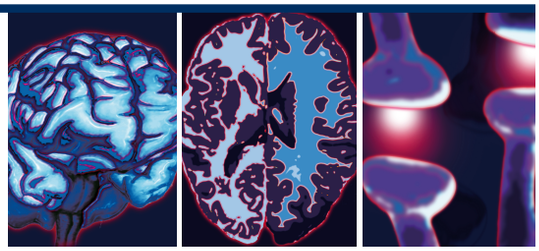

The 41st Congress of the European Association of Cognitive and Behavioural Therapies

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The Congress of the European Association of Cognitive and Behavioural Therapies is a meeting for researchers and clinicians to share empirical research regarding the etiology and treatment of mental health disorders using behavioral and cognitive therapy approaches. This year, more than 1100 people attended. A large amount of research was disseminated, with 112 symposia, 30 paper sessions, 200 posters, 15 keynote presentations and 33 workshops. This article discusses some key themes from the conference.

At the conference, prominent researchers acknowledged the success of cognitive–behavioral therapy (CBT), which is now the first-line treatment for a range of mental health disorders in the guidelines of the National Institute of Clinical Excellence (NICE). They attributed the dominance of CBT in the field to the firm commitment researchers and clinicians have made to develop a strong body of empirical evidence to support its implementation. However, they also warned that this empirical support is typically matched by the poor uptake of CBT by therapists in the community, and this is constraining the progression of the field [1].

T Dalgleish (MRC Cognition and Brain Sciences Unit, UK) put forward a 'glass half-full' argument when he discussed the importance of translational research and barriers to carrying out research of this nature effectively [2]. He commented that despite the success of CBT, there is equal evidence that a significant proportion of individuals, in particular those with severe and complex clinical presentations, do not benefit [3]. If the evidence for CBT is viewed from this perspective, then there is considerable scope to improve current interventions. However, as there is currently very little knowledge of how CBT treatments actually work, then it is very difficult to know how to best tailor interventions.

Translational research studies have tangible impacts on our understanding and practice of CBT, and research of this nature is fundamental to addressing this gap. These studies can be: embedded process–outcome studies in clinical trials; laboratory-based work on isolated components of therapy; and the dismantling of interventions within trials. Dalgleish suggested that as mental health problems are system wide, the most powerful translational studies are likely to come from large-scale clinical trials, which incorporate the input of key players from a number of fields (e.g.,

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neuroscience, policy, clinical psychology and qualitative researchers). Although he also cautioned that such studies are logistically difficult because they require substantial funding, a great deal of time and, in practice, different fields find it difficult to understand each other's points of view.

Importantly, he also argued that effective translational research only occurs when researchers and clinicians communicate clearly with one another. The traditional designs of randomized controlled trials, which follow strict treatment manuals and inclusion/exclusion criteria, are seen by many as irrelevant to the clients they see with multiple diagnoses and complex presentations [1]. To demonstrate that these therapeutic approaches hold 'real world' validity, more randomized controlled trials need to be conducted in primary care settings. Researchers also need to remain open to developing research methodologies to bridge this gap. In particular, transdiagnostic treatment approaches could be useful to address this issue [4].

D Clark (Oxford University, UK) continued this theme of translation from a service-use perspective when he talked about one of the most extensive efforts of disseminating CBT seen to date, 'Improving Access to Psychological Therapies' (IAPT) [5,101]. In 2007, the government in the UK committed UK£300 million to create a psychology service that specialized in the provision of CBT to treat adults with mild-to-moderate anxiety and depression. The initiative came about in response to observations that adults suffering from these conditions rarely received psychological help, and if they did, more often than not, the therapies received were not evidence based. Clark is the National Advisor for this scheme, which he believes has the potential to be implemented in other countries across Europe.

The guidelines of IAPT services are based on NICE recommendations. They recommend a stepped care approach to the treatment of anxiety and depression, and CBT is a highly recommended treatment for both disorders [102,103]. In practice, when a client first attends an IAPT service, he/she receives a comprehensive initial assessment of psychological functioning. Clients with severe problems take part in 'high-intensity' therapy. This is akin to traditional therapy approaches, with clients receiving a number of face-to-face therapy sessions (i.e., up to 22 sessions) with a highly skilled CBT therapist (e.g., a doctoral-qualified clinical psychologist). Clients assessed to have mild or moderately severe conditions take part in a 'low-intensity' guided self-help CBT program (i.e., computer and workbooks with telephone or face-to-face support). A 'low-intensity' therapist with an appropriate postgraduate qualification monitors the individual's progress and any issues arising from completion of the modules. In both low- and high-intensity conditions, a patient's progress is monitored through the session by completion of standardized psychological measures (e.g., depression and anxiety).

IAPT services have now been established in the majority of primary care trusts (PCTs) in the UK. PCTs are the local authorities within the National Health Service managing the provision of primary care (e.g., doctor's surgeries, dental practices and mental health services) in different communities throughout the UK. Clark compared data on the evaluation of IAPT outcomes across different PCTs [6]. He suggested that the success of each site at improving patient outcomes was highly variable, and a number of variables were important (e.g., number of treatment sessions). These results suggests that careful planning and implementation of CBT in clinical practice is critical, as in this case, small alterations to the protocol across sites were important to patient benefit. These findings underscore the importance of routinely monitoring CBT interventions to ensure best practice in the delivery of interventions in the community.

Whilst the scope of IAPT services to improve wellbeing is considerable, success is likely to be contingent upon continuing to develop clear guidelines regarding best practices in service implementation. Ideally, in the long term, these services will improve awareness of the importance and relevance of evidence-based therapies in primary care both within the field and the community. Furthermore, the initiative will provide much-needed training opportunities for community therapists to become skilled in the delivery of CBT. Importantly, the initiative improves access to psychological help for mild-to-moderate sufferers, some of whom, prior to intervention, may have been on track to develop severe and chronic conditions. Thus, IAPT is also important from the point of view of prevention. This is an important area that researchers currently have very little knowledge about.

'Prevention' was this year's European Association of Cognitive and Behavioural Therapies (EABCT) conference theme, and there were a number of interesting and informative talks in this area. In particular, D Hamiel presented an excellent study highlighting the potential of a teacher-led CBT intervention that aimed to prevent the development of post-traumatic stress disorder (PTSD) in schoolchildren [7,8].

In this study, a sample of fourth and fifth grade Jewish students (n = 1488) living in a city in southern Israel took part. During school time, a teacher led children through a 14-week intervention containing a number of modules covering general topics such as psychoeducation, CBT techniques, emotions and attention control. Of note, these were general skills and there was no mention of trauma in any of the modules taught. Each module was introduced by a fictional character called 'Adam'. After the intervention was implemented, it was up to the teacher's discretion to use the intervention in day-to-day situations (e.g., fights). Three months after the intervention, rocket attacks occurred in the area. Children who had taken part in the intervention were found to have lower levels of PTSD and mood disorders relative to a matched control sample. Thus, this study provided the first evidence that delivering a PTSD prevention intervention to a group of children before they were exposed to a trauma is beneficial. Before this, the only prevention work in the PTSD area had been conducted in the early weeks after exposure to traumatic events, and researchers had speculated that early interventions may be harmful [9].

In summary, a range of interesting and informative research was presented at this year's EABCT conference. A clear

message was provided concerning the need for researchers and clinicians to start to think about extending upon traditional approaches to research and treatment so that CBT may be more accessible to the wider public. People were encouraged to begin to think about how CBT could inform the development of prevention interventions for the general population. Furthermore, they were encouraged to consider the wider impact of current research and interventions on clinical practice by designing future studies that will bridge the divide between what happens in the laboratory compared with the clinic.

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