Rumination Focused Cognitive Behavioural Therapy for Anxiety and Depression
1- day workshop

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Bespoke Training
13th December 2021

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Funders

MRC Medical Research Council

wellcome trust

NARSAD RESEARCH
National Alliance for Research on Schizophrenia and Depression

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Dr Scott Langenecker, Dr Rachel Jacobs
All trial therapists, patients and participants

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Outline of Workshop

- Why target rumination/worry?
- Key ideas and principles underpinning therapy
- Evidence for RFCBT
- Assessment & Formulation
- Therapy Rationale
- Functional Analysis
- Concreteness, Absorption, Compassion
- Addressing difficulties

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Why target rumination/worry?

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Rumination/worry as a key pathological process

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Rumination/worry

Worry
Overthinking
Dwelling
Procrastinating
Overanalysing
Stressing
Getting stuck in your head

- Highly correlated
- Same experimental effects
- Similar process
- Repetitive Negative thought: passive, negative, abstract
- May have different goals/concerns
- Rumination: past, loss, self
- Worry: future, threat
- In reality, interweave
- Tackling one tackles the other

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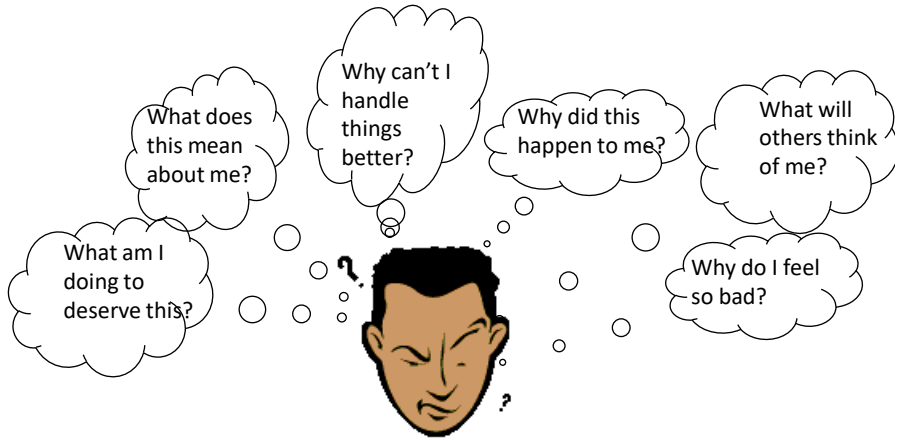
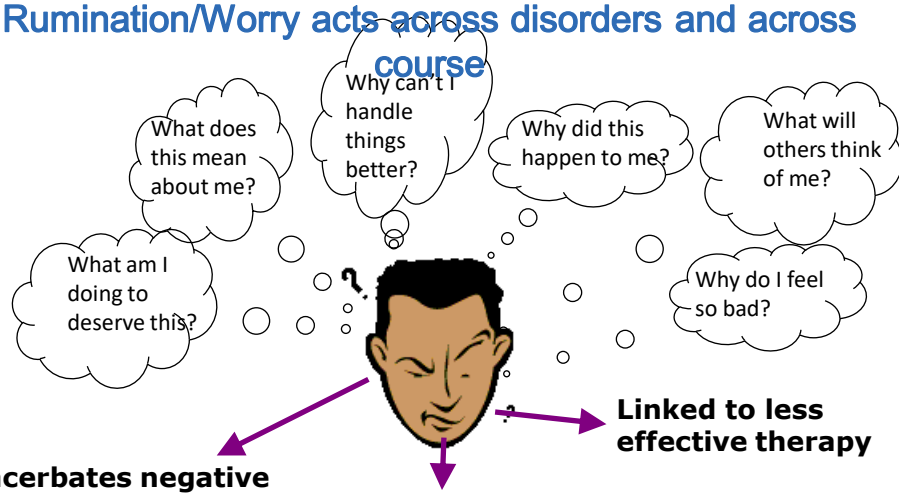


RUMINATION = recurrent dwelling on feelings, problems, upsetting events, negative aspects of self (Nolen-Hoeksema, 1991, 2000;Nolen-Hoeksema et al., 2008; Watkins, 2008)

Rumination/Worry acts across disorders and across course



Linked to less effective therapy

Exacerbates negative mood & cognition in experiments

Predicts onset, duration, severity of depression, anxiety, PTSD, substance abuse, eating disorders prospectively

Rumination as transdiagnostic process

Final common pathway

Vulnerabilities[1,2,3]
-neuroticism
- history of depression
- abuse
- deprivation
-Family history of mental illness
- stressful life events
-Cognitive style
-Gender & gender role

→ **Rumination/ Worry** →

Anxiety
Depression
Eating disorders,
Substance abuse[4,5,6]

[1] Spasojevic & Alloy 2001 Emotion
[2] Kinderman et al., 2013 PloS one
[3] Michl et al 2013 J. Ab Psych
[4] Ehring & Watkins 2008 IJCT
[5] Aldao, Nolen-Hoeksema, Schweizer 2009 Clin Psyc Review
[6] Nolen-Hoeksema et al 2007 J Ab Psych

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➔Rumination as a plausible target for treatment and prevention of anxiety and depression

(Topper, Emmelkamp & Ehring, 2010)

How to tackle this intervention target? By understanding rumination from basic experimental & clinical science

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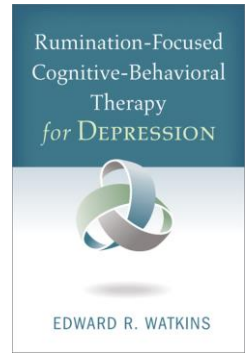
Summary of Rumination-focused CBT



1. Follows established CBT structure and techniques (e.g., Beck et al., 1979)

- Collaborative
- Socratic
- Initial assessment of goals, problems, background
- Structured session – review homework, specific focus, set homework
- Uses range of CBT techniques

2. Therapy is principle-based and flexible

Formulation based on function & context

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3. Cognitive science informs treatment development & content

(Watkins, 2016; Watkins et al., 2011)

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Based on CBT (Beck et al., 1979) with 2 changes:

1. Behavioural Activation (Functional analysis)

1. Identify antecedent cues to rumination
2. Control exposure to cues
3. Repeated practise of alternative helpful responses to these cues

2. Concreteness, experiential exercises

targets

Rumination-as-a-habit

Shift away unhelpful Processing style

Rumination-focused CBT (RFCBT)

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Shifting Processing Style

Recreate experience of processing style at odds with rumination:

1. Imagery/experiential exercises to enter mind-set
2. Schedule activities that promote style

Absorption experiences - "flow"

HOW?

Compassion experiences

Concreteness Training

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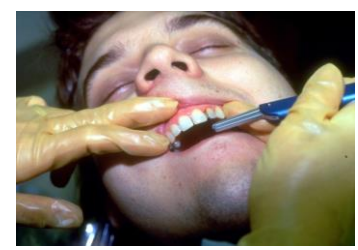
UNDERSTANDING RUMINATION

(see Watkins, 2016, ch. 2)

How do we respond to these situations?



Poll 1

Understanding Rumination 1: Rumination can be normal process driven by unresolved goals

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Lessons for psychological treatment

- Repetitive Thought should not be treated as always pathological
- Useful to **normalise the experience** – "we all do it" [*TOP TIP]
- Patients (& therapists) would benefit from **discriminating between when helpful (problem-solving) vs. unhelpful** (brooding) [*TOP TIP]
- ("Is it an unanswerable question? Is this leading to a useful decision or plan? "Is this helpful?" Is this working? Under what circumstances is it helpful? What are you doing when thinking is helpful?")

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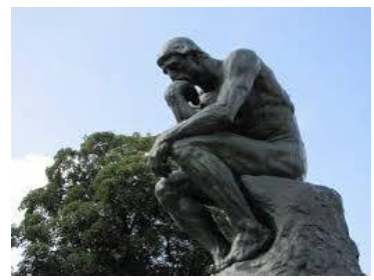
RF-CBT Principle 1: Normalize the patient's experience of rumination



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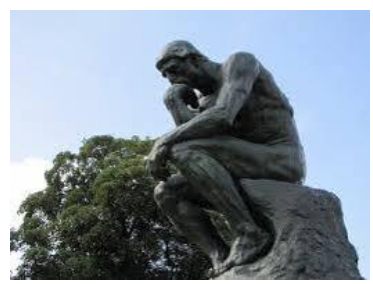

Normal; natural; reflects important personal concerns; validate experience & real difficulties

Poll 2

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Understanding Rumination 2: Pathological rumination = Mental habit

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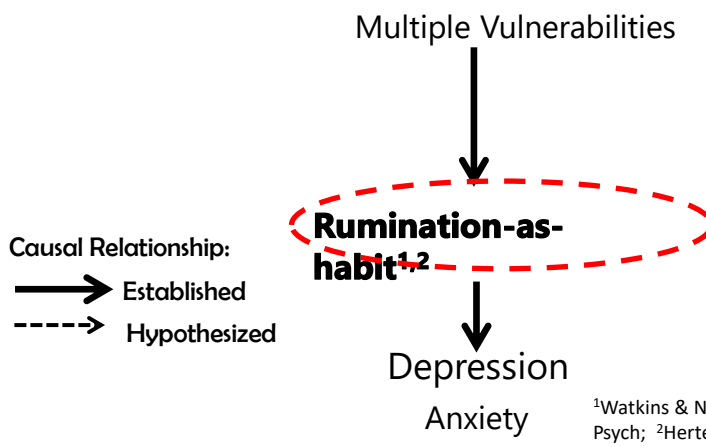
How can we understand rumination?



[1]Watkins & Nolen-Hoeksema 2014 J. Ab Psych; [2]Hertel 2004

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Rumination-as-habit[1-3]

Habit[4]	Pathological Rumination
1. Automatic hard-to-control	1. Automatic
2. Frequently performed	2. Frequent
3. Triggered by cueing context	3. Triggered by low mood/loss
4. Conditioning: R contingent on S; reinforced	4. Normal response to unresolved goals but unhelpful if repeatedly contingent on low mood, negatively reinforced
5. Resistant to change (goals, information)	5. Resistant to change

[1]Watkins & Nolen-Hoeksema 2014 J. Ab Psych; [2]Hertel 2004 chapter in Memory & Emotion; [3] Verplanken et al 2007, J.Pers Soc Psych; [4] Wood & Neal, 2007 Psych Review

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Changing Habits

Success

Disrupt the cues that trigger habit
Counter-condition alternative response to cues

Failure

Targeting information, goals, beliefs

Rumination-as-habit[1-5]

Return old context; stress, fatigue, load

Return

[1]Watkins & Nolen-Hoeksema 2014 J. Ab Psych; [2]Hertel 2004; [3] Verplanken et al 2007; [4]Verplanken & Wood, 2006 J Pub Policy & Marketing; [5]Marteau et al 2012 Science

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Lessons for RFCBT – rumination as a habit

- Habits resist informational interventions (Verplanken & Wood, 2006) – new info; change in goals
- Successful habit change involves [*Top Tip]
  - disrupting the environmental factors (time, place, mood) that automatically cue habit
  - counter-conditioning an alternative incompatible response to triggering cues (a helpful habit)
- Hence focus on identification of warning signs and then repeated practice of an alternative response under mood/stress challenge to develop more functional habit

Lessons for RFCBT – rumination as a habit

- Think about your own habits and what you can learn from them
- Think of an example of breaking out of a “bad habit” (e.g., stopping smoking). What helped? What made it harder?
- Think of an example of building “good habits”. What helped? What made it harder?
- Think of the impact of labelling “rumination-as-a-habit” for patients

Lessons for RFCBT – rumination as a habit

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Understanding Rumination 3: Rumination as avoidance [reward in habit]

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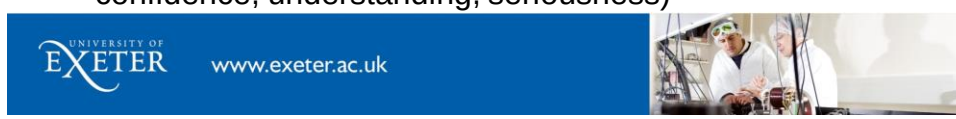
- Rumination conceptualized as avoidance (cognitive & actual) that is negatively reinforced (e.g., avoid risk of failure; pre-empt criticism; reduce intensity)
- Rumination becomes a learned habitual behaviour (Watkins & Nolen-Hoeksema, 2014).
- i.e. a response that someone has learned in the course of their life to particular environments

Avoidance

- Reinforced in the past by removal of aversive experience.
- Superstitious reinforcement
- Partial reinforcement
- Poor discrimination
- Differentiate between short-term versus long-term benefit
- [Think of possible functions of rumination – what might reinforce / drive patient's rumination?]

Avoidance

- Functions of rumination may include:
  - Avoid challenges of job or tedium of daily grind.
  - Avoid risk of failure or humiliation
  - Cognitive avoidance (worry) –preparation, planning
  - Pre-empting/preventing other's criticism / Anticipating potential negative responses/criticism to avoid actual criticism (second guessing – mind-reading)
  - Control of feelings; Avoid intense experience
  - Making excuses & generating rationalizations/justifications
  - Motivation – spurring oneself on
  - Avoiding an "unwanted" self
  - Seeking a "necessary" state-of-mind (certainty, control, confidence, understanding, seriousness)



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Reports of Avoidance

- Patients report early experiences of criticism/blame and trying to work out how to avoid it.
- Patients report using rumination INSTEAD of confronting problems in actuality.
- Using rumination as an excuse not to do things.
- "I am doing something about it by thinking about it"

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RFCBT Principle 4: Take a Functional-Analytic Approach (tackle habit)

Context Matters

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Context Matters

Function rather than Form

Antecedents – Behaviour – Consequences

Track "cycle of thinking & actions"

Variability / what works/what doesn't?

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Based on CBT (Beck et al., 1979) with 2 changes:

1. Behavioural Activation (Functional analysis)

1. Identify antecedent cues to rumination
2. Control exposure to cues
3. Repeated practise of alternative helpful responses to these cues

2. Concreteness, experiential exercises

targets

Rumination-as-a-habit

Shift away unhelpful Processing style

Rumination-focused CBT (RFCBT)

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Functional Analysis

1. Antecedent → Behaviour → Consequence

   Spot warning signs
   Increase awareness

   Identify function, reinforcement

2. Explore context & variability

   When/where/what does rumination occur or not?
   When/what/where/how is thinking useful or not?

3. Develop contingency plans

   Remove cues to habit; Find constructive incompatible yet reinforcing alternative in repertoire, repeatedly practice until new habit

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RFBCT Principle 5: Link Behaviours to Triggers and Warning Signs (tackle habit)

RFCBT Principle 6: Emphasize the importance of repetition and practice (tackle habit)

Understanding Rumination 4: Thinking Style

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What determines whether dwelling on a problem/upset leads to either

constructive resolution, Problem-solving, working through

OR

gets stuck in a distressing loop that goes nowhere?

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The WHY-HOW behaviour experiment

Experiential exercise for group

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Behavioural Experiment

- The broken down car exercise – recall/imagine time when needed to get somewhere important soon and car would not start . Get as vivid an image of this situation as possible. Imagine that you are in a real hurry

Poll 3 /Chat feedback

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How?

In sessions, more individualized, personalized:
Identify recent example of rumination; pick out examples of Why? questions etc

Probably found easier, more natural

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Why?

https://youtu.be/_n77eoOfRPE

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Thinking style & repetitive negative thought

Concrete specific
How? style

Problem Solving, Recovery

Multiple Vulnerabilities

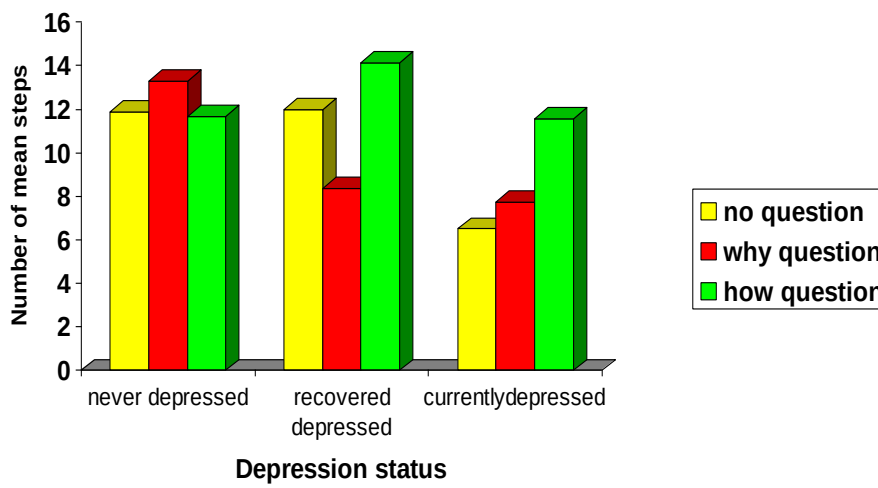
Repetitive Negative Thought[1]

Abstract global "Why?" style[2]

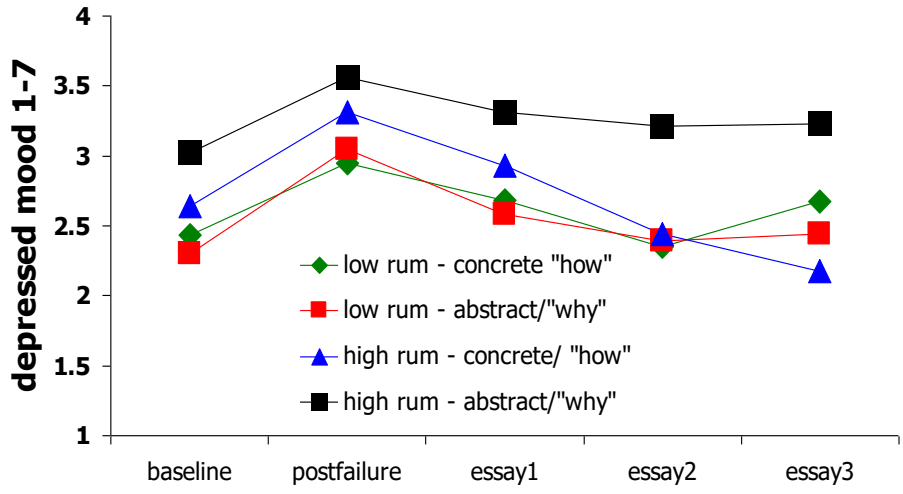
Depression
Anxiety

[1] Watkins & Nolen-Hoeksema 2014 J. Abnormal Psychology **123**: 24-34
[2] Watkins 2008 Psychological Bulletin **134**: 163-206

Watkins & Baracaia (2002) BRAT : Style of processing influences problem-solving



Watkins (2004) BRAT– Processing style influences recovery from upsetting event



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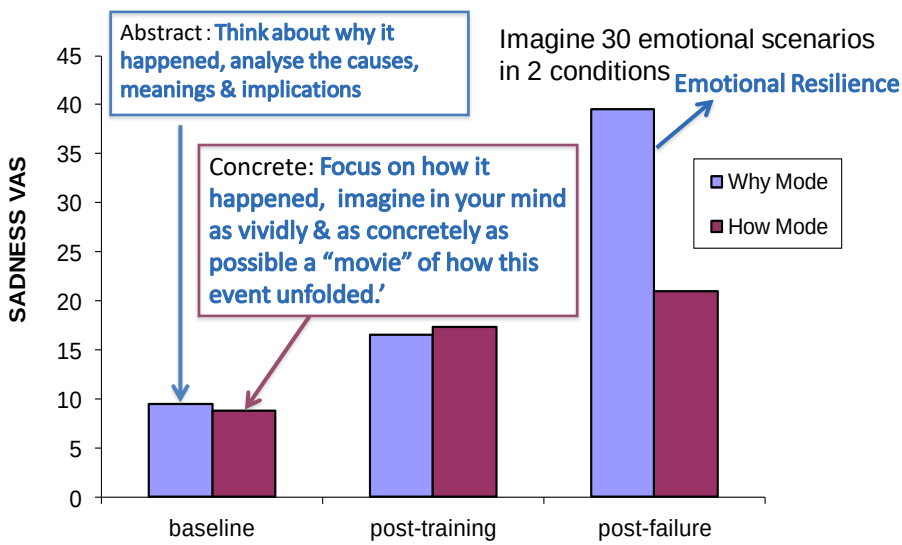

Emotion
2008, Vol. 8, No. 3, 364–378

1528-3542/08/$12.00 DOI: 10.1037/1528-3542.8.3.364

Processing Mode Causally Influences Emotional Reactivity: Distinct Effects of Abstract Versus Concrete Construal on Emotional Response

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Psychological Medicine (2012), **42**, 1359–1371. © Cambridge University P
doi:10.1017/S0033291711002480

Guided self-help concretenes intervention for major depres care: a Phase II randomized c

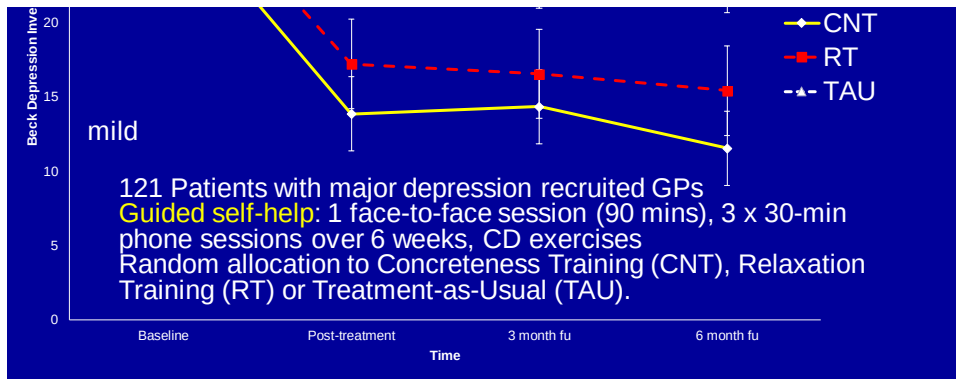
Psychological Medicine (2012), **42**, 1359–1371. © Cambridge University Press 2011
doi:10.1017/S0033291711002480

ORIGINAL ARTICLE

Guided self-help concreteness training as an intervention for major depression in primary care: a Phase II randomized controlled trial

E. R. Watkins[1]*, R. S. Taylor[2], R. Byng[3], C. Baeyens[1], R. Read[1], K. Pearson[1] and L. Watson[1]

[1] *Mood Disorders Centre, University of Exeter, UK*
[2] *Peninsula Medical School, University of Exeter, UK*
[3] *Peninsula Medical School, University of Plymouth, UK*



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Lessons for psychological treatment

- Training individuals to be more concrete (asking How?) is more adaptive when responding to negative situations than being abstract (asking Why?). [Top Tip*]

- Coach experiential exercises/ build up activities to shift out of abstract-evaluative rumination style

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RFCBT Principle 3: Encourage Active, Concrete, Experiential, Specific (**ACES**) Behaviour

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ACES

Focus on:

- Action
- Concrete
- Experiential
- Specific
- Behaviour to coach in patients
- Approach for therapist to model
- Guides to direct questions & strategies

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Work against ingrained tendency to be abstract

Doing rather than *talking about* things

Focus on specific & precise details of how event happened moment by moment (*micro-analysis*)

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Requires persistent effort to shape & socialize

Phrasing & questions of therapist critical – avoid vague, general, Why?; make concrete on behaviour at particular context and time, ask How?

Follow-up questions to drill down to specific response

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Seek actual behaviour conducted rather than interpretative or implicational terms (e.g., insulted)

Drill down until – know what exactly did; sensory & contextual details; can vividly and unambiguously picture the situation

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RFCBT Principle 7: Shift to an adaptive style of thinking

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Shifting Processing Style

Recreate experience of processing style at odds with rumination:

1. Imagery/experiential exercises to enter mind-set
2. Schedule activities that promote thinking style

Absorption experiences - "flow"

HOW?

Compassion experiences

Concreteness Training

Principles of RFBCT

(See Watkins, 2016, ch.3)

RFCBT principles

1. Normalize rumination

2. Make rumination an explicit target

3. Action, Concrete, Experiential, Specific (ACES)

4. Adopt a Functional-analytic approach

5. Link behaviour to warning signs

6. Repetition & Practise

7. Shift to adaptive thinking style

8. Focus on non specific factors (validation, persistence)

Principle 2: Make rumination an explicit target of therapy

Link rumination to symptoms & difficulties, goals

Make explicit agreement to target it

Highlight rumination as potential therapy-interfering behaviour – to name & call out in session

Value of audio-recording

Use therapy as stand-alone, module, or adjunct

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Principle 8: Focus on non-specific factors: Warmth, Empathy, Optimism, Validation, Persistence

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EVIDENCE

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Evidence for RFCBT

(in brief) (see Watkins et al., 2016, ch. 1)

1. Watkins et al., 2011 B J. Psychiatry. Individual RFCBT + TAU (ADM) > TAU (ADM) for adult treatment-refractory residual depression
2. Jacobs et al., 2016 PLoS One, individual RFCBT > assessment only for adolescents with history of depression
3. Hvenegaard et al (2019). Group RFCBT> group CBT for adult depression
4. Topper et al (2017) BRAT. For high worry/ruminating adolescents, internet RFCBT & group RFCBT prevent depression and anxiety relative to WLC

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Structure of Therapy
(principle-based, not session-based)

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Structure of Therapy

Early:

- Providing an idiosyncratic assessment
  - Providing a clear rationale for the focus on rumination (handouts 1,2)
  - Educate that rumination is a learnt behaviour.
- Incorporate the patients' developmental history into the rationale.
- Encourage practise at spotting rumination, avoidance and early warning signs of each, using formal homework (handouts 4,5,6)
- Initial functional analysis

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Structure of Therapy

Middle:

- Further functional analysis
  - Develop into contingency plans –functional responses to warning signs
  - Change environmental /behavioural contingencies
- Increase activity and reduce avoidance.
- Use behavioural experiments & experiential exercises, as relevant (to provide experience of functional alternatives)

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Structure of Therapy

Late:

- Further functional analysis
  - Develop into contingency plans –functional responses to warning signs
  - Change environmental /behavioural contingencies
- Consolidation – self-FA
- Relapse prevention (from start)

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Structure of Session

(standard CBT)

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(1) Brief review of time since last session.
(2) Set agenda for session.
(3) Feedback on previous session; discussion of the audio-recording of the previous session.
(4) Review of homework.
(5) Main focus for discussion and further practice in the session: functional analysis, behavioural experiments, experiential exercises, and homework planning.

[map out specific difficulty, FA → Exercise/experiment → IF-THEN plan – E[6]]

(6) Summary of issues explored and what was learnt.
(7) Setting new homework tasks.
(8) Feedback on session and arranging the next session.

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E6

- 1. Explore Experience
- 2. Experiment with Experience
- 3. Exercise and Engage

1. explore patients experience e.g., FA of specific situations (Principles 1, 4, 8)
2. Experiment alternative approach (Principles 3,7) e.g., Why-How
3. If helpful, plan for regular practice (listen recording of exercise, IF-THEN (Principles 5,6)

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ASSESSMENT

(assuming standard generic CBT assessment done: problems, goals, diagnosis, circumstances)
See Watkins et al., 2016 ch. 4

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Goals of initial evaluation:

1. Understand the experience of rumination for the patient – identify it as a relevant target
2. Orient the therapist to what context & consequences may be relevant for the patient.
3. Identify the antecedents & consequences of rumination and start formulation = identify possible moderators of rumination, hypothesize possible functions for the rumination.
4. Inform the therapist's socialization and engagement of the patient.

Components of Initial Assessment of Rumination

Section	Item
Step 1	Agenda
Step 2	General Assessment of clients experience of rumination
Step 3	Get explicit agreement to target rumination
Step 4	Goal Setting
Step 5	Introducing rumination as habit
Step 6	Monitoring Log home practice

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General Assessment of Rumination

Frequency, consequences, triggers, contexts, help to orientate patient to rumination as a key focus for therapy

We are interested in tackling the pattern of rumination so first we need to get a sense of the general pattern.

Therapists can be flexible with questions: The key aim is to use different questions to gather the information needed to get **the general sense of rumination**, and to cover the key dimensions (frequency, content, duration, context, consequences, what might explain the development of rumination).

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General Assessment of Rumination

Frequency:
"How often do you find yourself ruminating or dwelling on your problems and difficulties?"

Content/Themes:
"What do you tend to ruminate about?"

Duration:
"How long does this rumination tend to last?"

Context:
"When do you tend to find that you are worrying and ruminating more?"
"When do you tend to feel worse?"
"When does it tend to be better?"
"When does it tend to be worse?"
"What do you notice about your feelings that might be warning signs for your worry?"
"Are there situations, times, or places where it tends to happen more often?"

Context:
"When do you tend to find that you are worrying and ruminating more?"
"When do you tend to feel worse?"
"When does it tend to be better?"
"When does it tend to be worse?"
"What do you notice about your feelings that might be warning signs for your worry?"
"Are there situations, times, or places where it tends to happen more often?"

Consequences:
"What are the consequences of your rumination?"
"What effect does it have on you?"

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Establish rumination/worry as a target

Use summaries to explicitly highlight rumination and avoidance as a target for therapy:

- e.g., "It sounds like from what you said that worry/overthinking/rumination [use term used by patient] is having a big impact on you. When you are worrying, then you tend to feel worse, you find it hard to concentrate, you are more tired, you don't sleep so well. Etc Is that right?"

Use guided questions to see if client recognises value of tackling worry/rumination, e.g.,

- "What do you make of that?"
- "How much of an effect is worry/rumination/overthinking having on you?"
- "How much of a problem for you are these symptoms? [name those linked to rumination]"
- "What would happen if you were able to tackle/improve all these problems?"

Link the focus on tackling rumination / worry /avoidance to patients' goals – [this is likely to be straightforward if goals include tackling depression, anxiety, etc – relate back to consequences already observed or check impact of rumination and avoidance on these].

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Set therapy goals and link to rumination

- **Get a list of goals** – these may be positive (feel better, feel more confident), or negative (not get depression etc)
- **Make these goals as specific as possible** – tie them to actual changes in actions and behaviours, e.g., "What would you be doing differently if you made progress on this?"
- **Explicitly link these goals to the rumination/worry -** e.g., "Which of your goals do you notice are linked to the negative effects of rumination we just talked about?"
- **Summarise consequences and goals as to making rumination a target of therapy.**

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Introduce idea of rumination-as-habit / therapy rationale

Normalise rumination: rumination is normal and functional in limited amounts under the right circumstances, i.e. "it is not surprising that you use it - everyone else does too."

Rumination can drive problems: when used excessively, inappropriately or when out of balance, rumination (+avoidance) become problematic and can be central engines driving anxiety, depression, etc [Link to individualised consequences]

Rumination is unhelpful when it becomes a habit: We view worry as a habit. A habit is an automatic way of responding that has been learnt across repeated occurrences and occasions so that it is triggered without awareness or intention.

Habits come from learning: Excessive use occurs because of past learning – either copying others or previous occasions when you learnt that rumination was a useful strategy

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Introduce idea of rumination-as-habit/rationale

Habits can change: Because the habit was learnt, it can be overlearned with a new more adaptive strategy.

Therapist as a coach - This therapy coaches' clients into shifting out of the worry habit into a more useful habit. The therapist will act a coach, giving advice and support, and guiding clients on what to do.

Importance of being aware of the triggers - The trick to changing a habit is to become aware of the triggers to the habit and then to repeatedly practice a more helpful response instead of the unwanted habit (or to remove the triggers if that is practical and helpful to do). → self-monitoring, detailed analysis of recent examples

Therapy builds from clients' experience: learning a new more adaptive approach based on your own experience (building on own strengths → functional analysis; you own expert; finding what works/is helpful, applying more systematically)

Repeated practice: changing a habit takes rpractice, trying out new approaches over and over again

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FUNCTIONAL ANALYSIS (FA) at heart of RFCBT

(handouts 7,8,9)

Explore Experience = FA of **specific** situations or rumination episodes (Principles 1, 4, 8)

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Functional Analysis

1. Antecedent → Behaviour → Consequence

   Spot warning signs
   Increase awareness

   Identify function, reinforcement

2. Explore context & variability

   When/where/what does rumination occur or not?
   When/what/where/how is thinking useful or not?

3. Develop contingency plans

   Remove cues to habit; Find constructive incompatible yet reinforcing alternative in repertoire, repeatedly practice until new habit

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Functional Analysis

Used to help patients:

(a) recognise warning signs for rumination (cues for habit)

(b) develop alternative strategies and contingency plans (e.g., relaxation, assertiveness) (train incompatible response, IF-THEN)

(c) alter environmental and behavioural contingencies maintaining rumination, exert environmental control (e.g., shifting the balance from routine chores and obligations towards self-fulfilling activities; disrupt habit).

(d) shift towards more helpful thinking through practice

- **Focus on CONTEXT, VARIABILITY & situatedness**

- Under what conditions have you ruminated?
- Under what conditions have you not ruminated?
- Under what conditions is rumination helpful vs. unhelpful?
- How? When? Where? Who?

ABC

- **Antecedents → Behaviour → Consequences**
  - What is function of behaviour? (internal Q for therapist)
- What triggers the habit? What are warning signs? (antecedent; "What comes before?")
  - What reinforces the habit? (consequence, "What comes after?")

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Guide to FA in RFCBT: CUDOS
Questions to ask & to guide formulation:

- **C**ontext – When, where, who, what, how influences variability
- **U**sefulness – function, consequences
- **D**evelopment – when started, how learnt
- **O**ption**s** - alternatives

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Guide to FA in RFCBT: CUDOS

The **Context** that influences the target behaviour

- Specifying when, where, what, how and with whom ***it happens*** and when, where, what, how and with whom with ***it does not happen***.
- What precedes/triggers it?

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Triggers & Warning signs

Typically a chain from events (internal /external) to responses (sensations/actions/thoughts)- useful to map out chain to see which are common across habit, where can intercede

Common examples:

Events: news, criticism, argument, memory, intrusive image, making a mistake, reminder, being evaluated, being ignored

Cognitive: narrowing attention, self-focus, asking “Why?”, self-criticism

Action: withdrawal, distraction, procrastination, confrontation

Body Physiology: arousal, tension, headache, sinking feeling, hot, low energy, increased heart rate

Emotion: anxiety, anger, guilt, shame, low mood

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TRAP (BA)

Trigger – thought of rejection by therapist
Response (Warning sign) – heightened self-consciousness
Avoidance – reduce eye contact, rumination
Pattern - monosyllabic responses

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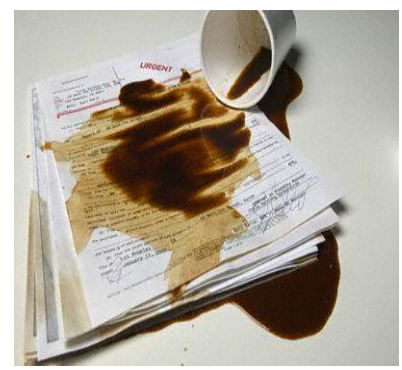
Environmental Context

GOOD AT WRITING BAD AT WRITING

Jill has a tidy space away from being bothered.



Jill's writing area is in a mess.

92

GOOD AT WRITING

Jill is focusing on the step by step details of what she is doing

BAD AT WRITING

Jill is focused on evaluating how well she is doing – will the writing be good enough?

INTERNAL /BEHAVIOURAL CONTEXT

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Guide to FA in RFCBT: CUDOS

- The **Usefulness/function** of the rumination or avoidance
  - What might be the function/purpose/goal of behaviour?
  - What are the consequences/outcomes/pros/cons/gains of behaviour?
  - What is avoided/reduced/increased?

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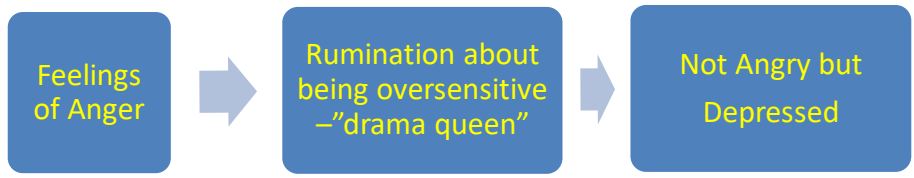
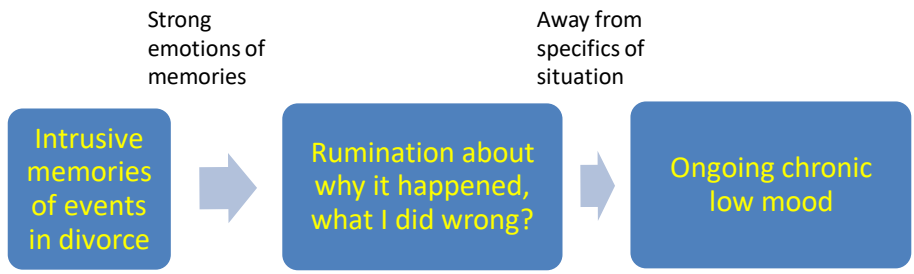
Usefulness (Function)



Think about possible triggers and functions of rumination

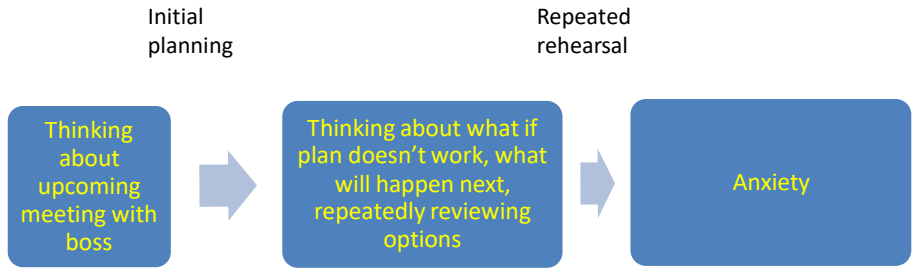
95

Usefulness (Function)



96

Usefulness (Function)



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Guide to FA in RFCBT: CUDOS

- The **Development** of the behaviour.
  - When did it start?
  - How was it learnt?
  - Who from?
  - First memory?
  - Was it useful then?

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Guide to FA in RFCBT: CUDOS

- **alternative Options or actions**
  - What is different between the times when behaviour is long/short/helpful/unhelpful?
  - Focus on variability
  - What can interrupt or stop the behaviour?
  - What happened just before you stopped behaviour?
  - What did you do /focus on /say to yourself?
  - What happened in world?

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Specific steps in FA

(1) Identify specific examples/memories

(2) Therapists uses questioning to map out in specific, concrete detail the sequence and process of behaviour (e.g., thinking) moment-by-moment (not caught up in content).

- Model & COACH approach (concrete, process-focused, Socratic questions – "What do you notice? What learnt? What helpful?")

(3) Ask about Context (Who, what, where, when, how) and consequences. Look for common steps, triggers, warning signs, consequences

(4) Compare alternative example that introduce variability (i.e., similar situation/task/difficulty where did not get stuck)

(5) Use differences to make IF-THEN plans /change environment/plan experiments/experiential exercises

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Step 1: Identify and overview a specific example of rumination, e.g., from self-monitoring, review of week

Day/time	What happened just before (what was the trigger)	What were you thinking about?	How long did it last	What were the consequences of ruminating – on how you felt or what you did?	Did you try to stop ruminating, and if you did what did you try, and did it work?	How did the rumination end?
Example 10pm Tuesday	Went to bed	Why do I feel this way? Why can't I sleep? Going over all the things I didn't do.	2 hours	Couldn't sleep Felt worse	Tried thinking about other things, told myself to stop – these helped for a little bit	I eventually fell asleep

TIPS: choose an example that is typical (i.e., habit); get brief overview of whole episode to confirm rumination and key junctures; focus on period of ruminative thinking rather than emotional event

Step 2: Get patient to recreate the scene & re-imagine the context and experience leading into the rumination as vividly as possible [ACES], focusing on sensory-perceptual experience and context – what can see, hear, feel, what said, done, tone of voice, what saying to self, where focus of attention

TIPS: ask patient to close eyes/focus attention; practice some brief relaxation; use instructions to locate re-imagining in present tense & field perspective ("As if there right now, in your body, looking out of your own eyes"); give rationale of learning about habit – triggers, processes, consequences; introduce the idea that the experience will be ***slowed down, second by second, frame by frame.***

Step 3: Prompt the client to describe the scene in as much detail as they can, engaging the senses to immerse the client back into the experience as vividly as possible. What can see, hear, feel, what said, done, tone of voice, what saying to self, where focus of attention

TIPS: Get sufficient detail to spot possible triggers, warning signs, loops, modifiers of rumination (what context is important; what internal patient state is important; what the patient is saying to self /going through head [images, words, tone, memories] and their effects;

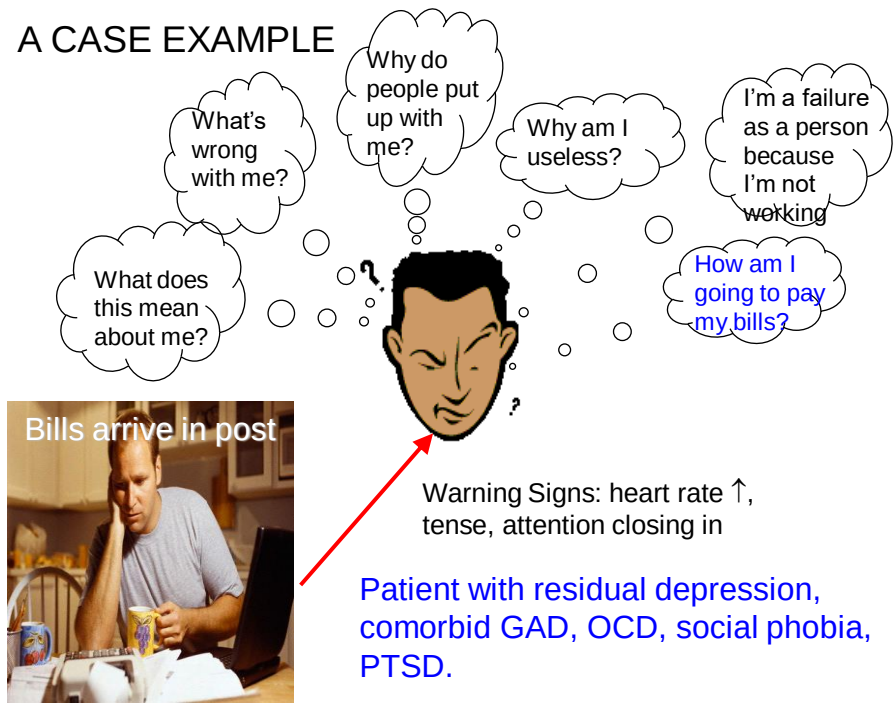
- Use contextually-bound questions i.e., "Just after you said to yourself "Why did he do that?", what did you notice the next moment?" – helps ACES, keep patient grounded, focused and paced.
- Slow it down – avoid compression of events, jumping ahead to track sequence of rumination

Step 4: Summarise what learnt from detailed analysis [triggers, loops, consequences]; review experience for patient [helpful e.g., perspective, slowed down, calming, insight vs. discomforting, difficult]
Highlight what was useful from the exercise

Step 5: *Formulate a function* for the behaviour (i.e., rumination) (iteratively over sessions). Collaboratively discuss function with the client and check if plausible. May need to review several episodes

For **Variability**: repeat all steps 1-5 with alternative examples – time matched to examples of rumination in terms of context/state [e.g., similar feelings/triggers] and difficulty, but with different consequences – to identify what variables can change rumination; time when rumination didn't' happen; thinking was helpful; rumination was briefer etc

A CASE EXAMPLE



Patient with residual depression, comorbid GAD, OCD, social phobia, PTSD.

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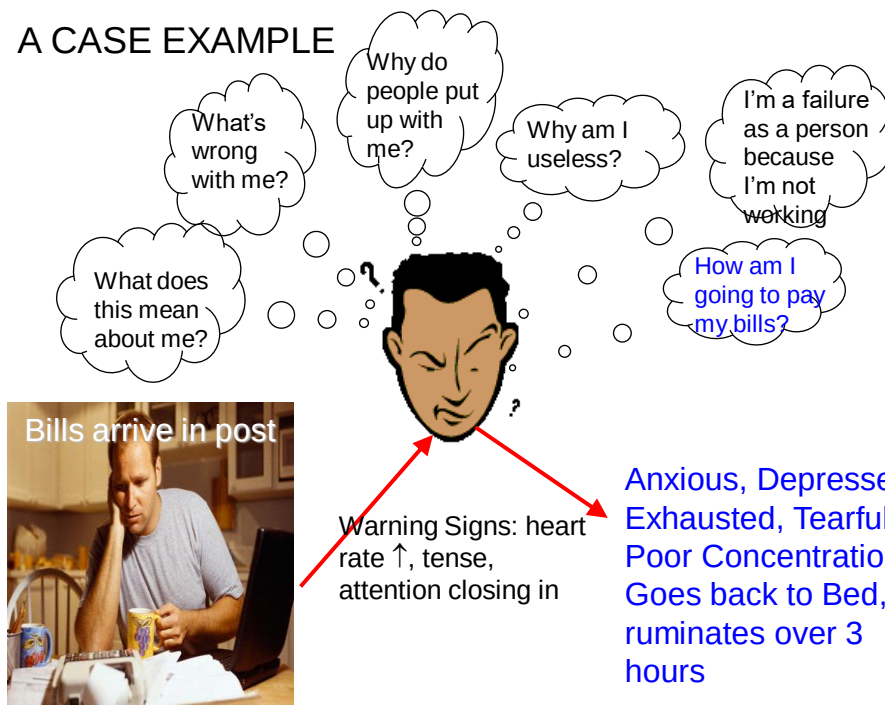
A CASE EXAMPLE



Anxious, Depressed, Exhausted, Tearful, Poor Concentration, Goes back to Bed, ruminates over 3 hours

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*A CASE EXAMPLE

Felt dismissed by partner when discussing decision

Warning Signs: heart rate ↑, tense, attention closing in

Tension reduced, Makes plan, Gets on with day, ruminates only 25 minutes

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FORMULATION

What comes before patient's rumination?
What follows the rumination?
What themes are the patient ruminating on?
What do the above suggest about possible functions of the rumination?
How can I further test this working hypothesis?
What are possible external environmental moderators that influence the frequency, duration, or usefulness of the patient's rumination?
What are possible behavioral or mental state moderators within the patient that influence the frequency, duration, or usefulness of his rumination?
What might be informative and therapeutically useful behavioral experiments to do in session?
What next steps might be possibilities for interventions?
What changes in environment and routines might interrupt the cues to rumination?
What might be good alternative behaviors for the patient to practice within an If–Then plan?

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Choosing treatment Interventions

Use shared understanding of function to generate and schedule plans:

- Collaboratively generate alternative behaviours to replace unhelpful behaviour that meet existing function. May need ABC of similar antecedent/situation with more positive consequence (Handout 9)
- Identify environmental factors that precede the target behaviour and then remove/increase to reduce/increase the target behaviour, with the changes scheduled into activity plans and homework.

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Main Interventions:

1. **Self-monitoring** (Handouts 4,5,6)

2. **Directly altering environmental contingencies**

3. **Developing contingency IF-THEN plans in response to warning signs (habit change)**

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E^6

1. Explore Experience
2. Experiment with Experience
3. Exercise and Engage

1. explore patients experience e.g., FA of specific situations (Principles 1, 4, 8), spot possible variability/alternatives
2. Experiment alternative approach (Principles 3,7) e.g., Why-How, self-other focused; critical vs compassion voice; shifts in imagery
3. If helpful, plan for regular practice (listen recording of exercise, IF-THEN (Principles 5,6)

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Initiating Interventions (E^6):

1. **Moderator of rumination identified via FA**
2. **Experiment/exercise to test**
3. **Make plans to repeatedly practice in daily life linked to cues**

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Altering contingencies

- Altering environmental contingencies directly – FA reveals aspects of environment that increase the likelihood of target behaviour
- Simple homework exercises set up as behavioural experiments can be tried from as early as session 1 or 2 to influence avoidance/rumination.
  - Change routine
  - Create a tidier work-space
  - Be active
  - Focus on one thing at a time
  - Focus on process rather than outcome

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Altering contingencies

- Use Socratic questions/thought experiments to determine which aspect of situation is central to avoidance or rumination (i.e., what is key function of behaviour?).
- e.g., For being alone is it feeling lonely, lack of encouragement, activities feel pointless done on own, lacking structure, lacking distraction?
- What aspect of being alone do you find most difficult?
- What do you really value about being with someone else?”

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Altering contingencies

- Use behavioural experiments to examine consequences of addressing environment –
- Listening to radio in morning to move focus away from feelings of tiredness
- If being alone is trigger, increase social contact
- If sad music in car triggers rumination, replace with alternative music
- If rumination triggered first thing in morning look at ways to change waking routine
- Increase structure, activity and routine

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Developing contingency plans

- Developing plans (If ...Then…) in response to warning signs & functional analysis–
  - strategies to break up the rumination/avoidance (INTERRUPT HABIT)
  - strategies to functionally replace them (need to be valued by client, available in repertoire) & thereby counter-condition new habit (LEARN NEW HABIT)

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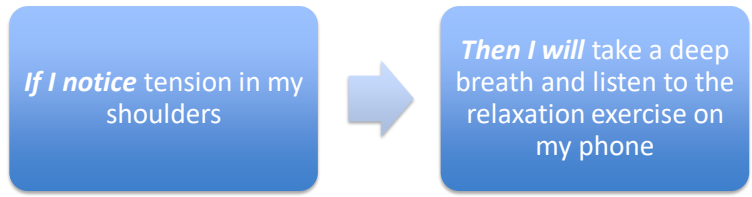
If-Then plans

- Recognising triggers and responding in a more helpful way [Designed to help to change habits]
- If I notice… (trigger) Then I will … (response)



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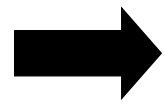
*TRAP & TRAC guides

Trigger –
Response
Avoidance
Pattern



Trigger
Response
Alternative
Coping
(Approach)

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How to choose the target trigger "IF"

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How to choose the target trigger "IF"

Trigger needs to be:

Frequent;
Contingent on rumination;
Early in sequence/chain;
Observable by patient;
"Final common pathway" to rumination

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How to choose alternative behaviour "THEN"

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How to choose the alternative behaviour

Incompatible with rumination, address its hypothesized function; constructive; path of least resistance

1. Function & Formulation: functional equivalence, addressing personal concern; reinforcing
2. Experiential Evidence – know it works;
3. Already in repertoire;
4. Practical and easy;
5. Closeness to warning sign – ecological link

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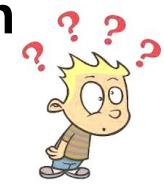
Functions of rumination



- Functions (overlapping/interacting) may include:
  - Seeking understanding and insight
  - Seeking control or certainty
  - Avoid risks in real world
  - Self-motivation – spurring self-on, not lapsing, put under pressure
  - Planning & preparation – attempt at problem-solving
  - Avoiding "unwanted self" [lazy, selfish, arrogant]
  - Seeking certainty/confidence / "state"
  - Self-justification – making excuses, rationalisations, justific of standards
  - Control of feelings

- Replace with more constructive alternatives:
  - Encouraging
  - Compassionate
  - Approach
  - Problem-Solving
  - Concrete

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Common alternative behaviours

Incompatible with rumination, address its hypothesized function; constructive; path of least resistance; from range of all CBT options

1. Applied relaxation;
2. Problem solving;
3. Replacing avoidance with approach (reframe function/goal) – activity scheduling, experiments
4. Concreteness;
5. Absorption;
6. Compassion

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Shifting Processing Style

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Shifting Processing Style

- Targeting processing style may be able to shift from maladaptive to adaptive RT

- Training individuals to be more concrete (asking How?) is more adaptive when responding to negative situations than being abstract (asking Why?).

- Coach experiential exercises/ build up activities to shift out of abstract-evaluative rumination style

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Changing Abstract thinking

- Practise at “How” questions

• Deliberate practice at focusing on concrete details, sensory context, sequence leading up to an event, and what can do next – Concreteness training
• Functional analysis of thinking
• Use of imagery
• Detailed prompts and questions from therapist

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Shifting processing style

Recreating experiences of being in a concrete style counter to rumination

Absorption experiences - “flow”

Compassion experiences

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ABSORPTION

Handout 10

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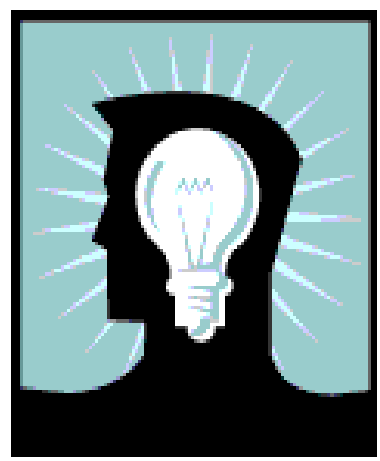
- Absorption experiences - recreate being caught up in the task, “flow”, “in the zone”, peak experiences (connected world direct way)



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ABSORPTION

1. Shift away "running commentary" in rumination
2. Shift from outcome to process focus
3. Overcome lack of connection and distance from world
4. Improve motivation

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Focus on holistic experiential shift via memories, images: thoughts, feelings, posture, sensory experience, bodily sensations, attitude, motivation, facial expression, action feelings

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"Flow" (Csikszentmihalyi, 2002)

- **Guides to judging whether absorbed; conditions to increase absorption:**
- Deep & effortless involvement in activity
- Merging of action & awareness
- Focused attention on the task at hand
- Balance between opportunity and challenge
- Clear rules, goals, immediate feedback
- Narrow temporal focus – immediate, present-moment
- Loss of self-consciousness
- Changed perception of time
- Connection with environment – self-guiding
- Focus on discovery, learning, growth – build self-potential

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Key elements in shifting style

- Requires preparation & socialisation into model, use of relaxation & imagery work as groundwork
- Identify specific memory of being absorbed
- Re-create and re-experience
- Find vivid memories and imagery of being in process-focused absorbed state – used to
- a. Kick-start adaptive mode
- b. Develop habit as alternative to rumination
- c. As example for functional analysis to make future plans

Experiential exercise and review – *Poll 4* /chat

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Key elements in shifting style

- Recreate mental state using questions (recreate) & guiding prompts (re-experience) to direct imagination to details – present tense, field perspective:
  - Sensory experience – *As vividly as you can see what you are looking at. Describe what you can see*
  - Motivation & Attitude
  - Posture – *As you become more absorbed, notice your posture of relaxation*
  - Physical sensations – *Notice the sensations in your body*
  - Feelings – *Experience and hold onto your feelings, letting them deepen*
  - Facial expressions –
  - Urges to actions
  - Attention – *What do you notice? Where are you focusing your attention?*

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ABSORPTION++

1. **Can be any activity – idiosyncratic**
2. **Absorption exercises can inform FA – what increases likelihood of being absorbed (state of mind; focus of attention; goals; environment; distraction; time pressure; preparation) – to feed into future plans**

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Problems with ABSORPTION

1. **Difficulty finding memories: use Principle 3 = ACES; make vivid; use Flow criteria as prompts**
2. **Recall of memory not helpful – counter-productive if not in experience and activating comparison/evaluation *"Why can't I do this now?":* optimise immersion in memory, in selection, review of memory and prompts to holistic experience**

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Problems with ABSORPTION

3. Is activity adaptive? Possible distraction or avoidance e.g., crosswords, computer games, social media:
Depends on detailed FA. Does activity connect with alternative mind-set at odds rumination and enables direct engagement with world? Does it build resources and skills or facilitate growth?

4. Remember: absorption mind-set used elicit helpful mind-set then applied current real-world situation

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Compassion

COMPASSION

- Compassion experiences - Recreating feeling compassionate, tolerant, caring, nurturing, non-judgemental

- Functional selection of compassion:
- Alternative to when rumination is used to motivate self ("spur self on") or to avoid become an unwanted self (e.g., not become selfish)
- Approach rather than avoidance alternative – framed as such
- Induce experience of compassion based past memories similar to absorption

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- Can use imagery building past experience (compassion to others close, self-as-child,etc) or compassionate imagery (avatars, Gilbert)
- Need to stay with experience and repeat re learning habit; link to warning signs
- Need to allow time to work through it

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- **Can be challenging and scary for patients**
- **Work up hierarchy from easier points of compassion to more difficult (e.g., other to self)**
- **Validate patient's experience**
- **Prompt to strengthen experience – ACES**
- **Experiential exercise: self-criticism; other; self**

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- Useful internal speech for patients to practice to scaffold self-compassion include:
- 1. Normalizing – *everyone makes mistakes; no-one is perfect*
- 2. Focus on progress made – steps completed, what got right, what can learn from situation
- 3. Highlight success and strengths – remind of other times that succeeded
- 4. Put the situation into perspective – *This was a difficult situation-most people would find it hard. This difficulty will pass.* Focus on process rather than outcome
- 5. Encourage to go onto next step – *You can do it; take it one step at a time*. Break down into smaller steps.

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- Non-verbal qualities of internal speech are critical : tone, volume, pitch
- Calm, gentle, warm, confident, firm, persistent, kind, straightforward versus critical, sarcastic, overbearing, ironic, nasty, cold, acidic

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- Avoid conceptual analysis/comparative thinking
- Break down & adapt to overcome barriers experientially
- Field rather than observer perspective; embodied
- Repeated practice in & out of session (taping)
- Use functionally

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- **ACTING IN A COMPASSIONATE WAY**
- **Encourage and plan to shift activities to facilitate compassion**
- **“What would I do more of if I were caring more for myself?”**
- **“What would I do less of if I were caring more for myself?”**

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ADDRESSING DIFFICULTIES

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ADDRESSING DIFFICULTIES

1. Return to basic therapy principles (Principles 1 -8 e.g., ACES, habit, repetition & practice

2. Change from “outside-in”. Act to goals rather than feelings. Move away from state-dependent action.

3. Review pros and cons of action – is this strategy working? Analysis vs experience

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FA & Therapeutic Hurdles

FA as a solution to most problems – point out difficulties & relate to therapy model

Relevant therapy-interfering behaviours (DNA, being abstract, changing topics, seeking reassurance, “yes but”) = avoidance

1. Formulate function of behaviour
2. Highlight behaviour whilst validating and normalising
3. Examine its consequences and usefulness
4. Look for potential variability [alternatives]
5. Introduce a useful alternative behaviour to try

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RFCBT principles

1. Normalize rumination

2. Make rumination an explicit target

3. *Action, Concrete, Experiential, Specific (ACES)

4. Adopt a Functional-analytic approach

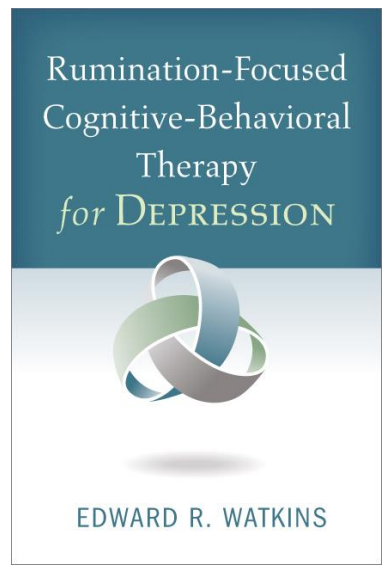
5. Link behaviour to warning signs

6. Repetition & Practise

Tackle as a habit*

7. *Shift to adaptive thinking style

8. Focus on non specific factors (validation, persistence)



IN-DEPTH RFCBT TRAINING & SUPERVISION

Piloting more-in-depth training with certification: 9 x full-days plus 2 cases supervised through, with video-tape evaluation

Regular practice and supervision needed to gain expertise in model – looking at remote training model to build a cadre of therapists in NHS and internationally

E-mail at D.Jago@exeter.ac.uk to register interest and join our mailing list

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Key Lessons

a. 3 lessons learnt;

b. One key thing will do differently with patients with worry/rumination

c. What is most helpful?

(Quiz)

154

Supported by wellcome trust

MRC Medical Research Council

NARSAD RESEARCH
National Alliance for Research on Schizophrenia and Depression

Collaborators: Prof Eugene Mullan, Prof Rod Taylor, Prof Jan Scott, Dr Michelle Moulds, Dr Nicholas Moberly, all trial therapists, patients and participants

e.r.watkins@exeter.ac.uk

mood disorders CENTRE

Thank you!

SMART Laboratory – Study of Maladaptive to Adaptive Repetitive Thought

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ADDITIONAL BACKGROUND SLIDES

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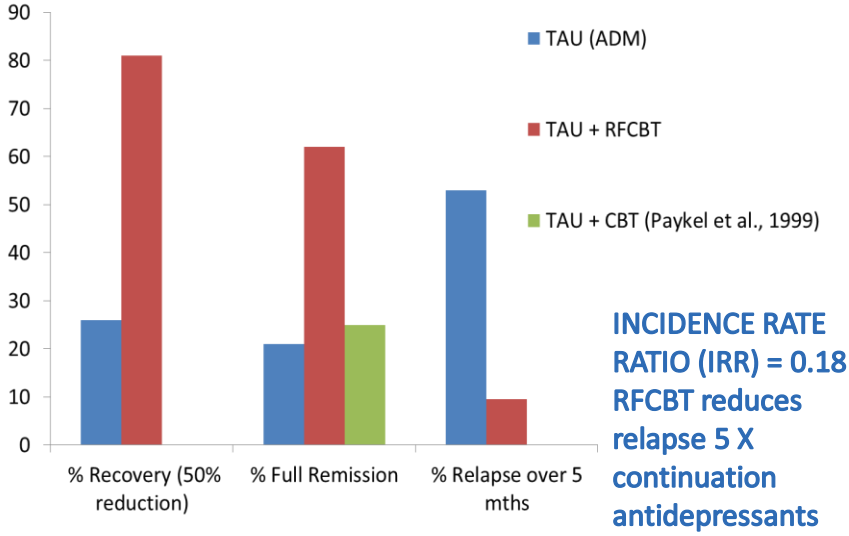
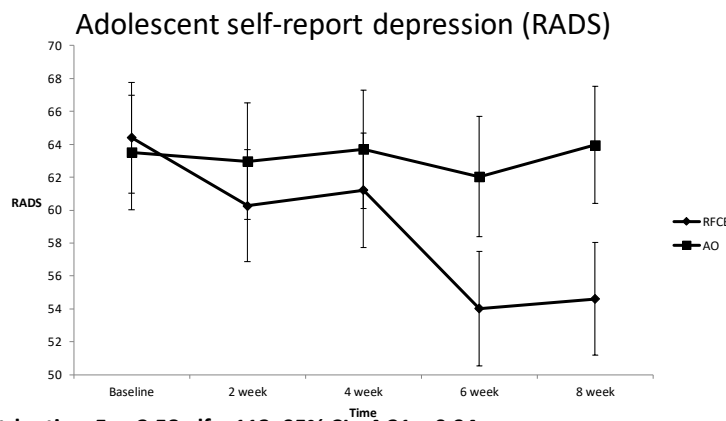
Watkins et al., 2011, B. J. Psychiatry

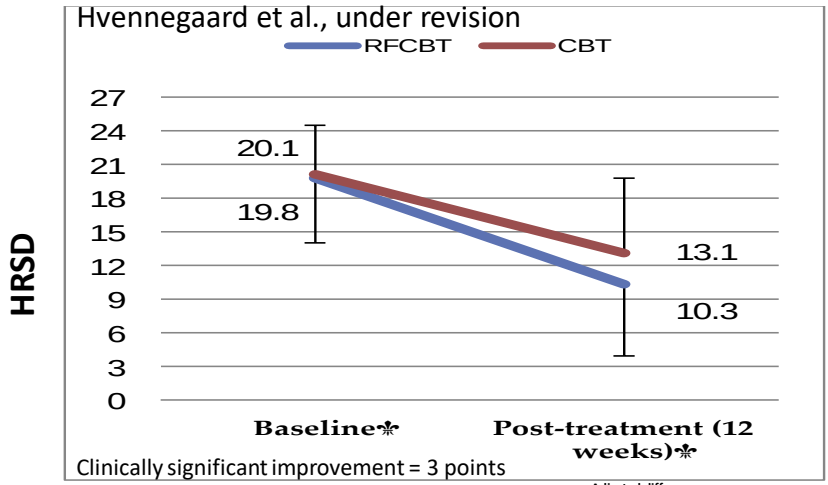


INCIDENCE RATE RATIO (IRR) = 0.18 RFCBT reduces relapse 5 X continuation antidepressants

RFCBT in adolescents with history of depression (residual symptoms) n = 33, individual RFCBT vs assessment only

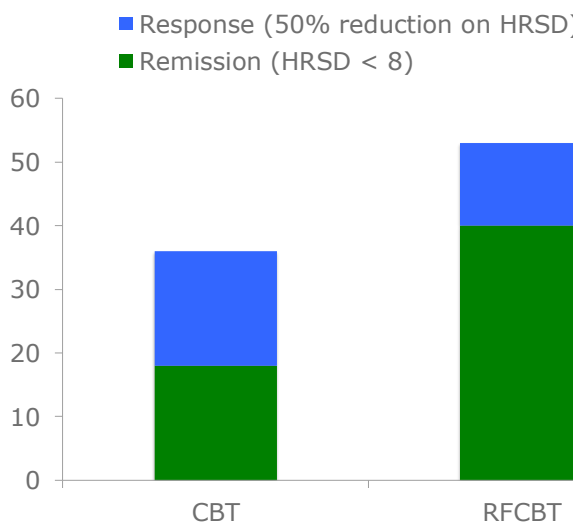


Treatment-by-time F = -2.58, df = 113, 95% CI: -4.21 – 0.94;
Jacobs, Watkins, Peters, Feldhaus, Barba, Carbray, & Langenecker (2016) PLOS ONE



ITT- analysis	CBT	RFCBT	CBT	RFCBT	Adjusted difference (95% CI)	P-value
HRSD	20.1 (4.4)	19.8 (5.8)	13.1 (6.8)	10.2 (6.4)	2.7 (0.5 to 4.9)	0.015

159



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Topper, Emmelkamp, Watkins & Ehring (2017) BRAT; ZonMW funded

251 x Dutch 15-19 year olds with elevated worry/rumination

↓

Randomised at chance

↙ ↓ ↘

Internet guided cognitive-behavioural therapy targeting rumination

Group CBT for rumination

Usual care

↓ ↓ ↓

12 month follow-up

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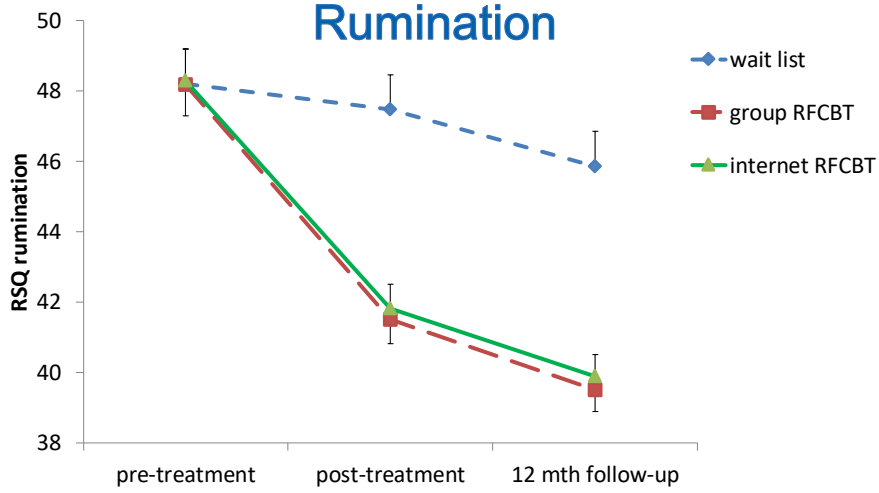
Internet RFCBT for Prevention: Rumination



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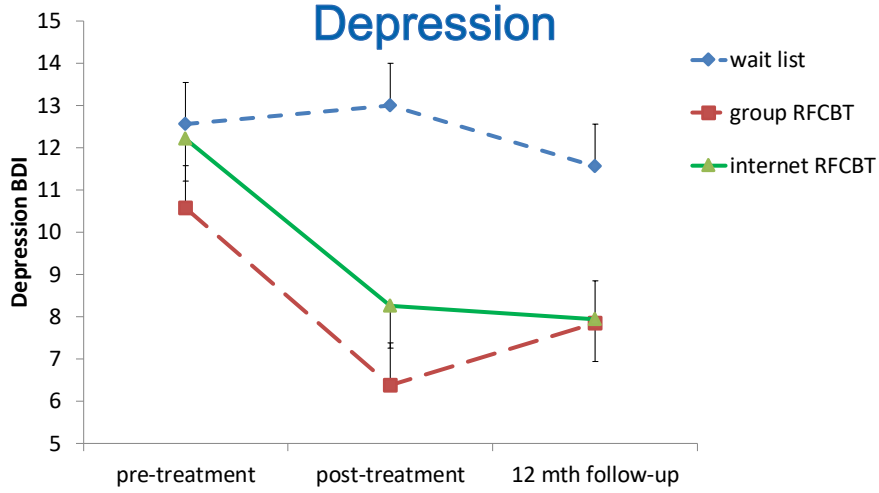
Internet RFCBT for Prevention: Depression



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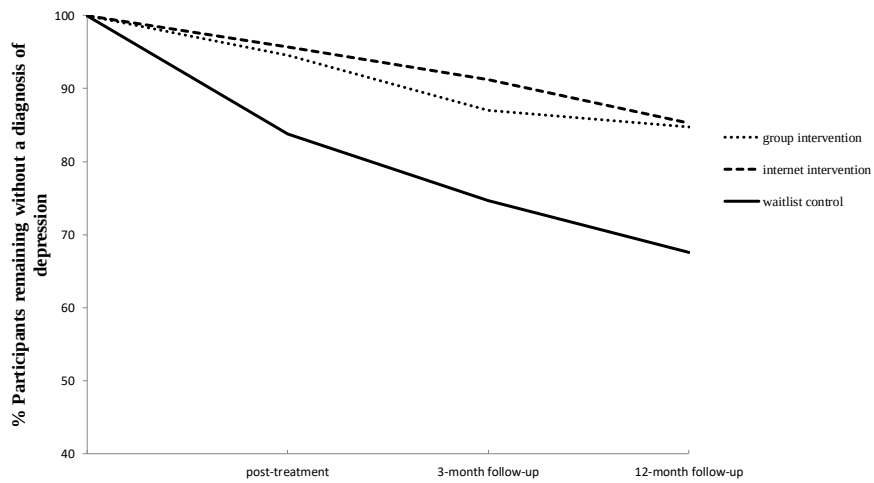
Preventing depression in high-risk Dutch 15-19 year olds



Cumulative proportion of participants remaining without a self-reported diagnosis of depression (PHQ-9).

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Preventing anxiety in high-risk Dutch 15-19 year olds

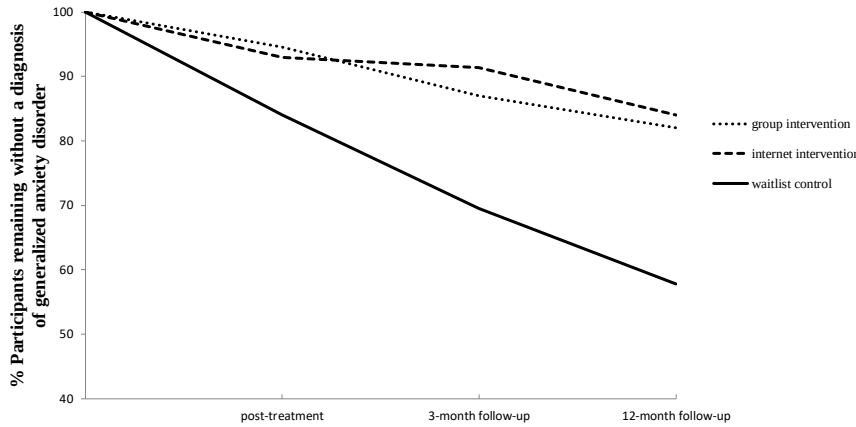

Figure 3. Cumulative proportion of participants remaining without a self-reported diagnosis of generalized anxiety disorder (GADQ-IV).

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Cook & Watkins (2016) Trials

235 x UK undergraduates olds with elevated worry/rumination, not currently depressed on interview, recruited online screener (4795, 1475 invited)

Randomised at chance

Internet guided RF-CBT

Internet self-help RF-CBT

Usual care

3 mth (78% retention), 6 mth, 15 month follow-up (69% retention)

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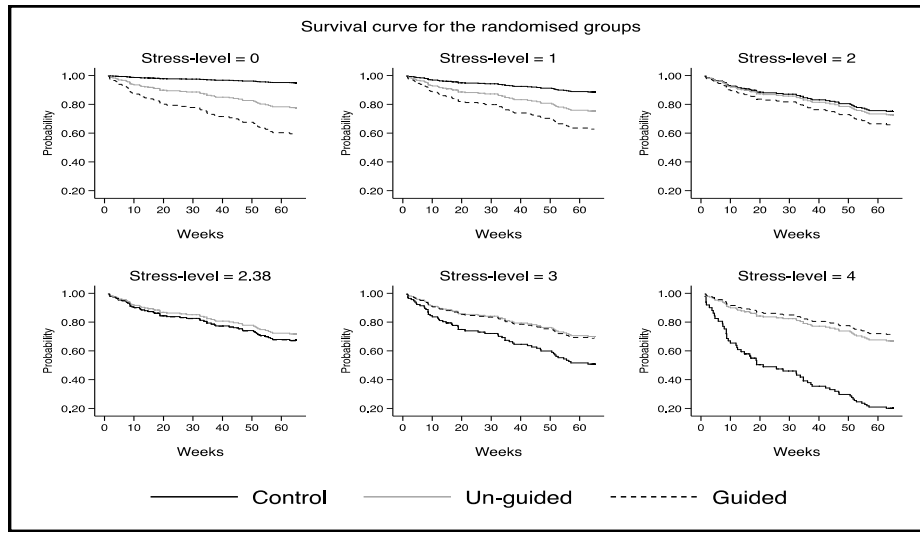

Controlling for the effect of baseline stress level, the hazard ratio for Guided vs control = 0.73 (95% CI: 0.38 to 1.39)

Group RFCBT

- Two variants
- (1) In Exeter, using BA variant explicitly uses BA terms with some RFCBT elements, avoidance key focus. Used open trial, moderate improvements (BDI reduce 10-15 pts). 90 min sessions
- Session 1: Introduction, Mood-avoidance links, self-monitoring
- Session 2: Examine avoidance, TRAPs, idea of alternative response. Record TRAPS

Group RFCBT

- Session 3: take ACTION, plan alternatives, visualise putting into action
- Session 4: Breaking down challenges – smaller steps
- Session 5: Rumination – form of TRAP, generate consequences and functions of rumination, Alternatives to rumination –How vs Why?.
- Session 6: Connecting with the Present – absorption exercise, use memory of absorption to interrupt rumination. Plan absorbing activities

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Group RFCBT

- Session 7: Self-compassion – interactive experiential exercise, Plan to be more compassionate
- Session 8: Learning from experience – become more aware of triggers. Discriminating context. Notice when each tool works best
- Session 9: Values – acting in line values
- Session 10: Resilience – review skills, plan for ongoing activity, relapse prevention plans, review experience of group.

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Group RFCBT

(2) Revised group plan emerged consideration BA groups plus development of rumination-focused prevention groups. 90 min sessions (?still in pilot). Main focus from beginning is Rumination.

Session 1: Introduction, Handling stress, introduce worry/rumination, examples generated group, rumination as habit, generate consequences, self-monitoring.

Session 2: Noticing warning signs, stepping out of habit – introduce if-then plans, changing circumstances.

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Group RFCBT

- **Session 3: Different Styles of thinking, experiential alternative to rumination-e.g., relaxation, How vs Why? Experiential exercise, link into if-then plan, practice with "hot" warning sign**
- **Session 4: Alternatives to rumination that serve function; useful rules of thumb (unanswerable questions, 30 min rule, lead to action?), absorption**
- **Session 5: Self-compassion, experiential exercise, acting in a more caring way towards self**
- **Session 6: Interpersonal Effectiveness, comparing effective vs ineffective, resilience**

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Rumination

(a key mechanism in depression)

Concrete specific
How? style

Problem Solving, Recovery

Multiple Vulnerabilities

Rumination-as-habit[1]

Abstract global "Why?" style[2]

Depression

Anxiety

[1] Watkins & Nolen-Hoeksema 2014 J. Abnormal Psychology **123***:* 24-34
[2] Watkins 2008 Psychological Bulletin **134**: 163-206

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problem. Being specific gives more options to fix a problem because it gives you clues as to what you could do differently in the future: for example, you could rest more, take more time, and improve your test-taking strategy.

How versus Why

Visualization exercise

Let us take you through an example of **abstract thinking in response to a potentially stressful situation**. Listen to the voice in the next exercise and try to follow the instructions as closely as possible.

00:00 00:00

Make a mental note of what you experienced in this situation, what you felt, what you thought, and what physical sensations you experienced and remember that for later .

Mark with the sliding scale how sad you are feeling right now (0-100%)

47

Mark with the sliding scale how tense you are feeling right now (0-100%)

50

Mark with the sliding scale how calm you are feeling right now (0-100%)

4

Mark with the sliding scale how energetic you are feeling right now (0-100%)

2

Mark with the sliding scale how focused you are feeling right now (0-100%)

5

Mark with the sliding scale how confident you are feeling right now (0-100%)

13

Now let's return to the image that you created before and try thinking more *Concretely* about the situation. Being concrete and specific mostly goes hand in hand with asking yourself questions that start with HOW. Listen to the voice and try to follow the instructions.

00:00 00:00

Make a mental note of what you experienced in this situation, what you felt, what you thought, what physical sensations

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Processing Style

- Theory and experiments ⇨ hypothesis that there are distinct styles of RNT, with distinct functional consequences
- Adaptive, constructive ruminative self-focus = concrete, process-focused, specific thinking, focused on the concrete & specific experience & process of how things happen moment-by-moment
- Maladaptive, unconstructive ruminative self-focus = abstract, general, evaluative thinking, thinking about why an outcome occurred (Moberly & Watkins, 2006; Rimes & Watkins, 2005; Watkins, 2004; Watkins & Baracaia, 2002; Watkins & Moulds, 2005; Watkins & Teasdale, 2001, 2004, Watkins, 2008, Psych Bull)

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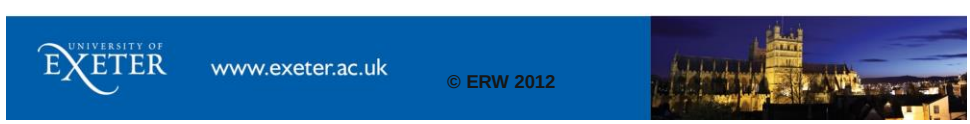
RFCBT

- Review of package
- Two interfaces – one for therapists, one for clients
- Task units – so patient knows what module to do next and therapist informed when section completed
- https://mindresolve.minddistrict.co.uk/
- Multi-media site – text, video, pictures, questionnaires, audio files
- Modules set-up to cover key elements of RFCBT with email support and guidance: Introduction to stress; self-monitoring; changing environment, IF-THEN plans, looking at function of worry; relaxation; absorption, concreteness; compassion



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Rumination-focused CBT (RFCBT)

Based on Cognitive Behavioural Therapy (Beck et al., 1979) with 2 changes:

1. A functional-analytical perspective using Behavioural Activation (BA) approaches based on view that **rumination is a learnt habitual behaviour** developed through negative reinforcement (Addis & Martell, 2004; Martell et al., 2001; Watkins, 2009; Watkins et al., 2007; Watkins et al., 2011)

2. Focus on **shifting processing style** via imagery and experiential approaches, based on theory & evidence that distinct constructive versus unconstructive modes of rumination (Watkins, 2008)

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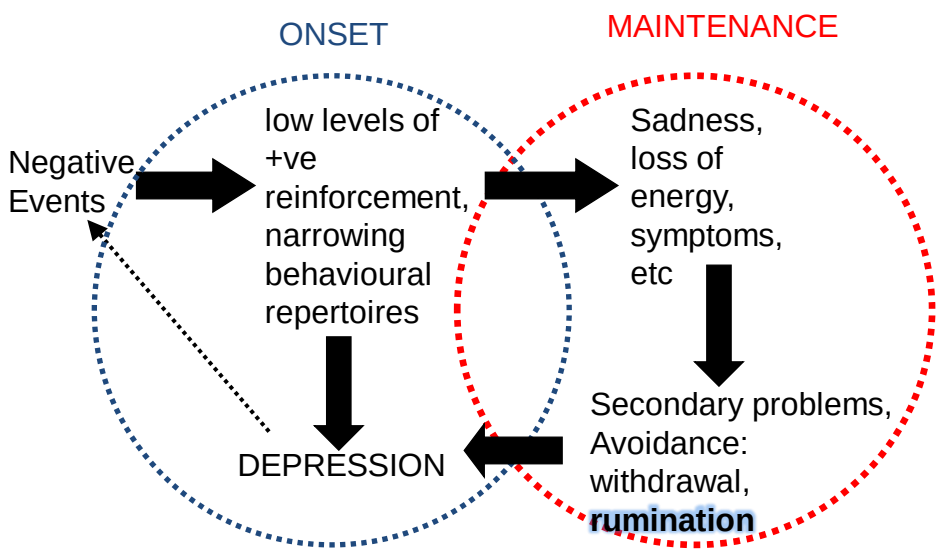

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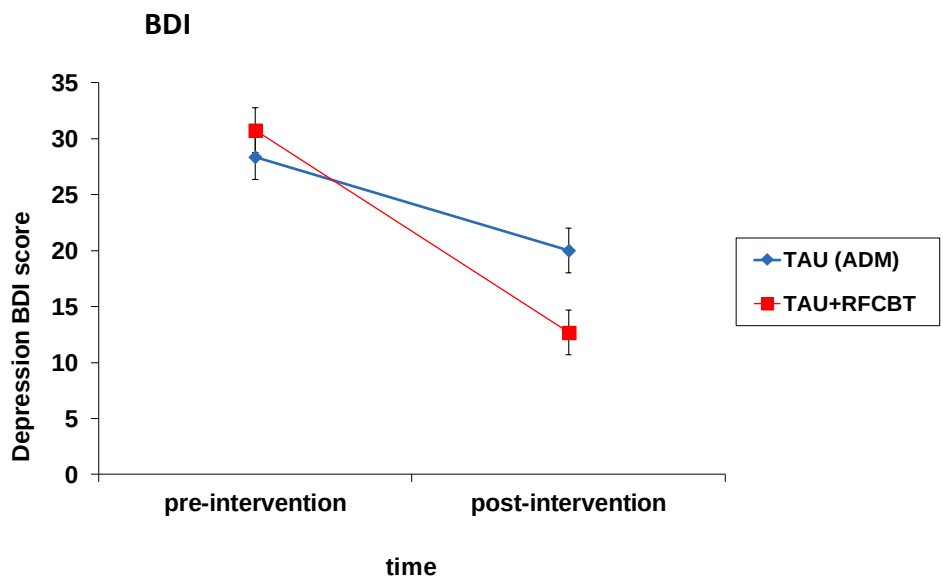
BJPsych The British Journal of Psychiatry
1–6. doi: 10.1192/bjp.bp.110.090282

Rumination-focused cognitive–behavioural therapy for residual depression: phase II randomised controlled trial

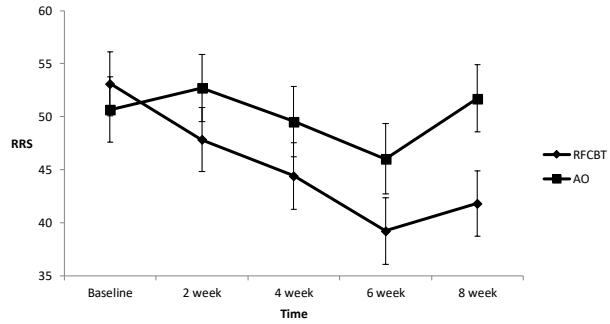
Edward R. Watkins, Eugene Mullan, Janet Wingrove, Katharine Rimes, Herbert Steiner, Neil Bathurst, Rachel Eastman and Jan Scott

- 1/3 depressed patients only achieve partial remission after treatment
- Tested whether targeting rumination would improve outcomes
- 42 treatment-resistant patients randomised to treatment-as-usual (all on antidepressant) vs TAU plus 12 weeks of RFCBT



RFCBT in adolescents with history of depression (residual symptoms) n = 33, individual RFCBT vs assessment only

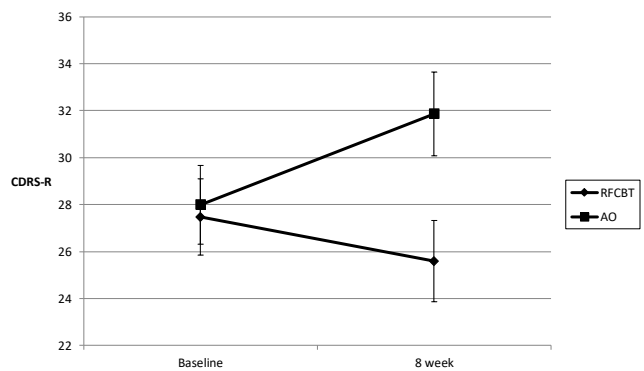
Rumination (RRS)



Treatment-by-time F = -2.76, df = 112, 95% CI: -4.72 – 0.80
Jacobs, Watkins, Peters, Feldhaus, Barba, Carbray, & Langenecker (2016) PLOS ONE

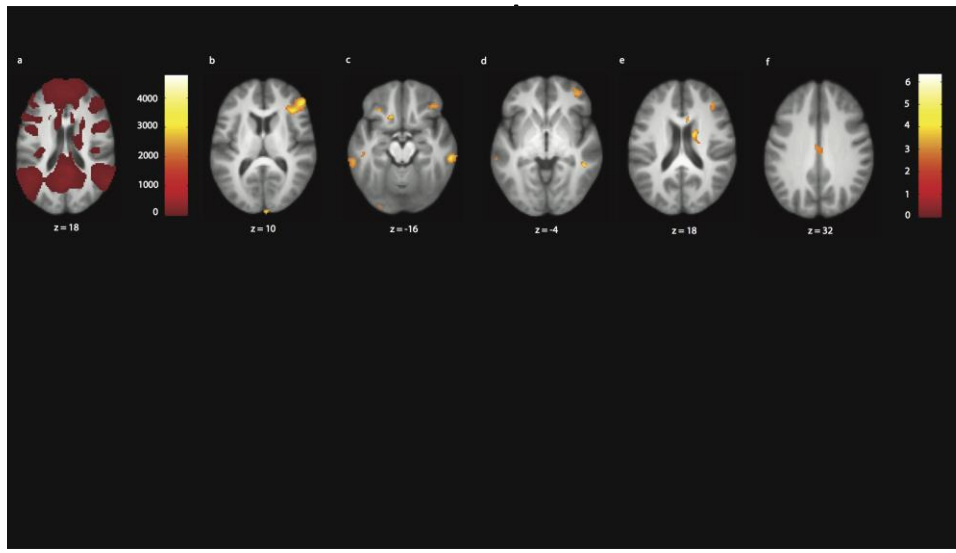
RFCBT in adolescents with history of depression (residual symptoms) n = 33, individual RFCBT vs assessment only

Observer rated depression (CDRS-R)



Treatment-by-time trend F = -1.44, df = 32, 95% CI: -3.04 - 0.17, trend
Jacobs, Watkins, Peters, Feldhaus, Barba, Carbray, & Langenecker (2016) PLOS ONE

Reduced DMN, and DMN to CCN connectivity in RFCBT group over 8



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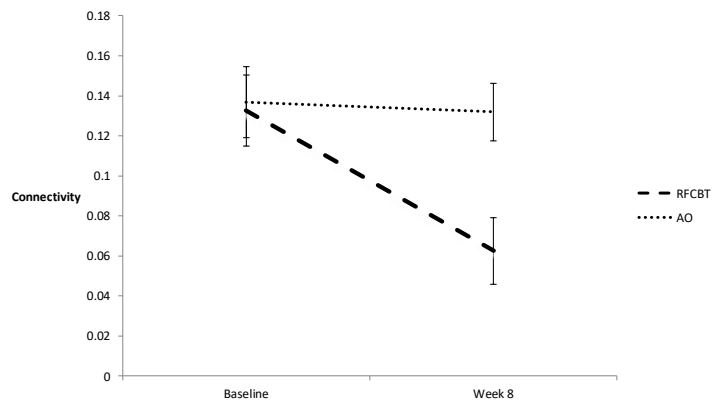
Change in connectivity between left PCC and right ITG

Rumination (RRS)



Correlated with change in RADS r = .69, $p < .01$ and change in RRS r = .48, $p = .03$

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Evidence for RFCBT

2. Prevention of depression and anxiety in high risk groups

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RFCBT – "MindReSolve"

Develop internet-based treatment to address treatment gap, increase coverage, volume, and convenience of treatments https://mindresolve.minddistrict.co.uk/

Examine RFCBT as primary prevention for depression – rumination in adolescence risk factor for depression, logical to target before depression

Depression Prevention & Resilience Promotion interventions need to be widely available & high volume – value of internet delivery

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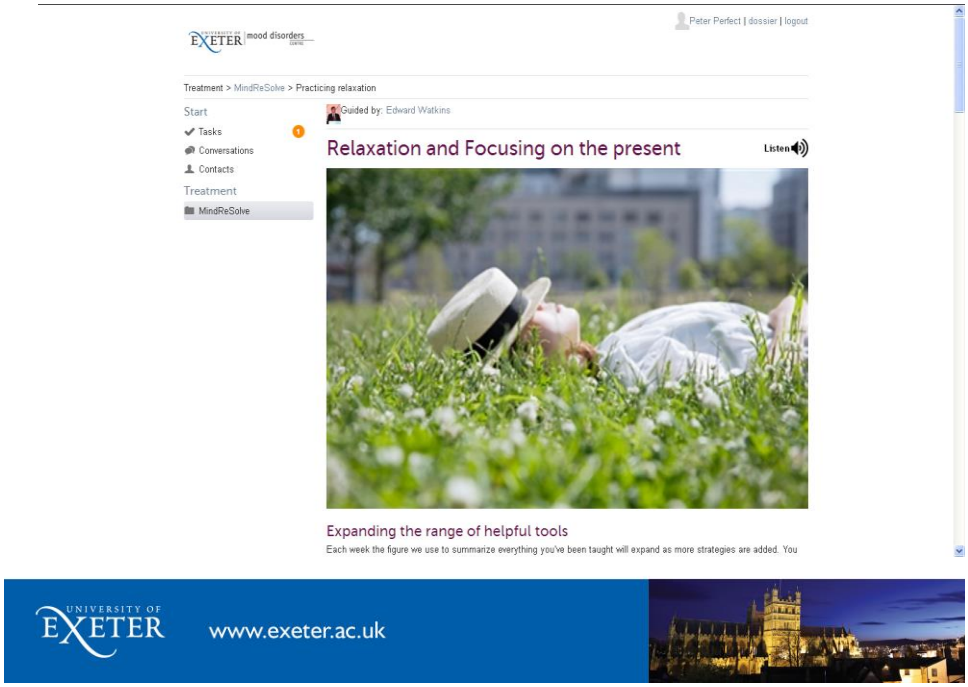
Peter Perfect | dossier | logout
mood disorders
Treatment > MindReSolve > Practicing relaxation
Start
Tasks
Conversations
Contacts
Treatment
MindReSolve
Guided by: Edward Watkins
Relaxation and Focusing on the present
Listen
Expanding the range of helpful tools
Each week the figure we use to summarize everything you've been taught will expand as more strategies are added. You

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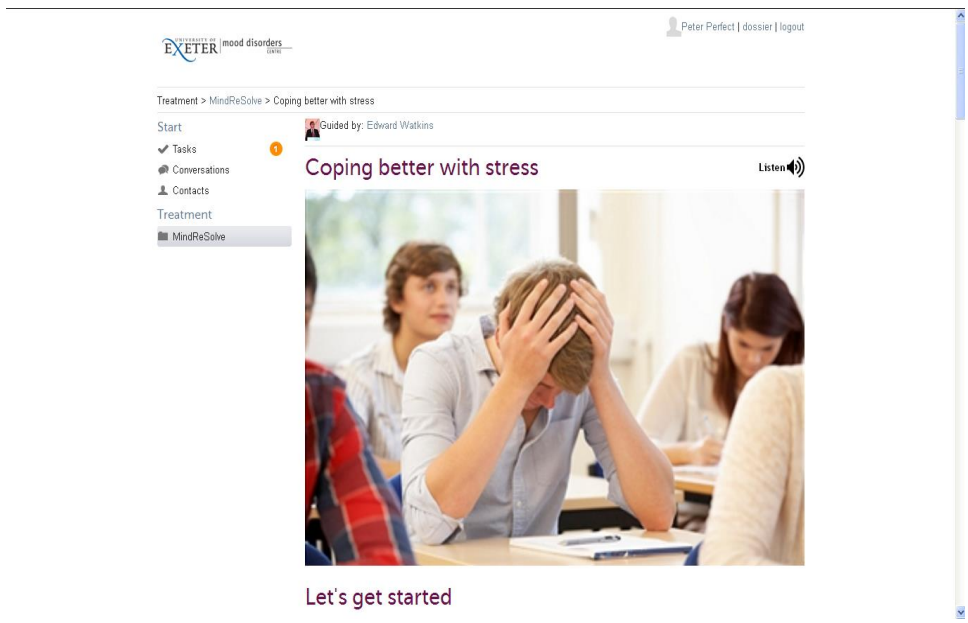
Peter Perfect | dossier | logout
mood disorders
Treatment > MindReSolve > Coping better with stress
Start
Tasks
Conversations
Contacts
Treatment
MindReSolve
Guided by: Edward Watkins
Coping better with stress
Listen
Let's get started


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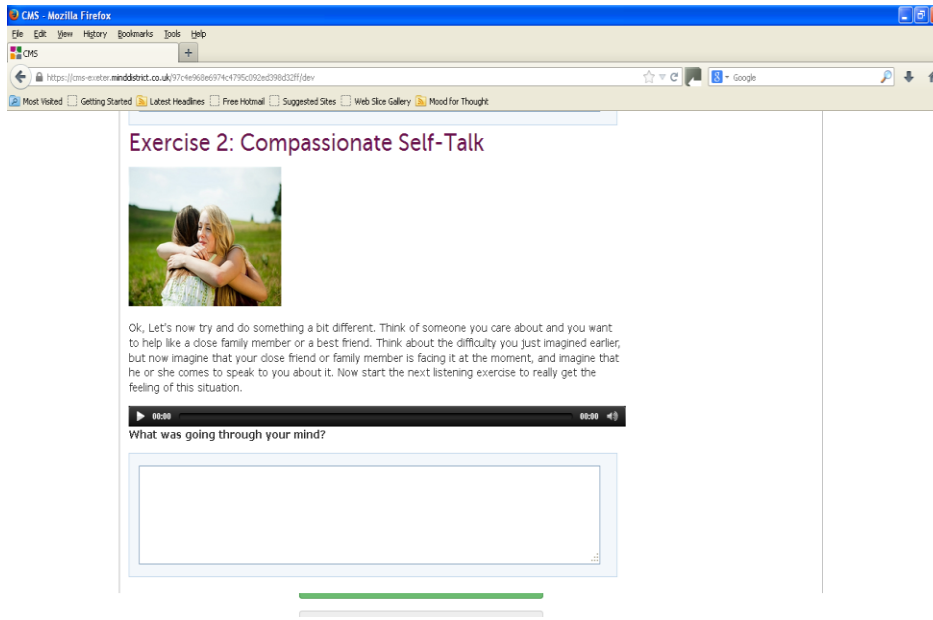

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Preventing depression & anxiety disorders by targeting excessive worry & rumination in adolescents & young adults.

Funder: ZonMw. PI: Ehring, Topper, Emmelkamp (Amsterdam/Muenster), Watkins (Exeter)

Sample: 254 x 15-19 yr old, 2nd school, university, Male & Female, Screened in top 1/4 worry (PSWQ) or rumination (RSQ) measures, no current clinical level symptoms
Design: Randomised controlled trial: internet RFCBT (online support) vs. group RFCBT vs. no treatment (n = 84 per cell)
Outcomes: Self-reported depression, anxiety, ED, substance abuse, worry, rumination, stress
Time points: Pre, post intervention, 3, 6, 12 month follow-up assessments

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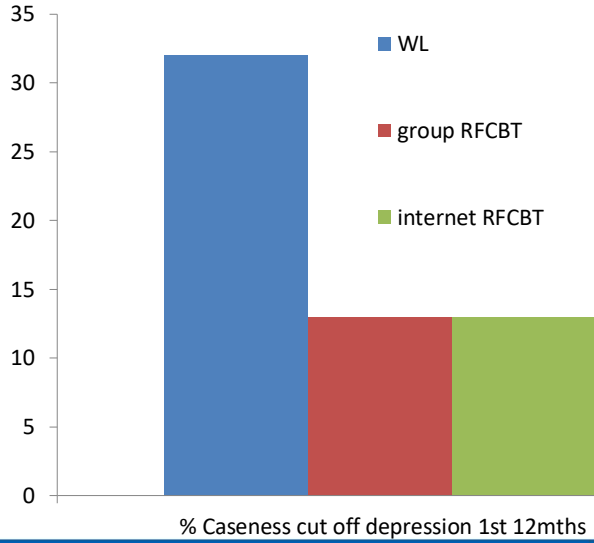
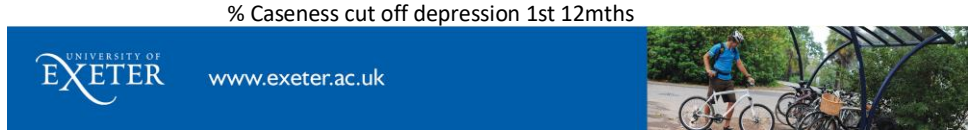
Caseness for depression based clinical thresholds



Incidence depression general population = 1.7% per year

INCIDENCE RATE RATIO (IRR) = 0.41

i-RFCBT reduces onset by >1/2 at 12 mth follow-up



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2. Preventing depression & anxiety disorders by targeting excessive worry & rumination in young adults.

Funder: PhD – Lorna Cook, Jenny Cadman, Ed Watkins (Exeter)

Sample: target 250 x 18-24 yr old, university, Male & Female, Screened in top 1/4 worry (PSWQ) or rumination (RSQ) measures, no current clinical level symptoms

Design: RCT: internet RFCBT (guided by PWP) vs. internet RFCBT (unguided) vs. no treatment, stratified by prior versus no previous MDE

Outcomes: Diagnostic interview for depression, Self-reported depression, anxiety, ED, substance abuse, worry, rumination, stress

Time points: Pre, post intervention, 6, 12 month follow-up

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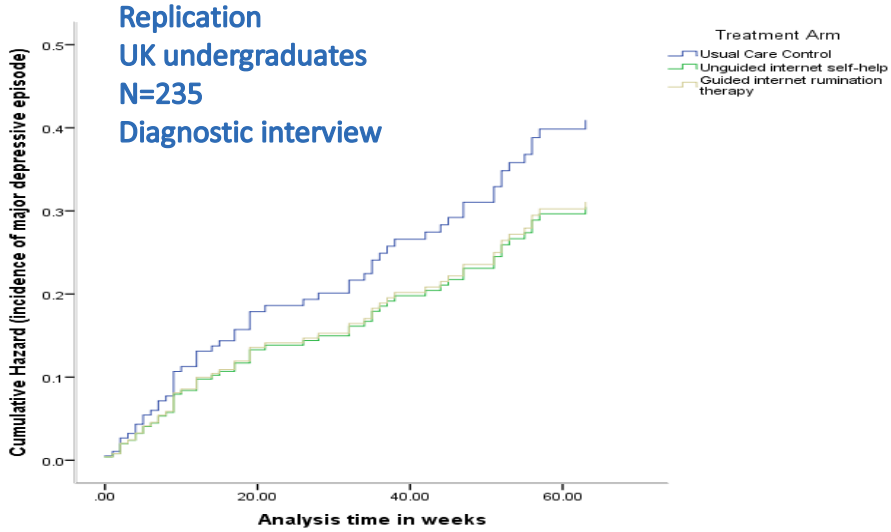
Cook & Watkins (2016) Trials
Replication
UK undergraduates
N=235
Diagnostic interview



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Evidence for RFCBT

3. Treating severe major depression

Hvenegaard, Watkins, Poulsen, Grafton & Moeller, in prep

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Does RFCBT outperform CBT for major depression?

- Two-arms randomized superiority trial, block randomization (random blocks, size 6-10)
- Power, N = 128 (Paykel et al., 1999; Watkins et al., 2011)
- Primary outcome: HRSD
- Secondary outcomes: HAM-D6, GAD-7, RRS
- Outcome assessors were blinded to treatment arm.
- Danish psychiatric outpatients with major depression
- Group RFCBT (11 X 2.5 hr) vs group classic CBT

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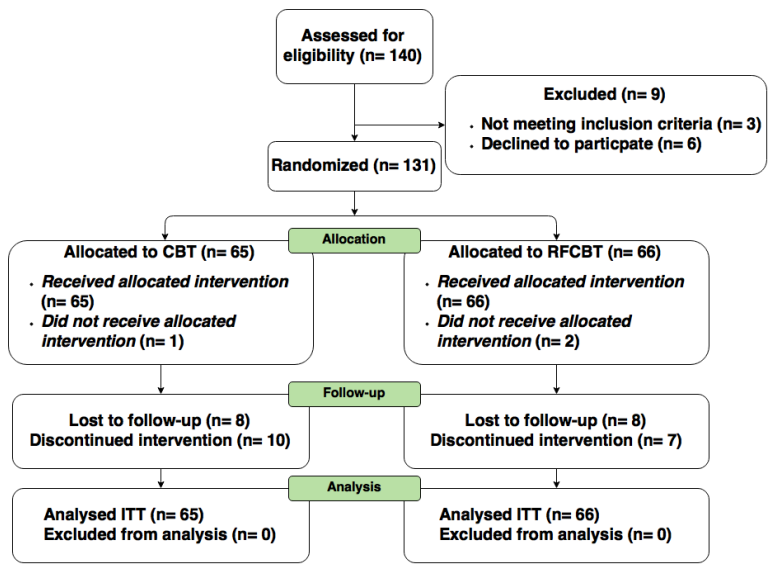

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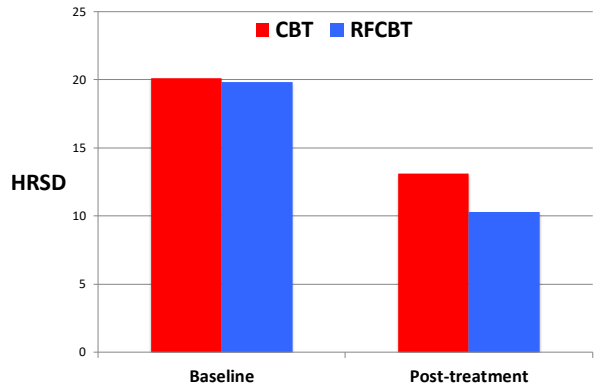

ITT- analysis	Baseline		Post-treatment		Adjusted difference (95% CI)	P-value
	CBT	RFCBT	CBT	RFCBT		
HRSD	20.1 (4.4)	19.8 (5.8)	13.1 (6.8)	10.2 (6.4)	2.7 (0.5 to 4.9)	0.015

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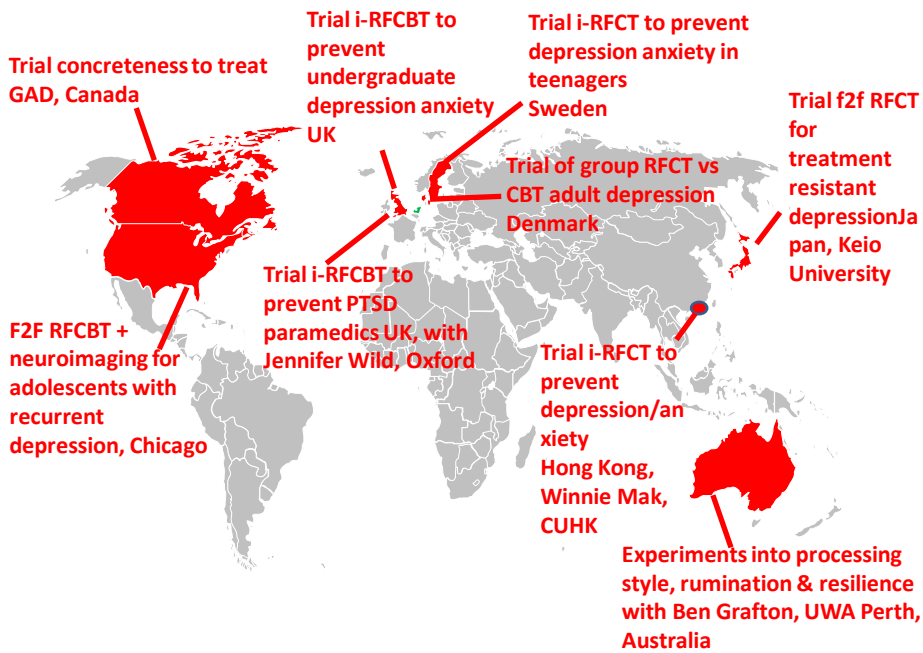

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