REPORT ON EABCT CONFERENCE 2022

By Mieke Ketelaars &
Maria Bekendam

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Preface

In September 2022, the scientific team of the Dutch Association for Behavioural and Cognitive Therapies (VGCt) attended the EABCT conference in Barcelona. What are the latest research results and how can we translate them to clinical practice? In the first part of this report, we asked keynote speakers about their field of expertise. The second part consists of a summary of several symposia.

Mieke Ketelaars has been working as a science journalist at the VGCt since 2019. Her activities include the development of products such as factsheets, podcasts and interviews. After studying Child and Adolescent psychology at Leiden University in the Netherlands, Mieke obtained her PhD at Radboud University Nijmegen. During that time she also worked as a psychologist. After several years as a university lecturer and program manager, Mieke became increasingly involved in translating scientific knowledge to a wider audience.

Maria Bekendam is a new addition to the scientific team and has been working as a science journalist at the VGCt since early 2022. She studied positive psychology at the University of Twente in The Netherlands and this year she will obtain her PhD at Tilburg University on the impact of psychological factors in patients with heart disease. After her research work, she was involved in education and student counseling as a university lecturer. Through interviews with experts and the development of factsheets and infographics, she aims to bridge the gap between scientific insights and clinical practice.

PART I

INTERVIEWS WITH KEYNOTE SPEAKERS

Ioana Alina Cristea

Current position: Assistant Professor at the Department of Brain and Behavioral Sciences, University of Pavia, Italy and a Research Affiliate at the Meta-Research Innovation Center at Stanford University, USA (METRICS).
Main interests: The efficacy and safety of various psychological and pharmacological interventions; strains of bias.

Your work is focused on appraising the efficacy and safety of psychological and pharmacological interventions. Do you think we tend to overlook safety issues and other negative effects of CBT?
We currently have very little information about potential negative events of psychological therapies, CBT included. The reasons are multifold. First, reporting of safety issues and adverse effects traditionally has not been customary for trials of psychological interventions. This is now beginning to change, as the implementation of reporting guidelines is improving for these trials, and there are even dedicated guidelines such as CONSORT-SPI. Second, we have few common, valid instruments for assessing adverse events to use across trials. Consequently, even when measured and reported, adverse events are reported in a heterogeneous way. As these events are rare and trials of psychological interventions usually have small or moderate sample sizes, we need to pool individual patient data from more trials to be able to capture the prevalence of adverse events.

As clinicians, what should we be looking for to prevent negative effects?
Here too, we have little data about what factors might make it more likely for patients undergoing psychotherapy to have negative experiences or even deterioration. We also know little about how to tackle these factors to minimize negative experiences or deterioration. One cross-sectional survey identified not being referred at what respondents considered as the right time, not receiving the right number of sessions, and not discussing progress with their therapist as being associated with negative experiences of psychotherapy. A qualitative analysis identified themes related to unethical behavior, lack of core therapy skills like empathy or structuring a session, therapist inflexibility such as not considering the patient's broader context.

You're also interested in strains of bias, such as financial and non-financial conflicts of interest. Is there a lot of bias in CBT-oriented research?
Traditionally, it was believed that psychological interventions, such as CBT, were particularly prone to a form of intellectual bias, called researcher allegiance- the researcher's belief in the superiority of their "own" treatment and its associated theory of change. The research on whether "allegiant" investigators produce biased outcomes resulted into mixed results. I believe these contradictory findings are mostly due to differences in how allegiance was measured across studies and to the limited validation of measurement tools. Conversely, financial conflict of interest associated with psychological interventions has received less attention, though its role in biasing outcomes is well-established across all fields of medicine. I have argued and believe we should look more into this, particularly as for digital

psychological interventions that are easier to disseminate and monetize, also by the for-profit industry. We should also keep an eye to founders selling “new” and “promising” treatments before enough high-quality data is available for their safety and efficacy.

How can scientists and clinicians identify bias?
There are instruments to assess bias for different study designs, such as the Cochrane risk of bias instrument for randomized trials. The Joanna Briggs Institute also offers a range of critical appraisal tools to assess the trustworthiness of published reports (https://jbi.global/critical-appraisal-tools). However, these instruments require a certain specialized expertise, as for example good knowledge of the crucial issues in the planning, conduct and reporting of trials. Alternatively, particularly for busy clinicians, there are science blogs and even courses on how to critically read the research. For mental health, the best example is the Mental Elf (https://www.nationalelfservice.net/about-mental/), where experts without conflicts of interest review publications in this field, with an eye to limitations and bias.

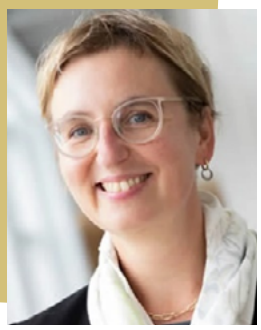
Your recent papers tend to focus on digital interventions. Do you think bias is more prevalent there?
I believe the opposite is true. Trials of digital interventions are more recent, so had to be conducted and reported at higher standards, to be published. As such, they are, for example, more likely to be registered prospectively, to follow reporting guidelines or to share individual patient data. They are also more likely to use a common set of validated instruments to assess outcomes and to have less missing data, as patients have to fill in instruments digitally. On the other hand, as I previously mentioned, digital interventions are easier to disseminate and as such more attractive for the for-profit industry. So, we have to watch out for biases associated with financially gaining from these interventions.

IOANA’S LITERATURE SUGGESTION ON:

- The evolution of psychiatry as a scientific discipline:
  Ryznar, Elizabeth and others (eds), Landmark Papers in Psychiatry, Landmark Papers In (Oxford, 2020; online edn, Oxford Academic, 1 Jan. 2020).

- Mechanisms of change in psychotherapy research:
  Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annu. Rev. Clin. Psychol.*, *3*, 1-27.

- How to prove your therapy is effective:
  Cuijpers, P., & Cristea, I. A. (2016). How to prove that your therapy is effective, even when it is not: a guideline. *Epidemiology and Psychiatric Sciences*, *25*(5), 428-435.



Emily Holmes

Current position: Professor in Psychology at the Department of Psychology, Uppsala University, Sweden and at Karolinska Institutet's Department of Clinical Neuroscience.
Main interests: Psychological treatment innovation in mental health – both in creating new techniques and reaching more people; mental imagery.

Your work centers around psychological treatment innovation in mental health. What new innovations do you think are potentially interesting?
I think we need innovations that make psychological treatment simpler and more precise in order to respond to the immense need of psychological treatment worldwide. Novel interventions or tools that take less time, require fewer resources and can be used in places where trained psychotherapists are rare, could complement 'traditional' treatment approaches and open new avenues for innovation.

You have been focusing on the potential of mental imagery. What's the evidence base thus far?
Some techniques that include mental imagery are already part of psychological treatments today. The specific work we are doing on trying to reduce intrusive images of trauma with a novel cognitive intervention is still at a research level and not part of clinical practice. We are currently running two large clinical trials to build up the evidence base of this intervention. First pilot trials with trauma patients and a large body of laboratory work with non-clinical populations have shown promising results so far.

Why is mental imagery such a powerful tool, and is it for everyone?
Mental images (in contrast to pure verbal thinking) carry a great deal of emotion, which can make them quite overwhelming, e.g. in the case of intrusive mental images or 'flashbacks' that haunt people who experienced trauma. At the same time this strong emotional component makes mental images a powerful tool to work with in psychological treatments, for example when 'rescripting' the content of distressing images or using positive, hopeful images to increase motivation.

EMILY'S LITERATURE SUGGESTION ON:

- Recent advances in understanding of intrusive memories and trauma:
  Iyadurai L, Visser RM, Lau-Zhu A, Porcheret K, Horsch A, Holmes EA, James EL. Intrusive memories of trauma: A target for research bridging cognitive science and its clinical application. Clin Psychol Rev. 2019 Apr;69:67-82. doi: 10.1016/j.cpr.2018.08.005. Epub 2018 Aug 23. PMID: 30293686; PMCID: PMC6475651.

- Intrusive mental imagery interventions:
  Laura Singh, Lisa Espinosa, Julie L. Ji, Michelle L. Moulds & Emily A. Holmes (2020) Developing thinking around mental health science: the example of intrusive, emotional mental imagery after psychological trauma, Cognitive Neuropsychiatry, 25:5, 348-363, DOI: 10.1080/13546805.2020.1804845.

Carmelo Vázquez

Current position: Full professor of Psychopathology at the Complutense University of Madrid, Spain.
Main interests: The role of positive emotions and positive interventions in emotional disorders.

Positive psychology seems to be gaining ground. Why do you think that is?
Indeed I believe that positive psychology, although its name does not convince many, covers aspects of psychology that are fundamental but have been very much neglected. In the field of basic research and the neuroscience of emotions, the domain of positive emotions is becoming increasingly important and there is a recognition that psychological well-being is a legitimate goal of human beings. Therefore, psychology must also be seriously concerned with its study and promotion.

Well-being was originally discussed in terms of hedonism and eudaimonia. In today's society, which perspective seems to receive more attention? And on which perspective are positive psychological interventions based most?
In the field of psychological interventions, and especially in the clinical setting, I think there is perhaps a greater emphasis on eudaimonic perspectives. However, there are very interesting programs, based on neuroscience findings, to try to reduce anhedonia, which is a cross-cutting element in many clinical problems. Anyway, hedonia and eudaimonia are very much intertwined. Those activities that give meaning to our lives usually also give us pleasure, so the distinction is sometimes rather artificial.

What can positive techniques bring that other techniques cannot?
One advantage of these techniques is that they fit nicely into the mental models of human functioning and needs that normal people have. People don't go to psychologists just to alleviate problems but to try to be happier, have more meaningful lives, and grow personally. Positive techniques certainly bring an evidence-based breath of fresh air to the panoply of existing interventions.

Do you consider positivity to be more a trait or a state? In other words, can we train everyone in positivity?
If we'd think of depression, let's say, we probably wouldn't consider the issue of whether "negativity" can be changed. Of course, positivity can be trained, and it has the same limits as training other aspects of human functioning. For example, we may not be able to improve sensitivity to reward (which may be more of a trait), but we can improve learning to savor the experience, improve positive relationships with others, or improve the expression of gratitude. With all of that, we are changing fundamental aspects of how people function daily.

Recently you have researched the power of positive beliefs during COVID-19. What is the main message of that paper?

The interesting thing about that research is that it demonstrates the subtleties of what we naively call “positive” or “negative”. In that paper, we show that having beliefs of being linked to humanity, which, in principle, seems positive, is a double-edged belief. In a pandemic situation, that belief predicts post-traumatic growth, but it also predicts post-traumatic symptoms. So, feeling linked to the world, in a human-to-human transmitted pandemic situation, has positive but also negative effects. This is an elegant example of how simplistic messages about positive psychology are absurd. Reality is very complex, and the science of well-being has to dissect that reality using the best methods.

CARMELO’S LITERATURE SUGGESTION ON:

- The science of subjective well-being:
  Diener, E., Heintzelman, S. J., Kushlev, K., Tay, L., Wirtz, D., Lutes, L. D., & Oishi, S. (2017). Findings all psychologists should know from the new science on subjective well-being. *Canadian Psychology/psychologie canadienne*, 58(2), 87.

Gerhard Andersson

Current position: Professor in Clinical Psychology at Linköping University, Sweden.
Main interests: Evidence-based internet treatments for various conditions such as depression and anxiety disorders.

In a recent paper you co-authored you state there is a terminology issue within the field. What is the problem and how does it affect clinical practice?

This is not a problem only for this field, but also concerns psychotherapy overall with lack of standardized terms of therapy orientations. CBT is, for example, an umbrella term that can be close to meaningless as a description as it can involve strikingly different approaches and even goals. Internet interventions suffer from the numerous terms for the use of digital techniques and we highlighted this in our paper without finding a simple solution. Needless to say, this can be confusing for clinical practice. One example is the difference between guided self-help treatments mainly using text and asynchronous support, versus real-time video therapy that has been practiced much during the pandemic but is much less backed up by research.

In a 2017 paper you found a mixed attitude towards digital treatment for depression. Five years down the line, do you think digital treatments have become a more acceptable format?

The more we get used to the format, the more it will be accepted as a complement and increasingly used as part of client management. For example, online questionnaires (if secure) have major benefits over the old paper-and-pencil versions. Clients are also helped by the memory support in internet interventions as they can return to their treatment modules and repeat. A good therapeutic alliance can also be obtained.

An important benefit of digital treatment is its cost effectiveness. Are there other benefits compared to face to face treatments?

Both pros and cons. I would argue that internet interventions by definition become more “pedagogic” but of course there are clients who need the face-to-face contact and may even not be suitable for manualized treatments. We have partly handled this by tailoring treatments and also allowing clients to decide what treatment components to work with - and yes they can! In three trials we have found that it is possible without any loss of effects. Another benefit is that much data is collected for research. But it needs to be stressed that this does not mean that we CBT therapists will stop seeing our clients. Only that we have one more tool to work with to see more clients and help them more efficiently.

What are the biggest future challenges we have to solve in order to implement digital interventions on a global scale?

In our experience (24 years now) we are still convinced that some kind of therapist support is needed for many, if not most, clients. Fully automated and brief app-based treatments are less effective and suffer from dropout rates. To spread internet-CBT on a global scale we need to find a way to provide support in different languages and perhaps train lay persons to provide the support.

GERHARD'S LITERATURE SUGGESTION ON:

- Internet approaches to psychotherapy:
  Andersson, Gerhard; Berger, Thomas (2021). *Internet approaches to psychotherapy*: Empirical findings and future directions. In: Barkham, Michael; Lutz, Wolfgang; Castonguay, Louis G. (eds.) Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (7th ed.) (pp. 739-762). Hoboken, NJ: John Wiley & Sons.

Paul Gilbert

Current position: Professor of Clinical Psychology at the University of Derby and honorary visiting Prof at the University of Queensland, Australia.
Main interests: Evolutionary approaches to psychopathology with a special focus on mood, shame and self-criticism in various mental health difficulties; Compassion Focused Therapy.

It sounds appealing, the idea of creating a compassionate society. But how is that possible when social and economic conditions are so unequal?
It's important to understand the causes of inequality before one can address them. Clearly, these are many and complex. However, compassion begins with motivation. Without some desire to address issues such as climate change, inequality and so forth, it's very tricky to help people move forward. Indeed, as goes for any process of change; it is hard to achieve without motivation training. Therapies and indeed all change processes have to work with people's motivation and address issues such as avoidance, denial and so on.
Once individuals begin to think about the need to have a more compassionate community to address injustices (such as the 'me too movement', Greenpeace, Amnesty International or compassion in farming), compassion communities can be built by forming alliances and communities that pursue focused goals. The compassion in politics group (https://www.compassioninpolitics.com/) are working with politicians who have an interest in creating a fairer and sharing world. It's clear that we have had a more compassionate politics than we do now. For example, immediately after the Second World War, we created societies that orientated towards better social support and healthcare and equality, but with the rise of neoliberalism, this has been chipped away and today not enough people vote for -- or get the politicians they need - to promote social fairness. There are problems in how the right-wing media and politicians entice people to vote in their 'self-interest' or at least what they think is their self-interest but often isn't.

In a recent paper you co-authored, you found that compassion protects mental health and social safeness in times of COVID-19. What does that mean?
It means that you're able to be self-supportive. But it also means that if you're able to be open to compassion from others and to have that compassion available to you, you're less likely to struggle with mental health problems. There's also some evidence that if you are compassionate/helpful/caring to others, and you find that meaningful, that is also a protector. If you're self-critical, focus on the fear of an illness, maybe limited in eliciting the help from others or if you are lonely and cut off from others, that's not such a good thing.

Is compassion a skill you can train?
Compassion is first and foremost a motivation based on a basic algorithm of stimulus sensitivity to suffering. This in turn triggers the response to try to alleviate and prevent suffering. So, there are three types of training: 1) ways for motivation training, 2) training in order to be distress-stimulus sensitive and tolerate suffering, and 3) training to behave appropriately rather than impulsively or unwisely. For example, while some therapists get their basic train-

ing and then pretty much leave it like that, other therapists are much more compassion motivated in the sense that they want to continue to train so that they can become more in tune with their clients and have greater courage and wisdom of knowing how to be helpful to them.

If so, do you think it is a skill that should be incorporated into CBT?
CBT today is not what it was 20 or 30 years ago because today it's a very broad church indeed. In CFT there are 12 basic competences for compassion; six relate to how we become sensitive to and distress tolerant, and empathic towards domains suffering; and six that focus on the nature of compassionate action. Even though I'm experienced, I'm still learning how to do some of these processes better and indeed learnt things at this conference. So it's an ongoing process, really. If we think of compassion as just a set of skills, then we are missing the point. Compassion has to be about motivation, otherwise you could be sensitive to suffering but you don't actually act compassionately. We know many people have the skill for empathy, but they don't always use it. Many people are very keen to get fit and lose weight but then they don't actually engage in behaviours that will achieve that aim. So, in most psychotherapies behavioural change, even in the face of motivation, can be tricky.

What changes when we train compassion?
There's now considerable evidence that compassion as motivation training impacts a whole range of biopsychosocial processes, including various neuro circuits - the autonomic nervous system, etc.

GILBERT'S LITERATURE SUGGESTION ON:

- Evolution and compassion focused therapy:
  Gilbert, P. (2020). Compassion: From its evolution to a psychotherapy. *Frontiers in Psychology*, 3123.

- Care and share versus control and hold:
  Gilbert, P. (2021). Creating a compassionate world: Addressing the conflicts between sharing and caring versus controlling and holding evolved strategies. Frontiers in Psychology, 11, 582090.

- Applications of compassion focused therapy:
  https://www.amazon.co.uk/Compassion-Focused-Therapy-Clinical-Applications/dp/0367476908/ref=sr_1_4?crid=A1A43M873V72&keywords=compassion+focused+therapy-&qid=1640885583&s=books&sprefix=compassion+foc%2Cstripbooks%2C37&sr=1-4.

Kerry Young

Current position: Consultant Clinical Psychologist and Clinical Lead of the Woodfield Trauma Service in London, UK.
Main interests: Mental imagery techniques, particularly imagery re-scripting and its application in the field of trauma.

It could be argued that we should not develop new PTSD treatments but work on improving those we have. There has been debate about this standpoint among experts. What are your thoughts on this?
I don't have any strong views on this. We know that memory-focused treatments can be very effective but there is still room for improvement, particularly with more complex PTSD presentations. I think we should look at ways of improving the effectiveness of current treatments and explore any novel but promising treatments.

With the recent war in Ukraine, we see a rise in refugees. Are their psychological problems similar to those of other war victims?
PTSD and depression are very common (30-50%) across all refugees. Ukrainian refugees' rates of PTSD will vary depending on how much trauma they have witnessed. I have not seen any reports about whether or not their rates of psychological problems are similar to other refugees.

If a patient with PTSD suffers from feelings of guilt, how can CBT be applied?
It is very important to explore and target guilt in PTSD as it tends to be a key factor in maintenance. I direct readers to a recent paper of my team (below), which explains exactly how to target guilt in PTSD and even has accompanying films to demonstrate techniques.

Patients with PTSD in The Netherlands often do not receive the guideline TF-CBT. Poor recognition of traumatic experiences (and consequently PTSD) in patients is one of the reasons for this. Do you have similar experiences in the UK? What should clinicians be aware of?
PTSD is well-recognized by primary care mental health services in the UK. Patients are offered only evidence-based treatments for PTSD if they are seen in our free National Health Service. If patients access paid-for PTSD treatments, they are less likely to receive evidence-based care.

KERRY'S LITERATURE SUGGESTION ON

- Guilt in PTSD:
  Young, K., Chessell, Z., Chisholm, A., Brady, F., Akbar, S., Vann, M., . . . Dixon, L. (2021). A cognitive behavioural therapy (CBT) approach for working with strong feelings of guilt after traumatic events. *The Cognitive Behaviour Therapist*, 14, E26. doi:10.1017/S1754470X21000192.

- Managing dissociation in refugees:
  Chessell, Z. J., Brady, F., Akbar, S., Stevens, A., & Young, K. (2019). A protocol for managing dissociative symptoms in refugee populations. *The Cognitive Behaviour Therapist*, 12.

Keith Dobson

Current position: Professor of Clinical Psychology at the University of Calgary, Canada.
Main interests: The development of models and treatment of depression, particularly using cognitive-behavioural therapies.

Among others, your recent work focuses on mental disorder stigma in the workplace. What are barriers that have to be overcome for a more understanding and accommodating workplace in this context?

We have known for some time that stigma related to mental disorders is an enormous problem, and in some studies, stigma has been identified as having equal or greater impact to people with the lived experience of mental illness as the disorder itself. Stigma can take multiple forms, including social stigma (stigma towards others), self-stigma (self-limitation, including not asserting oneself or applying for positions or opportunities that would be appropriate), and structural stigma (policies and procedures that negatively affect those with mental illness). Although social stigma is often the focus of intervention programs, helping people with mental health problems to be able to advocate for themselves is very important, as are the development of policies and procedures that permit the inclusion and optimal participation of everyone in various settings. In Canada, we are attempting to address all of these levels of stigma through programs that we have developed and evaluated. Much of this work is conducted through the Mental Health Commission of Canada, and I encourage people to read their website, and in particular the work of the Opening Minds program.

What effect did COVID-19 have on social stigma in the workplace?

One of the paradoxical effects of the recent pandemic is that it has in a sense become more acceptable to be socially isolated, and to not engage with others. I have heard that people with social anxiety and depressive disorders have to some extent benefited from the move to remote workplaces. The challenge emerges, however, as the pandemic ends and people move back into the live classrooms and workplaces. A second aspect of the recent pandemic is that much of the informal communication that happens in an office or work setting did not take place. Virtual meetings tend to be somewhat more formal than in person, and so people have had reduced social inclusion and participation. Particularly for people with mental health problems, moving back into an in-person work environment will pose the challenge of not only continuing their actual work employment requirements, but reengaging in the social community.

Other than reducing stigma concerning mental illness, what role is there for promoting well-being and resilience? Can positive psychology insights be relevant in this context, for example?

There is an enormous opportunity to recognize and promote well-being. There are now many studies that show the major determinants of a sense of personal well-being, including self-esteem, the ability to express oneself, physical activity, and social engagement. Many workplaces have in fact attempted to augment social opportunities during the pandemic,

through non-business oriented meetings, and my sense is that this is to the benefit of these workplaces. I am also aware of a large study that was done in Spain at the beginning of the pandemic, in which participants were randomly assigned to either normal social activities or enhanced socialization. Not surprisingly, the group with the enhanced social engagement experienced improved well-being and less depression. These determinants of personal well-being are not unique to any particular setting or type or individual, but can be used more or less universally to enhance people's sense of optimism, engagement, and well-being.

The other aspect of this question is related to resilience. The definitions of resilience include the idea of overcoming an obstacle, or dealing with a threat or challenge. In order to develop resilience, therefore, one has to be exposed to a challenge or a difficulty. One could argue that the recent pandemic has been a challenge for everyone, and in this sense we are all developing resilience to the threat of a global pandemic. I am not convinced, however, that we are generally building a sense of resilience in society. Without trying to overstate the issue, my sense is that people faced with adversity often look for external causes, and tend to blame those causes for the challenges. Instead, to build resiliency, I believe that individuals should look internally and look more for the things that they can do, the ways in which they can accept and demonstrate responsibility, and the ways that they can reward themselves for these actions. There are many strategies to do these activities, of course, including developing self-awareness, reaching out to be a positive force in society, addressing issues that are currently being avoided, and generally developing skills, activities and positive aspects for one's stage of life.

You have also focused on differentiating anxiety and depression with assessment tools. What is, in your opinion, one of the most psychometrically sound and validated tools for this?

First, I would note that the constructs of anxiety and depression are highly correlated. This correlation has been recognized for many years, and there are descriptions of the developmental trajectory where many shy and anxious children develop anxiety disorders in late adolescence or early adulthood, and then become vulnerable to later depression. Also, we know that many scales related to your anxiety and depression correlate between themselves. Thus, if a scale was developed that minimized the correlation between these two constructs, it would potentially misrepresent the natural relationship. This said, the DASS (Depression Anxiety Stress Scale) is a well-developed and validated measure of these dimensions. It is most used in research, though. So if people are looking for a clinically useful way to measure anxiety and depression, I recommend the GAD-7 to measure anxiety and the PHQ-9 for depression, as these are related to the DSM dimensions of generalized anxiety and depression, respectively, and can be used across time to measure symptom reduction in clients.

KEITH'S LITERATURE SUGGESTION ON:

- Stigma of mental illness:
  Dobson and Stuart, The stigma of mental illness, Oxford University Press, 2021.
  General introduction of CBT: *Handbook of Cognitive and Behavioral Therapies*, 4th edition (Dobson & Dozois, Guilford Press, 2019).

Claudi Bockting

Current position: Professor of Clinical Psychology in Psychiatry at Amsterdam University Medical Centers and co-director the interdisciplinary Centre for Urban Mental Health at the University of Amsterdam, The Netherlands.
Main interests: Potentially modifiable etiological factors of onset, relapse and chronicity of common mental health disorders using an interdisciplinary complex systems approach.

You focus on new pathways and complex systems methodology to explore new targets for interventions of depression. What are some of the main findings thus far?

With my research team I focus mainly on depression, but with our Centre for Urban Mental Health at the University of Amsterdam we focus on mental health problems and the three most common mental health conditions, i.e. anxiety disorders, addiction and depressive disorders. We zoomed out to examine not only individual factors, but also group factors like family, school, neighborhood and urban and societal factors. We found that living in the city was associated to a higher risk of having these three mental health conditions, but only if within country more than 50% of the people live in urban areas (van der Wal et al., Lancet Psychiatry, 2022). Now we are studying what the mechanisms are that contribute to more mental health conditions in the cities. Especially, because this might offer new target points for interventions to prevent and/or reduce the disabling impact of mental health conditions.

In the aftermath of COVID-19, what role do you think e-mental health will have now and in the future?

COVID-19 gave us more than the importance of e-health. It provided clear evidence that policy making, like school closur and other types of lockdown, had a substantial effect in increasing mental health conditions. We developed a conceptual feedback model that predicts that these policy measures have not only short term negative effects on mental health worldwide, but also long-term negative effect. These long term effects are the result of self-reinforcing feedback mechanisms resulting for instance in relapse (Lokman & Bockting, Lancet Psychiatry, 2022). We could offer policy makers our knowledge to prevent future policy making that has profound negative effects. On the e-health, it is reassuring that many of the clinicians now work with e-health, including video calls, as addition to their face to face session. The next step would be to facilitate clinicians so they can offer evidence based e-health instead of e-health that is based on evidence based principles (because they do not always work).

Can you give an example of an effective online intervention for the treatment of depression?

With my team I studied an intervention that is effective in treatment of depression (behavioral activation). We designed an online version (Act and Feel/Doe en Voel) and trained lay counselors. We studied in a RCT the effect in Indonesia in individuals with depressive disorders, indicating good effect on reduction of symptoms and promoting remission (Arjadi et al, 2018, Lancet Psychiatry). We also tested the Dutch version in primary care with POH/nurse practitioners guidance. I guess this is one of the most relatively simple online interventions, but effective.

In a recent research article you conducted a meta-analysis of relapse prevention strategies for depression and anxiety in youth. Although depression and anxiety relapse numbers in youth are high, research is scarce on that subject. Why is that?

This in indeed puzzling. We might be a bit hesitant to study this because we think relapse is not an issue at such a young age. Also, as clinicians we might be too optimistic about the long term effects of our treatments. It was remarkable that for anxiety disorders, no RCT was conducted worldwide focusing on relapse prevention in youth.

CLAUDI'S LITERATURE SUGGESTION ON:

- Tomorrow's science for psychological treatments:
  Holmes, E. A., Ghaderi, A., Harmer, C. J., Ramchandani, P. G., Cuijpers, P., Morrison, A. P., ... & Craske, M. G. (2018). The Lancet Psychiatry Commission on psychological treatments research in tomorrow's science. *The Lancet Psychiatry*, 5(3), 237-286.

Todd Farchione

Current position: Research Associate Professor in the Department of Psychological and Brain Sciences at Boston University (BU), USA. **Main interests**: Emotion regulation processes, identifying mechanisms of change in treatment, and developing new preventative measures and improved treatments for emotional disorders.

You are director of the Unified Protocol Institute. Could you elaborate on this Unified Protocol: what does it entail and what is it based upon?
The Unified Protocol (UP) is a psychological treatment consisting of five "core" modules or components based on CBT elements of proven effectiveness that target temperamental characteristics, particularly neuroticism and resulting emotion dysregulation, underlying all anxiety, depressive, and related disorders. By addressing shared mechanisms, the UP can be used to treat a wide range of mental health problems with a single protocol.

In your research, what defines emotional disorders?
Emotional disorder is a term that has been used to group anxiety, depressive, and related disorders, such as somatoform and dissociative disorders. The grouping is based on the idea that the onset and maintenance of these disorders is due to shared temperamental vulnerabilities, particularly neuroticism and resulting dysfunction in the interpretation and regulation of emotion. What is interesting is the possibility that the discrete diagnostic categories (based on the DSM), may simply reflect minor variations of a broader underlying syndrome.

When it comes to transdiagnostic or symptom focused treatment, is one more preferable than the other?
I think in most clinical situations, the UP is preferable to symptom focused treatments for emotional disorders. As the UP was developed to explicitly address the core deficits shared across emotional disorders, it can simultaneously reduce symptoms across comorbid conditions, which is more parsimonious. Further, the focus on transdiagnostic mechanisms, as opposed to symptoms provides offers clinicians greater flexibility in applying the treatment to a range of presenting symptoms and disorders while also allowing them to more easily personalise the treatment to meet the needs of their individual client.

You have conducted numerous studies on the effectiveness of treatment with the transdiagnostic Unified Protocol, what are the main findings thus far?
A large randomized controlled trial conducted by our research group revealed that the UP has equivalent efficacy compared to established gold standard single disorder cognitive-behavioral therapy protocols in treating patients with principal anxiety disorders (Barlow et al., 2017); this equivalence was sustained at 12 month follow up (Eustis et al., 2020). Recent meta-analyses (Sakiris & Berle, 2019; Carlucci et al., 2021) have confirmed that the UP significantly improves symptoms of internalizing disorders with effect sizes comparable to single-disorder interventions. These meta-analyses also demonstrated that treatment with the UP leads to increases in adaptive emotion regulation strategies. Further, a recent study showed that in a treatment seeking sample with anxiety disorders and comorbid conditions,

treatment with the UP was linked to significant reductions in the dimension of neuroticism itself (Sauer-Zavala et al., 2020).

TODD'S LITERATURE SUGGESTION ON:

- Transdiagnostic treatment and neuroticism:
  Barlow, D. H., Curreri, A. J., & Woodard, L. S. (2021). Neuroticism and disorders of emotion: A new synthesis. *Current Directions in Psychological Science*, 30(5), 410-417. https://doi.org/10.1177/09637214211030253.

Caroline Braet

Current position: Professor of Psychology at Ghent University, Belgium.
Main interests: Developmental and clinical aspects of childhood therapy with focus on depression and eating problems.

More recent work of yours is focused on emotion regulation among children. Why is emotion regulation in children, and emotion regulation in general, only recently receiving increased attention in research and clinical practice?
In recent years, the field has paid more attention to transdiagnostic processes (underlying different problems, often explaining comorbidity or the staggering of symptoms in one person, over time), including emotions and their regulation (after all, regulation seems to be an underlying mechanism in 75% of all disorders).
On the one hand, this interest can be explained by the growth in research; after all, there are now better measurement tools to determine emotion regulation. On the other hand, in CBT there was perhaps too much focus on cognitions and behaviour, and there is now a trend that states that emotions are also part of life (and at the heart of it) and you should therefore dwell on them in treatment as well. The mindfulness hype has rightly called for more attention to emotions here too.

You developed an emotion regulation-protocol for children and adolescents. How are children in this protocol guided in developing adaptive coping strategies?
Emotions are part of life but, the way we have learned to deal with them can differ. We distinguish adaptive and maladaptive emotion regulation strategies. These are strategies that are not negatively or positively associated with developing psychopathology. But, in a protocol, you have to have an eye for all possible strategies and on all deployments (strengthen one, weaken the other) and you always have to guard that one strategy is never necessarily right or wrong, it is about the right choices and the flexibility to deploy them appropriately. However, in our protocol we have also included skills that have to be learned first, as they pave the way (or are the condition) for emotions to become manageable and emotion regulation strategies to better stick. These are the skills: awareness, acceptance and self-compassion. We don't see these skills as working stand-alone: they are part of a protocol, in a fixed order. You can't pick just one. And then they must be followed by further practice of adaptive emotion regulation strategies.

Your recent research papers also examine emotional eating and obesity. To what extent do you think prevention can play a role in this?
Some children are more vulnerable than others. At least three factors can explain differences: Their awareness of emotions, their temperament, their cognitive self-control. If these are at the extreme end of the continuum, you have children who have more emotions, are not aware of them and cannot control them. They do feel the arousal of the emotions, which is unpleasant, and then choose palliative coping: reducing the symptoms (arousal) without acknowledging the source of the emotion. Emotional eating is an example of this. For those

children, prevention is appropriate. In forty per cent of school-age children, their feelings are the reason they eat (i.e. eat without being hungry), we define this as emotional eating. In the emotion regulation training we have developed, we let children dwell on their emotions. get the feeling that they can do something with the emotion and then do not have to seek distraction in eating. Our study already found evidence for adding ER training on top of 'multidisciplinary obesity treatment' (MOT) in children who eat emotionally. Other studies are still ongoing, but we are cautiously positive.

Can you give an example of an effective emotion regulation intervention among youngsters?

Are you familiar with the four steps of 'emotional coaching' according to Gottman? It is meant for parents. Coaching can determine how a child deals with emotions. The first step is to be aware as a parent that there is an emotional experience, that your child is feeling something. This seems simple (e.g. in case of pain) but, what if your child feels shame or guilt? Do you see this as an opportunity for emotional coaching?

The second step is to name the feeling; we name the emotion out loud. Does a knee hurt or does the child feel angry, frustrated or irritated? We teach the child that there are types of feelings and that they all have different names and belong to an emotional experience.

The third step - this one is often skipped - is about validation; acknowledging the feeling. When you are sad and crying over the loss of your pet, it is important to say: this sadness is justified, in this situation it is right to be sad. Usually we quickly help the child with distraction or avoidance, this is not how you teach awareness. If a child falls and cries, we say: 'Come, let's go find mummy' or the child gets a sweet. In doing so, we ignore the pain the child feels; we don't acknowledge that it is a right feeling in that situation, we try to distract the child from the pain. Actually, this is bizarre, because this does not teach the child that feelings are part of life and there are no opportunities to learn to regulate.

Step four is then learning to regulate. Here, children learn to look for what the feeling is telling them, what the source of the emotion is and whether they are willing to tolerate the emotion for a while, accept that this feeling is there now and only then change. Frustration, for example, tells me something about the goals I can't yet achieve but, tolerating and thinking about it will already reduce the intensity; this is then tackled further with, for example, other thought 'I still have a lot to learn'; 'I can't want everything at once'; 'life is trial and error'; and best supported with self-compassion: 'I can be more gentle with myself'. Or it leads to a constructive conversation with the parent about the reason for the frustration and whether there is a solution (problem-solving can then be taught.)

CAROLINE'S LITERATURE SUGGESTION ON:

- Emotional parental coaching:
  Gottman, J. M., Katz, L. F., & Hooven, C. (1996). Parental meta-emotion philosophy and the emotional life of families: Theoretical models and preliminary data. *Journal of Family Psychology*, 10(3), 243. doi:https://doi.org/10.1037//0893-3200.10.3.243.

- Emotional regulation training in children and adolescents:
  Braet, C. & Berking, M. (2019). Emotieregulatietraining bij kinderen en adolescenten. Therapeutenboek. Houten: Springer. ISBN 9789036823074.

PART II

SUMMARIES OF SYMPOSIA

Older people are younger than we think

More focus on CBT in older people necessary

Mental health problems such as anxiety and depression are roughly as common among the elderly as among the young. Yet the rate of referrals among the elderly is three times lower. How can this be? Who actually are these elderly people? And can they too still benefit from treatment?

Older people are vulnerable and suffer from all kinds of ailments. Of course, you tend to sleep worse when you are older. And surely it can't be wise to shake things up in later life. These are the ideas we really need to get rid of, according to the symposium speakers 'Cognitive and behavioural approaches for older adults with mental health problems'.

More than just age discrimination

It is concerning to see how little enthusiasm there is for the symposium. According to a recent United Nations estimate, by 2024, one in 10 world citizens will be 65 or older. By 2079, that figure will have risen to 20 per cent. So, in fact, we cannot avoid it; working with older people will increasingly become the norm. But then, of course, they have to be referred. What is causing these low referral rates? Age discrimination is certainly part of the problem, but the speakers say there is more to it. In fact, several studies suggest that older patients show a different behavioural picture. A picture that is less likely to be recognised.

Minimum age

This calls for more research into age differences, exactly what researcher Melissa Guineau is doing. The tricky thing, however, is that scientific research works with different age limits. By way of example, the WHO speaks of elderly at an age limit of 65, but the CDC has already set that limit at 60. With such different definitions it's not only tedious to arrive at clear figures, it also makes it difficult to understand any differences in symptomatology.

Guineau therefore used a large dataset of 30,000 participants, looking at outcomes on the OQ-45 without defining age limits beforehand. The analyses revealed two clear turning points: around the age of 30 and around the age of 50. At these ages, the symptom picture changes. This makes the idea, that older people are 60-ish, 65-ish or even 75-ish seem outdated.

Of course, identification of these tipping points alone is not enough to recognise older people. Guineau therefore also investigated which symptoms play a central role at certain ages. Some symptoms were found to be relevant at any age. These include, for example, the feeling that something bad is about to happen, the feeling of being weak, or feelings of nervousness. Other symptoms, however, were found to be more age-specific and should be better highlighted to referrers.

Working with depression and personality problems

Once recognised, there is of course also the question whether elderly people can be treated effectively. This certainly appears to be the case. Although research really needs to pay more attention to this growing group, Gert-Jan Hendriks argues that CBT works well in the elderly in the case of anxiety symptoms. Possibly even better than in younger people. An additional advantage is that the dropout rate is actually lower.

But psychological problems other than anxiety also seem to be treatable. For depression, for instance, Noortje Janssen finds positive effects of behavioural activation. With eight weekly sessions, depression could be tackled just as well as treatment as usual, with the effects of behavioural activation showing up faster. There is also some evidence of better cost-effectiveness. Those data are even more relevant against the side effects of medication. According to Janssen, medication often does not work as well and the likelihood of dangerous side effects is high when combined with medication for physical problems.

But even when the problems are much more comprehensive, elderly people can benefit from treatment. Thus, researcher and clinical psychologist Silvia van Dijk presents evidence for the added value of group-focused schema therapy with psychomotor therapy over treatment as usual. To be fair, those positive results disappeared with the advent of COVID-19, but that seems to be mainly due to the restrictions in place at the time, which did not allow face-to-face visits for groups.

The conclusion is clear: older people also benefit from CBT. And if you think you're not working with the elderly, then please realise that symptoms change at the age of 50. Older people are younger than you think.

Working with older people will increasingly become the norm

Cognitions important in treatment outcome of children with social anxiety disorder

More attention needed

More attention should be paid to cognitive factors in the treatment of children with anxiety disorders, according to psychologist Lynn Mobach. In the symposium 'Optimising the assessment and treatment of childhood anxiety', she spoke about the cognitive profile and its significance for practice.

Although CBT treatment is the golden standard for children with anxiety disorder, not all children benefit equally from treatment. In particular, children with social anxiety disorder appear to be a vulnerable group with a less favourable treatment prognosis. The reason for this is not known, although there are suspicions in the field, according to Mobach. 'Cognitive theories argue that social anxiety is maintained by negative thoughts and cognitive biases about social situations. Treatment for adults with social anxiety disorder is specifically tailored to these maintaining cognitions using behavioural experiments and video feedback, among other things. The situation is different in children, because in this group we still know much less about cognitive biases and the conditions under which they are visible. The treatment of children with social anxiety disorder therefore currently consists of a generic approach that is also used for other anxiety problems.'

Specific cognitions

That is why Mobach first examined whether specific dysfunctional thoughts and a bias in the interpretation of social situations (interpretation bias) exist at all in children with social anxiety disorder. 'Dysfunctional thoughts include, for example, thoughts such as 'I'll be bullied' or 'Kids will think I'm weird'. Interpretation bias is more about the tendency to interpret ambiguous social situations as negative or threatening. For example, when two children are laughing together, a (third) child with social anxiety disorder may interpret this negatively as 'They are laughing at me' rather than 'They are having fun together.'

Indeed, the results of Mobach's study point towards a specific cognitive profile for social anxiety. Children with social anxiety disorder were more likely to have dysfunctional thoughts and were more likely to interpret ambiguous social situations in a negative way compared to children with other anxiety disorders. Mobach also found evidence of the importance of that cognitive profile for the final treatment outcome. 'Children who showed a stronger improvement in their treatment in terms of dysfunctional thoughts and interpretation bias were found to ultimately benefit more from treatment. Conversely, children who showed less improvement were also found to benefit less from treatment.' An important result, the researcher stresses, as it suggests that this is where there is something to be gained in terms of treatment effectiveness.

Children with comorbid mood disorder are at a disadvantage in their treatment

Comorbid mood disorders

Unfortunately, we often see that children with social anxiety problems also experience other problems, such as depressive symptoms. According to Mobach, research still pays little attention to this when it comes to investigating dysfunctional thoughts and interpretation bias. ‘We mainly look at the primary disorder, in this case social anxiety. At the same time, we know that practice is much more complex and comorbidity is no exception.’

Mobach therefore looked at whether the cognitive profile of socially anxious children with a comorbid disorder was different from that of socially anxious children without comorbid problems. This indeed proved to be the case: children who also struggled with a mood disorder in addition to their social anxiety disorder had more socially dysfunctional thoughts than children without a comorbid mood disorder. In itself not that strange, says the researcher. ‘If you look at the content of thoughts in mood disorders, you often see cognitions about personal failure. In children who have mood symptoms in addition to social anxiety, you would expect such cognitions to also occur within social situations.’ However, this also means that children with comorbid mood disorders are already at a disadvantage in their treatment. Not so much because they benefit less from treatment, but because they often have more symptoms at the start of treatment. It is important for the psychologist to be aware of this.

Practically applicable

According to Mobach, it will become clearer in the coming years whether - as with adults - we should move from a more generalist approach in children to a specific treatment for social anxiety problems. ‘I think this could improve treatment effectiveness, but whether it does will have to be demonstrated in follow-up research.’

Mobach, L. (2021). Disorder-Specific Cognitive Distortions in Childhood Social Anxiety and their Role in Treatment Outcome. [Doctoral dissertation, Sl: sn].

Leaflet for CBT not needed

But do engage with your patient

Whereas package leaflets are often pages long in the pharmaceutical world, they are completely absent in CBT. And yet there is solid evidence that CBT can be associated with negative effects. The good news? Negative effects do occur frequently, but not more often than with other forms of treatment, and they are relatively harmless.

Talking about possible negative effects of CBT is not something that is immediately appealing. Yet - judging by the number of visitors to the symposium 'The dark side of the moon - Negative effects in psychological treatments' - there does seem to be enthusiasm for it. A good thing, because the field is still struggling with too many uncertainties about that dark side of CBT.

One such question, for instance, is how the negative effects of CBT compare with those of other forms of treatment. Researcher and psychologist Perl Carlbring therefore compared CBT with psychodynamic therapy in a large-scale study. As it turned out, CBT did not fare badly: in fact, patients in psychodynamic treatment reported negative effects more often than patients in CBT. Carlbring also found that those symptoms are likely to be inherent to the negative effects. For example, patients with traumatic experiences report traumatic memories coming to the surface. An interesting fact, because one can wonder to what extent these are side effects.

The internet of (negative) things

Besides a comparison with other forms of treatment, it is of course also interesting to know whether the format of CBT plays a role in experiencing negative effects. To investigate that, researcher Frederieke Fenski analysed the frequency and type of negative effects of an internet intervention targeting depression. A number of interesting insights emerge from the analyses. For instance, negative effects certainly appear in internet interventions. Moreover, some of those effects seem to be a direct result of the format of the programme. For instance, the researcher found that 20 per cent of the negative effects were related to stress around the online format. So while internet interventions should theoretically be more accessible, this does not always prove to be straightforward. Lack of contact and problems around implementation also appeared to influence side effects. Similar to Carlbring's face-to-face treatments, however, Fenski also found that it is mainly symptoms that patients perceive as negative effects.

We should not confuse negative effects with the mechanism of action

Operating mechanism?
Sometimes negative side effects are very obvious. For example, in the case of sleep restriction therapy, a treatment for patients with sleep problems that involves matching sleep probability to sleep ability.
The evidence base for sleep restriction therapy is large, but the simple approach also has a downside: sleepiness. For instance, a qualitative study from a few years back reported that as many as 94 per cent of patients experienced extreme sleepiness as a side effect of treatment. According to Leonie Maurer, however, this is rarely reported in the literature. In a small study of hers, she indeed found evidence of increased sleepiness, particularly in the evening and in the first two weeks of treatment. Exactly those weeks in which there was a sharp reduction in sleep time. Maurer additionally found that the sleepy feelings had a basis in reality, with poorer reaction times to tasks requiring speed of action.

But then, is this problematic? From Maurer's research, we can see that it is not that big of a problem. Because even in the control group (consisting of patients) sleepiness was found to be common. Not so strange when you consider that this is exactly why patients enter treatment. Moreover, Maurer argues, sleepiness can also be seen in the context of the mechanism of action: sleep restriction works because you induce sleepiness. The same parallel can be drawn to the anxious patient who reports feelings of fear during exposure treatment or the patient with PTSD who faces unpleasant memories in trauma treatment.

Informed consent
But when negative effects are common, how does the therapist deal with them? That question is central to Leonie Gerke's research. According to Gerke, there are two principles around giving information about side effects: the principle of nonmaleficence and the right to autonomy. As therapists, we obviously do not want to harm our patients. But by informing patients about the risks of treatment, you may be sending a negative signal, giving patients negative expectations. Those negative expectations can then negatively affect treatment outcomes. In this sense, one might assume that it is better not to inform patients. At the same time, patients have a right to be informed so that they are able to make their own decisions.

Gerke's research shows that, in practice, this leads to an awkward split among therapists. Because while most therapists think informed consent around side effects is a good idea in the context of transparency, autonomy and creating realistic expectations, half of the therapists are concerned that such information leads to an increase in patients' anxious feelings. A third of therapists are also concerned that it discourages patients from treatment or reinforces negative expectations. The corollary is that few therapists name the risks and negative effects of CBT.

To change this, Gerke recommends that training in the principles of informed consent is embedded in psychological training. In doing so, it is important that therapists realise that information about potential risks and side effects need not be harmful. Indeed, Gerke suspects that openness about this increases recognition of side effects and dealing with them.

Learning to interpret

Cognitive bias modification as pretreatment module for children with OCD

Cognitive Bias Modification (CBM) is often investigated in the treatment of problematic substance use. However, researcher Elske Salemink also sees opportunities when it comes to treating adolescents with compulsive symptoms. In the symposium 'Optimising the assessment and treatment of childhood anxiety', she presented her findings.

We have known for years that the way you look at the world and how you interpret information about it, affects how you feel and how you behave. This is true for anxiety symptoms, depression, but also for compulsions. With this in mind, Salemink and other researchers devised a new training for adolescents with compulsive problems that can be used without the intervention of a therapist during the waiting list period.

Different route

During the so-called Cognitive Bias Modification of Interpretations training (CBM-I), adolescents are read short vignettes via computer that can trigger negative interpretations. However, the vignettes are followed up by a neutral or positive interpretation. An example of such a vignette: Your father has to work long overtime unexpectedly and is not home yet when you have to go to bed. You can't say goodnight to him and think that will bring bad luck. You go to sleep anyway. A thought is not a predictor. Can you just get past the thought that something will happen to your father? Yes. You can just let this unpleasant thought pass. Salemink: 'With CBM, you actually train the brain for half an hour each time to interpret specific situations in a different way.'

In two studies on its application, the researcher found evidence of the training's effectiveness: youths with compulsive symptoms showed a clear reduction in symptoms compared to youths on the waiting list. A great result for an automated training programme. But because the complaints do not fall below the clinical threshold, Salemink does warn that CBM is not suitable as a standalone approach in a clinical population. Rather, she sees it as an option in combination with CBT, or within a stepped-care programme.

Rapid activation

According to Salemink, the training has added value mainly because it works through a different route than CBT. 'In CBT, you work through an explicit approach: you talk about thoughts, identify the errors in them and try to change the associated behaviour that way. And we know that works.' But according to the researcher, CBT does ask a lot, especially of children. 'It's quite a lot to look at your thoughts in that way. Especially since we know that some of those thoughts come very quickly, making it hard to control them.'

In CBM, negative cognitions are not consciously challenged as they are in CBT. However, Salemink would not go so far as to say that it capitalises on automatic thoughts. 'There is a lot of debate in the scientific community about what exactly automatic means. Interpretations can be automatic, but they can also be very conscious.' Rather, the researcher speaks of a route via rapid activation.

Tailor-made
The beauty of the training is that - despite the absence of a therapist - it can still be customised. Salemink: ‘Originally, we worked through the one-size-fits-all principle, where vignettes were not personalised. However, we noticed that some of the stories did not appeal to the children. In that case you can read a lot and it does have some effect, but in the end, as a child you don’t always feel involved’. Salemink therefore looked for another way and ended up with a division into complaint domains. Instead of being presented with all compulsive domains, a youth is presented with those complaint domains it suffers from. So a youth with a fear of soiling is given vignettes specifically based on interpretations around filth.

Parallel or pretreatment?
Whereas the pilot study had the training run parallel to the treatment, in the extended study it was deployed as a pretreatment module with also an option for a waiting list intervention. According to Salemink, there is something to be said for both options. ‘The advantage of the pretreatment module is that young people can already start working on their problems before real help has started.’ Moreover, the researcher saw that it helped young people when they were apprehensive about treatment. The training can therefore function as a form of psycho-education.

On the other hand, a combined approach could be mutually reinforcing. However, this requires further elaboration in terms of individualisation, Salemink says. ‘In the ideal scenario, you would want to introduce the new cognitions you come up with with your therapist into the programme. That way, adolescents can further practise with them themselves, during, but also after treatment.’

On hold
The results have been known for some time, but because of the pandemic, there has hardly been an opportunity to present them at conferences. Perhaps that was also the reason why the project has been on hold for a while. Partly thanks to the enthusiasm at the EABCT, Salemink has new plans. In the coming period, she wants to look at possible predictors that determine the effectiveness and added value of the training. In addition, she has been inspired to explore the potential of CBM in other complaints, including social anxiety.

Want to know more? Then read the open access article:
https://www.sciencedirect.com/science/article/pii/S2211364921000166

The training can therefore function as a form of psycho-education

Physical activity as an add-on to CBT

CBT is not a sofa-type treatment, as everyone knows by now. But that adding vigorous physical activity can lead to better treatment outcomes, is not yet common knowledge. In the symposium 'Physical activity as augmentation strategy for Cognitive Behavioural Therapy' at the EABCT conference, four speakers told their stories.

Of course, we would prefer CBT to work for everyone, but that is not the reality. In recent years, therefore, we have been looking at using add-on agents that can increase treatment efficiency. One of the big contenders in that area is physical activity. Although we do not know the exact mechanism of action behind it, we know that physical activity enhances brain functions, leading to better learning efficiency and memory enhancement.

Depression

In theory, something like this sounds nice, but in practice, proper implementation is not always easy, according to Janna Vrijsen's research. She investigated its added value in depression in a pilot study. Instead of weekly sessions where physical activity was scheduled throughout the week, she chose a design with 45 minutes of medium-intensity physical activity immediately followed by CBT.
The results were mixed. Indeed, the group that started physical activity first showed better treatment outcomes. However, physical activity also had consequences for dropout rates. In fact, that also turned out to be higher. Is that the trade-off we should consider? Not according to Vrijsen. She attributes the higher drop-out rate mainly to problems in making a good schedule, which is not always easy in a research setting.

Physical activity can lead to improved outcomes but can also affect dropout rates

Other possibilities

Physical activity is also being explored as an add-on strategy for other problems. In his talk, for instance, Jasper Smits discusses its effects in smoking cessation. According to him, physical activity is particularly interesting when people struggle with a high sensitivity to anxiety. It is then in fact a form of introspective exposure.

Yet another application can be seen in the research by Grace McKeon and Simon Rosenbaum. They investigated the feasibility of an online lifestyle intervention combined with a physical activity module among rescue workers. The results are encouraging, but McKeon and Rosenbaum do recommend using support partners or peer facilitators. Precisely because these individuals have no background in sports, but have experience of the experiences of rescue workers, help is more readily accepted.

PTSD

A stylistic break in the positive results is fence-sitter Eline Voorendonk, who talks about the effects of intensive trauma treatment. During this trauma treatment, patients with PTSD are admitted for eight days and go through a programme of exposure, EMDR and physical activity. Although the effects of the programme have been discussed in several studies, the added value of physical activity remained unknown until now. However, the results of Voorendonk's study show that the addition does not lead to better treatment outcomes. Moreover, physical activity again seems to be associated with slightly higher dropout rates. Incidentally, the latter is not reflected in patients' preference: a slight majority expressed a preference for treatment with physical elements.

What do the results mean in practice? Should we put on our tracksuits en masse and get on the treadmill? It seems a bit early for that. However, it does seem that adding physical activity is feasible and we are seeing tentative positive effects. However, this has to be set against the increased risk of dropout seen in several studies.

It works but #how?

The role of expectation disconfirmation in VR exposure

The inhibitory learning model does not put habituation to fear at the centre of exposure, but the falsification of the patient's expectations. But during VR exposure, feared consequences remain absent in many cases because they simply cannot occur. After all, you cannot be bitten by a virtual dog, or die in a virtual plane crash. What does this mean for the theoretical model we adhere to? That is exactly the question researcher Sara Scheveneels is trying to answer.

Since the beginning of her research career, Scheveneels has studied the inhibitory learning model. Interest in VR has been added to this in recent years. 'The lack of attention to the apparent inconsistency between the most dominant model of exposure on the one hand and the efficacy of VR exposure on the other, intrigues me.'

Different expectations

Her first research into it now dates back to 2019. In it, Scheveneels set her sights on people with a fear of speaking in front of an audience. In a VR environment equipped with a virtual audience, participants had to give a presentation. Prior to the VR exposure, participants indicated to what extent they expected certain negative outcomes while speaking. After the exposure, participants were asked which of these expectations they could test out during the VR exposure.

Scheveneels suspected that some expectations could be better tested and disproven in a VR environment than others. She therefore divided those expectations into three categories: expectations about how people themselves think they will react (panic, faint), expectations around reactions from the audience (booing, walking out) and expectations about negative judgements from the audience (they think I'm stupid). Whereas the last two are actually impossible or harder to disprove with VR, the first type of expectation can be tested in a VR environment.

In line with what Scheveneels expected, participants indicated that they could indeed test their expectations about their own reactions better in the VR environment than expectations about audience reactions and negative judgements. Interestingly, the extent to which one could test expectations during the VR exposure was not related to treatment outcome, and it was not the case that participants with mainly expectations about their own reactions (which proved more testable in VR) benefited more from VR exposure.

Presence

Should we then conclude that the inhibitory learning model does not hold up when it comes to explaining the effects of VR exposure? According to Scheveneels, it is too early for that. 'It is true that, based on this research, there is no immediate evidence that expectancy disconfirmation is the major driving factor. But we still have some limitations to the research as well.' For instance, in practice, measuring expectation disconfirmation properly is not so easy.

A study on fear of spiders is now in its final stages

By extension, the degree of ‘presence’ someone experiences could also influence expectation disconfirmation. Scheveneels: ‘VR can feel so ‘real’ that individuals could potentially do have the expectation that they could, for example, be bitten or crash with a plane. But if you then ask that afterwards, people realise that that is not possible at all.’ There could thus be a discrepancy between the subjective feeling during VR and the cognitive reporting afterwards. A discrepancy that complicates research into the role of expectancy disconfirmation during VR exposure, but which could also explain why VR exposure does work.

Broader view

According to Scheveneels, however, the questions surrounding VR exposure can be placed in a broader perspective. Indeed, the researcher argues that we still have questions and loose ends for other forms of exposure as well. ‘There is some evidence indicating that an inhibitory association is formed during extinction in the lab. But can you translate that knowledge directly to what happens during clinical exposure treatment?’ That does not mean Scheveneels is questioning the effectiveness of exposure. ‘Exposure works tremendously well, there is no doubt about that. But it is good to study how it works, so that we can further improve treatment and long-term effects based on that.’ In collaboration with Iris Engelhard, Katharina Meyerbröker and Dirk Hermans, Scheveneels will therefore conduct further research into the underlying mechanisms of action in VR exposure . A study on fear of spiders is now in its final stages.

Practise

Although some of her research is quite fundamental in nature, the researcher also sees its clinical relevance. ‘I sometimes find the inhibitory learning model quite a strict model to follow during exposure with my patients. It remains difficult to find a good balance between what the patient is willing to do and sticking to the premises of the model.’ Precisely because not everything has been tested yet and the evidence base for some recommendations is not convincing, Scheveneels believes that as a therapist you have the freedom to shape exposure in a way that is feasible for the patient, without having to adhere too strongly to the recommendations from the inhibitory learning model.

Transdiagnostic and effective: the Unified Protocol

For some time, there has been increased attention for transdiagnostic treatment methods. The symposium 'Unified Protocol for transdiagnostic treatment of emotional disorders' showcased the latest insights and various adaptations of this transdiagnostic treatment protocol. Is the Unified Protocol adaptable for online use? Is it effective for children with emotional disorders? Overall, the effects are promising.

Unified disorders

In short, the Unified Protocol (UP) is a form of CBT for individuals with depression, anxiety disorders and other related disorders. In the UP context, these disorders are grouped together as emotional disorders. The rationale is that different diagnostic categories such as depression and anxiety disorders are based on shared temperamental vulnerabilities, particularly neuroticism, causing dysfunction in the interpretation and regulation of emotion. The UP specifically targets these emotion regulation deficits. But, is the UP effective in targeting these deficits?

Boston University researcher Elizabeth Eustis examined the effectiveness of the UP compared to diagnostic-specific protocols for anxiety disorders with a 12-month follow-up. 179 participants were randomly assigned to either the UP or to a single disorder CBT-based protocol. Both at post-treatment and at 12-month follow-up, the UP and diagnostic-specific protocols were equally effective for a reduction in anxiety disorder severity. According to the Boston researchers, an added benefit of the UP is that it can be flexibly applied to a range of disorders, making it more efficient and cost-effective for clinicians than single-disorder treatments.

The UP in Scandinavia

Studies on the effectiveness of the UP are not limited to the United States. Researchers from Denmark noticed the lack of an evidence-based protocol for mixed patient groups. They also noted that comorbidity in clinical practice is the rule, rather than the exception. With the increasing waiting lists, a more efficient transdiagnostic approach was worth examining. Nina Reinholt from Copenhagen University studied the effectiveness of a 15-week UP treatment for 47 psychiatric outpatients with diagnosed anxiety disorders. With moderate to large reductions in anxiety symptoms, improved well-being and general functioning at the end of treatment, results showed that the UP treatment can be successfully applied to psychiatric outpatients. Interestingly, patients with comorbid depression profited more from the UP treatment than patients without comorbid depression. A pre-post effectiveness study for the UP protocol for depression and anxiety incorporating the use of an app is planned to be conducted in 2023.

E-health adaptations

Extending on the use of apps in treatment, internet-based adaptations of the UP are promising. In general, internet-based treatments have the advantages of lower stigmatization, less

practical barriers like time, mobility and distance and it can facilitate transfer into the patients' everyday life. The COVID-19 pandemic marked a turning point for internet-based treatments: it instigated higher demand for flexible, internet-based approaches and increased acceptance among psychotherapists. Carmen Schaeuffele from the Free University of Berlin, examined a 10-week internet-based UP adaptation with modules and exercises among 129 patients with anxiety, depressive and somatic symptom disorders. They either received UP treatment or were placed on a waitlist. Patients in the internet-based UP group showed greater changes in symptom distress, positive and negative affect, life satisfaction and symptoms of anxiety and depression over time than patients in the waitlist group. Notably, the mean number of diagnoses in the fairly comorbid sample dropped from almost three to under one at post-treatment. This finding is comparable to face-to-face UP interventions, and shows that internet-based UP treatments can effectively address symptoms and comorbidity. Schaeuffele will focus new research on exploring ways to personalise guidance in internet-based treatment, for example the possibilities for patients to personalize the order of treatment modules.

The UP for children

As for adults, comorbidity among emotional disorders in children is high. The UP treatment for children is overall similar to that for adults, but parents are actively involved in UP treatment for children. To test the effectiveness of a 15-week UP treatment, Cristina Canavarro from the University of Coimbra conducted a three-month follow-up study with 32 children aged six to twelve years. The children were mostly diagnosed with anxiety-related disorders. Results indicated that symptom severity according to the therapists' reports significantly decreased from pre- to posttreatment. Anxiety levels, as reported by the children, significantly decreased over time and were maintained at three months follow-up. These results are promising, since this UP protocol is the first transdiagnostic, parent-child group intervention for children outside the United States.

Cost-effectiveness of the UP

Jorge Osma from the University of Zaragoza conducted a 12-month follow-up study to evaluate a 12-sessions UP group format compared to treatment as usual (CBT-based individual and disorder-specific treatment). Patients (n = 152) were mostly diagnosed with adjustment disorder, major depressive disorder and generalized anxiety disorder. Overall, both groups showed a significant improvement in anxiety and depression severity and no differences between the groups were found.

However, Osma and fellow researchers conducted a follow-up cost-effectiveness study for both treatments showing that the group format allowed patients in the UP group to receive more sessions in a shorter period of time, with lower cost per treatment session compared to the treatment as usual. With similar effectiveness, but better cost-effectiveness of the UP group treatment, Osma and colleagues advocate UP as a treatment of choice in the Spanish public mental health system.

Positive psychology interventions: effective in diverse settings

In recent years, research studies on positive psychology interventions are gaining momentum. During the symposium 'Evidence-based positive interventions in mental disorders' a number of insights and developments in the positive treatment of mental disorders were discussed. Why focus on positive aspects in therapy in the first place? Is it suitable in psychiatric settings? And how effective is positive psychology in geriatric depression?

Traditional versus positive

Although traditional CBT for depression is effective for 50-60% of patients, it also faces some disadvantages. With an average of 20%, the dropout rate is fairly high for traditional psychotherapy and homework is often not done. Patients are afraid of feeling worse or incompetent after focusing on their problems. More importantly, the reduction or absence of depressive symptoms after therapy does not automatically translate into increased well-being. Broadening the focus of traditional CBT by including optimism, strengths and life-goals may align better with patient expectations.

Researcher Nicole Geschwind from Maastricht University examined the effects of positive CBT on depression compared to traditional CBT. Int his study, 49 clients all underwent eight sessions of traditional CBT and eight sessions of positive CBT in randomized order. Results showed that effects on depression for traditional and positive CBT were comparable in the first eight sessions. However, after the switch to either traditional or positive CBT, depressive symptoms were more improved for positive CBT patients. Surprisingly, no significant differences were found for positive affect, optimism and well-being.

Positive interventions and depression in women

With psychological disorders and symptoms disproportionally affecting women, what are the effects of positive interventions in a female population? In a study discussed by Carmelo Vazquez, traditional CBT and a positive psychology intervention (PPI) were compared to treat depression in women. 96 adult women with a DSM-IV diagnosis of major depression were randomly allocated to either traditional CBT or 10 sessions of PPI. Both interventions were effective in reducing clinical symptoms (40.8% symptom reduction in traditional CBT and 34% in PPI; 57% no longer met diagnosis criteria in CBT and 51.1% for PPI) and there were no significant differences between groups in main outcomes. However, in a more recent study, both female and male clients responded better to PPI as opposed to traditional CBT if they had more comorbidities. Vazquez and colleagues emphasize the need for larger replication studies as similar results can include PPI as an empirically validated treatment for depression.

Older age

Elderly patients with depression are another group that can benefit from positive psychology and well-being interventions. As people get older life transitions such as retirement,

losses, grief and loneliness can trigger the onset of depression. In addition, depressed elderly do not tend to seek psychological help due to stigma and consequently, the depression remains unrecognized or untreated. Specifically relevant in the elderly population is well-being in the later stages of life. Hedonic well-being (the pursuit of happiness) tends to remain stable. Eudaimonic well-being (the pursuit of meaning and purpose) generally decreases with age, particularly purpose in life and personal growth. This decline in eudaimonic well-being is an important vulnerability factor for depression.

University of Bologna researcher Chiara Ruini examined the effects of an eight-week program to promote well-being for 103 patients aged 60 and older. Results of the first pilot study showed decreased depression and increased eudaimonic well-being at the end of the eight weeks. A follow-up study showed that increases in well-being were maintained six months after ending the eight-week program. Ruini stresses the need for RCT's and international replications of positive interventions for elderly people.

Well-being in schizophrenia

Not only people with depression, but also people with schizophrenia can benefit from improved well-being. Specifically, well-being is a significant predictor of remission in schizophrenia, it is related to better therapeutic response and better medication adherence. However, only very few RCT's included well-being.

Based on the Broaden-and-Build theory (positive emotions lead to a broadening of experience and the building of resources to cope with negative emotions), researcher Carmen Valiente and her colleagues developed a positive psychology protocol based on previous positive psychology, Mindfulness and Acceptance and Commitment interventions. A comparison between the protocol treatment and treatment as usual showed that self-acceptance and experienced environment control as part of well-being improved in the protocol treatment. Other measures of well-being were the same in both groups. There were no effects of the protocol treatment on experienced symptoms, indicating that positive interventions in this patient group are complementary to conventional interventions.

This decline in eudaimonic well-being is an important vulnerability factor for depression

COVID-19: causing suffering or promoting resilience?

COVID-19 impacted all of us in one way or the other in the last two years. During the symposium 'COVID-19, mental health and psychosocial factors' the latest insights on the psychological impact of COVID-19 were discussed. Are results all doom and gloom, or are there perhaps additional psychological benefits that come with a global pandemic? What are individual experiences during the past two years of being in on-and-off lockdowns? What about increasing pandemic paranoia?

Tsunami of mental health problems

At the start of the pandemic, press reports in the UK predicted a 'tsunami' of mental health difficulties. Researcher Richard Bentall from the University of Sheffield knew from previous research that the impact of collective catastrophes (wars, earthquakes, previous pandemics) in the past has not been large. Some research shows that feeling like 'we're all in it together' may even promote resilience. Does this also hold for the COVID-19 pandemic?

Bentall and colleagues set out to examine the impact of the pandemic on mental health in the UK. 2025 UK adults of 18 years and older were recruited for a survey study in March 2020 (wave 1). Participants completed standardized measures of depression, generalized anxiety and trauma symptoms relating to the pandemic. Results showed only a modest increase in the prevalence of mental health problems during the early stages of the pandemic. Anxiety or depression and trauma symptoms were predicted by young age and the presence of children in the home. Anxiety and depression were also predicted by low income, loss of income and pre-existing health conditions. However, results of a study conducted later in the pandemic (wave 6) showed that significantly higher rates of anxiety, depression and mental-health seeking were prevalent among individuals with debt problems due to the pandemic. According to Bentall and fellow researchers, this underscores the importance of debt as a socioeconomic factor that can pose a significant threat to mental well-being, especially during a pandemic.

Experiences of the elderly

How are elderly people impacted by the pandemic? Kate Bennett and colleagues from the University of Sheffield conducted a qualitative study to examine their sense of belongingness during the pandemic and the impact COVID-19 had on their resilience. They interviewed 33 elderly people at the start of the pandemic and 29 elders later on. Even though social distancing measures caused uncertainty in their lives, most participants found creative ways to connect with family and friends at the beginning of the pandemic. As the pandemic and social distancing rules continued however, their sense of belonging was challenged as the alternative ways to connect with others, such as Zoom-calls for example, did not replace the desired proximity to others. Other older adults experienced gaps of belongingness when they were forced to quit (social) activities or lost loved ones.

The ongoing disruption and gaps of this sense of belonging during the pandemic, persisting uncertainty around the severity of the virus, the unknown individual consequences, and the

losses of loved ones impacted people's well-being. Many participants reported increased anxiety, isolation, frustration, loneliness, feeling of depression, and lower mood. This in turn impacted the older adult's resilience. Bennett concludes, however, that the impact of COVID-19 on the elderly is rather heterogeneous and policy and practice have to take this into account.

Dark and bright sides in Spain

From the UK to southern Europe, Spain was one of the countries with the highest number of COVID-19 infections and mortality rates. Carmen Valiente and her colleagues set out to examine the mental health impact of the pandemic on the Spanish population and to identify predictors of distress. In addition to the negative outcomes of depression, anxiety and PTSD, Valiente also measured well-being as a positive outcome. A representative sample of 2122 citizens participated in a survey during the peak of the pandemic in Spain. As for the negative outcomes, depression and anxiety were present in 22% and 20% of the sample, respectively. This is slightly higher than in the years before the pandemic. Interestingly, average well-being scores were also fairly high in this sample as compared to the general population in a pre-pandemic study. Somewhat similar to the UK study by Bentall and colleagues, the strongest predictor of well-being was gross annual income. As for predictors of distress during the pandemic, anxiety about COVID-19 was the strongest factor, followed by increase in substance use, loneliness, mental health difficulties, direct exposure to COVID-19 and age (young people being hit harder) and gender (women showed more depression and anxiety during lockdown than men).

Measures of pandemic paranoia

The pandemic also created a heightened state of general fear as to whether others' actions and intentions can be trusted. This pandemic paranoia is defined by paranoid cognitions that focus specifically on the threat posed by others to oneself because of the pandemic. Lyn Ellett from the University of London tested the psychometric properties of a scale to measure pandemic paranoia: the Pandemic Paranoia Scale (PPS). A set of 28 items were developed that centered around the beliefs that other people are intentionally spreading the virus, others are talking about each other in the context of COVID-19 and distrust in the government or conspiracy beliefs. The items were tested in international samples (n = 2510) from Australia, Germany, Hong Kong, the UK and the USA. The items were correlated with already existing questionnaire items on conspiracy, paranoid thoughts and COVID-19.

Results indicated three valid underlying factors for 25 items of the scale: persecutory threat (15 items), paranoid conspiracy (6 items) and interpersonal mistrust (4 items). Based on the survey results, 37% of the sample experienced interpersonal mistrust (others cannot be trusted for guidance and keeping their community safe), 29% paranoid conspiracy (powerful people use COVID-19 to control the general population) and 11% persecutory threat (others will intentionally inflict physical or psychological harm via the pandemic). Interestingly, there were significant differences in pandemic paranoia between countries, with highest scores in Australia and lowest scores in Germany. In future studies, Ellett plans to further examine these differences in pandemic paranoia between countries.

Impact in Italy

In Italy, the UK study on the impact of COVID-19 on mental health was replicated by Panzeri and colleagues at the university of Padova. A representative sample of 1048 Italian adults of 18 years and older were recruited to fill out questionnaires on depression, generalized anxiety and trauma. Somewhat similar to the UK study, findings indicated that higher prevalence of these measures were associated with being female, younger age, having minors in the household, pre-existing health issues, having somatic symptoms and living in the center-south regions of Italy where the virus started to spread.

To examine the other side of the coin, the researchers also focused on resilience during the pandemic and what factors impacted on it. For this study, a representative sample of 1038 adults filled out online questionnaires on depression, anxiety, self-rated health, self-esteem, loneliness and PTSD. Resilience was defined as having low levels of depression and low levels of anxiety. Results showed that 70% of the sample developed resilient outcomes. 30% of the sample were non-resilient with moderate to severe anxiety and depression associated with the pandemic. Risk factors hindering resilience mostly comprised intolerance of uncertainty, loneliness, living with children and COVID-19 related anxiety and PTSD symptoms. Panzeri and colleagues emphasize the need for psychological interventions targeting these constructs to sustain and promote resilient outcomes.

VGCt Fact sheet *(Dutch association for behavioural and cognitive therapies)*

Cognitive behavioural therapy for insomnia

Insomnia, also known as habitual sleeplessness, is a chronic sleep disorder. The patient experiences trouble falling asleep or staying asleep, despite adequate opportunity for sleep. Some people have the feeling that they did sleep, but don't feel rested in the morning. Symptoms commonly reported by people suffering from insomnia include tiredness, sleepiness, concentration difficulties, and emotional problems, such as being irritable and feeling depressed.

How to recognize insomnia?

The patient:

- Experiences difficulty falling asleep or staying asleep
- Experiences difficulty with their sleep quality
- Experiences impairment of their daily functioning due to their sleep problems
- Experiences inability to sleep despite adequate opportunity for sleep
- Does not have any other mental disorders or medical conditions (psychosis, pain, pruritus) or use any substances (medication, drugs) that may cause sleep problems

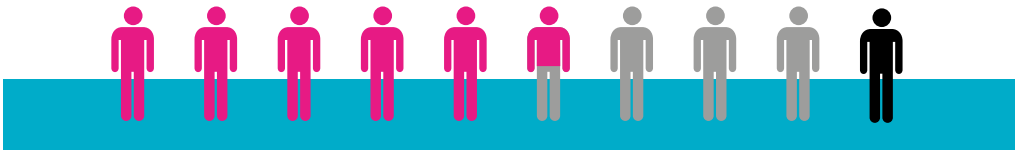
Facts

- Cognitive behavioural therapy (CBT) has been the treatment of choice for adult insomnia for more than twenty years.
- The effectiveness of CBT, in a group or online format, has recently also been established as a treatment for insomnia in adolescents.
- In DSM-5, the distinction between insomnia as a primary or secondary disorder was abandoned. Insomnia can be treated regardless of the presence of any other disorders (or their treatments).

Cognitive behavioural therapy for insomnia (CBT-I)

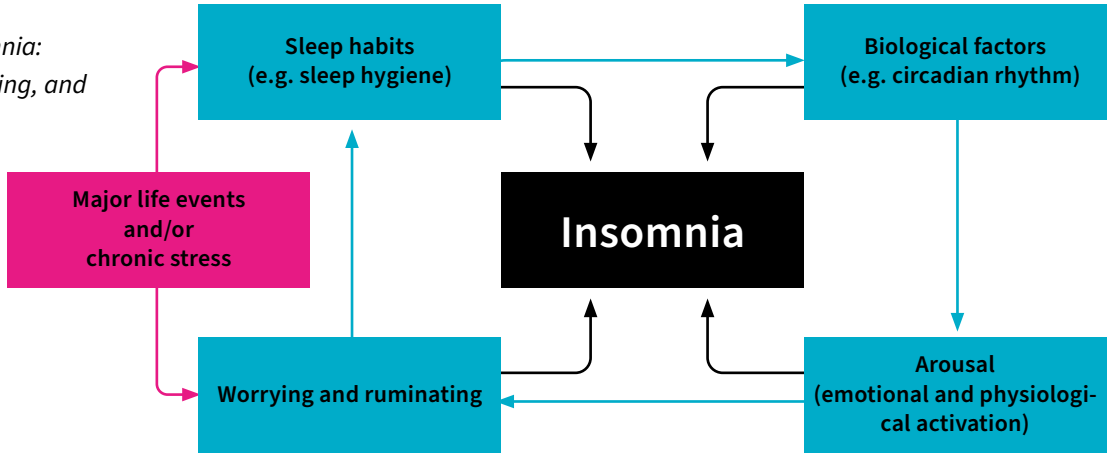
- Is brief: six sessions of 60 to 90 minutes usually suffice
- Is structured, goal-oriented, and uses a well-defined approach
- Is as effective as medication in the short term, but more effective in the long term
- Consists of a combination of various techniques, all with established effectiveness for insomnia (recommendations for sleep hygiene, restriction of time in bed, stimulus control, relaxation exercises, and cognitive therapy).

Following treatment, 55% to 90% of all clients experience significantly better sleep.



VGCt Fact sheet

Vicious cycle of insomnia: triggering, exacerbating, and maintaining factors



How to motivate a client for CBT

If people choose CBT, they learn how they can reduce, or sometimes even reverse, their insomnia by changing their behavior. Many people suffering from insomnia opt for the ease of medication: taking a pill so they can sleep. What they don't realize, however, is that medication has negative effects too. After taking sleep medication, people often feel groggy during the daytime and have difficulties concentrating, and the effectiveness of the medication diminishes with time, so they have to keep increasing the dose. In addition, with longstanding use, medication use leads to addiction. If the medication is stopped abruptly, the sleep problems will return to a heightened degree. So initially, CBT-I requires more effort than just taking a pill. But CBT-I usually takes a maximum of three months, and clients experience an effect right from the start. More importantly, in the long term CBT-I gives better results than medication.

Causes

Insomnia may be caused by psychophysiological hyperarousal (mental overactivation), poor sleep habits, hormonal changes (e.g., during adolescence, pregnancy, or menopause), worrying due to major life events and chronic stress (such as relationship difficulties, being bullied, divorce, the death of a loved one, problems at school or work, or financial problems), or a combination of these factors. Once sleep problems have arisen, they are usually maintained because people develop habits that actually disrupt a healthy circadian rhythm.

Comorbidity

Insomnia is quite common and becomes chronic if not treated. Spontaneous recovery is rare. Five to ten percent of the adolescent and adult population suffer from a clinically significant insomnia disorder, with a higher prevalence among girls and women. Insomnia can be accompanied by a diversity of other problems. There are strong indications for mutual relations with depression, anxiety, and ADHD. Adolescents mainly experience problems falling asleep, while adults more commonly have difficulties maintaining sleep.

Who provides treatment for insomnia?

Refer your patient preferably either to a clinician with experience in the diagnosis and treatment of insomnia, or to a specialized treatment center for sleep disorders. It is also important that the clinician has specialized knowledge of CBT and sleep in different populations such as children, adolescents, or the elderly. Therapists who are registered members of the VGCT are trained in cognitive behavioural therapy and are certified in the BIG-register (under the Dutch law for individual health care professions). You can also search the register on the VGCT website.* A list of Dutch treatment centers for sleep disorders can be found on the website of the Dutch association for sleep/wake research: nswo.nl

** The VGCT register shows all cognitive behavioural therapists and cognitive behavioural social workers who have completed their training and shared their contact details.*

VGCt Fact sheet *(Dutch association for behavioural and cognitive therapies)*

Cognitive behavioral therapy for depression

An individual is said to have a major depressive disorder when they can no longer function properly as a consequence of a depressed mood or have lost interest in activities and can no longer enjoy them.

How to recognize a major depressive disorder

- Prolonged period of depressed mood, sadness or apathy
- Inability to enjoy daily activities
- "Flattening of affect" or increased emotional reactivity
- Unexplained changes in appetite or weight
- Sleep problems: sleeping too much or too little
- Fatigue or loss of energy
- Unusually agitated or slowed movement
- Decreased ability to think and concentrate
- Strong feelings of worthlessness or guilt
- Recurring thoughts about death or suicide

Facts: Depression

- Is quite common: nearly 20% of all adults in the Netherlands experience this disorder during their lifetime
- Is not always recognized. Individuals with depression who consult their family doctor often report sleep problems or fatigue.
- Is more common among individuals with a lower educational level, and individuals who are single, unemployed, disabled, or have a lower income.
- Does not have one clear cause, but develops due to a combination of biological, mental and social factors.
- Can be treated effectively with medication[1)] and/or psychotherapy, such as cognitive behavioral therapy, behavioral activation, interpersonal psychotherapy, and brief psychodynamic psychotherapy.
- In cases of mild or moderate depression, psychotherapy is the treatment of choice.

CBT for depression is as effective as medication

Cognitive behavioral therapy (CBT) for depression

- Is relatively brief. Varies from 10 to 20 sessions of 45 to 60 minutes.
- Is structured and goal-oriented, and uses a well-defined approach.
- Is the most thoroughly evaluated intervention for depression, with demonstrated effectiveness: 50% to 67% of all clients feel better after CBT.
- Also has beneficial effects in the long term.
- Is as effective as medication, even in cases of severe depression.
- In cases of severe and chronic depression, the effect is slightly better if CBT is given in combination with medication. Note however that medication also has disadvantages, such as side effects and dependency.

VGCt Fact sheet

50% to 67% of all clients respond well to CBT

How to motivate a patient for CBT

To motivate patients for cognitive behavioral therapy, it is important to give them psycho-education about the maintaining factors of depression. One of these factors is the tendency in individuals with a depressed mood to initiate fewer activities, meaning they will experience less fulfilment, which in turn makes the depressed mood worse. Breaking this pattern is the first step toward recovery. Furthermore, CBT teaches patients to acknowledge, explore, and adjust their negative interpretations of situations.

Comorbidity

Depression often co-occurs with other symptoms, like feelings of anxiety. There are several similarities between depression and grief. However, during a major depressive episode, the depressed mood persists for a longer period, and is usually not linked to specific thoughts about loss. Depression is often comorbid with conditions like anxiety and obsessive-compulsive disorders, substance-related and addictive disorders, burnout, and personality disorders.

Who offers treatment for depression?

In cases of mild depressive symptoms, the family doctor can give psychoeducation about depression, and encourage the patient to restart doing activities. If this is not sufficient, the doctor may suggest a self-help program guided by a nurse-practitioner. Your patient should preferably be referred to a practitioner with expertise in depression or to a specialized treatment center. Psychotherapists who are registered members of the VGCT (Dutch association of behavioral and cognitive therapies) have received training in CBT and are generally also certified health care professionals under the Dutch law for individual health care professions. On the VGCt website you can search the register.*

Relapse prevention

After a major depressive episode, the relapse risk is high (50-85%). In order to reduce this risk, effective interventions have been developed, such as Preventive Cognitive Therapy (PCT), and Mindfulness-Based Cognitive Therapy (MBCT). Both of these interventions are effective after successful treatment with antidepressants. PCT also works well after remission by other treatment modes, such as CBT. When patients continue taking their antidepressant medication after recovery, starting PCT offers extra protection against relapse. If recovered patients want to reduce their medication, PCT has been demonstrated to be effective, and MBCT may also be effective.

**In the VGCT register, you will find all cognitive behavioral therapists and cognitive behavioral social workers who have completed their training and have shared their contact details.*

[1] For more information about the use of antidepressant medication, see the fact sheet of the Dutch center for information about anxiety and depression NedKad (Nederlands Kenniscentrum Angst en Depressie)