BABCP CONFERENCE 2014 ABSTRACTS

Poster Presentations 1 ......................................................................................................................... 2

The Effectiveness of the STEPPS Group Within a UK Secondary Care Setting: A Case Study ……… 2
Cognitive Behaviour Therapy: A South Asian service users’ perspective ............................................. 4
"All these negative thoughts come flooding in": the phenomenology of rumination in young people with depression ………………………………………………………………………………………………………… 4
Effectiveness of CBT for Obsessive Compulsive Disorder (OCD) in a young person with PANDAS … 5
The impact of secure electronic video submissions for students undertaking CBT training…………… 5
Treatment of Post Traumatic Stress Disorder in a person with Autism Spectrum Disorder and a Learning Disability: a Case Study …………………………………………………………………………………… 6
The impact of victims’ responses to bullying on the attitudes and behaviours of peer bystanders…6
Differences in physical sensation reporting following mood induction in relation to alexithymia and medically unexplained symptoms………………………………………………………………………………… 7
ACT & Adoption: Application of the Acceptance and Commitment Therapy model to support adoptive parents pre- and post-placement…………………………………………………………………….. 7
Fighting Fear: A preliminary evaluation of a novel trans-diagnostic CBT and mindfulness group treatment for anxiety disorders…………………………………………………………………………………………. 8
PTSD in sub-Saharan Africa: Reviewing the Applicability and Success of Cognitive Models and Interventions……………………………………………………………………………………………………… 8
Psychological interventions for children with long-term physical conditions and psychiatric comorbidities ……………………………………………………………………………………………………………… 9
CBT for common mental health problems in children with neurological and cognitive difficulties 10
The role of Self-Practice/Self-Reflection (SP/SR) in the training of Psychological Wellbeing Practitioners (PWP) ………………………………………………………………………………………………………. 10
Is offering choice over treatment a realistic option for early intervention service? Views from servicve users and an early intervention for psychosis staff team………………………………………………………….. 11
Service user perspectives on the use of outcome measures in psychological therapy………………… 11
Polyvagal Theory: practical implications for CBT practice………………………………………………… 11

Poster Presentations 2 ......................................................................................................................... 12

Community Engagement - Eis Ledaber ……………………………………………………………………….. 12
Observer Vantage Perspective and Rumination: Understanding their Relationship in Depression 13
Behaviour Change in the presence of Fusion with Catastrophic, Pain-Related Cognitions in Acceptance and Commitment Therapy ………………………………………………………………………….. 13
Treating childhood fears in children on the higher end of the autism spectrum through drama .. 14
Treatment Progress in Medium Secure Settings for Women: Changes in Symptomatology, Personality and Need from Admission to Discharge …………………………………………………………….. 14
Team formulation: A literature review exploring the practice and evidence base ……………………… 14
Is 16 the magic number? A meta-analysis of low intensity CBT for psychosis …………………………… 15
Cognitive Behavioural Therapy for Emetophobia and The Role of Negative Beliefs about Emotional Expression .......................................................... 16

The Treatment of Compulsive Checking in an Older Gentleman with Cognitive Impairment: A Case Presentation .......................................................... 17

Assessing event-specific repetitive thought: A subtype-level, transdiagnostic measure ................. 17

Developmental trajectories of childhood internalizing symptoms from 17 months to 8 years of age: Early risk and protective factors for adolescent internalizing problems ........................................ 18

Development and validation of the Japanese version of Responsibility Attitude Scale and Responsibility Interpretations Questionnaire .......................................................... 19

Comparing Immediate Recall Memory Biases in Depressed and Non-Depressed Adolescents ........... 19

Treating Social Anxiety: A 70 year-old Grandmother Meets a New Social World .......................................................... 19

Panic attacks or intrusive memories: an easy diagnostic error? ...................................................... 20

An exploration of the construct of bitterness in adults .................................................................... 21

Social Inclusion – Recognising the needs of the Polish Community ................................................. 22

Effectiveness of Group CBT in Routine Clinical Practice in a South London IAPT Service ................................. 22

Can people with anxiety and depression learn mindfulness? A Meta-Analysis ......................................... 24

Are elevated manic symptoms in children related to disorder diagnoses? Preliminary results from the Longitudinal Assessment of Manic Symptoms (LAMS) Study ......................................... 24

Poster Presentations 1
Wednesday 23rd July

The Effectiveness of the STEPPS Group Within a UK Secondary Care Setting: A Case Study

Sinead Lambe, University of Bath

Borderline Personality Disorder (BPD) is a serious and prevalent condition. However available interventions are often long and costly, providing a challenge for services with limited resources. The Systems Training for Emotional Predictability and Problem Solving (STEPPS) programme is a 20 week Cognitive Behaviour Therapy based intervention aimed at providing a cost effective alternative. However evidence for its use in the UK is scant. This case study aims to address this. Five service users were referred to the community mental health team. Each presented with a diagnosis of BPD and a history of self-harm, predominantly cutting and overdosing behaviours, which had escalated over the past two months.

The STEPPS program views BPD as arising due to deficits in the person’s internal ability to regulate emotional intensity. Hence the first twelve sessions focused on psychoeducation and emotional management skills, where service users learn to predict the course of emotional states, anticipate stressful situations and develop functional coping strategies. The last eight sessions then focused on behaviour management skills, which include goal-setting, sleep hygiene, physical health, abuse avoidance and interpersonal relationship management.

By the end of treatment there was a 32% reduction in self-reported impairment resulting from BPD symptoms. Scores on the Beck's Depression Inventory (BDI) also reduced by 30% from the baseline range of 26-55 (M=43.7, SD=12.3) to a range of 9 to 35 (M=30.5, SD=18.8) at end of treatment.
These results are comparable with randomized controlled trials with American samples and indicate the potential utility of this intervention within the UK. By the end of treatment there was a 32% reduction in self-reported impairment resulting from BPD symptoms. Scores on the Becks Depression Inventory (BDI) also reduced by 30% from the baseline range of 26-55 (M=43.7, SD=12.3) to a range of 9 to 35 (M=30.5, SD=18.8) at end of treatment.
This study looks at South Asian service users' experiences of cognitive behavioural therapy for low mood and/or anxiety.

Five South Asian participants were recruited to take part in a qualitative study to explore their experience of accessing CBT for low mood and/or anxiety in a primary care setting. Participants were interviewed using a semi-structured interview and the resultant data was analysed using hermeneutic interpretative phenomenology.

The data analysis identified certain key themes. The first theme was that CBT was experienced by the service users as helpful in the short term, although not in the long term. Additionally, the supportive aspect of the therapeutic relationship was experienced as more helpful than implementation of specific CBT techniques. A degree of conflict between cultural issues and CBT was reported. Finally, CBT was experienced as more helpful for anxiety than it was for low mood.

The findings are consistent with the notion of Asian culture emphasising a more collectivist, supportive nature, in contrast with the more individualistic and challenging emphasis of CBT. As a predominantly Western model developed mainly with a white, middle class population, CBT may require some adaptation in order to maximise its effectiveness with an Asian client group. An integration of CBT and counselling might be helpful in treating a minority group whose cultural values and history identifies more readily with an supportive counselling type framework. This notion is consistent with previous literature in this area.

Individuals with depression describe repetitively thinking about their depressive symptoms, the cause of these symptoms and their consequences. This rumination includes many 'why' questions about self-worth and negative comparisons with others. Rumination has already been associated with adolescent depression in quantitative studies. This study was the first to use qualitative methodology to find out how rumination is actually experienced by young people with depression.

Seven young people with depression attending a Child and Adolescent Mood Disorder Service were interviewed about their experience of rumination. The semi-structured interview included questions about content, associated emotions and start and stop triggers. Transcripts were analysed using interpretative phenomenological analysis (IPA), to capture the richness and diversity of their experience of rumination. Emergent themes were verified by participants.

The young people with depression in this study described experienced rumination as a disorientating cognitive battle, in which they felt under attack. "It’s trying to get out of its little drawer in your head and it’s really, like, disruptive" (Bryony). Rumination was said to elicit sadness predominantly, but also anger and anxiety, with mood and rumination often maintaining each other. "I’m thinking about more and more things, so it’s like piling on top, so, the mood just kind of keeps going down" (Liz). Finally, interpersonal interaction was reported to play a key role in starting and stopping rumination episodes. "And then we both just kind of carried on talking about the past and feeling bad about it" (Tim).

Certain elements of young people’s experience of rumination emerged as distinct from adults. There was a particularly vivid sense of being attacked by rumination, with a strong negative emotional impact. Addressing the experience of being overwhelmed by rumination may be particularly important when working with depressed young people, particularly if it has some bearing on the irritability and anxiety...
associated with depression in this age group. The influence of other people on rumination behaviour also seemed more prominent for young people in this study than for adults (Pearson et al., 2008). These aspects now warrant further quantitative investigation with larger samples. The young people with depression in this study described experienced rumination as a disorientating cognitive battle, in which they felt under attack. "It’s trying to get out of its little drawer in your head and it’s really, like, disruptive" (Bryony). Rumination was said to elicit sadness predominantly, but also anger and anxiety, with mood and rumination often maintaining each other. "I’m thinking about more and more things, so it’s like piling on top, so, the mood just kind of keeps going down" (Liz). Finally, interpersonal interaction was reported to play a key role in starting and stopping rumination episodes. "And then we both just kind of carried on talking about the past and feeling bad about it" (Tim).

Effectiveness of CBT for Obsessive Compulsive Disorder (OCD) in a young person with PANDAS

Sarah Mills, University of Bath; Susannah Lloyd, Oxford Health NHS Trust
A case report outlining protocol driven Cognitive Behaviour Therapy (CBT) for Obsessive Compulsive Disorder in a young man with comorbid tic disorder and a diagnosis of PANDAS (Paediatric Autoimmune Neuropsychiatric Disorders associated with Streptococcal infection)
The young man’s difficulties appeared to have developed at an early age with obsessional thoughts relating to safety and responsibility. These had continued to the present day and behavioural avoidance appeared to play a significant role in maintaining the problems. He expressed a preference for addressing the obsessions and compulsions before his tics so it was agreed that he would be offered CBT for OCD based on the protocol outlined by Bolton, Williams, Perrin, Atkinson, Gallop, Waite & Salkovskis (2011). Improvement in OCD symptoms was achieved in 12 sessions of CBT delivered through a community CAMHS clinic.
The Child Obsessive Compulsive Inventory was used as the primary outcome measure. The Outcome Rating Scale (ORS) and Session Rating Scale (SRS) were used to measure change over time and patient satisfaction with treatment.
Improvement in OCD symptoms was achieved in 12 sessions of CBT delivered through a community CAMHS clinic.

The impact of secure electronic video submissions for students undertaking CBT training

Megan Edwards, University of York; Byron George, University of York; Lynn Burnell, University of York
The viewing of CBT practice allows students to gain specific feedback and identify areas for development from the commencement of CBT training. It is known that interactive methods including viewing actual practice enhance clinical supervision effectiveness (Milne 2009). The importance of operating in accordance with data protection law poses increasing challenges for students and practitioners alike leading to delays in receiving regular valuable feedback and in students submitting their DVD on time. A new policy and procedure were developed with support from key departments (IT and the Student assessment office) detailing the processes and security required for students to share with their information governance departments. The new approach will be adopted alongside current process for the first year, in order to pilot it with students who agreed to submit in this manner. Results will be presented in a qualitative manner, with feedback from all parties involved and with clarity as to the specific processes that were developed and their impact on both students and markers. The implications of this new approach for students in training will be considered as well as the wider implications of ensuring that not only students but all CBT practitioners are able to use a secure method for not only submitting their work, but also in an ongoing manner for ensuring that the most effective use is made of clinical supervision in order to maintain best practice. Differing approaches to achieve this will be examined and related to practice.
Results will be presented in a qualitative manner, with feedback from all parties involved and with clarity as to the specific processes that were developed and their impact on both students and markers.

Treatment of Post Traumatic Stress Disorder in a person with Autism Spectrum Disorder and a Learning Disability: a Case Study

Neil Carrigan, University of Bath; Kate Allez, 2gether NHS Foundation Trust; Lorna Hogg, University of Bath

One of the difficulties in assessing and treating post traumatic stress disorder (PTSD) in people with a learning disability (LD) is that it may not present with the typical symptoms associated with the disorder. The problem may be compounded if the patient also has Autism given they may struggle to describe their inner mental life. This may be why there is a dearth of literature on the treatment of PTSD using cognitive behavioural approaches for people with autism and a LD; especially one that relies heavily on cognitive reappraisal of the meanings associated with the trauma memories (e.g., Ehlers, Clark, Hackmann, McManus, & Fennell, 2005).

The case reported here is of the successful treatment of a young man diagnosed with autism and a mild LD. Three years prior to seeking treatment he was the victim of a violent sexual assault. This led to symptoms that included flashbacks, nightmares, anger outbursts and avoidance of places that reminded him of the attack. Treatment involved 12 sessions of cognitive therapy for PTSD using the approach developed by Ehlers et al (ibid).

Treatment led to a reduction in symptoms and scores on a self report measure (CRIES) as well as self reported elevation in mood. Careful questioning, adaptation of language and elucidation of concepts, allowed the patient to fully engage in therapy. Even with a diagnosis of autism and mild LD, he was able to engage in reappraisal of the meanings associated with his assault which in turn led to reductions in his symptoms of PTSD.

The impact of victims’ responses to bullying on the attitudes and behaviours of peer bystanders

Nicole Sokol, Macquarie University; Kay Bussey, Macquarie University; Ronald Rapee, Macquarie University

School bullying is increasingly being recognised as a group phenomenon, which both affects and is affected by bullies, victims, and bystanders alike. Through their attitudes towards the victim and behavioural reactions, peer bystanders have the potential to influence bullying situations and to reduce the negative consequences experienced by victims. While various individual and situational factors have been found to influence the attitudes and behaviours of peer bystanders, the effect of the victim’s response to being bullied has yet to be clarified. This study examined how different victim responses influence peer liking and bystanders’ behavioural intentions when witnessing physical and verbal bullying.

Australian fifth- and seventh-grade students (Mage = 11.13 and 13.18 years, respectively; N=206; predominantly Caucasian) completed online questionnaires about hypothetical videotaped bullying scenarios in which the victims’ responses (angry, sad, confident, ignoring) were experimentally manipulated.

Peer liking was found to be the lowest for angry victims, especially among females and students who themselves experienced more victimisation. Bystanders were most likely to report intentions to assist sad victims by adopting defender behaviours or informing a teacher. By contrast, more active victim responses (i.e., angry and confident) increased reported intentions to adopt outsider behaviours. These findings suggest that a victim’s emotional and behavioural response to bullying is a salient situational factor affecting peer bystanders’ attitudes and behaviours.

Peer liking was found to be the lowest for angry victims, especially among females and students who themselves experienced more victimisation. Bystanders were most likely to report intentions to assist sad
victims by adopting defender behaviours or informing a teacher. By contrast, more active victim responses (i.e., angry and confident) increased reported intentions to adopt outsider behaviours.

Differences in physical sensation reporting following mood induction in relation to alexithymia and medically unexplained symptoms

Faith Martin, University of Bath; Jeremy Gauntlett-Gilbert, Royal National Hospital for Rheumatic Diseases; Paul Salkovskis, University of Bath

The role of affect in the cause of “medically unexplained symptoms” is unclear. It has been suggested that an inability to recognise emotions, known as alexithymia, plays a causal role in generating medically unexplained symptoms. It is thought that a failure to attribute physical changes to emotional state leads instead to their attribution to an underlying physical problem and the experience of physical sensations including pain.

Participants with medically unexplained symptoms, including chronic fatigue syndrome and fibromyalgia, completed physical state measure (visual analogue scale) before and after induction of a low mood. Alexithymia was measured using the Toronto-Alexithymia scale (Bagby, Parker & Taylor, 1994).

Interim analysis in this ongoing study has revealed no correlation between alexithymia and reporting of physical states before or after the mood induction. No significant differences were observed in physical sensation reporting between baseline and post-mood induction. Current achieved power (with n=17) would be sufficient to detect a large correlation of 0.6 or a large effect (d=0.8 or greater) for t-tests. Early results suggest that if there is any relationship between alexithymia and the impact of mood change on physical or psychological state, this is not a large relationship. Results suggest that a failure to attribute physical sensations to mood state is not a large causal factor in medically unexplained symptoms.

ACT & Adoption: Application of the Acceptance and Commitment Therapy model to support adoptive parents pre- and post-placement

Stephanie Hutton, Staffordshire University

Adoption preparation groups and parenting programmes for adoptive parents tend to focus on using attachment theory to understand the needs and behaviours of children who are placed for adoption, alongside behavioural techniques to manage children’s behaviour once they are placed. The focus of training is usually on the history, needs and difficulties of the children with little consideration of the internal world of the adopters. However, research suggests that the progress made by children in adoptive families is influenced by adoptive parent factors as well as child factors.

ACT has been applied to parenting interventions in general as well as with specific populations such as parents of children with developmental disabilities, autism, and acquired brain injury, with some promising results. A literature search failed to find any evidence of ACT being applied within pre- or post-adoption training and support.

This paper aims to summarise how an ACT approach could be beneficial to adopters from both a professional and personal perspective. It assumes that there are differences between birth parents’ and adopters’ journeys to parenthood, and the presentation of birth compared to adopted children, which make a specific adoption-focused use of ACT valuable.

Each of the six elements within the ACT model of psychopathology will be considered in light of a typical adopters’ journey from loss, to assessment and eventual matching and placement of children. Typical ways that adopters respond to adopted children’s needs will be described within these patterns. The six core therapeutic processes will be explored in terms of what could be offered to adoptive parents both in preparation for and after adoption.
It is anticipated that incorporating an ACT perspective alongside the use of attachment theory in both prospective adopter group work and post-adoption parent support would add value and increase placement stability.

The author is currently developing a reflective workbook for prospective adopters which includes some elements from ACT.

Those practitioners supporting adoptive families through training, support or direct therapeutic work could usefully apply an ACT perspective. Gathering data on the efficacy of this will be vital to inform wider practice and help services involved in assessment and support (typically in social care or adoptive agencies) move away from focusing solely on child factors.

Fighting Fear: A preliminary evaluation of a novel trans-diagnostic CBT and mindfulness group treatment for anxiety disorders

Saquib Ahmad, West London Mental Health Trust - Hounslow IAPT

Anxiety disorders can be highly disabling to individuals and are the most economically costly. CBT protocols have shown efficacy for the treatment of most anxiety disorders. There is also growing evidence to support group treatment for individual anxiety disorders. However the evidence base for treating a range of anxiety presentations in a group setting is in its infancy.

Due to increased demands on services to treat a larger number of patients who often have complex presentation, where co-morbidities are the norm and not the exception and time is of an essence, some services are offering as little as 6 sessions to treat a presentation which would ideally be treated using up to 20 sessions. The need for a group interventions which is not only cost effective but also clinically efficacious has become necessary. Fighting fear; a group treatment option for treating anxiety was based on these very needs.

Patients were recruited through routine clinical practice following referral from GPs. The patients were assessed and screened for appropriateness to a group intervention for anxiety. The model used was a trans-diagnostic model of anxiety which could be applied to various anxiety disorders. The protocol combined CBT with mindfulness to treat anxiety in 10 sessions where each session was 2 hours long. We recruited 6 patients; 3 social anxiety disorder, 1 GAD and 2 panic disorders (1 of which also had PTSD). Of the 6 that started the group 4 completed treatment. Intention to treat analysis showed that 5/6 patients improved on the IAPT MDS (includes PHQ9, GAD and WSAS) which was administrated at every session. 3/4 improved on their anxiety disorder specific measures (ADSMs) by the end of treatment in relation to their initial scores. 3/4 patients showed improvements on the PHQ9, 1 did not, however they remained subclinical from beginning to end. 3/4 improved on the GAD7 and all patients improved on the WSAS from beginning to end. The 2 patients that withdrew also showed improvements on all MDS questionnaires however we were unable to attain their end of treatment ADSMs. A patient experience survey was administrated at the end of treatment which demonstrated that those who engaged in all aspects of the intervention made the largest improvements and these gains were maintained at the 1month follow-up.

The results demonstrate that this model and treatment approach is effective at reducing the symptoms of panic, social anxiety and GAD; however improvements are relative to their level of engagement in treatment. Furthermore it also demonstrates that addressing general principles of anxiety can be used to treat various anxiety disorders in a group setting and in the case of one patient it can subsequently also reduced the symptoms of a co-morbid condition without a direct intervention.

Further research is required with a much larger sample size and controlled groups; however at present these results are promising and demonstrate the effectiveness of a trans-diagnostic group intervention for anxiety disorders which is also cost effective.

PTSD in sub-Saharan Africa: Reviewing the Applicability and Success of Cognitive Models and Interventions

Faith Martin, University of Bath; Claire Bourne, Coventry University; Ailsa Russell, University of Bath
Post-traumatic stress disorder (PTSD) is an important issue in sub-Saharan African countries where violent conflict and natural disaster are frequently reported. The cognitive model of PTSD (Ehlers and Clark, 2000), has received substantial support. However its applicability to a sub-Saharan Africa context is unclear. Various interventions exist to target PTSD. Their use and cultural adaptations require synthesis. Cognitive-behavioural therapy (CBT) has been found effective for treating PTSD but its effectiveness in this context requires analysis.

To address these three issues, Medline, PsycInfo, EMBASE and CINAHL were searched for sub-Saharan African nations names and trauma terms. Studies providing novel data relating to the model were included. Intervention studies using a control group were identified, from which CBT effect data were extracted.

18 studies addressed elements of the model, providing support for it, particularly relating to appraisals of threat and evidence for use of avoidance and rumination strategies as attempts to manage trauma memory. Fourteen intervention studies were identified, revealing use of a wide range of psychological interventions and inclusion of participants without PTSD diagnosis. Cultural adaptations focused on culturally relevant content. Eight CBT studies were identified. Meta-analysis revealed “Narrative Exposure Therapy” (NET) not to be effective, whilst more standard CBT appears effective.

Overall, the lack of focused model-related research and heterogeneity in intervention studies highlights the need for further theory based, high-quality research.

Adaptations to render CBT culturally appropriate can be drawn out for wider practice, highlighting the importance of considering mode of delivery and using culturally relevant content in metaphors.

Psychological interventions for children with long-term physical conditions and psychiatric comorbidities

Sophie Bennett, UCL Institute of Child Health; Anna Coughtrey, Great Ormond Street Hospital; Roz Shafran, UCL Institute of Child Health; Tara Murphy, Great Ormond Street Hospital

Children with long-term physical illnesses are significantly more likely to develop common mental health disorders than otherwise healthy children (e.g. Green et al., 2005; Reilly et al., 2013). Cognitive behavioural interventions are recommended for the treatment of psychiatric morbidity in children, but there is no guidance for their treatment in children with long-term physical illness, and there remains an unmet need in this population (e.g. Ott et al., 2003).


This paper first presents the results of a recent systematic review of 10 studies examining the effectiveness of psychological interventions, mainly CBT, aimed at treating psychiatric morbidity in children with long-term physical illness.

It then goes on to describe the cognitive behavioural treatment of a young person with depression/anxiety in the context of epilepsy.

The intervention was not adapted specifically for young people with a physical illness.

The systematic review demonstrates that cognitive behavioural interventions can be successfully used to treat anxiety and depression in the context of long term physical illness. The case illustration of a young person who received such an intervention found significant reductions in symptoms of depression and anxiety across the course of intervention.

There is some preliminary evidence that Cognitive Behavioural Therapy has positive effects in the treatment of depression and anxiety in children with long-term physical health conditions. However, the current evidence base is weak, and there is a necessity for fully powered Randomised Controlled Trials to establish the efficacy of psychological treatments in this vulnerable population.
Results from the systematic review, and clinical evidence such as this case illustration, suggest that it is possible to use standard evidence-based treatments for psychiatric morbidity in young people who also have a physical health condition.

**CBT for common mental health problems in children with neurological and cognitive difficulties**

**Daniel Stark, Great Ormond Street Hospital; Fiona McFarlane, Great Ormond Street Hospital; Isobel Heyman, Great Ormond Street Hospital; Roz Shafran, Institute of Child Health; Tara Murphy, Great Ormond Street Hospital;**

Neurological / neurodevelopmental disorders increase the likelihood of mental health difficulties in children. This population often have cognitive difficulties. Similarly, population rates of cognitive problems in children with mental health disorders are approximately nine times higher than the background population. It therefore appears that weaknesses with language, attention, memory and executive skills may be a risk-factor for mental health difficulties. Cognitive deficits can also significantly impede traditional evidence based treatments, so their assessment and integration into case formulation is key to successful treatment planning and delivery.

In the absence of specific randomised controlled trials, we propose that the current best approach involves accounting for cognitive difficulties and tailoring traditional evidence based treatments. This approach will be described, including examples using case studies.

In all cases, significant adaptations were required to evidence based treatments, whilst retaining the key principles. Delivery of these modified protocols in a case series led to improvements in anxiety and depression on standardised measures.

Whilst there is a strong evidence base for cognitive-behavioural therapy for children with common mental health difficulties, it is often unclear how to implement this in children who have co-occurring neurological and cognitive difficulties. The cases discussed required significant adaptations, designed to facilitate child and family access to existing evidence based treatment protocols.

Taking account of children’s individual cognitive profiles, in conjunction with cognitive-behavioural theory allows adaptation of existing evidence based treatment protocols. Preliminary clinical evidence indicates that clinical effectiveness can be maintained with theory consistent adaptations to treatment. Evidence based treatments can thus be more fully accessed by children and families who have historically may have had difficulty accessing evidence based treatments.

**The role of Self-Practice/Self-Reflection (SP/SR) in the training of Psychological Wellbeing Practitioners (PWPs)**

**Allán Laville, Charlie Waller Institute, University of Reading**

Experiential learning can take many forms but one method within clinical training programmes is the use of Self-Practice/Self-Reflection (SP/SR; Bennett-Levy, Turner, Beaty, Smith, Paterson, and Farmer (2001). This involves participants to practice therapeutic techniques on themselves and then write a reflective blog based on their experiences.

Participants completed a pre-questionnaire detailing their expectations of SP/SR and then a post-questionnaire reviewing their experience of SP/SR.

Results were that students found using SP/SR led to a better understanding of the interventions from a patient perspective, contributed to general skill development and supported a deeper level of understanding of the treatment interventions.

The findings of this study highlight how the benefits of using SP/SR within a clinical training programme far outweigh the cons (i.e., staff time required in initially delivering the training, reviewing blogs and facilitating supervision sessions).

It is hoped more PWP programmes will adopt the SP/SR approach and by doing so, allow participants to develop their reflective writing and clinical practice within a supportive and structured experiential learning environment.
Is offering choice over treatment a realistic option for early intervention service? Views from service users and an early intervention for psychosis staff team

Felicity Cowdrey, University of Bath; Kate Chapman, Avon and Wiltshire NHS Trust (AWP); Lorna Hogg

National guidelines and policy promote collaborative decision-making and choice. For psychosis, the duration of untreated illness is operationalized in terms of administering antipsychotic medication, establishing it as the ‘front-line’ treatment. This makes it harder to offer choice over treatment despite the fact that individuals with psychosis often chose not to take medication and emerging evidence suggests that cognitive behaviour therapy may be an effective first line intervention. The aim of this study was to investigate staff and service-user perspectives on choice over treatment for psychosis.

Service-users and staff from an EI for psychosis team completed a survey. The survey items consisted of multiple-choice questions as well as rating scales used to measure the direction and intensity of attitudes regarding choice over treatment. Participants were encouraged to provide extra comments after each question. Qualitative and quantitative analyses were employed.

Staff felt most confident about not prescribing antipsychotics if the service-user had engaged well in psychological therapy or if they were still engaging in routine activities. Conversely, if the service-user was not engaging well with the service and had a more severe symptom profile, staff would find it harder to offer choice. There was huge variability in responses when staff endorsed statements regarding choice over treatment. Specific themes extracted from the staff responses included factors influencing prescribing, decision-making around treatments and attitudes towards interventions. Data collected from service-users is currently underway. Full results will be reported.

Staff identified ways in which they facilitated informed choice and joint decision-making regarding treatments for psychosis. However, a number of barriers to truly offering choice were identified including individual attitudes, service-level influences and the nature of psychosis.

There is emerging evidence that CBT may be effective for people with psychosis who choose not to take antipsychotic medication. This paper identified some of the potential barriers to translating this research into practice. Service-user views on CBT for psychosis will also be elicited.

Service user perspectives on the use of outcome measures in psychological therapy

Graham Thew, University of Bath; Louise Fountain, Avon and Wiltshire Mental Health Partnership NHS Trust; Paul Salkovskis, University of Bath

Despite much research into the benefits of outcome measurement, service user opinions on this as part of the therapy process have surprisingly not been investigated. This study aimed to assess service users’ experiences of completing measures during psychological therapy, with a view to exploring how therapists can maximise how helpful measures are in therapy.

Fifteen service users of a secondary care adult mental health service completed surveys about the use of measures in their current episode of care, and ten clinicians within the service provided information about their use of, and attitudes towards, measures.

Despite mixed experiences in how measures were explained and used, service users showed generally favourable attitudes towards their use in therapy, with them being perceived as most helpful when well integrated into sessions by their therapists. Service users highlighted a clear need for therapists to consistently discuss the results of measures and their responses, feeling this does not always occur.

Although small-scale, this study highlights various clinical, service-level, and research implications. While there are well-documented benefits of using measures in therapy, greater attention should be being paid to service users’ experiences of this, with a specific focus on how, rather than simply if measures are used. With services aiming to increase the use of measures, it is important this occurs in a way that maximises their perceived helpfulness for those completing them.

Therapists should consider how they introduce, explain, and integrate measures within sessions, whether this occurs consistently, and how this could be improved.

Polyvagal Theory: practical implications for CBT practice
The Autonomic Nervous System has played a major role in our understanding of an individual’s reactions to themselves and the world around them, especially with regard to threat detection, and this is a basic foundation for therapeutic intervention. Recent theoretical and phylogenetic developments led by Stephen Porges (Porges 1995) have identified a much more complicated system which interacts with our social functioning.

A literature review specifically focused on the implications for CBT practice and to identify specific areas for research opportunities identified six major themes where CBT practice and research would benefit from the integration and exploration of the application of Polyvagal Theory. These areas included: identification of which level of phylogenetic function is operating in the individual as this seems to have a profound impact on individual cognitive ability and response to trauma; vagal tone as a physiological marker of stress; heart rate variability as a measure of psychophysiological variability; respiratory sinus arrhythmia as a positive index of social and emotional regulation; the relationship between behaviour and the social engagement system and neuroception, how individuals shift between defensive and social engagement strategies.

These insights open up the opportunities for new innovative ways of working especially at the interface between physical and psychological factors and especially at the possibility of an exciting new range of tools and interactions which can provide the measurement of physiological areas of psychological experience. Polyvagal theory is beginning to have a profound impact on practice in a wide range of areas including anxiety, emotional regulation and trauma.

**Poster Presentations 2**

**Thursday 24th July**

**Community Engagement - Eis Ledaber**

**Presenter: Raphael Kada, Six Degrees Social Enterprise; Debra Frazer, Six Degrees Social Enterprise**

Salford population stands at 216,127 with 5,187 being Jewish. IAPT expect 15% of the population to be seen yet just two patients from the Jewish community were referred in 2011. Continued investigation into causes for low uptake from the BME Jewish community in Salford identified patients unwilling to trust generic mental health services and afraid of being misunderstood.

The organisation set out to employ and train a workforce from the Jewish community to serve that population which is culturally and religiously acceptable to that community.

Community engagement through consulting local Rabbis, communal leaders, third sector agencies and providing one to one psychological therapy based on CBT principles together with educational wellbeing groups. Self referrals were accepted at flexible venues, times and gender with religious and cultural needs met.

An equivalent referral rate from the Jewish community to the wider generic population with nationally acceptable recovery rates achieved.

Results noted that outcome measures are not an accurate assessment of distress and alternative measures deserve consideration.

Some clients specifically requested a non-Jewish worker.

Psychological practitioners have voiced the need for specific BME supervision, currently provided to address difficulties such as living and working in the same community and to increase cultural competence throughout the team.

What emerges is not how culturally competent practitioners are but rather how culturally competent they are perceived to be by the BME community.
The tighter knit a community is the greater the need to be working from within and not outside that particular community.

**Observer Vantage Perspective and Rumination: Understanding their Relationship in Depression**

Ly Huynh, University of New South Wales, Sydney, Australia; Authors: Michelle Moulds, University of New South Wales, Sydney, Australia

Rumination and recalling emotional memories from a third-person observer vantage perspective both play maladaptive roles in depression. While there is correlational evidence linking rumination, observer vantage perspective, and abstract processing, there is little experimental investigation into the nature of this relationship. The current project aims to further investigate this relationship in order to identify potential targets for the treatment of depression.

The two studies replicated the methodology of Libby, Shaeffer, and Eibach (2009), and investigated the relationship between vantage perspective and mode of processing bidirectionally with regard to neutral actions in high and low dysphoric participants.

When perspective was manipulated and mode of processing was measured, high dysphoric participants showed a greater tendency toward abstract processing than low dysphoric participants (Study 1; N = 112). When level of processing was manipulated and perspective was measured, high dysphoric participants showed a greater tendency to adopt an observer perspective than low dysphoric participants. Additionally, relative to concrete processing, participants in the abstract processing condition had a greater tendency to adopt an observer perspective, irrespective of dysphoria status (Study 2; N = 186).

Together, these results indicate a unidirectional causal relationship, whereby processing mode causally influences vantage perspective.

Thus, these findings support targeting abstract processing in the treatment of depression in order to address the negative consequences associated with both abstract processing and recalling/imagining events from an observer vantage perspective.

**Behaviour Change in the presence of Fusion with Catastrophic, Pain-Related Cognitions in Acceptance and Commitment Therapy**

Lottie Morris, University of Bath; Dimitri Gavriloff, University of Bath; Axel Vitterso, Royal National Hospital for Rheumatic Disease

Cognitive behavioural therapies are widely used in the treatment of people suffering with chronic pain. Acceptance and Commitment Therapy seeks to enhance psychological flexibility through increasing acceptance, present-moment awareness, and committed action/behavioural change, reducing cognitive fusion, and developing a sense of self-as-context, or meta-cognition. The present study sought to investigate, using single case design, the relationship between fusion with pain catastrophizing cognitions, and behavioural change. Service users experience exposure, behaviour change, and defusion exercises from day one of the programme. While behavioural change and defusion are likely to have a symbiotic relationship, it was hypothesised that behavioural change would precede defusion.

10 participants in a pain management programme completed the Pain Catastrophising Scale (PCS), revised to measure fusion with cognitions in addition to the extent to which these cognitions are experienced. Participants also reported their level of behaviour change on a Likert scale. Scores were triangulated with clinician ratings of participants' levels of committed action. Measures were taken at six baseline time-points, 12 time-points during treatment, and at three follow-up time-points.

Most participants showed reductions in pain catastrophizing and fusion, and increases in behavioural change throughout treatment, and at follow-up. There were no temporal differences in changes in catastrophizing, fusion, or behavioural change.

These results have important implications for treatment: patients were able to implement behavioural change immediately in treatment, in the presence of high levels of fusion with catastrophic beliefs.
Theoretical implications of this are discussed, from both ACT and traditional cognitive behavioural perspectives. This study suggests that therapist concerns about encouraging behaviour change and exposure early in therapy may be unfounded.

**Treating childhood fears in children on the higher end of the autism spectrum through drama**

*Haris Karnezi, Trinity College Dublin; Kevin Tierney, Trinity College Dublin*

Childhood fears that persist over time and interfere with the children’s normal functioning may have detrimental effects on their social and emotional development (1). It has been well documented in the literature that children with autism suffer from intense fears more than their typically developing peers (2). Yet, research on the treatment of fears in this population is scarce. Cognitive behaviour therapy is considered highly effective in treating fears and anxieties (3). However, given that many childhood fears are based on fantasy, the applicability of CBT may be hindered by cognitive immaturity. Furthermore, lack of motivation to engage in therapy is another commonly encountered obstacle.

The purpose of this study was to introduce and evaluate a more developmentally appropriate intervention model, specifically designed to provide phobic children with the motivation to address their fears. To this end, principles and techniques from cognitive and behaviour therapies are incorporated into the ‘Drama in Education’ model. The method involves using the phobic children’s own creativity to involve them in the therapeutic process. The children are invited to engage in exciting fictional scenarios tailored around their strengths and special interests. Once their commitment in the drama is established, a problem that they will feel motivated to solve is introduced. To resolve it, the children will have to overcome a number of obstacles culminating in an in vivo confrontation with the fear stimulus.

The study examined the application of the model in three single cases. Results in all tree cases shown complete elimination of all fear related symptoms. Preliminary results justify further evaluation of the Cognitive Behaviour Drama model. It is time and cost effective ensuring the clients immediate engagement in the therapeutic process.

**Treatment Progress in Medium Secure Settings for Women: Changes in Symptomatology, Personality and Need from Admission to Discharge**

*Clive Long, St Andrew’s; Olga Dolley, St Andrew’s; Clive Hollin, St Andrew’s*

Service evaluations of medium secure facilities for women are underrepresented in the extant literature. Rates of treatment completion are poor and services have not been geared to gender specific needs. Analysis of women admitted to secure forensic services indicates the need for specialist therapeutic regimes particularly for those with borderline personality disorder and for those with convictions for arson and a history of alcohol dependence/ misuse. Based on the characteristics of the patient population admitted and the development of a gender specific, ‘best practice’ service it was hypothesized that positive changes in symptomatology, personality and need would be evident from admission to discharge from a women’s medium secure service.

A single pre-post test design was used with comparisons made between admission and pre-discharge points on a variety of psychometric measures. Pre-post measures show significant changes in terms of symptomatology (Brief Psychiatric Rating Scale; Beck Depression Inventory; Modified Post Traumatic Stress Disorder Symptom Scale); personality (Millon Multiaxial Inventory III); and need (Camberwell Assessment of Need Forensic Version). Significant within treatment change in key clinical areas is encouraging given poor outcomes for women reported in other research. Findings cannot be unequivocally attributed to treatment interventions employed and further work is needed to address the issue of early engagement and the effective tailoring of treatment to the needs of a heterogeneous population.

**Team formulation: A literature review exploring the practice and evidence base**
**Valentina Short, Durham University and Tees Esk and Wear Valleys NHS Foundation Trust**

**Helen Stain, Durham University; Lauren Mawn, Durham University**

Team formulation is a growing practice in mental health and learning disability services. It is proposed that it helps the teams’ knowledge and understanding of clients’ difficulties, maintenance factors and interventions required to alleviate problems. This paper reports on an extensive literature review on team formulation that was conducted to examine the process, outcome and client experience of team formulation.

An initial scoping search identified definitions of team formulation and was followed by a systematic search of all relevant major databases. Inclusion and exclusion criteria were applied and no literature was excluded based on quality. Thematic analysis identified key and recurrent themes in the literature. Seven qualitative studies, one quantitative study, four pilot studies of mixed methods, three service evaluations and two audits were identified. A further 19 studies included practice accounts, guidelines, opinion papers and reports. Themes identified included: team functioning, treatment planning, understanding the client, promoting hope and recovery, implementation, training, client involvement, staff experience, reliability and validity.

The themed synthesis of existing literature identified perceived benefits to team formulation. However, the review highlighted that there is a scarcity of high quality research, little emphasis on clearly defining ‘formulation’ or ‘team formulation’, and a predominant focus on qualitative data collection. Indeed, there is a dearth of research that confirms team formulation as an evidence based practice, and a lack of examination of links to treatment planning or clinical outcomes.

Studies report that team formulation promotes psychological understanding of complex mental health problems and behaviours. The majority of literature supports the use of a CBT model to underpin this understanding. Qualitative studies of staff experience report that it is generally found to be a helpful activity. However, formulations developed by teams may not be created collaboratively with clients and the implications of this are not understood. Furthermore, team formulations undertaken by teams with little or no CBT training may impact on the fidelity of the CBT model as described by Beck.

---

**Is 16 the magic number? A meta-analysis of low intensity CBT for psychosis**

**Cassie Hazell, University of Sussex; Clara Strauss, Sussex Partnership NHS Trust; Mark Hayward, Sussex Partnership NHS Trust; Kate Cavanagh, University of Sussex**

Please note that the meta-analysis is currently being conducted and will be finalised by the end of March 2014, in time for preparing the poster for the conference.

NICE guidelines recommend 16 sessions of CBT for people with psychosis. While a number of meta-analyses have found CBT for psychosis (CBTp) to be an effective intervention, it is still not widely available in the UK. One way of addressing this problem is through offering fewer than 16 sessions. However, the effectiveness of briefer forms of CBTp is not well established. The present meta-analysis reviews the effectiveness of brief CBTp for a range of outcomes, and the potential moderators at play.

A search of PsycInfo, Web of Knowledge and Scopus was conducted using the key terms: (COGNITIVE BEHAVIO* or COGNITIVE THERAPY or CBT) and (PSYCHOSIS or PSYCHOTIC or SCHIZO*). A total of 8,613 papers were identified, with 16 meeting the meta-analysis eligibility criteria e.g. CBTp is less than 16 sessions or delivered by a non-therapist.

Both pre-post and between-group effect sizes will be presented for a range of clinical outcomes. Moderator analyses are being conducted in order to explore if the number of direct therapist contact hours, the number of therapy sessions and therapist training are moderators of outcome. Results will be discussed in relation to NICE treatment guidelines for psychosis. Limitations of the included studies and of the meta-analysis will be discussed. Implications of findings for increasing access to CBTp will be explored and suggestions for future research will be made.

This research questions the NICE guidelines currently stated for those with psychosis. Low intensity CBT is not currently available for those with psychosis - this meta-analysis is the first step to questioning this empirically.
Rosanna Chapman, Department of Clinical Psychology; Morwenna Roberts, Department of Clinical Psychology

Miss D was a thirty one year old single female who had no previous contact with mental health services. She had been referred to an Improving Access to Psychological Therapies (IAPT) service following an assessment with the Primary Care Liaison Service. She had suffered from emetophobia for four years but had previously utilised relaxation, mindfulness and self-help information to manage anxiety. At assessment, Miss D’s depression and anxiety symptomology fell in the severe range and her scores on the emetophobia questionnaires were above the clinical mean.

It was hypothesised that whenever Miss D experienced physiological sensations of anxiety, such as becoming hot or experiencing butterflies in the stomach, she would misinterpret them as being a sign of impending vomit. In response to this, Miss D experienced negative cognitions about what would happen if she vomited, believing that she would lose control of her emotions and act in a way that was unacceptable, such as crying and screaming. She also had an image of being carried away in an ambulance due to the severity of her behaviour. These cognitions would inadvertently increase feelings of anxiety and therefore increase the accompanied physiological changes, some of which were experienced as gastrointestinal, such as feeling sick in the stomach. In response to anxiety, Miss D would engage in an array of behaviours to minimise the likelihood of vomiting. She would selectively attend to any changes in physiology, checking feelings in her stomach or checking to see if she was getting hot. She would also monitor the environment for people who may be ill. Selectively attending to vomit related stimuli was hypothesised to increase anxiety by repeatedly activating negative cognitions. She would engage in safety behaviours, such as washing her hands in very hot water and checking expiry dates on food. It was hypothesised that these behaviours prevented her from finding out that she could not eliminate the possibility of vomiting. She avoided many things such as eating any food that was undercooked or out of date and talking about vomit. Avoidance of feared situations meant that she failed to habituate to anxiety or gather evidence about coping ability, which was hypothesised to increase anxiety.

Twelve sessions were offered in accordance with the service requirements, including two assessment sessions and ten intervention sessions. Assessment involved the use of a semi-structured interview used by the service, covering the individual’s background history, description of the presenting problem, goals, medication, occupation and strengths. In addition, a more detailed assessment of the presenting problem was conducted. The GAD-7 and PHQ-9 were administered on a weekly basis in accordance with service requirements and outcome data was recorded every two weeks, as the questionnaires used were developed for fortnightly use. Two vomit related questionnaires (Specific Phobia of Vomiting Inventory, SPOVI; Veale, Ellison, et al., 2012 and Emetophobia Questionnaire, Emet-Q; Boschen & Riddell, 2005) were administered on the first and last intervention sessions.

Following assessment, an idiosyncratic CBT formulation was collaboratively devised. The intervention was based upon this formulation and involved a combination of psycho-education, in vivo exposure to vomit related material, verbal discussions, surveys and behavioural experiments involving dropping safety behaviours. Miss D’s scores on both emetophobia questionnaires had reduced over the course of therapy and her post-treatment on the SPOVI had fallen below the clinical mean (Veale et al., 2012). Her self-reported coping ability had also increased and by session eleven and she had been able to stay in the room when a friend was sick without feeling anxious. She also had not taken anti-emetic medication since the fifth session and had also gone two working days without Propranolol. Miss D’s general anxiety had decreased over the course of therapy, with scores moving from the severe range to the moderate range. Miss D’s depressive symptoms had also shown a decline over the course of therapy until the final session, moving from the severe to the moderate range. This case study demonstrates some evidence for the effectiveness of using a cognitive behavioural approach for emetophobia, using symptom specific outcome measures. As suggested by Davidson et al. (2008), beliefs about loss of control were central to understanding emetophobia in this case. Miss D’s assumptions about having to keep control of her emotions due to others’ inability to cope with her
distress was thought to be maintaining the anxiety about vomiting. This suggests that, although the continuation of exposure work may have been useful, further work on altering these assumptions may have been more beneficial. Also, given that Miss D’s phobia was of vomiting, rather than vomit alone, in session exposure using fake vomit may have been of limited utility. As it is both impractical and unethical to induce vomiting (Veale, 2009), it was not possible for therapy to facilitate exposure to Miss D’s phobia, in the same way that is possible for other specific phobias, such as animal phobia.

This case study has demonstrated the importance of beliefs about emotional control in emetophobia. For this case, vomiting was anxiety provoking as it was thought to precede a loss of emotional control, which was believed to be unacceptable. It also highlighted that the perceived coping ability of others in response to vomiting is important. Therefore, future conceptualisations of emetophobia may consider how beliefs about emotional control and about the reactions of both self and others relate to the development and maintenance of anxiety about vomiting.

The Treatment of Compulsive Checking in an Older Gentleman with Cognitive Impairment: A Case Presentation

Vera Hughes, University of Bath

OCD in later-life is a largely neglected area (see Calamari, Janeck, & Deer, 2002). Little is known about the phenomenology of late-onset OCD and whether the cognitive behavioural model (Salkovskis, Forrester & Richards, 1998) applies in its standard form to older populations. This paper will aim to explore the phenomenology of later-life OCD utilising the case example of Mr C, a 72 year old gentleman referred with a history of compulsive checking and short-term memory problems. Mr C reported that the onset of compulsive checking followed a perceived decline in his short-term memory. At the time of initial assessment, Mr C engaged in a checking ritual every night before bed, noting that this had become more rigid over time. He also reported intrusive thoughts and images pertaining to his family being attacked in the night by an intruder. He reported feeling responsible for ensuring their safety. An idiosyncratic formulation was developed, drawing on the cognitive behavioural model of OCD (Salkovskis, Forrester & Richards, 1998). Treatment modifications were made in response to information obtained from neuropsychological assessment.

Measures assessing OCD (Obsessive Compulsive Inventory, OCI), anxiety (Beck Anxiety Inventory; BAI) and depression (Beck Depression Inventory; BDI-II) were obtained at baseline and on a weekly basis throughout therapy.

Following seven sessions of CBT, compulsive checking behaviours and associated self-doubt had reduced to non-clinical levels. Improvements in OCD behaviours were associated with a reduction in anxiety and depression symptoms.

This case provides an illustration of the usefulness of CBT for late-onset OCD and suggests insight into the potential phenomenology of OCD in later life.

Assessing event-specific repetitive thought: A subtype-level, transdiagnostic measure

Suraj Samtani, University of New South Wales; Michelle Moulds, University of New South Wales

The construct of Repetitive Thought has come about recently in the literature as rumination, worry, and similar constructs have been grouped under this broader umbrella term (Watkins, 2008). Examining repetitive thinking in a transdiagnostic manner allows us to examine the causes and consequences of this cognitive process beyond the boundaries of major depression and the anxiety disorders (e.g., in eating disorders, Axis II disorders). Current models of Repetitive Thought divide the construct into two subtypes: an analytical (maladaptive) subtype and an experiential (relatively adaptive) subtype. Existing scales of Repetitive Thought only assess the analytical subtype, and also confound repetitive thinking with symptoms of various disorders. This project is aimed at creating a self-report measure (the RTS) that is transdiagnostic, assesses both subtypes, and is content valid.
Two parallel versions of this scale have been developed: a trait- and a state-version. The state-version has been developed given the potential clinical utility of a scale that assesses repetitive thinking in relation to a past or upcoming traumatic or stressful event. Exploratory Factor Analyses (N = 595) of the state-version revealed that a seven-factor solution resulted in a model with good fit. The seven subscales extracted were: Analysing Behaviour, Experiencing Emotions, Experiential Vivid Recall; Experiential Reliving; Experiencing Physical Sensations; Analysing Implications; and Analysing Causes. A confirmatory factor analysis (N = 410) revealed that the subscales could be grouped under higher-order Analytical and Experiential Repetitive Thought factors. The scale measures the two subtypes suggested by current models of repetitive thought. This scale will allow clinicians to assess repetitive thinking in relation to a particular (traumatic/difficult) event, such as in the case of PTSD or depression, and to track its frequency on a regular basis. It will also provide information about the type of repetitive thinking clients engage in.

Developmental trajectories of childhood internalizing symptoms from 17 months to 8 years of age: Early risk and protective factors for adolescent internalizing problems.

Magdalena Zdebik, Université de Montréal; Sylvana Côté, Université de Montréal

Mental health disorders are a major cause of suffering in many young people. The risk of having at least one mental health disorder by age 16 years has been reported to be as high as 36.7% (Costello et al., 2005). Although research on externalizing disorders has steadily grown, there is much left to learn about the development and the aetiology of internalizing disorders, as well as their risk and protective factors. It is vital that we understand how internalizing problems arise, and develop effective treatment and interventions. This study prospectively describes longitudinal trajectories of internalizing symptoms, a major risk factor for later internalizing disorders such as anxiety and depression. Our main objective was to identify group-based developmental trajectories of internalizing symptoms from early childhood (1.5 years) to middle childhood (8 years) and examine how the different trajectories predict later self-reported internalizing problems at 13-14 years old.

The Québec Longitudinal Study of Child Development (QLSCD), consisting of an initial sample of 2123 children born from 1997-8 and their parents, was used for this study. Measures were collected when children were 5, 17, 29, 41, 53 and 60 months-old and 6, 7, 8 and 13-14 years-old and the response rate of the cohort has been excellent. Child internalizing symptoms were measured from 17 months to 8 years using parental reports on the Behaviour Questionnaire (BQ; Tremblay et al., 1991) and were used to create developmental trajectories. Composite scores of risk and resilience factors were constructed for the early childhood and mid-childhood period using variables from different domains (parental mental health: e.g.: depression and anxiety; parenting practices: e.g.: positive vs. coercive or controlling parenting; child care environment; e.g.: age of entry, quality of care) and pre and peri-natal variables (collected at 5 month) were also analyzed. Self-reported anxious and depressive symptoms were assessed using the BQ when participants were 13-14 years-old.

Preliminary analysis identified two types of internalizing factors present across childhood: the first related to an inhibited temperament and the second to anxious and depressed symptomatology. By identifying independent and joint group-based developmental trajectories of these two factors, estimated in SAS, we predict later self-reported internalizing problems at 13-14 years-old and the protective and risk factors related to internalizing problems in adolescence. This work will move forward our understanding of the individual, family and environmental factors that may promote mental health among children at-risk for internalizing disorders. The strength of this project reside in the longitudinal methodology covering over 14 years, the large sample size of the cohort, and the innovative research questions that can be asked with the newly available adolescent assessments. Identifying specific vulnerabilities at different stages of development can help customize cognitive behaviour therapy not only at the individual/child level, but also at the family-functioning level. The effects of preventive intervention are often modest, but they may be improved if interventions are personalized according to identified protective and risk factors over the course of childhood.
Development and validation of the Japanese version of Responsibility Attitude Scale and Responsibility Interpretations Questionnaire.

Ryotaro Ishikawa, Chiba University, Japan; Authors: Osamu Kobori, Chiba University, Japan; Eiji Shimizu, Research Centre for Child Mental Development, Graduate School of Medicine, Chiba University, Japan

Distorted beliefs about responsibility attitude and interpretation are a central theme in cognitive models of Obsessive-Compulsive Disorder (OCD). This study aimed to develop Japanese versions of the Responsibility Attitude Scale (RAS-J) and Responsibility Interpretation Questionnaire (RIQ-J).

Participants in Study 1 were 118 non-clinical Japanese students who completed the RAS-J and RIQ-J to confirm the test-retest reliability of these scales. In Study 2, 98 participants (OCD group = 37; anxiety control group = 24; healthy control group = 37) completed the RAS-J, RIQ-J, and other measures to assess the validity of the RAS-J and RIQ-J.

Both scales had adequate concurrent validity, demonstrated by significant correlations with other measures of OCD, anxiety, and depression. Group comparison data using ANOVA indicated that RAS-J and RIQ-J scores for the OCD group not only differed from the non-clinical group, but also from the clinically anxious comparison group.

This study demonstrated that the newly developed RAS-J and RIQ-J effectively measure responsibility attitude and responsibility interpretation in Japanese OCD patients. This is the first report on responsibility attitudes and interpretations in a Japanese sample of OCD patients. These findings have implications for clinical work, especially in cognitive behavioural therapy (CBT) with obsessive-compulsive clients.

Comparing Immediate Recall Memory Biases in Depressed and Non-Depressed Adolescents

Presenter: Faith Orchard, University of Reading; Shirley Reynolds, University of Reading; Craig Steel, University of Reading

Cognitive Behavioural therapy (CBT) appears to be less effective at treating depression in adolescents compared to adults (e.g. Kennard et al., 2006; Goodyer et al., 2007). It is assumed that the cognitive model of depression is applicable to adolescents but this has rarely been tested. This paper reports on the assessment of recall memory bias in adolescents aged 13-18 years.

Three groups of adolescents will be compared; 1. Adolescents with a diagnosis of depression (based on K-SADS), 2. Adolescents with elevated symptoms of depression and 3. Adolescents with no symptoms of depression. Groups 2 and 3 are being recruited from the community, and group 1 is being recruited from the NHS CAMHS. Based on current recruitment rates we anticipate that we will report data on 42 participants per group. Adolescents complete a self-description questionnaire and rate themselves on a mixture of positive and negative adjectives. They are then given a surprise recall task and are asked to recall as many of the words as possible (Kelvin, Goodyear & Teasdale, 1999).

Total positive and negative word recall will be calculated. Between-group differences in responses will be analysed using one way ANOVAs and correlations between depression severity and positive and negative word recall.

The results will inform the development of CBT for depressed young people. If depressed young people do have memory biases, existing methods can be further adapted. If cognitive biases are not characteristic of depression during adolescence then significant development of novel CBT methods may be necessary.

Treating Social Anxiety: A 70 year-old Grandmother Meets a New Social World

Ann O’Hanlon, Queens University Belfast; Gerard McAleer, Queens University Belfast; Joanne Younge, Queens University Belfast
Margaret is a reserved 70-year old Christian mother and grandmother who lives with her husband of 47 years in a small rural village. She was very unhappy in her marriage and attributed her low mood to her husband’s drinking and his extended stays in public houses. Margaret’s way to cope was to spend hours most days on bus journeys just to get out-of-the-house. On these trips however, Margaret actively avoided meeting or engaging with others, fearing that she would make mistakes socially and be judged harshly. Margaret experienced both a significant fear and a marked avoidance of social situations where she might feel embarrassed or be judged negatively. This fear interfered significantly with her daily routine, and meant she was isolated socially. Margaret was ultimately given a diagnosis of social anxiety with depression.

Margaret grew up in a busy household of eleven children. Feeling overlooked and inferior, it is hypothesised that Margaret developed core beliefs: “I am not important” and ‘I make mistakes easily’. It is further hypothesised that Margaret developed rules around keeping people at bay to regain some control and off-set potential criticisms: “if I keep others at a distance, they won’t see my mistakes”. The first four of fifteen sessions addressed Margaret’s low mood, while the remaining sessions addressed her worries about making mistakes socially and being judged negatively. Drawing on Clark & Wells social anxiety model Margaret gained insights into her anxiety. A wide range of interventions were used, including thought records to enable Margaret to consider her assumptions and worries. Behavioural experiments also provided really great ways to enable Margaret to check out her worries that others would be nasty or judgemental around mistakes. In one such experiment, Margaret observed reactions when the therapist deliberately made a ‘mistake’ in playing the piano as badly as possible in a public area. In another experiment Margaret deliberately let go one side of a tray, so that cutlery would fall nosily to the floor in a busy restaurant. Despite a lifetime of anxiety, Margaret observed that people were not critical in these instances.

In fifteen sessions Margaret made full recovery; all her goals were met, she is engaging confidently with others, her scores on a range of measures have improved significantly (e.g. pre and post SPIN of 45 and 0 respectively). Through this time Margaret also gained confidence and awareness for her own unique strengths in social interactions, including her innate intelligence, her exceptionally strong people skills and her considerable life experience. Margaret’s life has now changed unrecognisably as she reports excitement and enjoyment in a new social world that has now opened up to her. In a six month follow-up these results were being maintained.

Time was taken to build trust with Margaret, and to elicit her exact concerns socially through a range of techniques including downward arrowing. Taking time to build trust was especially important given Margaret’s awareness of the potential for embarrassment when discussing deeply personal concerns. In drawing out the model, Margaret began to understand the factors that were inadvertently contributing to her anxiety, particularly her negative thinking, and her extensive array of safety behaviours; the latter included using her phone to pretend to be busy, keeping her eyes down to avoid eye contact, and standing a distance away from the bus stop. Unwittingly, these safety behaviours had also denied Margaret opportunities to test her appraisals of danger so that these then persisted unchecked, despite repeated non-occurrence. In the final videoed experiment, Margaret was videoed giving an informal speech to a small group of older adults in the Republic of Ireland about retirement N Ireland. Even at the times when she was most anxious, or worried about her mind going blank, Margaret could see that this anxiety was not apparent in the video. To the contrary, Margaret reported that she looked relaxed, confident and comfortable with others. Margaret spent many decades with a paralyzing social anxiety, that had caused her significant distress, disruption and confusion. Margaret’s life has now changed unrecognisably as she reports excitement and enjoyment for a new social world that has now opened up to her.

- Older people with social anxiety can make a full recovery with CBT, even when that anxiety has been present for around 70 years

Panic attacks or intrusive memories: an easy diagnostic error?

Vera Hughes, University of Bath; Authors: Dr Jim Nightingale, University of Bath
Posttraumatic stress disorder (PTSD) is an adverse reaction to traumatic events. Symptoms include repeated re-experiencing of the event, hyper-arousal, emotional numbing and avoidance (Ehlers & Clark,
In a select number of cases, an individual may re-experience intense physical and emotional sensations associated with a traumatic event, without simultaneous recollection of the event (affect without recollection; Ehlers & Clark, 2000). This paper will describe the case of JE, a 30 year old women referred to IAPT for support in managing persistent ‘panic attacks’ and low mood. JE completed two 6-week low-intensity IAPT anxiety management courses but reported no reduction in her symptoms. JE was subsequently stepped up to high-intensity IAPT for a more detailed assessment.

Recurrent ‘panic attacks’ were conceptualised as intrusive memories stemming from a traumatic event that occurred several years previously. This was based on two key observations 1) the quality and characteristics of the ‘panic attacks’ were comparable to those of traumatic intrusions and 2) initial scores on the measure of trauma symptomology fell within the clinical range. Treatment followed Ehlers and Clark’s (2000) Cognitive Therapy for PTSD. JE received eight weekly 90 minutes sessions.

JE completed measures of trauma symptomology (Impact of Events Scale-Revised; IES-R), depression (Patient Health Questionnaire; PHQ-9) and anxiety (Generalised Anxiety Disorder Scale; GAD-7). A VAS was used to measure the frequency of ‘panic attacks’ (intrusive memories). Measures were administered at baseline and on a weekly basis throughout therapy.

At the end of therapy, JE reported a complete cessation in ‘panic attacks’ (intrusive memories). Trauma scores reduced to non-clinical levels and JE reported that memories regarding the traumatic event felt more coherent, resolved and less emotionally salient.

JE did not initially present with complaints relating to past traumas, rather, persistent panic attacks. Indeed, patients may not always disclose past traumas or identify the link between prior traumatic events and current symptoms. This presentation therefore raises the potential usefulness of assessing trauma in patients presenting with panic disorder type symptoms. This may be particularly the case if previous CBT treatments for panic disorder have proven ineffective and/or symptoms have a ‘trauma flavour’.

An exploration of the construct of bitterness in adults

Sarah Mills, University of Bath; Paul Salkovskis, University of Bath; Chris Gillmore, Avon & Wiltshire Partnership Mental Health NHS Trust

The concept of bitterness was first introduced to the academic literature by Linden (2003). Through his clinical practice he identified a group of individuals who continued to be affected by negative life events far beyond what might be considered a ‘normal’ response timeframe. Linden conceptualised bitterness (or ‘embitterment’) as a complex emotion and described it as “…[a] feeling of having been let down, of injustice and helplessness together with the urge to fight back and the inability to identify a proper goal.” (Linden, Baumann, Rotter & Schippan, 2007 p. 160). He suggested that an embittered response is one of many possible psychological reactions to an “exceptional, though normal negative life event such as unemployment [or] divorce” (Linden, Baumann, Lieberei & Rotter, 2009 p. 140).

There is little empirical evidence thus far to support the existence of bitterness as a valid construct and there is little published material from anyone outside Linden’s own research group in Germany. However, the three previous studies that do exist in this area (Linden, 2003; Linden et al., 2007, Linden et al., 2008) provide promising findings which merit further study. The exploratory nature of this study therefore builds on the emerging literature in this field. The development of an English language measure of the construct and then piloting this measure within a small clinical group are the focus of this study.

A new measure of bitterness has been developed and data gathered from approximately 300 non-clinical participants. Factor analysis will be conducted using this data. The measure has also been piloted within a small clinical group of participants accessing secondary mental health services.

Results will be presented. Data has been gathered and is being analysed currently. The implications of the results will be discussed in terms of our understanding of adult mental health and factors which may influence therapy outcomes.

If bitterness is shown to be a construct separate to others such as low mood and anger then this has implications for CBT practice. The development of a measure of bitterness may help therapists to identify such difficulties in their clients and to account appropriately for these within their formulation and when building an alliance.
Social Inclusion – Recognising the needs of the Polish Community

Gosia Pelikan, Six Degrees Social Enterprise; Anna Kowalcyk, Six Degrees Social Enterprise
The UK has the highest number of Polish migrants in Europe (Central Statistical Office, 2013). The evidence suggests that while the level of stress within this group is estimated to be higher than in any other ethnic group in England and depressive symptoms are quite common (Kucharska, 2012), few Polish people reported seeking any form of professional support (Kozlowska, Sallah & Galisińska, 2008). Reports highlight that this might be due to the language difficulties, poor understanding of the NHS and confusion regarding their entitlement to healthcare (Patel, 2010).

The aim of our project is to create a co-produced and language appropriate psychological service for the Polish community in Salford in which they feel supported and can establish contact with fellow Poles. The objectives are to investigate the psychological needs of the Polish community, review current service provision and liaise with the Polish authorities such as churches and schools to improve engagement with the Polish community. Method used is the implementation of an online survey, researching online forums and liaising with the Polish authorities.

Though the research is still ongoing, current results suggest a lack of culturally and language-appropriate psychological services, social support and a demand for such services.
To engage the Polish community and develop co-produced services which can improve access to psychological support and community engagement.

Effectiveness of Group CBT in Routine Clinical Practice in a South London IAPT Service

Alexander Sim, Wandsworth IAPT; Authors: Nathan Appasamy, Wandsworth IAPT; Helen Layton, Wandsworth IAPT; Katie Bogart, Wandsworth IAPT
Since 2008, the Improving Access to Psychological Therapies (IAPT) programme has been running within the NHS for the general population who may be encountering difficulties in their lives in matters such as depression and other mental health conditions such as anxiety or low self-esteem. Within IAPT, individual Cognitive Behavioural Therapy (CBT) is the most commonly provided therapy, however meta-analyses and randomised controlled trials have shown that group CBT can be as effective as individual 1-2-1 therapy (Cuijpers, van Stratem, & Warmerdam, 2008; Brown et al., 2011; Horrell et al., 2013). It has been suggested that group CBT may be more cost effective to provide than individual CBT (Brown et al., 2011).

The Wandsworth Psychological Therapies & Wellbeing Service (Wandsworth IAPT) has been running CBT groups for a range of mental health difficulties since gaining IAPT funding in 2009. A retrospective audit of the groups run in this service between 2009 and 2014 was conducted; from this recovery and retention rates were calculated by each group type. The group interventions developed by the service include six to eight session CBT groups for managing anger, anxiety, depression, low self-esteem, and improving Wellbeing in Later Life. Wandsworth IAPT also provides Self-Confidence Workshops based on the June Brown model (Brown, Elliott, Boardman, Ferns & Morrison, 2004). The service also developed an idiosyncratic 10 session self-confidence building course for women who have experienced domestic violence, the New Horizons Course.
Throughout the running of these different groups, outcome data was collected on a session by session basis for each service user by means of the Patient Health Questionnaire PHQ-9 and the Generalised Anxiety Disorder Questionnaire (GAD-7). The PHQ-9 consists of 9 questions designed to assess a client’s level of depression (Kroenke, Spitzer, & Williams, 2001). The GAD-7 consists of 7 questions designed to assess a client’s level of anxiety (Spitzer, Kroenke, Williams, & Löwe, 2006). Using service users’ scores for the PHQ-9 and the GAD-7 from their first group session and their last, their “movement to recovery” was calculated. “Moving to recovery” is defined by IAPT as the number of people who at initial assessment had a PHQ-9 score of 10 or more or GAD-7 score of more than 8, but at final session did not (IAPT, 2011).

IAPT services are encouraged to achieve a target of “half of those who complete treatment, moving to recovery” by 2015 (IAPT, 2008), i.e. a 50% of the total number of people seen by the service “moving to recovery” by 2015. In line with IAPT central’s criteria for the calculation of “moving to recovery”, this study only included those who attended more than one session of the groups, as these were the only
patients with two data points from which to compare outcome scores and calculate “movement to recovery”. Additionally, in line with guidelines produced by IAPT central (IAPT, 2011), those service users whose scores were below 10 on the PHQ-9 and below 8 on the GAD-7 at their first data point are classed as “non-caseness” and are not included in calculating recovery rates, as “non-caseness” is deemed not severe enough to chart “movement to recovery”.

(These results are from a preliminary data analysis and may be refined before the poster presentation)

157 people were booked on Anger Management Courses in the service, of which 64 attended at least one session and 92 did not attend the course at all; this equates to a 41% attendance rate and 59% non-attendance rate. Of the 64 that attended at least one or more sessions, 14 were at “non-caseness” at their first data point and so were excluded, leaving a total of 50 where 34 achieved a “moved to recovery” in their outcome scores (68% “moving to recovery” rate).

128 people were booked on to Anxiety Management Courses in the service, of which 66 attended at least one session and 62 did not attend the course at all; this equates to a 52% attendance rate and 48% non-attendance rate. Of the 66 that attended at least one or more sessions, 11 were at “non-caseness” at their first data point and so were excluded, leaving a total of 55 where 33 achieved a “moved to recovery” in their outcome scores (60% “moving to recovery” rate).

141 people were booked onto Managing Moods Courses in the service, of which 72 attended at least one session and 69 did not attend the course at all; this equates to a 51% attendance rate and 49% non-attendance rate. Of the 72 that attended at least one or more sessions, 3 were at “non-caseness” at their first data point and so were excluded, leaving a total of 69 where 30 achieved a “moved to recovery” in their outcome scores (43% “moving to recovery” rate).

20 people were booked onto New Horizons Courses in the service, of which 14 attended at least one session and 6 did not attend the course at all; this equates to a 70% attendance rate and 30% non-attendance rate. Of the 14 that attended at least one or more sessions, 2 were at “non-caseness” at their first data point and so were excluded, leaving a total of 12 where 8 achieved a “moved to recovery” in their outcome scores (67% “moving to recovery” rate).

96 people were booked onto Self-Confidence Workshops in the service, of which 41 attended at least one session and 55 did not attend the course at all; this equates to a 43% attendance rate and 57% non-attendance rate. Of the 41 that attended at least one or more sessions, 8 were at “non-caseness” at their first data point and so were excluded, leaving a total of 33 where 23 achieved a “moved to recovery” in their outcome scores (70% “moving to recovery” rate).

188 people were booked onto Self-Esteem Courses in the service, of which 91 attended at least one session and 97 did not attend the course at all; this equates to a 48% attendance rate and 52% non-attendance rate. Of the 91 that attended at least one or more sessions, 19 were at “non-caseness” at their first data point and so were excluded, leaving a total of 72 where 33 achieved a “moved to recovery” in their outcome scores (46% “moving to recovery” rate).

18 people were booked onto Wellbeing in Later Life Courses in the service, of which 17 attended at least one session and 1 did not attend the course at all; this equates to a 94% attendance rate and 6% non-attendance rate. Of the 17 that attended at least one or more sessions, 5 were at “non-caseness” at their first data point and so were excluded, leaving a total of 12 where 4 achieved a “moved to recovery” in their outcome scores (33% “moving to recovery” rate).

The above results compare favourably with IAPT’s target of 50% of clients “moving to recovery” between first and last contact. The results also compare favourably with the “moving to recovery” rate of Wandsworth IAPT service as a whole, where the overall “moving to recovery” rate is estimated at 50% for 2013. These results are of significant value where funding is limited, as group CBT seems to demonstrate comparable clinical effectiveness to, but may be more cost effective, than individual CBT (Brown et al., 2011). However further cost effectiveness analysis by health economists would have to be conducted to understand where the savings actually are, for example even though groups can provide more capacity for service user uptake is there a knock on effect of increased administration costs?

As an area for future development, it would be essential to explore reasons for the high drop-out rates from these groups, as this may help services improve their retention rates. It would be important within this analysis to separate out the difference in drop-out figures for those with high non-attendance (i.e. they attended less than half their sessions but more than two) and those with complete non-engagement
(i.e. they were signed up to participate in a group but never attended any sessions other than their initial screening assessment at entry to the service).

Finally, it would be of use to the service to investigate dynamics involved in group sessions that may have a contributing effect to recovery rates that are not present in individual CBT, such as group process factors like universality and group cohesiveness (Yalom, 1970). The main implication of these findings is that the symptoms of a range of different mental health difficulties can be effectively treated in routine clinical practice using group CBT interventions, which potentially operate at a lower cost than individual CBT (Bonin, Beecham & Brown, 2012) and that additionally more services users can be accommodated in group CBT without increasing service users’ waiting times or the service’s client uptake.

Can people with anxiety and depression learn mindfulness? A Meta-Analysis

Elizabeth Clark, University of Sussex & Sussex Partnership NHS Trust; Clara Strauss, University of Sussex & Sussex Partnership NHS Trust; Kate Cavanagh, University of Sussex

There is growing evidence demonstrating mindfulness-based interventions (MBIs) are associated with improved psychological health and wellbeing. Although MBIs are currently used with patients with anxiety and depression, it is not clear whether these effects are underpinned by changes in mindfulness in this group. The meta-analysis evaluated the effects of MBIs on mindfulness skills, compared to control conditions, for people currently experiencing anxiety or depression. The relationship between increased mindfulness skills and symptom improvement was also investigated.

Four electronic databases were systematically searched for papers meeting study eligibility criteria. Meta-analyses were performed using Review Manager 5.2 and SPSS 20.0.

Eight RCTs, including 396 participants were eligible. Compared to control conditions, MBIs were associated with higher mindfulness skills, $g = 0.49$, and lower symptom scores, $g = -0.46$ post-intervention. Amongst MBI participants, as mindfulness improved, symptoms reduced, $r_s = .82$, $p = .01$.

Participants with anxiety and depression in MBIs were more mindful post-intervention than control groups. Furthermore in MBI participants, improved mindfulness shared 67% of the variance with symptom improvement. These findings support the proposed mechanisms underlying MBIs and promote clinical usage of these interventions. However, there may be alternative explanations for these findings and further research is required.

The results of the current meta-analysis provide tentative evidence suggesting that MBIs may be beneficial for people with anxiety or depressive disorders. Therefore we suggest in the future MBIs may be considered for inclusion in treatment guidelines. However, first we would recommend further research is conducted assessing the relative benefits of MBIs in comparison to other currently recommended interventions (e.g. CBT for depression and anxiety) before MBIs are incorporated into health care guides.

Are elevated manic symptoms in children related to disorder diagnoses?

Preliminary results from the Longitudinal Assessment of Manic Symptoms (LAMS) Study

Jessica Watts, Michael Rutter Centre; Rebecca Barton, Michael Rutter Centre; Gordana Milavic, Michael Rutter Centre; Dennis Ougrin, Michael Rutter Centre; Eleanor Leigh, Michael Rutter Centre

Understanding the link between symptom clusters and diagnoses is pertinent due to the delay to diagnosis that many experiencing mental health problems report, particularly in relation to Bipolar Disorder (BP, Baldessarini et al. 2007). The Longitudinal Assessment of Manic Symptoms (LAMS) study, which began in the U.S.A (Findling et. al. 2010) is now running in the U.K. enables such a comparison, which is consistent with the recent research proposal - Research Domains Criteria (RDoC – Cuthbert & Kozak 2013). Elevated symptoms of mania (ESM) are a core feature of BP and are also related to other disorders such as Attention Deficit Hyperactive Disorder (ADHD), making diagnosis complex. Therefore assessing the developmental relationship between symptom dimensions e.g. ESM, and diagnosis is important.
Children (6-12yr olds) seeing generic mental health services are screened using the Parent General Behaviour Inventory 10 item Mania scale (P-GBI-10M), which infers emotion regulation ability. Children scoring ? 12 on the P-GBI-10M create the ESM+ group, and below the ESM- group. A baseline assessment, including psychiatric interview (using the K-SADS-PL-W, Findling et. al. 2010), self-report questionnaires and WASI is completed and families are followed every 6months.

Ongoing U.K. recruitment has identified 714 eligible children, 118 have been screened and 78 baselines completed (62 ESM+ and 16 ESM-). Preliminary results show higher rates of ADHD and Disruptive Disorders (particularly Oppositional Defiant Disorder, ODD) within the ESM+ compared to EMS- group ($\chi^2 (1, N = 69) = 11.15, p < 0.003$) and ($\chi^2 (1, N = 69) = 7.572, p < 0.01$) respectively.

Results from the U.K. study indicate ESM are related to ADHD and disruptive disorder, but not to mood disorder, diagnoses at baseline. This is likely to be due to the preliminary nature of the results. Continued recruitment and future analysis will shed light on this, as well as investigate the possible link between baseline symptoms and disorder development.

Although this study does not directly assess the use of therapy, including CBT, it does study the progression of childhood mental health disorders over time, from a young age. This is vital in order to improve our understanding of mental health difficulties and disorders in young people and therefore enhance the development of novel treatment approaches in the future.