system, and time to start with a therapy. Torture is a severe and complex trauma and it is defined as the willful and deliberate infliction of pain and suffering

by person or persons for the purposes of obtaining some information coercing the will of the victim or for other purposes. Subjects: The study was conducted with 24 male patients who were diagnosed with PTSD and history of the torture. The most common reported method was psychological torture, but also different kind of physical torture (beating, phalange, cold-water shower, burnings with cigarettes, and food/water deprivation). Testing: All subjects were carefully screened using the SCID, MMPI, PDS, and clinical interview by specialist. Analysis: Multiple regression analysis was performed to examine the presence and severity of PTSD symptoms but also to assess the presence and symptoms of other psychiatric disorders. The two symptoms that occur more frequently with the victims of the torture: intrusive memories and avoiding thoughts of torture. Reluctance to talk and express feelings, presence of the negative emotions and fear, sadness, and posttraumatic growth could implicate the development of treatment resistant condition

Behavioural Medicine

Keynote Address

'I Will Not Change My Old Mumpsimus For Your New Sumpsimus': Treatment of Medically Unexplained Symptoms

Professor Trudie Chalder
Cognitive Behavioural Psychotherapy Department of Psychological Medicine, King's College London

Unexplained physical symptoms without identifiable organic pathology are referred to by a variety of labels: irritable bowel syndrome, chronic fatigue syndrome and fibromyalgia to name but a few. Everyone experiences physical symptoms, unrelated to specific aetiology from time to time. However, when the symptoms become the focus of an individuals attention the severity of the symptom often increases and varying degrees of disability results. The aims of this lecture are a) to address some of the controversies surrounding somatic symptoms and their classification. For example, the utility of the somatoform disorder classification will be addressed and the issue as to whether the functional syndromes are one entity or many will be discussed b) to describe a generic cognitive behavioural model of understanding the psycho-physiology of somatic symptoms c) to describe cognitive and behavioural interventions which can be adapted to the needs of the individual d) to describe ways of engaging patients in the therapeutic process by using a language which is acceptable to the patient and which is likely to engage rather than alienate the patient e) to examine some of the evidence for cognitive behavioural interventions for these disorders.

Symposia

Therapist and Patient Factors in the Treatment of Chronic Fatigue Syndrome

Convenors & Chair: Trudie Chalder and Kate Rimes, Institute of Psychiatry, Kings College London

Testing the Cognitive Behavioural model of CFS. Does it stack up?

Moss-Morris R School of Psychology, The University of Southampton, UK Spence M Department of Psychological Medicine, The University of Auckland, New Zealand

Introduction: Cognitive behavioural (CB) models of chronic fatigue syndrome (CFS) propose that an organic insult such as a viral infection acts as a precipitant to behavioural and cognitive responses that mediate between the acute illness and the chronic syndrome. The purpose of this study was to investigate the validity of this model by testing whether variables operationalised from the (CB) model could predict the development of CFS following an acute episode of glandular fever. Method: Participants included 246 primary care patients with serological evidence of infectious mononucleosis (glandular fever), and no previous history of CFS or related disorders. They completed an initial questionnaire at the time of acute infection which included the Hospital Anxiety and Depression Scale, Perceived Stress Scale, the Negative Perfectionism Scale, the Illness Perception Questionnaire-Revised (IPQ-R), and the Behavioural Responses to Illness Questionnaire (BRIQ). Six months after the initial infection participants completed a second questionnaire which was used to determine whether they met published diagnostic criteria for CFS. Results: 8% of the sample met diagnostic criteria for new onset CFS six months' post infection. Logistic regression controlling for age, gender, and severity of glandular fever symptoms found that those who went on to develop CFS had significantly higher levels of negative perfectionism ($p < .05$), anxiety ($p < .05$) , depression ($p < .01$), negative illness beliefs ($p < .01$) and all-or-nothing behaviour at the time of infection than those who did not develop CFS. Discussion: In accordance with the CB model of CFS, high personal expectations, negative mood, interpreting symptoms in a negative fashion and responding to symptoms in an all-or-nothing fashion were associated with the onset of post viral CFS, but perceived stress and excessive resting was not. Conclusions: These findings suggest that early CB interventions which target both personal and illness beliefs may help to prevent the onset of post viral CFS. Providing simple behavioural advice around a gradual return to activity rather than an all-or-nothing response to symptoms may also prove to be helpful.

Cognitive and behavioural aspects of fatigue in a Brazilian population: cross-cultural comparisons

Jin Cho, H Institute of Psychiatry, King's College London.

Background: Fatigue is universal, but the concept of chronic fatigue syndrome (CFS) as a severe illness attributed to physical causes seems to be a unique phenomenon in the West. According to the research, several cognitive-behavioural factors seem to perpetuate CFS: physical attribution of cause, fear of exercise, avoidance as a coping strategy and focusing on bodily symptoms. These factors, in turn, seem to be influenced by several sociocultural variables which might be uniquely observed in the West e.g. a biomedical world view of mind-body dualism, awareness of CFS, the sensationalised media and CFS-related secondary gain. CFS is practically unknown in Brazil and the population is less biomedically orientated. This thesis aims to assess the role of sociocultural factors in the development of CFS through a cross-cultural comparison between Brazil and the UK. Hypotheses: 1) Perpetuating factors of fatigue are less prevalent among Brazilian patients with unexplained chronic fatigue (UCF: a subsyndromal counterpart to CFS). 2) Brazilian UCF patients are less disabled and report shorter fatigue duration. METHODS: A cross-sectional survey at primary care level was conducted in São Paulo and London. 3914 consecutive attenders in Brazil and 2459 in the UK, all aged 18-45 years, completed a screening procedure with the Chalder Fatigue Questionnaire and the 12-item General Health Questionnaire. 452 UCF patients in Brazil and 178 in the UK completed the second phase answering the Cognitive and Behavioural Responses to Symptoms Questionnaire and the Brief Disability Questionnaire. Results: In accordance with the hypotheses, British UCF patients were: more likely to be a member of a self-help group, more likely to have had sick leave or received sickness benefit due to CFS; more likely to attribute their fatigue to physical causes; more likely to behave in an all-or-nothing pattern; more likely to use rest as a coping strategy; fatigued for a longer period; and more disabled. Nevertheless, contrary to the hypotheses, Brazilian UCF patients had more fear of exercise, more catastrophising beliefs and more ideas of damage. Conclusion: Despite the unexpected findings concerning some fearful cognitions, perhaps to be explained by lower education level and the current socio-economic unrest in Brazil, the current data support the overall premise of a worse outcome among UK patients, and hence the role of sociocultural factors in the development of CFS, more specifically in its perpetuation.

Does the therapeutic alliance affect outcome in the context of a RCT of CBT versus counselling for chronic fatigue in primary care?

Godfrey E Institute of Psychiatry, King's College London Chalder T Institute of Psychiatry, King's College London Ridsdale L King's College London Seed P King's College London Ogden J University of Surrey

Objectives: To develop a brief measure of the therapy process in order to to check treatment fidelity and quantify the active ingredients of CBT and counselling. To employ this measure to examine which therapeutic ingredients were associated with outcome in a sample of patients from a randomised controlled trial (RCT) of cognitive behaviour therapy (CBT) versus counselling for patients with chronic fatigue in primary care. It was hypothesised that the two therapies would be clearly distinguishable and that in terms of process variables and that common elements between the two therapies, such as the therapeutic alliance, would be important in predicting outcome. Design: The data for this study was collected alongside a RCT in primary care. The results of this trial revealed no significant difference in effect between the two therapies on the main outcome of self-reported fatigue (Ridsdale et al 2001). Audio-taped therapy sessions from the RCT were assessed by two independent raters using a newly devised measure in order to examine adherence to the treatment protocols in the RCT and to establish the relative contributions of process variables to levels of fatigue at six months follow up. Methods: Tapes from seventy-one patients participating in the RCT were assessed to form the basis of the process analysis. The main outcome was self-reported fatigue measured on the Chalder Fatigue Questionnaire (Chalder et al 1993). Data reduction was achieved via a principal component analysis. Factors were entered into a multiple regression analysis to produce a final model of predictors of outcome. Results: The process measure showed that although the treatments could be distinguished, there was some overlap between them. Emotional processing was significantly associated with a good outcome. This reflected the patient's ability to process their emotional material during therapy, such that the more a patient engaged with and processed their distress, the lower their final fatigue score. Together baseline fatigue and emotional processing explained 26% (adjusted R2 = 0.26) of the total variance in final fatigue scores at 6 months follow-up. Conclusion: A new process measure was successfully developed which now warrants further testing. It was able to unpack and distinguish the "active ingredients" which predicted outcome across different psychological treatments. The findings lend preliminary support to the view that specific techniques associated with particular "brand names" of therapy are not necessarily the "active ingredients" that help patient's change in the primary care

setting. Emotional processing predicted outcome for patients with chronic fatigue and therefore future research might explore this in more depth in order to understand better how it can be facilitated.

Treating CFS in primary care: which patients, which therapies, which therapists?

Wearden A University of Manchester, School of Psychological Sciences, Manchester, UK

In 2002, an independent working party commissioned by the UK Department of Health to consider how the health service should best provide for patients with chronic fatigue syndrome (CFS; also known as myalgic encephalomyelitis, or ME), recommended that CFS should be managed wherever possible in primary care. This recommendation was made partly on the basis of considerations such as the scarcity of resources in secondary and tertiary care and problems with patient access to specialist care settings; additionally the benefits of early and authoritative diagnosis, and avoiding unnecessary referral and investigation were recognised. Psychological and behavioural therapies such as cognitive behaviour therapy (CBT), graded exercise therapy (GET) and pragmatic rehabilitation (PR) have been shown to be effective treatments for CFS when delivered in secondary care. However, while there are a handful of studies in which chronic fatigue more broadly defined has been treated, there are no published trials of such treatments for patients with CFS in primary care. The evidence base for treating CFS in primary care is therefore thin.1Drawing on a disparate literature pertaining to the treatment of medically unexplained symptoms and syndromes in primary care, and on experiences derived from running an ongoing treatment trial of pragmatic rehabilitation for CFS in primary care,2 this paper will review patient, therapy and therapist factors which may be critical to the successful provision of treatment. Firstly, I will argue that an important feature of any successful therapeutic approach is likely to be the provision of an explanation for the patients' symptoms which both suggests mechanisms and relates explicitly to the patients' particular concerns. There is a popular belief that patients with CFS are resistant to explanations involving psychosocial factors, but this may be less the case in primary than secondary care settings. Secondly we know something about predictors of outcome and response to treatment in chronic fatigue and CFS; in general, patients with more adaptive illness beliefs do better, but social and employment related factors may also be important, and multi-disciplinary primary care teams may be well-placed to address them. Thirdly, we need more research on the feasibility of training non-specialist primary care staff to deal effectively with this complex condition.

Psychological Models of Service Delivery in Cardiac Care

Convenor: Jo White, King's College Hospital, London

The effect of structured informational care in patients with non-cardiac chest pain

Lennox T Tees, Esk and Wear Valleys NHS Trust Mac D A Tees, Esk and Wear Valleys NHS Trust Phelps D Tees, Esk and Wear Valleys NHS Trust Baker C Tees, Esk and Wear Valleys NHS Trust Haq I Tees, Esk and Wear Valleys NHS Trust Adams P Tees, Esk and Wear Valleys NHS Trust Freeston M Tees, Esk and Wear Valleys NHS Trust

Background: Approximately one third of people referred to the Newcastle Rapid Access Chest Pain clinic present with non-cardiac chest pain. Despite the good prognosis for this group, many people are not reassured by investigation and remain disabled by their symptoms, experience impaired quality of life and have repeated medical contacts. Bass and Mayou (2002) proposed that there are opportunities for early intervention with this group, suggesting that people need to be provided with individually tailored informational care, that accounts for their concerns about their symptoms. They reported the effectiveness of CBT with this group. Our study extends this work to investigate whether a short CBT psycho-educational intervention offered in the rapid access clinic setting is effective. Method: Structured Informational Care (SIC) based on cognitive- behavioural principles was developed in discussion with the cardiologists and cardiac nurse at the clinic. 40 patients were assessed in the baseline group (usual care). 41 patients were then assessed after receiving usual care plus SIC, as delivered by the cardiac nurse in clinic. Patients completed the Chest Symptom Perception Questionnaire (CSPQ) - a modified version of the Illness Perception Questionnaire - before and after their visit to the clinic. The main dimensions of interest were the "emotional representation" and "illness coherence" subscales. The data was analysed by ANCOVA using baseline measures as covariates. Results: There was a large significant effect of SIC for "illness coherence" suggesting that people who received SIC better understood their symptoms than those who received usual care after the clinic. There was a trend towards an advantage of SIC for "emotional representation" but both groups felt more emotionally reassured after clinic. This supports the notion that cognitive behavioural aspects of the SIC keyed into participants' cognitive and emotional representations about their chest pain. Conclusion: A brief discussion and intervention based on cognitive behavioural principles with patients with non-cardiac

chest pain improves patients' understanding of their symptoms and is feasible as part of everyday practice at the clinic.

The Hypertension Self-management Project

Gillespie, G Northumbria Healthcare NHS Trust, Stone D Northumbria Healthcare NHS Trust Challinor R Northumbria Healthcare NHS Trust Lawrence J Northumbria Healthcare NHS Trust Tapsfield W Northumbria Healthcare NHS Trust

There is increasing recognition of the need to support patients to take an active role in managing a range of chronic conditions, reflecting the complex links between health behaviours and health outcomes. A number of health-related behaviours are implicated in the cause and treatment of hypertension, one of the most important risk factors for vascular disease. Hypertension is prevalent and, despite national guidelines for its management, identification and control are sub- optimal. Although various self-management programmes have been evaluated, there are many different models of self-management and few published trials of self-management interventions for patients with hypertension. This project aimed to do the following;1) develop a multi-disciplinary self management intervention, based on adult education/psychological principles, for patients with essential hypertension 2) pilot the intervention with 3 small groups of patients (total N=18),3) assess the acceptability and perceived usefulness of the content and process to patients in order to further refine the intervention,4) assess whether the intervention is associated with short-term adverse effects on anxiety/depression symptoms,5) identify blood pressure trends among patients over a 6 month period following the intervention. In addition to describing the project and its outcomes, the presentation will reflect on it as one form of psychology service development and delivery within a CVD prevention setting.

Developing a psychology service for cardiac rehabilitation

Sigel P South London & Maudsley NHS Trust Sanders J Guys' & St. Thomas NHS Foundation Trust Hunter M South London & Maudsley NHS Trust

The psychological needs of cardiac patients are well established (Hemingway and Marmot, 1999; Lane, Carroll, Ring, Beevers and Lip, 2002) and the National Service Framework for Coronary Heart Disease includes recommendations for provision of psychological assessment and treatment (Department of Health, 2000). Yet significant barriers exist to addressing these needs. Less than one- third of cardiac rehabilitation teams include a psychologist (Breen, Brodie and Bethell, 2005) and many patients with physical health problems are reluctant to disclose psychological symptoms to medical professionals (Cape and McCulloch, 1999). Meeting the needs of cardiac patients is a project funded by the Guy's and St Thomas' Charity to address this gap in service provision. This paper will describe the design of the project within the service context, including mechanisms developed to increase access to and acceptability of psychological services. During the first year, 61 patients accepted a referral for psychological assessment, representing more than 25% of patients attending cardiac rehabilitation. Their presenting needs as well as the range of interventions offered - from psychoeducation sessions to cognitive behavioural therapy for individuals and in groups - will be described with relevant case material. Evaluation of the overall impact of the project is currently in progress.

Men's experience of heart attack: a qualitative study

Hutton J and Perkins S Institute of Psychiatry, London

White et al (2004) presented a qualitative study of women's experience of myocardial infarction and cardiac rehabilitation. A number of themes emerged, notable a tendency to minimise the impact of the event and a wish to get back to 'normal', which could not be sustained. The majority of people experiencing myocardial infarction and participating in cardiac rehabilitation are male and the outcome of rehabilitation is better for men (e.g. Emery et al 2004). However, there is a lack of qualitative exploration of these experiences for men specifically, which this study aims to address. Ten men aged between 40 and 70, who had had a myocardial infarction within the last six months, were interviewed using the same schedule used by White et al. This covered events around the infarction, its impact on various aspects of life, ways of dealing with these experiences and experience of cardiac rehabilitation and other medical services. The interview transcipts were analysed qualitatively using Interpretive Phenomenological Analysis. The themes which emerged, which related to views of the self, the illness and the future, ways of coping and experiences of rehabilitation, will be described, discussed in terms of the previous literature, and compared to those which emerged for the women in White et al's study. Implications for services and future research will also be discussed.

Panel Debate

Possibilities and Pitfalls of Expanding CBT to Return People to Work

Chair: Chris Williams, University of Glasgow

Panelists:
Chris Williams, University of Glasgow, Simon Darnely, Prisma Health Ltd, Trudie Chalder, Institute of Psychiatry, Kings College London, Graham Turpin, Division of Clinical Psychology, British Psychological Society

Lord Layard, in the first Sainsbury Centre for Mental Health lecture in September 2005, suggested that CBT should be used to help people receiving incapacity benefit to recover from or improve their management of their disabling condition (e.g. depression, anxiety, chronic pain, chronic fatigue syndrome) and return to work. Issues likely to be addressed in this panel debate include: how to use CBT to help people return to work, clinical and cost-effectiveness of CBT in this context, drawbacks or cautions in using CBT for this purpose, training health professionals to provide effective interventions, social and ethical issues, incapacity benefit reforms, government agendas regarding return to work, and consideration of whether other factors or methods of intervention need to be considered. There will also be an opportunity to raise questions concerning the therapeutic relationship/rapport and Return to Work Dr Simon Darnely works for PRISMA, a disability rehabilitation company that uses a cognitive behavioural approach to help people return to work. Professor Trudie Chalder from the Institute of Psychiatry has extensive experience in using CBT with people with medically unexplained symptoms (e.g. chronic fatigue syndrome), which are associated with considerable disability. Professor Graham Turpin is the Vice Chair of the Division of Clinical Psychology at the British Psychological Society and Director of the Clinical Psychology Unit at Sheffield University.

Child and Adolescent

Keynote Address

Evaluating The Effectiveness Of Interventions For Autism Spectrum Disorders

Professor Patricia Howlin, Institute of Psychiatry, Kings College London

Even a cursory trawl of the Internet reveals a whole range of “miracle” interventions for autism spectrum disorders (ASD), including special diets, drugs, vitamins, physical and sensory programmes, chelation and other detoxification therapies, or devices said to dissipate the “electrical charges” causing behavioural problems. However, few interventions involve control studies of any kind and when appropriate research methodology has been applied the results are generally far from impressive. Until recently, the only interventions with a moderately sound evidence base were highly intensive- and expensive- home based behavioural programmes, focussing on pre-school children although replication studies have failed to support claims that such interventions could result in “recovery” from autism. However, there is now a concerted effort by a number of researchers in the field to conduct randomised control trials, involving different psycho-social interventions and older children. The value of cognitive-behavioural therapies for individuals with ASD is also beginning to be explored. This paper will examine the way in which approaches to the treatment of individuals with ASD have changed in recent years, the limitations of much of the research in the field, and ways in which the approach to evaluation is finally becoming more rigorous and systematic.

Symposia

The Development of Anxiety Across the Lifespan

Convenor & Chair: Alice Gregory, Psychology Department, Goldsmiths College and Institute of Psychiatry, Kings College London

Older People and Anxiety

Sturgeon-Clegg I, North East London Mental Health Trust and City University

During this section of the symposium anxiety will be discussed in relation to the current cohort of people aged over sixty five. An overview of the prevalence of anxiety and related mental health difficulties will be presented. Triggers to anxiety, precipitating and maintaining factors will be discussed in relation to this cohort of older people as well as the efficacy of Cognitive-Behavioural interventions. Information will be presented in relation to the presenter's experience of working with this age group. Therefore worry as a dominant feature of anxiety in this age group will be examined using case examples. One of the particular features of the current cohort of older people is that they survived the Second World War either in active service, reserved occupations or as child evacuees and witnesses of the bombing of Britain. The presenter will cite her recent research project, which looks at the long-term effects of experiencing both evacuation and the bombing of London as children. She will discuss the surprising lack of symptoms of anxiety-related difficulties and therefore will postulate that various protective factors were present during the participants' wartime experiences. She will briefly re-examine the established theories regarding the development and maintenance of anxiety-related difficulties in relation to her research.

Juvenile Mental Health Histories of Adults with Anxiety Disorders

Gregory A Institute of Psychiatry, King's College London and Goldsmiths College, University of London Caspi A Institute of Psychiatry, King's College London and University of Wisconsin, Madison Moffitt T Institute of Psychiatry, King's College London and University of Wisconsin, Madison Koenen K Department of Society, Human Development, and Health, Harvard School of Public Health Eley T Institute of Psychiatry, King's College London Poulton R Dunedin Multidisciplinary Health and Development Research Unit, University of Otago

Objective: Detailed information about the psychiatric histories of adults with different types of anxiety disorders is limited. Such information was examined in order to inform: 1) nosology; 2) preventions. Method: We used a prospective longitudinal study of a representative birth cohort (N = 1037). We made psychiatric diagnoses according to DSM criteria at ages 11, 13, 15, 18, 21, 26 and 32 years. For adults with anxiety disorders at 32 years, follow-back analyses ascertained first diagnosis of anxiety disorders as well as histories of different types of juvenile disorders. Results: Of adults with each type of anxiety disorder, approximately half had been diagnosed with psychiatric disorder (one- third with an anxiety disorder) by age 15 years. The juvenile histories of psychiatric problems for adults with different types of anxiety disorders were largely non-specific. Histories of anxiety and depression were most common. There was also some specificity. Adults with posttraumatic stress disorder had histories of conduct disorder whereas those with other anxiety disorders did not. Conclusions: The overall lack of specificity in the developmental histories of adults with anxiety disorders supports a hierarchical approach to classification, with a broad class of anxiety disorders, having individual disorders within it. The early first diagnosis of psychiatric difficulties in individuals with anxiety disorders suggests the need to target preventions early in life.

The role of Vicarious learning in the development of childhood fears

Field, A University of Sussex

Vicarious learning has long been considered a viable pathway for the acquisition of fear in childhood, but to date there has been little experimental work to verify this assumption. Two experiments investigated whether exposing 6 to 9 year old children to pictures of novel animals presented alongside pictures of adult facial expressions (fearful or smiling) altered their fear-relevant beliefs (self-report and reaction time tasks such as affective priming) and avoidance behaviour towards those animals. In the first study, children were followed-up over a six-month period and demonstrated that their changed fear beliefs could persist some time after the initial learning episode. In the second study children showed significant avoidance behaviour of animals that had been previously paired with pictures of faces showing fearful expressions. These findings suggest that relatively innocuous vicarious learning experiences can have a dramatic impact on children's fear belief systems and can promote avoidance behaviour. These results are discussed in the context of how such thoughts and behaviours might develop into more extreme phobic responses.

Interpretation and anxiety in young children

Creswell C University of Reading and Cooper P University of Reading

Introduction: Numerous studies have now reported associations between anxiety and cognitive variables in young people. These studies have generally been limited by small samples comprising children from broad age bands, thereby preventing an adequate exploration of developmental differences. Furthermore, how children come to develop anxious cognitive styles remains largely unexplored. Method: This presentation describes the first wave of a longitudinal study of anxiety and cognition including 134 year one children (aged 5/6 years). The children were initially screened and identified as high/low anxious based on parental report. Children then completed pictorial assessments of anxiety, interpretation of ambiguous situations and emotional expressions. The primary carer also completed self-report measures of anxiety and interpretation of ambiguous scenarios and reported on their expectations of their child's response to ambiguous scenarios. Results and discussion: The results will be discussed in relation to (i) associations between child anxiety and interpretation of ambiguity and emotional expressions; (ii) associations between carer and child cognitive variables. Most notable are the findings that associations between cognitive variables and anxiety that appear to be robust among older children were not found in this younger sample. As we have found in an older sample, however, parental expectations about the child's response to ambiguity related to parental anxiety and interpretation, rather than child self-report variables. Conclusion: The results of this study caution against generalising the results of studies including children from broad age ranges to the youngest participants. Instead we must consider the likelihood of developmental differences in the association between anxiety and cognition. Future assessments in this prospective study will help to (i) clarify the nature of this association through development, and (ii) evaluate the role of parental cognitions in the

development of children's anxious cognitive style. This research represents a preliminary step towards identifying developmentally appropriate targets of intervention for the prevention and treatment of anxiety.

Cognitive Processes in Social Anxiety: Evidence in Children, Adolescents and Young People

Convenor and Chair: Lusia Stopa, University of Southampton
Discussant: Sam Cartwright-Hatton, University of Manchester

Can Clark And Wells' (1995) Cognitive Model of Social Phobia be Applied to Young People?

Taylor K Buckinghamshire Mental Health NHS Trust McManus F Oxford Cognitive Therapy Centre Clark D M Department of Psychology, Institute of Psychiatry

Background: Social phobia is a common and disabling condition for both children and adults. In recent years Clark and Wells' (1995) cognitive model of social phobia has led to the development of an effective treatment protocol for the condition in adults (Clark, Ehlers, McManus, Hackmann, Fennell, Campbell, Flower, Davenport & Louis, 2003). Given the typically young age of onset and chronic course of the condition, it would seem sensible to establish the applicability of this model to young people. Method: An analogue population of 171 schoolchildren aged 11 to 14-years old completed a booklet of questionnaires measuring social anxiety and the variables specified in Clark and Wells' (1995) cognitive model. Results: High socially anxious children scored significantly higher than low socially anxious children on measures of all the variables specified in Clark & Wells' (1995) model, which are: negative social cognitions, self-focused attention, safety behaviours, anticipatory processing and post-event processing. Stepwise multiple regressions further indicated that negative social cognitions, self-focused attention and post-event processing were the best predictors of social anxiety in this population and predicted significantly more of the variance in social anxiety than in depression. Conclusions: The results suggest that although Clark and Wells' (1995) model of social phobia was developed with reference to an adult population it may be equally applicable to younger people with social anxiety. Given the typically early onset and chronic course of the condition it seems important to investigate whether the treatment arising from this model can be as effective with a younger age group as it has been with adult populations. Results from this study suggest treatment programmes for social anxiety in young people should target negative social cognitions, self-focussed attention, anticipatory and post-event processing and any safety behaviours or avoidance.

Social Anxiety and Self-Evaluation of Social Performance in a Non-Clinical Sample of Children

Morgan J University of Sussex Banerjee R University of Sussex

In an investigation of socially anxious children's social behaviour and self- evaluation, 28 high socially anxious and 28 low socially anxious children, aged 11-13 years, appraised their performance before and after participating in a role play task. Half of the children were given video feedback prior to giving their post- task self-evaluations. High socially anxious children anticipated poorer performance on the role-play task and some group differences in observed social performance were evident. Self-evaluations from video feedback only improved for the high socially anxious children who displayed more eye contact, gave longer verbal responses, and used more constructive strategies in the role-play scenarios.

Using facial expressions of emotion to explore interpretation and attentional information processing biases in children with increased social anxiety

Hadwin J A, Garner M, Mogg K and Bradley B, University of Southampton

Experimental studies using a number of different paradigms highlight that community samples of children with increased trait and social anxiety or those with clinical levels of anxiety demonstrate information processing biases for the detection of threat in their environment. Developmental research has suggested that the presence of information processing biases in childhood indicates a potential risk factor for increased anxiety later in life and has highlighted its importance to understand cognitive factors associated with the development of anxiety in children and adults. This paper reviews empirical evidence exploring the relationship between increased anxiety/social anxiety in late childhood and information processing biases towards negative (i.e., fearful or angry) photographic and schematic facial expressions of emotion. It reports data from a number of studies using different experimental paradigms

to highlight a relationship between increased self-report trait and social anxiety with the interpretation of ambiguous facial expression of emotion and time taken to find negative facial expressions in a visual search task. The results of this research have significant implications for understanding age-related change in information processing biases for threat in children and the development of theory and research in childhood anxiety.

Interpretative biases in social anxiety: Does social anxiety influence the way in which adolescents interpret ambiguous and mildly negative social events?

Vine J & Stopa L University of Southampton

Interpretative biases are assumed to play a major role in maintaining social anxiety. Socially anxious adults interpret ambiguous social events negatively and interpret negative events in a catastrophic fashion. However, there is little research to support the extension of this theory to children. The aim of the current study was to determine whether social anxiety is associated with interpretative biases in adolescents. Interpretations were assessed using a modified version of the Ambiguous Social Situations and the Social Events Catastrophisation Questionnaires (Stopa and Clark, 2000). Social anxiety in adolescents was associated with a tendency to rank negative interpretations of ambiguous social, but not non-social situations, as more likely to come to mind and to rate them as more believable. Social anxiety was also associated with a tendency to rate mildly negative social events as catastrophic. The results provided support the extension of cognitive theories of social anxiety from adults to adolescents.

Self-appraisal and post-event processing in young adults

Dannahy L & Stopa L University of Southampton

The cognitive model of social phobia by Clark and Wells (1995) proposes that following a social event, individuals with social phobia will engage in post-event processing, during which they conduct a detailed review of the event. This study investigated the relationship between self-appraisals of performance and post-event processing in individuals high and low in social anxiety. Participants appraised their performance immediately after a conversation with an unknown individual and prior to an anticipated second conversation task one week later. The frequency and valence of post-event processing during the week following the conversation was also assessed. The study also explored differences in the metacognitive processes of high and low socially anxious participants. The high socially anxious group were found to experience more anxiety, predict worse performance, underestimate their actual performance, and engage in more post-event processing than low socially anxious participants. The degree of negative post-event processing was linked to the extent of social anxiety and negative appraisals of performance, both immediately after the conversation task and one week later. Differences were also observed in some metacognitive processes. The results are discussed in relation to current theory and previous research.

Panel Debate

Systemic aspects of CBT - current research and clinical perspectives

Convenor: Anne Stewart, Oxfordshire Mental Healthcare Trust and University of Oxford,
Chair: Nicky Dummett, East Leeds PCT and Sam Cartwright-Hatton, University of Manchester
Panelists: Sam Cartwright-Hatton, University of Manchester Cathy Creswell, University of Reading Anne Stewart, Oxfordshire Mental Healthcare Trust and University of Oxford Andrew Lewis-Smith and Sion Roberts, Wolverhampton City Primary Care Trust Chris Williams, University of Glasgow

There has been increasing interest in involving families within CBT for young people, and growing evidence for the effectiveness of adding a family component to CBT with this age group. Within the family therapy tradition, there is also increased interest in the use of CBT strategies to understand and help families. Adults as well as young people may be strongly influenced by the cognitions and behaviour patterns of those living with them. Understanding these processes and working with the family may potentially enhance the effectiveness of CBT in a wide range of diagnostic areas and age groups. For this panel debate we have gathered together CBT experts from a range of different perspectives who are using a family-based approach within formulations, treatment or self help. Clinical and research issues will be addressed and the aim is to give an overview of current debate in this field. The presentations will be followed by a panel discussion with questions and answers from the floor.

Open papers

Maternal Mental Health and Psychological Interventions in Childhood

Chair: James Murray, Health and Social Services Department, Guernsey

An exploration of negative thoughts as a normal phenomenon after childbirth

Hall P L Bolton, Salford and Trafford Mental Health NHS Trust Wittkowski A University of Manchester

The period following the birth of a child brings many transitions into a woman's life that affect major psychological and social changes, including feelings of loss. If new mothers experience negative thoughts at this time when societal expectations are of happiness, this may lead to feelings of unacceptability and guilt. This study aimed to investigate the prevalence of negative thoughts after childbirth in non-depressed mothers. Following identification of negative thoughts experienced by women who had suffered postnatal depression (using qualitative semi-structured interviews and interpretative phenomenological analysis), the Postnatal Negative Thoughts Questionnaire (PNTQ) was developed and validated. A quantitative survey was then conducted which asked non-depressed mothers to indicate how often they experienced the negative thoughts or images described in the PNTQ. A total of 185 questionnaire packs were completed by mothers with recruited through baby weight clinics and health visitors. Twenty-two participants scored above the cut-off point of 12 on the Edinburgh Postnatal Depression Scale and were therefore excluded from the study. The sample consisted of 158 mothers with a mean age of 31 with young infants (mean age was 3.5 months). The majority of these mothers were white, married or co-habiting and had their first child (57.6%). This sample of non-depressed mothers endorsed all but one item of the 54 negative cognitions detailed on the PNTQ. The item none of the mothers acknowledged pertained to sexual abuse of their child. The mothers most frequently endorsed cognitions, such as 'I must show everyone that I'm coping' and 'if there's something wrong with my baby, it's my fault'. A number of overarching themes emerged and were as follows: the need to be perfect, high or unrealistic expectations about motherhood, a sense of responsibility, thoughts of death or impending doom and negative judgements by others. Further analyses revealed no differences in PNTQ answers between first-time mothers and experienced mothers, younger and older mothers or younger and older babies. Marital status was also not identified as a protective factor. The present study provides new information about the prevalence of negative thoughts after childbirth in non-depressed mothers. Almost 64% of mothers thought that their lives should be centred wholly on their infant and over 62% experienced thoughts of their baby dying. The results considerably extend the findings by Jennings et al (1999). Furthermore, the prevalence of negative thoughts after childbirth did not appear to dependent upon social factors, such as number of children, marital status, age or child's age. Such findings challenge the assumption that mothers who have had previous experiences of childbearing may be less vulnerable to experiencing negative thoughts. The fact that these thoughts appear common in non-depressed mothers has implications in terms of the need for 'normalising' the experience of both depressed and non-depressed women. Normalising the presence of these negative thoughts may be helpful in the treatment of depressed women. The challenge of designing a cognitive behavioural focused group & engaging people that don't want to know!

The relationship between theory of mind and executive functioning to maternal recognition of infant cues and bonding

Turner J University of Manchester Wittkowski A University of Manchester Hare D University of Manchester

A unique relationship exists between primary caregivers and infants, and the interactions that occur within this relationship are crucial to the infant's development. No studies to date considered the possible impact of executive functioning on mothers' responsiveness, bonding or her ability to interpret infant cues (such as facial experessions). For this reason, this study examined associations between theory of mind ability, executive functioning, recognition of infant cues and maternal bonding in a sample of non-clinical mothers. A correlational design was employed. Participants were 64 mothers with young infants (3 weeks to 12 months). They completed a number of measures assessing theory of mind ability (Prjective Imagination Test; Blackshaw et al, 2001), executive functioning (Hayling and Brixton Tests; Burgess & Shallice, 1997; The Color Trails Test; D'Elia et al, 1996) and bonding (Postpartum Bonding Questionnaire; Brockington et al, 2001). Photographs of infant facial expressions were utilised to assess ability to recognise infant cues of emotion (Emde et al, 1987). Significant

relationships were detected between theory of mind ability and recognition of infant cues, and between executive functioning and recognition of infant emotions. Mothers who appear to correctly interpret infant cues also appear to be able to appropriately suppress over- learned responses and to correctly identify people's theory of mind. Associations between bonding and performance on executive functioning measures as well as scores on theory of mind ability were not identified. Interestingly, no significant associations were observed for theory of mind ability and executive functioning. This study contributes to our understanding of the factors which influence the mother-infant relationship. For example, our findings provide some support for the role of metacognitive monitoring (i.e. theory of mind ability) in influencing mothers' relationships to their infants. This is in line with Fonagy et al's (1995) suggestion that the processes by which the developing relationship between mother and infant could breakdown were through the mother failing to recognise the infant's negative affective signals or failing to employ her own theory of mind and reflect to the infant an appreciation of his/her emotional state whilst responding in a way that indicates that she is not overwhelmed by infant distress. Despite a number of methodological limitations, this study provides a process by which subtle difficulties or potential problems with the tasks of parenting may be recognised and responded to in order to prevent the manifestations of poor mother-infant relationships and possible insecure/difficult attachments.

Evaluation of a stepped care service for perinatal mental health

Joice,A STEPS Primary Care Mental Health Team, Glasgow

This paper presents preminary results from a service evaluation of a stepped care model applied to perinatal mental health. The STEPS Primary Care Mental Health Team aims to provide services, utilising cognitive behavioural therapy, at multiple levels to increase access to mental health service for people with mild to moderate mental health problems. Perinatal mental health services have been developed for each step available; individual therapy, groups, non face to face contact, working with others, and population based approaches. The team has developed these local services to support the implementation of Glasgows Perinatal Integrated Care Pathway. This has resulted in the team seeking parnerships across the wider health network to deliver services. To date the evaluation has focused on the provision of two interventions: Provision of a perinatal natal depression group in partnership with an adjoining Community Health and Care Partnership (CHCP) and South Glasgows maternity services was evaluated using the Edinburgh Postnatal Depression Scale and a Group Satisfaction Questionnaire Training based on cognitive behavioural therapy for health visitors and midwifes to increase their confidence in working with people with depression which was evaluated using the Training Acceptability Rating Scale The results have shown that the Perinatal Depression Group is effective in reducing the EPDS score. Group members have been highly satified with the format and support available. The most reported benefit from the group is the opportunity to talk openly about how they felt and meet other people feeling the same as themselves. The results from the training will be presented along with an outline of the challenges faced in implementing stepped care across disparate services in the health system

The effects of mindfulness meditation practice on behaviour and attention in a primary classroom

Iyadurai, S Reading Educational and Child Psychology Service

Introduction: The mindfulness meditation practice (Calm Breathing) was derived from Mindfulness Based Stress Reduction (Kabat-Zinn 1990) and Mindfulness Based Cognitive Therapy (Segal, Williams and Teasdale 2002), adapted and abbreviated for use with children. Mindfulness meditation has been used successfully, with groups of adults for a variety of problems including relapse in depression (Teasdale, Segal and Williams 2000), anxiety (Kabat-Zinn 1992), improving mindful awareness and attention (Ruths 2004), physical conditions and chronic pain. Mindfulness meditation is widely known for promoting calm acceptance across a variety of situations, but there is little evidence from use with children. Methods/Techniques: The basic techniques used consisted of stretches with focused attention, a body scan (bringing awareness to each part of the body in turn) in a relaxed seated position, followed by maintaining awareness of the breath at the nostrils and use of a calming thought with each outbreath. The practice was used three times a day with the whole class. Measures taken were structured observation of each pupil in the class, and Goodman’s strengths and difficulties questionnaire (SDQ) completed by the class teacher for each pupil, immediately prior to intervention and after sven weeks of intervention. Results/Outcomes: Over the period of intervention, there were statistically significant improvements in the SDQ measures of Emotional difficulties, Conduct difficulties, Peer Problems and Prosocial behaviour, and in levels of childrens on-task behaviour on the observational measures. Conclusion/Discussion: These promising findings are discussed in the context of the research literature on mindfulness meditation and other work by the author using mindfulness based cognitive therapy for anxiety. Results may also be available from a current study using a larger sample size and control group.

Using TV and films within cognitive behavioural therapy with children and adolescents

Murray J, Health and Social Services Department, Guernsey

Adolescents Murray James Health and Social Services Department, Guernsey Children watch on average around two and a half hours of television a day (UK Time Use Survey, 2000). This includes a wide variety of different films, cartoons, and soap operas, providing children with vicarious experiences of a broad range of characters and situations. Film and TV have been used in a generic therapeutic context for many years (Hesley and Hesley, 2001), often as a way of raising issues for discussion, or helping clients identify with characters or situations. This paper seeks to explore how film and TV can be used within a specifically cognitive- behavioural framework, particularly with children and adolescents. The use of film and TV within CBT will be discussed in relation to four main areas, using clinical examples and video segments. These areas are: exposure to aversive stimuli; modelling functional behaviours and cognitions; as a tool for developing theory of mind skills; and as a tool for practicing skills (such as identifying negative automatic thoughts and cognitive biases). Since this area is one where there is little existing research, this paper will not present research results, but instead concentrate on possible clinical applications.

Diabetes, depression and adolescent issues: can CBT help?

Brownrigg A Northumbria University Harkness P Hartlepool child and adolescent mental health service

Adolescents, who have diabetes, are more likely to develop depression compared to their non diabetic peers. The impact of depression can have significant impact upon diabetic management, thus increasing the risk of serious illness. Add to this challenging combination- the adolescents stage of development, search for independance, influence of peers and occasional anti parental stance. Viewed in this way it is apparent that CBT may have a role in assisting the young person to reduce depressive symptoms, improve glycemic control and to understand more fully their developing thoughts, feelings and behaviours. Importantly, CBT may help the adolescent to understand the links between diabetes, depression and self care. This study is based upon a detailed literature review which sought to understand the faesibility of CBT to treat depression which also impacts upon and complicates diabetic self management and glycaemic control. The findings have direct relevance to clinical practice and key issues have been used in direct treatment. We have also explored the treatment issues via adolescent perception. Exploring young peoples accounts adds further acknowledgement to this debate and suggests the need for incresed availablity of CBT. Case study material illustrates the importance of addressing the adolescents health perception, developmental stage and cognitions. Without due exploration adolescents are putting themselves in danger. Adolescents can be helped to refocus their attention to diabetic treatment compliance, which can reduce when depressed, thus potentially improving health outcomes. Adolescents place high importance to the views of peers, despite not always being honest with each other about significant health dilemmas, especially depression. CBT can help them clarify the significance of this upon their health and well being. CBT clearly has the potential to improve glycemic control for adolescents with diabetes and depression. CBT can provide an opportunity for the adolescent to understand thier lives more fully, and enhance personal awarness re choices they make about diabetic management. Exploring narrative accounts from young people, together with lack of available evidence helps illustrate the need for further reserach in this area.

Posters

Children and Adolescents

“Beep Beep Don’t Hit My Car” Treating PTSD in a Five Year Old Following a Road Traffic Accident

Brownrigg A, Northumbria University

Introduction: Harry (a pseudonym) aged five was involved in a road traffic accident. His story features fire breathing dragons, angels, mountains and the BIG blue car. Harry became the storyteller and I become the actor. Our game illustrated his thoughts, feelings, his highs and lows, his fears, and his journey to recovery. Methods: I uterlised formulation driven CBT, the creative use of "self" and a little narrative exploration. This game became the vehicle to apply an amended cognitive model of PTSD. The therapy consisted of 3 family sessions and 8 individual sessions with Harry. Transcripts from audio recordings, art work, child and family feedback, together with therapist reflections have been used to critique treatment process and outcomes. Harrys dragons left, the angels come back to play, the tress

grew back onto the mountain and the BIG blue car disappeared. Harrys symptoms lapsed, his pre accident behaviour returned, the family reactions and sensitivity returned to usual levels. Pre and post measures indicated positive change which was maintained at 6 months. A key challenge for child and adolescent practitioners is adapting adult cognitive models for use with children. Furthermore, children are brought to therapy often by their concerned parents who want their child "fixed" quickly. This case study explores the relationship between parents, child and therapist, and explores its relevance to the CBT intervention for the child's PTSD symptoms. The key learning from this case was to remember to hear all parts of each persons story, to think how they interrelate and to understand the power of metaphor, creativity and how as a child therapist we sometimes need to "wing it".

A Pilot Study of Cognitive Influences of Anxiety, Depression and Sleep Problems

Carter P, Gregory A, EleyT, Institute of Psychiatry, Kings College London

Introduction: Anxiety and sleep problems are some of the most prevalent difficulties facing children. In contrast to what is known about these difficulties in adults, little is known about cognitive correlates of these difficulties in childhood. This pilot study capitalises on tasks which have been successfully linked with anxiety and sleep problems and adapts them for use with children. Methods: The sample will be a school based community sample of 100 8-9 year olds, and a further 200 10-13 year olds at a later stage. Parents will complete a battery of questionnaires and sub-sets of the children will be seen twice for the purposes of test retest reliability. Self report measures will be used to examine anxiety, depression and sleep problems in children. Aspects of cognitions will be examined using adapted adult tasks, including the Catastrophizing Interview, the Global rumination task and an ambiguous scenarios task. The children will also be administered the Wechsler Intelligence Scale for Children to control for intelligence. Results: Methodological considerations and challenges faced when adapting adult questionnaires for use with children will be discussed. Furthermore, we hope to have some preliminary results by the time of presentation. Conclusion: The tasks needed extensive adaptation before they were considered appropriate for use with children. Amongst consideration for changes were: 1) vocabulary used; 2) timing issues; 3) rating scales. Information about the psychometric properties and associations of these adapted measures are now needed.

'Elephants Under the Carpet': A Cognitive Behavioural Rationale for the Use of Metaphor in Child CBP Using ICS

Levinson M, University of Derby

Introduction: Metaphor use is widespread in clinical work with children. There hasn't been a coherent explanatory rationale for this within child CBP. Researchers in child CBP (c.f. Stallard 2002) suggest best clinical practice integrates the understanding and use of diverse theoretical frameworks, building a holistic, coherent model. Commentators agree research is needed on which components of which treatments are producing positive effect sizes and why and how these interventions work. Although ICS is a complex information-processing model, (Barnard 2004), the researcher has used it as a visual-narrative metaphor to explain to children how their problems may have been created and maintained and found it helpful in designing visual-narrative metaphors for children. This study sought to ascertain whether ICS could generate an adequate rationale for metaphor use in child CBP. METHOD: A literature review critically analysed theory and evidence from domains selected as relevant to the research question. These included ICS, child cognitive development, child CBP and metaphors and their therapeutic usage. The review attempted to synthesise a coherent explanation of why metaphors appear to work well with children and how best to use them. Exemplars were included. Results:Conventional Piagetian theory would allow that only a child over 12 years who had gained the stage of formal operations should be able to understand metaphor. There was ample empirical evidence to suggest that this not the case (Goswami 2001). Current research suggests that even young children have the same cognitive processing architecture as adults but lack the experience, confidence, practice and knowledge to consistently use it effectively (Goswami 2001). ICS describes this architecture and its interactional processes. ICS allows that metaphors employing multiple sensory dimensions may be processed faster because of the concurrent functioning of subsystems with both direct and indirect access to the implicational subsystem. If the metaphor accesses the processing system through multiple subsystems then there would be multiple image records perhaps amplifying the impact and memorability of the metaphor. Metaphors with affective and visceral impact may be processed faster due to the direct access of the body state subsystem to the implicational subsystem. DISCUSSION: Adult research suggests that for maximum impact, metaphors should be intentional or intentionally exploited by the therapist, collaboratively elaborated and repeated. Research about children suggests metaphors work best when they are multidimensional, chosen with 'an eye to' the child's interests and cognitive development. Familiarity with and knowledge of the component parts; child friendly language; visual and contextual cues; feedback; guiding and coaching can all help the child understand the metaphor. 'Externalisation' metaphors may foster engagement and motivation by reducing any threat to the child and distancing them from the shame associated with psychiatric symptoms

CBT for Children and Adolescents: An Introductory Course 2004-2005

Walker S, Newcastle CBT Centre, Newcastle, North Tyneside & Northumberland Mental Health NHS Trust and Freeston M, University of Newcastle & Newcastle CBT Centre, Newcastle, North Tyneside & Northumberland Mental Health NHS Trust

Introduction: A 16-session course in CBT for Children and Adolescents was conducted in Newcastle in order to allow participants to develop knowledge of the principles of CBT & their application to psychosocial difficulties that can affect young people. The course was a joint venture between the Northern Regional Child & Adolescent Training Scheme of the University of Newcastle, the Newcastle Cognitive and Behavioural Therapies Centre, and experienced clinicians from around the regio. Trainers: Training was provided by experienced CBT practitioners from mental health and educational services for children and adolescents in the region with different areas of expertise and interest. Trainees:Those attending the course came from a range of backgrounds and experiences. A total of 18 participants attended the course, with varying experience in CBT and CAMHS. Course structure: The first seven sessions provided an introduction to CBT principles such as CBT theory, core skills, and formulation. The concluding nine sessions covered a range of specific disorders. Training was provided on these aspects by trainers with specific experience in such areas. Training methods: Each session lasted 4 hours in total, with breaks included. The format of teaching covered a range of methods including presentations, observation, and role play. Feedback was taken at the end of each session via questionnaire. Attendance: This varied from 11 to 17 over the course, with a mean of 13 trainees attending any session. Feedback was requested at each session with an average of 72% of trainees responding. With the exception of one session, response rates exceeded 50% for each session. Feedback: Every session scored 5 or above out of seven on all of the dimensions indexed for teaching quality: Quality; Content; & Teaching Methods. The average scores for each were 5.8, 5.9 & 5.8 respectively. For teaching level, mean levels were very close to 'Just Right' across all sessions, for both personal level and level for the group. Feedback demonstrated that there were several aspects of the course that had been particularly appreciated: role play, observation, a range of trainers delivering the training, and case discussion. Participants indicated that they had found videos, handouts, materials to take away and lists of resources particularly useful and would have liked to see more of these opportunities available. A number of areas for consideration for future courses were highlighted, including enrolment, attendance, end of course feedback, and some practical issues around demonstrating work with younger children.

Factors Predicting Adjustment in Children of Parents with Spinal Cord Injury

Wright K, Department of Child and Adolescent Psychiatry, Milton Keynes

Coping with distress is a fundamental concept in theory, research and clinical practice within psychology (Fields & Prinz, 1997, p.937). Whilst the adult literature on coping has received great attention, coping research in children is lacking in comparison (Compas, 1987).The purpose of the study was to use the Lazarus and Folkman (1984) model of coping as a theoretical framework to explore factors that predict adjustment in children of parents with spinal cord injury. No previous published studies have attempted to examine this under-researched group using an established psychological model. A cross-sectional design was used to explore a number of variables that might predict adjustment in children of parents with spinal cord injury. Twenty-eight parents with spinal cord injury took part, providing information about their spinal cord injury and demographic information about their child. Parents with spinal cord injury also completed the Child Behaviour Checklist (CBCL) and the General Health Questionnaire (GHQ-12). A further 19 partners of parents with spinal cord injury completed a GHQ-12. A total sample of 23 children aged 7-18 years participated, completing four self-report measures: the Kidcope, the Locus of Control Scale for Children, the Culture Free Self-esteem Inventory and a newly designed measure of cognitive appraisal. Adolescents also completed the Youth Se! lf-Report (YSR). Results indicated that adjustment in children of parents with spinal cord injury was not significantly different to children in the normal population. Some of the factors hypothesised to account for adjustment in children of parents with spinal cord injury, based on the Lazarus and Folkman (1984) model of coping, were found to have support. This included the coping resources self-esteem and locus of control, specific coping strategies (Self-criticism, Resignation and Emotional Regulation) and parental mental health. Cognitive threat appraisal was also found to positively correlate with adjustment in the children, but did not predict. The study found that adjustment problems are not prevalent in children of parents with spinal cord injury, although a minority do experience difficulties. It has succeeded in identifying factors that predict adjustment in this population. There are clinical implications for the provision of psychological support and for promoting awareness of this population. Theoretical implications exist in broad support of the Lazarus and Folkman (1984) model and in support of cognitive and systemic theory.

Eating and Impulse Control

Keynote Address

Beauty and the Beast: The Contribution of Clinical Research to the Understanding and Treatment of Eating Disorders

Dr Roz Shafran, Oxford University Department of Psychiatry

Research has provided some answers to the specific question of what factors are responsible for the persistence of bulimia nervosa and binge eating disorder and effective cognitive-behavioural treatments are available. There is less known about the maintenance and treatment of anorexia nervosa in adults and almost no data on the large proportion of patients with 'eating disorder not otherwise specified'. This talk will use interactive software and address two questions: First, 'What maintains eating disorders?' and second, 'What are the recent advances in their treatment?' It will be suggested that dispensing with traditional diagnostic categories helps to answer both questions and has significant advantages for the dissemination of efficacious treatments.

Symposia

Moving Beyond Diagnosis in Eating Disorder Research

Convenor: Hannah Turner, University of Southampton
Chair: Rachel Bryant-Waugh, University of Southampton

Cognitive-emotional-behavioural therapy (CEBT) for the eating disorders: Working with beliefs about emotions

Corstorphine, E South West London and St George's Mental Health NHS Trust & Institute of Psychiatry, Kings College London

Links between cognitions, emotions and behaviours are well known in the maintenance of eating disorders. A number of protocols exist for working with the cognitions and behaviours in these interactions. However, there is a subgroup of patients who have particular difficulty in tolerating negative mood states (affect regulation difficulties), and these protocols are less effective when working with such cases. Clinical research has considered the utility of emotion-based therapies (particularly Dialectical Behaviour Therapy) to address this emotion- behaviour interaction. However, such 'level 1' interventions centre on teaching skills that allow the individual to tolerate their emotional distress, but do not address its source (i.e. beliefs about the unacceptability of experiencing and expressing emotions). There is no such established protocol for 'level 2' interventions - treatments that help the individual to challenge the basis of the emotional distress and to reduce the function of the associated impulsive behaviours. This presentation will outline Cognitive Emotional Behavioural Therapy (CEBT) - a recently developed 'level 2' intervention, aimed at enabling patients to: Understand the experience, expression and function of their emotions, Identify and challenge their beliefs about emotions, Attend and respond to their emotions adaptively, Reduce the need for maladaptive coping (e.g. eating disordered behaviours). This presentation is suitable for all clinicians who have direct patient contact and who wish to expand their skills in working with cases where affect regulation is a significant problem.

Identifying clinically relevant sub-groups across the eating disorder population: the potential usefulness of combining eating disorder and psychological features

Turner H University of Southampton Bryant-Waugh R University of Southampton Peveler R University of Southampton

Background: The usefulness of the current eating disorder diagnoses continues to be widely debated and a number of studies have been conducted investigating alternative ways of sub-grouping this population. However the majority focus solely on eating disorder features and those that have investigated potentially clinically relevant variables are restricted by their use of narrow sub-groups of the population. This study aimed to: 1) explore whether distinct sub-groups of patients can be identified on the basis of eating disorder features across the whole eating disorder population in contact with health services, and 2) explore whether there are aspects of the wider clinical presentation that might be specifically associated with these different sub-groups, and which in turn might usefully inform

treatment. Method: The sample consisted of 183 patients assessed for treatment at a Community Eating Disorder Service. All participants completed: the Eating Disorder Examination; the Attachment Style Questionnaire; and the Utrecht Coping List. Cluster analysis was used to identify naturally occurring sub-groups based on eating disorder features and analysis of variance methods were used to explore specific associations between the psychological features and the identified groups. Results: Data analysis suggested five clusters. These groups will be described and compared with existing diagnostic criteria and preliminary analysis relating to the other features assessed will also be reported. Conclusions: The clinical utility of eating disorder classification systems might be usefully enhanced by the assessment of wider aspects of the clinical presentation, thus allowing for more appropriate tailoring of interventions to presenting features.

Can people with anorexia read other people's minds?

Tchanturia K Russell T Doherty L Young V Schmidt U, King's College London, Institute of Psychiatry

Background: Theory of mind (ToM) is the 'ability to represent one's own or another's mental states such as intentions, beliefs, wants, desires and knowledge' and 'is believed to be an outgrowth of social intelligence'. There is robust evidence that ToM is impaired in autism disorder and schizophrenia, i.e. neurodevelopmental disorders with profound impairments in social intelligence. There are a number of reasons for investigating ToM in anorexia nervosa (AN). First people with anorexia nervosa have an impaired ability to detect emotional signals from others (Kucharska-Pietura, et al., 2004; Zonnevijlle-Bender et al., 2002) and themselves (Schmidt et al., 1993); second, people with AN find intimate social relationships difficult (for review see Schmidt & Treasure, in press). Third, a proportion of AN cases have autistic spectrum disorders and conversely those with autism spectrum disorders are often underweight and overactive (Gillberg et al, 1998; Bolte et al., 20002; Sobanski et al., 1999), Finally, decision making - which is OFC related - is impaired in AN (Cavedini et al 2004., Tchanturia et al., submitted), which is thought to result from impairment in processing one's self-mental states (Abu-Akel, 2003). In a previous study (Tchanturia et al., 2004) we failed to find significant differenced between women with AN and healthy controls (Total N=40) in verbal and cartoon ToM tasks developed by Happé and collaborators (1994). We speculated that this negative finding might be to do with the nature of the tasks as the stories and cartoons used in this study were fairly cognitive and represented "cold" rather that "hot" cognition. Method: 21 patients with AN and 21healthy controls were given Happé's ToM tasks and a series of control stories and images ("cold") and Baron Cohen's (2001) (more emotional "hot") eye task where participants had to guess what emotions were shown in the pictures. A control gender discrimination task was also performed on the eye pictures. Results of this as yet ongoing study are as follows: 1) We replicated our previous finding that AN were slower in both physical and ToM tasks. 2) People with AN found the eye task more difficult than healthy control subjects. Conclusions: Our hypothesis regarding difficulties of AN patients to detect emotional states of others was confirmed empirically. There is a limited studies in the field of emotional cognition and AN. Mapping the cognitive and emotional characteristics of the eating disorder population is highly significant in order to understand nature of the illness better.

Narcissism and narcissistic defences in the eating disorders: Associations with cognitions, behaviours and emotional processing

Waller G CNWL Mental Health NHS Trust and Institute of Psychiatry Sines J University of Kingston

Background: There is considerable evidence that narcissism plays a role in the eating disorders. However, the literature to date has focused on the outer display of narcissism (grandiosity, entitlement, lack of empathy), rather than the defensive cognitive and behavioural styles that are associated with this characteristic. This study examined the role of narcissism and narcissistic defences in the eating disorders, considering links to cognitions (both disorder- specific and schema-level), behaviours and emotional processing. Method: The sample consisted of 70 adult eating-disordered women. Each patient completed: the O'Brien Multiphasic Narcissism Inventory (OMNI); the Eating Disorders Examination-Questionnaire; the Young Schema Questionnaire-Short form; and the Toronto Alexithymia Scale. Multiple regression analyses were used to determine associations of OMNI scores with the severity of cognitive, emotional and behavioural features Results: There were clear and meaningful links between the patient's OMNI scores and both their eating-related and schema-level cognitions, with different patterns of association across elements of narcissism and the narcissistic defences. Similarly, those with high OMNI scores reported greater levels of difficulty in describing their emotions. However, these cognitive and emotional associations were not reflected in links between narcissism and eating-related behaviours. Discussion: It is important to understand the role of narcissistic defences, rather than simply focusing on the elements reflecting grandiosity. Many cases in the eating disorders do not display that feature, and clinical interventions need to be directed accordingly. The lack of association with eating behaviours means that behavioural experiments need to be targeted at other elements in the individual's cognitive- behavioural profile.

Eating Disorders: Control, Rumination and Other New Avenues

Convenor & Chair: Douglas Maisey, North Tyneside Primary Care Trust
Discussant: Esther Cohen-Tovee, Newcastle, North Tyneside and Northumbria Mental Health NHS Trust and University of Newcastle Upon Tyne

Proximal antecedents to a perceived loss of control over eating, shape and weight in women with eating disorders: A descriptive study using semi-structured interviews

Ducklin E University of Teesside Maisey D North Tyneside Primary Care Trust

The background for this study comes from cognitive behavioural models of eating disorders, specifically the transdiagnostic model of eating disorders (Fairburn et al, 2003) and the maintenance model of anorexia nervosa (Fairburn et al, 1999). Models of eating disorders have emphasised the importance of control and how the loss of control over eating, shape and weight can be distressing to this patient group as it may signify complete loss of self control. It may also contribute to the maintenance of the difficulties, as losing control could suggest to the patient an even greater need for future control, which may in turn lead to more extreme restriction of food intake. Although research has been conducted into the triggers to binge eating, which is generally accompanied by a sense of feeling out of control, there is little, if any research, which has focused on triggers to loss of control more generally. This study focused particularly on the element of 'perceived loss of control over eating, shape and weight' mentioned in Fairburn et al's (1999) maintenance model of anorexia nervosa, and aimed to obtain a deeper understanding of the factors which lead women with eating disorders to feel out of control of their eating, shape and/or weight. This was done by conducting semi-structured interviews with a clinical sample of women with eating disorders. The interviews investigated the various phenomena which served to trigger a sense of loss of control such as the kinds of thoughts, feelings, behaviours, images and physiological sensations which were experienced. Preliminary findings suggest that a wide range of emotional states appear to precede episodes of loss of control.

Thoughts about weight and shape

Williamson E University of Newcastle Maisey D North Tyneside Primary Care Trust
Freeston M University of Newcastle & Newcastle Cognitive Therapy Centre

Background: Weight-shape preoccupation is a common in eating disorders but has not received as much attention other features. This study draws on the methodology developed for the study of intrusive thinking and ruminative thinking in anxiety disorders to examine features of weight-shape preoccupation in an analogue sample. First, the study established the range and level of preoccupation reported by this sample. Second, it seeks to establish relationships between preoccupation and behaviours that may be found in eating disorders. Third, it examines the relationship between preoccupation and other cognitive variables and distress. Method: A sample of 119 undergraduate students, 78% female, with a mean age of 21.7 years (SD = 2.0) completed the Weight-Related Intrusions Inventory developed for this study. Items were drawn from existing questionnaires used in the study of intrusive thoughts as well as weight and shape related items based on the eating disorders literature. Participants also provided information allowing calculation of BMI and ratio of actual weight to their self-declared ideal weight. Hierarchical regression was used to examine a series of a priori hypotheses. Results: Results indicate that 34% of the sample (all female) reported thinking about their weight or shape at least 5 times a day. Higher thought frequency, once gender, age, and BMI had been controlled for, was associated with a higher actual: ideal weight ratio, more behavioural strategies aimed at weight control, and more checking/comparing of body weight/shape. Further, higher thought frequency was associated with greater body dissatisfaction, greater impact of weight-shape concerns, and higher levels of distress. Interestingly, other analyses suggest a degree of insight, even among those with high degrees of preoccupation who are troubled by their thoughts. Discussion: The results of this study indicate that among this sample of young adults, mostly women, thoughts about weight/shape were at high levels for a significant proportion of the sample. Further, this thinking is strongly associated with a range of variables that are typically found among eating disordered patients. The results of this study suggest that weight/shape thinking may be an integral part of a self-maintaining cognitive-affective-behavioural complex. Although this study does not address clinical levels (although high levels of dissatisfaction, distress, behaviours and interference were observed among a proportion of the sample) and cannot address causality, the pattern and strength of the relationships does raise the question as to whether this thinking is a mere epiphenomenon, that is, a consequence or concomitant of the other well-recognized features found among the eating disorders. Alternatively, as in some anxiety disorders, this thinking could be a key phenomenon and play a maintaining role (or potentially even a causal role) in the dissatisfaction, distress, unhelpful behaviours and interference in day-to-day activities observed among the eating disorders.

A study investigating the content and process features of ruminative thinking in women with eating disorders

Belshaw T Newcastle Cognitive and Behavioural Therapies Centre Freeston M Newcastle Cognitive and Behavioural Therapies Centre

The current empirical study was undertaken in an attempt to add to the body of knowledge on cognitive states in eating disorders, with a view to exploring intrusive, ruminative thoughts in this client group. Studies investigating intrusive thoughts in clinical disorders have been ongoing for the past three decades, especially in terms of obsessive-compulsive disorder. However, no study has focused on ruminative thinking in eating disorders to date, despite the range of overlapping characteristics with OCD, and the research suggesting that dysfunctional thinking is a key feature of the high relapse rates with eating disorders. This study systematically described the key features of ruminative thinking in 21 women with eating disorders, in terms of its content (themes) and the processes involved (e.g. severity, form, appraisal, and coping strategies used). It also attempted to explore the relationships between the respective features identified and other clinical phenomena, including depression. In essence, two main findings emerged. Firstly, the presence of ruminative thinking as an important clinical phenomena in eating disorders. All participants reported preoccupations related to their eating disorder ranging from mild to severe symptomatology - all reporting at least one hour per day. A significant proportion of the sample were spending more than eight hours per day ruminating on themes such as food and eating, and perceptions of their weight and shape. The ruminations were found to be distressing and perceived as uncontrollable, and the responsibility for the thoughts was placed with the individual, as opposed to outside influences. Most of the sample tried to do something to cope with these thoughts, yet felt their strategies were inefficacious. Secondly, links were observed between the structure of ruminative thinking in EDs and the structure of worry in GAD, suggesting worry is an integral feature of EDs, not a by-product of them. This study, despite its small numbers, provides evidence for the further exploration of cognitive states in the study of cognitive treatments for eating disorders. In particular, it raises the issue of exploring worry as a legitimate treatment target.

Intellectual Disabilities

Symposia

Life Events, Trauma Impact and Treatment in People with Intellectual Disabilities

Convenor: John L Taylor, Northumbria University, Newcastle upon Tyne and Northumberland, Tyne & Wear NHS Trust
Chair: Chris Hatton, Lancaster University

The Bangor Life Events Scale for Intellectual Disabilities (BLESID)

Lee S. L University of Wales, Bangor Hastings R University of Wales, Bangor Noone S University of Wales, Bangor

Objectives: To construct an informant-rated life measure for use in research into intellectual disabilities; to explore the feasibility of using informant ratings of impact; exploratory analyses of the validity of the new instrument. Design A cross-sectional postal survey design was used. Method: Forty-three parents of adults with intellectual disabilities living in the family home completed the Bangor Life Event Scale for Intellectual Disabilities (BLESID), the Psychiatric Assessment Schedule for Adults with Developmental Disabilities (PAS-ADD) Checklist and the Behaviour Problems Inventory (BPI). Demographic data on the adult with intellectual disabilities were collected. Results: The most frequently experienced negative life events were being taken to an unusual place, change in daily routine, and bereavement. Participants experienced a mean of 5.05 life events in the previous 12 months. Previously found associations between life events and affective symptoms were partially replicated. Two life events were associated with higher scores on the affective disorder scale of the PAS-ADD: care by non-regular carer ($p = .058$) and increased arguments ($p = .093$). Two different life events were significantly positively correlated ($p < .05$) with challenging behaviour: verbal abuse and witnessing physical attack or verbal abuse. Conclusions: The BLESID has a workable overall structure and is suitable for completion by non-professional carers of people with intellectual disabilities. The general pattern of associations between life events, as measured with the BLESID, and measures of challenging behaviour and mental health are in agreement with the previous literature. It is unclear from the current data whether informant-rated "impact" is a useful or valid measure for future life events research in this population.

Developing a Measure of the Impact of Traumatic Life Events on Adults with Intellectual Disabilities

Wigham, S Lancaster University and Northumberland, Tyne & Wear NHS Trust

Objectives: The link between traumatic life events and mental ill health is well established in the literature on post-traumatic stress disorder (PTSD) and abuse, and there are numerous assessments of trauma symptoms for the general population. The main objective of this study was to develop new self-report and informant measures of symptoms associated with traumatic life events that are relevant and accessible to people with intellectual disabilities and those supporting them. Method: Using structured interviews, questionnaires and focus groups, six service users, two advocates, two family carers, plus 16 paid staff and clinicians from mental health and forensic intellectual disabilities services in Northumberland were consulted about their views on symptoms associated with traumatic life events. They were also asked which symptoms from existing general population measures of PTSD they considered to be relevant to the people with intellectual disabilities. Results: Themes were derived from the data using content analysis. The themes that emerged guided the inclusion of the items included in the new measures. The majority of the emerging symptom themes were consistent with general population studies. However, there were some differences that have been noted in previous studies of children and abuse in ID, such as loss of previously acquired skills, and behaviours that challenge services. Study participants also indicated that some symptoms in the general population PTSD measures may be too difficult to reliably access in many people with intellectual disabilities (e.g. depersonalization). Conclusions: The next stage of the research project is to examine the reliability and validity of the newly developed trauma impact measures.

Treating Chronic Nightmares of Sexual Assaults

Thomas G Shropshire County Primary Care NHS Trust and University of Birmingham
Stenfert Kroese B Shropshire County Primary Care NHS Trust and University of Birmingham

Background: Imagery rehearsal therapy for people who suffer from recurring nightmares has been shown to be a successful intervention. Very little research has been conducted on post-traumatic nightmares sufferers with learning disabilities or the efficacy of imagery rehearsal therapy with this population. Method: This paper presents two descriptive case studies to illustrate the application of imagery rehearsal therapy with adults with learning disabilities. The approach used is adapted from existing imagery rehearsal therapy protocols. Drawings were added to aid attention, information processing, and retention. Results: Both descriptive case studies indicated that the intervention resulted in significant reductions in distress because of nightmares and provided some evidence that these positive results were generalised into waking life. Conclusions: As a short and simple method, imagery rehearsal therapy appears to be very suitable for people with learning disabilities.

Treating PTSD after a Physical Attack - A Case Study

Stenfert Kroese B Shropshire County Primary Care NHS Trust and University of Birmingham Holt N University of Birmingham

Background: This case study concerns a 47-year old man with an intellectual disability who was suffering from post-traumatic stress disorder (PTSD) after being attacked in the street. Details of the assessment are presented and a formulation based on an established cognitive model of PTSD is given. Details of the intervention are also described. Method: Baseline was compared with a seven-week period of anxiety management intervention followed by a ten-week period of Imagery Rehearsal Therapy. The interventions were evaluated using individualised recording forms and standardised measures (Hospital Anxiety and Depression Scale and Impact of Events Scale). Data from the recording forms were analysed using t-tests to compare baseline with the two intervention phases. Results and Conclusions: The outcome measures indicated that PTSD symptoms had significantly abated, particularly after Imagery Rehearsal Therapy was applied. Particular difficulties and limitations in the adaptation and implementations of CBT for people with intellectual disabilities are discussed.

Developments in the Application of CBT for People with Intellectual Disabilities

Convenor: John L Taylor, Northumbria University, Newcastle upon Tyne and Northumberland, Tyne & Wear NHS Trust Chair: Raymond W Novaco, University of California, Irvine, USA

CBT for People with Intellectual Disabilities and Mental Health Problems: A Review of the Evidence

Taylor J L, Northumbria University, Newcastle upon Tyne and Northgate & Northumberland, Tyne & Wear NHS Trust

People with intellectual disabilities (ID) have an increased vulnerability of to mental health problems. However, historically psychological therapists have been reluctant offer individual therapy to people with ID as this would necessitate building close therapeutic relationships with people perceived as unattractive because of their disability - the 'unoffered chair'.In this paper the evidence to support the effectiveness of cognitive-behavioural therapies for emotional and mental health problems amongst people with ID is selectively reviewed, with particular reference to treatment outcome research that has been carried out recently in the UK, Australia and North America. This evidence is contrasted with that available to support the reactive behavioural interventions and priority clinical research questions for future enquiry are highlighted. There have been several recent reviews concerning psychotherapy for people with ID and mental health problems. The evidence to support the use of psychological therapies with this client group, particularly cognitive-behavioural therapy, is limited but promising suggesting that therapeutic disdain for this population is no longer justified. Further research into the applicability and sustainability of these therapies with these clients across clinical problems and service settings is indicated.

Biopsychosocial Case Formulation for People with Intellectual Disabilities and Mental Health Problems: Evaluation of and Introductory Workshop for Direct Care Staff

Ingham B Northgate & Prudhoe NHS Trust, Northumberland and University of Newcastle upon Tyne Clarke L Northgate & Prudhoe NHS Trust James I A. University of Newcastle upon Tyne

Introduction: Biopsychosocial approaches that have been developed in mainstream mental health services may be applied to specialist mental health in intellectual disability (ID) services. Case formulation is purported to be a key element of biopsychosocial approaches. Therefore, the development of knowledge and skills in case formulation may be an important, initial step in a strategy to implement biopsychosocial approaches within a specific mental health in ID service. To this end, a brief biopsychosocial case formulation training workshop was designed and delivered for staff within such a service. This study aimed to evaluate whether the workshop had an effect upon participants' awareness of biopsychosocial case formulation. Method: A brief training workshop on biopsychosocial case formulation was delivered to a group of unqualified nursing staff (n = 10). A biopsychosocial case formulation measure was presented to participants before and after training to measure changes in awareness of formulation. A workshop evaluation questionnaire was also presented at the end of the workshop. Results: Participants were more likely to identify aspects of a biopsychosocial formulation approach within a case formulation after they had received training in biopsychosocial formulation. Participants found the workshop to be highly satisfactory and felt that it had increased their mastery of formulation. Conclusions: The training workshop was shown to have some effect on awareness of biopsychosocial case formulation in direct care staff in a specialist mental health in ID service. Subsequently this training supported the implementation of biopsychosocial approaches within that service. In addition to replicating these findings, further evaluation into the effectiveness of this training in other healthcare settings is required.

Further Developments in the Adaptation of Cognitive Therapy for Detained Women with Intellectual Disabilities and Personality Disorders.

McKenna, M Northumberland, Tyne & Wear NHS Trust

In addition to their offending behaviours, women within forensic populations also present with personality difficulties that can impede their rehabilitation, and challenge both the system and staff caring for them. The most prevalent of these difficulties are described in DSM IV as Borderline and Anti-social Personality Disorder. Therapeutic interventions are not always routinely available for this group or the difficulties they present. Recently, however, interventions have been developed to address these difficulties both within health and criminal justice settings. Further, the Department of Health has recently published guidelines for the development of services for patients with personality disorders. There is no reason to suppose that the mental health needs of women with intellectual disabilities (ID) in forensic services will be any different from women without ID. Research in forensic services for women with ID indicates that personality disorder characteristics are prevalent and are an area of unmet clinical need. The current study involves the evaluation of an adaptation of an established form of cognitive therapy for outpatients with anti-social or borderline personality disorder. The aims of the study are to determine: (1) whether the intervention can be successfully adapted for the client group; and (2) whether the adapted intervention is effective with the client group, In this paper the initial outcome data from the study is presented regarding the acceptability of the intervention for women with ID, and its effectiveness using patient and staff-ratings of changes in targeted problem behaviours

When Not to use CBT with People with Learning Disabilities

Stenfert Kroese B, Shropshire County PCT and University of Birmingham

In the light of the recent, rapid growth of the use of CBT within learning disabilities, this paper will discuss some of the issues relevant to efficacy and ethics of such an approach. There remain questions regarding the evidence base (e.g. Sturmey, 2005) and any therapeutic approach offered to this group of service users must be especially accountable, as people with learning disabilities are not always in a position to make informed choices regarding therapeutic services offered to them. Personal characteristics and circumstances may reduce the likelihood of good outcome. They include cognitive ability, motivation and consent, other treatment approaches running in parallel, and the level and nature of support services. Environmental conditions may also be contra- indicative. Particularly, 'toxic', 'unreasonable' living conditions and the expectation that the person is 'treated' in isolation are problematic. Taken together with a lack of opportunity for 'self regulation', a CBT approach may, under such circumstances, not be suitable or even justifiable. Finally, this paper will discuss some of the characteristics required of therapists (such as experience, training, supervision, ability to be flexible and involved in other aspects of the service user's life) and will conclude with a number of clinical and research implications.

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