Cognitive Remediation and Emotion Skills Training

(CREST)

Inpatient pack-Part II (Recommended after CRT)

South London and Maudsley NHS Trust
& Institute of Psychiatry, Psychology and Neuroscience, King's College London

updated January 2021

This work was supported by the Psychiatry Research Trust, the NIHR Biomedical Research Centre for Mental Health, South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry, King's College London, and by an NIHR Programme Grant for Applied Research (Reference number RP-PG-0606-1043). The views expressed herein are not necessarily those of the NHS, NIHR or the Department of Health.

Contributors

Professor Kate Tchanturia PhD, Consultant (lead) Clinical Psychologist for the National Eating Disorders service at the Maudsley Hospital
Dr Claire Baillie, Senior Counselling Psychologist for inpatient treatment programme
Dr Clare McFie, Counselling Psychologist for inpatient treatment programme

We are grateful to our Clinical team:

Dr Victoria Mountford, Principal Clinical Psychologist
Dr Amy Brown Senior, Clinical Psychologist
Dr Caroline Fleming, Counselling Psychologist
Dr Claire Money, Counselling Psychologist
Dr Amy Harrison PhD, Chartered Clinical Psychologist

Past members of the Research team:

Dr Helen Davies, PhD, DClinPsych
Emma Smith, Psychology Research Assistant
Rebecca Genders, Psychology Research Assistant

This is the fourth and most up to date version of the CREST manual.
In light of the current research we are aiming to add experiential exercises to complement this clinician manual with activities to improve emotion expression and social interaction.
Please use this manual only after contacting us:

Kate.Tchanturia@kcl.ac.uk

Institute of Psychiatry, Psychology & Neuroscience
Psychological Medicine

Section of Eating Disorders

Kate Tchanturia
Professor in Psychology of Eating Disorders

16 De Crespigny Park
Box PO59
Denmark Hill
London SE5 8AF
Tel +44(0)20 78480134
Fax +44(0)20 7848 0182
Kate.tchanturia@kcl.ac.uk

Contents

Introduction

What is the CREST Manual?
This manual contains structured modules. There are 5 key modules and a further 2 optional modules which can be used to individualise the therapy to specific patient needs. The therapy can usually be completed within 8 to 10 sessions.

The aim of this module is to help patients to recognise and tolerate emotions and incorporate the skills learnt in the therapy sessions to everyday life. This is conducted through the use of psychoeducation, visual material, simple exercises and homework. It is intended to be a collaborative exploration of the patient's thinking and emotional processing styles, giving the patient basic language and skills to understand, manage and express their emotions. A useful motto for this approach is 'managing the negative to get to the positive,' hence a strong emphasis on seeking out and holding onto positive emotions while exploring experiences of negative emotions.

The manual is based on scientific research evidence. Please see Appendix 3 for more detail on the supporting evidence and how the manual was refined following a series of research projects within our department.

When should this intervention be introduced?
This intervention could be introduced to the patient immediately after admission to an inpatient unit and can be offered irrespective of other interventions they are undergoing. The simple educational, playful, and concrete style of the therapy can serve as a good starting point to develop rapport and gently prepare patients for further psychological work.

How should this manual be used?
Each of the sessions typically last between 30 and 45 minutes. **Patients differ** in their style and pace when completing the exercises as well as their motivation to work through the material. Therefore, the **therapist will need to be flexible** and creative whilst still trying to work closely within the structure and overall aims of the manual.

The manual is a **guide** for thinking about emotional processing. For some patients, there will be greater emphasis on the exercises and less on reflection; whereas for others, there will be less focus on the exercises and more reflection. The pace of the sessions can greatly depend on individual differences and the physical and psychological status of the patient. Thus, not all the exercises in each session have to be worked through and the length of sessions will also differ, depending on the individual. The amount of engagement with homework tasks can also vary, thus the differing amounts of time spent on reflection on homework should be taken into account. Some modules will also be more or less relevant for different patients, the therapy can be individualised by spending more time on the modules which address the patients current areas of difficulty e.g. some patients have no idea how to identify when they are having an emotion and others will be able to do this but have no idea how to manage how they feel. We have included a list of all exercises in Appendix 2.1 to help keep track of which exercises have been covered in which session.

HOWEVER, please note that the flexible use of this manual is only permissible when working in a clinical context. When using CREST for research purposes the manual protocol must be adhered to.

As you will see, the intervention is not illness or symptom related. The manual was intentionally designed to **broaden the patient's perspective** of their current situation and focus on **everyday** emotional skills. This manual is largely informed by focus groups involving patients, clinicians and carers; up to date research findings from our research team; and, of course, clinical observations based on experiences of using the outpatient manual 'MANTRA' (Maudsley Model of Anorexia Nervosa Treatment for Adults). The CREST manual also incorporates patient feedback, including areas of difficulty they have shared with us. Please see the reference list provided at the end of the manual for further information on these various sources.

Please note: if the patient has not completed Cognitive Remediation Therapy (CRT) prior to starting this manual based psychological intervention, it may be helpful to start from optional module 5 of this manual, which covers thinking about thinking. Even if the patient has previous, historical experience of CRT, it may be beneficial to cover this material as a reminder of the work completed. We also know from the work we have done for patients with autism spectrum conditions (ASC) and anorexia nervosa (AN) comorbidity that the exercises provided in the optional module 5. "Thinking about thinking" and module 6. "Recognising and interpreting other people's emotions", can be helpful to support autistic people with an eating disorder. On the other hand if there is a limited number of sessions and emotional regulation is the key difficulty it is acceptable to start from Module 1 "Thinking about emotions".

Foundation sessions

These sessions will begin by linking the patients' cognitive style to basic emotional processing and then move through 4 modules related to different aspects of emotional processing. The exercises are used as platforms for discussion rather than to be practiced repeatedly.

Homework is introduced in the first session to encourage practicing flexibility, bigger picture thinking and various emotional skills.

Therapist Style

- Predominantly, the therapist's stance in delivering this module is to be **interested** and **curious** about the patient's experiences whilst working through the exercises and discovering how these reflect real life situations.
- Secondly, the therapist should guide the discussions and tasks towards **positivity**, shifting away from the patient's automatic negative bias. Remember: always end a session on a positive!
- Thirdly, it is important that the focus is on **collaboration** ('doing with') where both therapist and patient are engaging in the tasks and reflecting together on these. Try to establish some shared goals in the first couple of sessions as this can help keep the work focussed and therefore more effective.
- Fourthly, be **motivational**, drawing on skills and strengths that the patient already possesses, as well as **congratulating** any attempts to change or try something new within, or outside of sessions, however small.
- Fifth, the therapist should encourage and model **flexibility**. It is important to make the patient aware that the manual and sessions can be tailored to their needs. For example, some patients might like to practice a particular skill from a previous session which should be encouraged as a homework task whilst moving through future sessions. Similarly, certain sessions can be extended if the therapist thinks this will be beneficial to the patient, e.g. taking two sessions to cover the Thinking about Thinking theme if your patient has no prior experience of CRT. Shared goals can help you both decide which themes to focus on the most.

- Finally, it is desirable to be **creative** and, particularly in the initial sessions, to provide a **playful** environment where exercises are viewed as fun and easy to experiment with. Embarking on a new type of therapeutic intervention can be daunting for patients, so therapists should aim to be **transparent** and **reassuring** about the process and what we are hoping to achieve within the ten sessions.

Core Module 1

Thinking about emotions

Session 1

Thinking style summary

a) Start the session by reflecting on thinking styles and what the patient has learnt about their thinking styles either from previous therapies or the Thinking about Thinking Theme if you started with this (CRT).

b) If you started with "Thinking about thinking", reflect on the homework from this module. Hopefully this will enable the patient to reflect on any difficulties they had and start making the link between thinking styles and emotion in everyday life. In particular, encourage the patient to think about how it *felt* to challenge themselves in this way.

Therapist Tip: Try to link **thinking styles** with **emotion** if this is relevant to the individual. For example: one patient reported that she becomes overly detailed in her approach to tasks when she experiences performance pressure and we identified how anxiety impacts on her flexibility in thinking. We reflected at the beginning of the emotion work that this was a good example of how thoughts and feelings are related.

You could also explain that having an increased awareness of our thinking styles can be very helpful because we are in a position to explore whether our current thinking styles are helpful or unhelpful and without this awareness we would find it very difficult to make any changes. Remind the patient that it is not about having a 'right' or 'wrong' thinking style, but about reflecting on the range of thinking styles available when they approach everyday tasks.

Session 1: Linking thinking and feeling

Linking thinking and feeling

"So, we have learnt something about how you think about things in everyday life and we have also discussed how our emotions can affect the way we approach things. The next part of this intervention is going to focus on how emotions and thinking are linked."

See Appendix 1 for further information that may be helpful to discuss at this point.

Exercise 1: Emotion word sorting

Materials required: – emotion word cards (cards with positive and negative words written on them).

Aim:
The aim of this task is to see if patients

- Can differentiate between positive and negative emotion words
- Find it difficult to discriminate between these two groups of emotions
- Notice that either positive or negative emotion words are easier/harder to differentiate

Instructions
Start by tipping all of the words onto the table. You can say something along the lines of:

> *"As you can see, we have many words to describe different emotions. We're going to do an exercise to begin to see what words we recognise when describing emotions. I'd like you to start by finding 'positive' emotion words and, when I say switch, move to finding 'negative' emotion words. We'll switch a few times during this and the whole exercise will take about two minutes."*

When this has been done a few times, you can reflect on the task with the patient.

Reflections:

- Did you find the task easy or difficult?
- Was it easier to find one group of emotion words?
- Did they feel anything whilst doing the task?
- Do you notice anything?

***Therapist tip*:** it is important, from the outset, to explain that negative emotions are not bad, they are simply negative in relation to positive.

Negative bias? Do you wear gloomy spectacles?

"If you have found it easier to find words for negative emotions this might indicate a negative bias is operating. This means, without meaning to, you are drawn to notice negative emotions and experiences more than positive ones. It is like wearing gloomy spectacles which filter out positives and amplify negatives."

Patient reflection question: What impact do you think this would have on someone's mood over time? "*In a later session, we will look at some strategies from positive psychology which can help balance a negative bias.*"

Exercise 2: Emotions and thinking

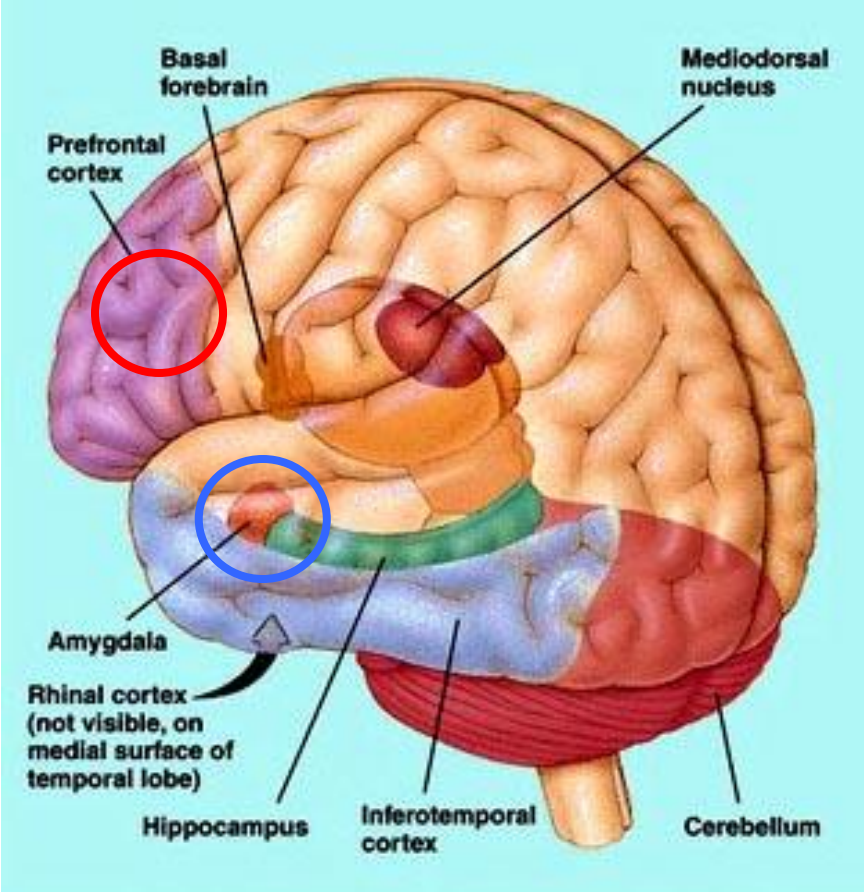
Aim:
The aim of this task is to explore and inform in a simple way how the cortex (cognitive part of the brain) and limbic system (affective part of the brain) interact with each other.

Instructions:
Read a précis of the following information for the patient whilst showing them the picture of the brain on the following page.

"This front part of our brain (circled in red) is responsible for our thinking and a different part of our brain called the Amygdala (circled in blue), is associated with emotional processing.

"Research shows that these different brain areas are responsible for thoughts and feelings; however, they are also connected and inform each other. So, for example when we face danger, such as a snake, we might feel scared, run and only afterwards think why we did it.

"Research has shown that by labelling our emotions, activity in the emotion centre of our brain (the amygdala) is reduced. When we can identify and label the emotion using the thinking part (point to prefrontal cortex) the emotion part (amygdala) doesn't have to work so hard. If activation is stuck in the emotion part of the brain, we can't do anything with it. But if we bring it into the thinking part of the brain, we can process it and do something about it."



"Ideas from Compassionate Mind Therapy teach us that if we shout at the emotional part of ourselves or criticise it, it gets more emotional. What it needs from us is curiosity, acceptance and comfort, just like we would offer to a frightened young child or animal. Our emotional mind is a lot like a young person/animal, it is not sophisticated, and it does not think about things, it just reacts to them. Our emotional mind needs our thinking mind to be compassionate towards it and help it out!"

Patient reflection question:

- How does your thinking mind talk to your emotional mind at the moment?

Exercise 3: Emotional Processing Cycle

Use this exercise to consider the process of how emotions and thinking are linked further using the flow diagram below.

Aim:
This part is also educational and further extends learning of how the cortex and the limbic system work together to produce an emotional response. It also demonstrates how different people can have **different responses** to incoming information, that **no response is right or wrong**, and that we can have **mixed responses** in any one situation. (We have sometimes found it useful to highlight that there are parts of the cycle where it is easier to make adaptations, e.g. how different thoughts about the same event can lead to different feelings – blame bus driver >anger; blame self> fear/guilt; but there are parts that happen more quickly and instinctively which we have less control over e.g. jumping out of the way of the bus.)

The following information is provided for the therapist with no expectation to turn the session into didactic teaching. You may find it useful to share the information with your patient before looking at the emotional processing cycle:

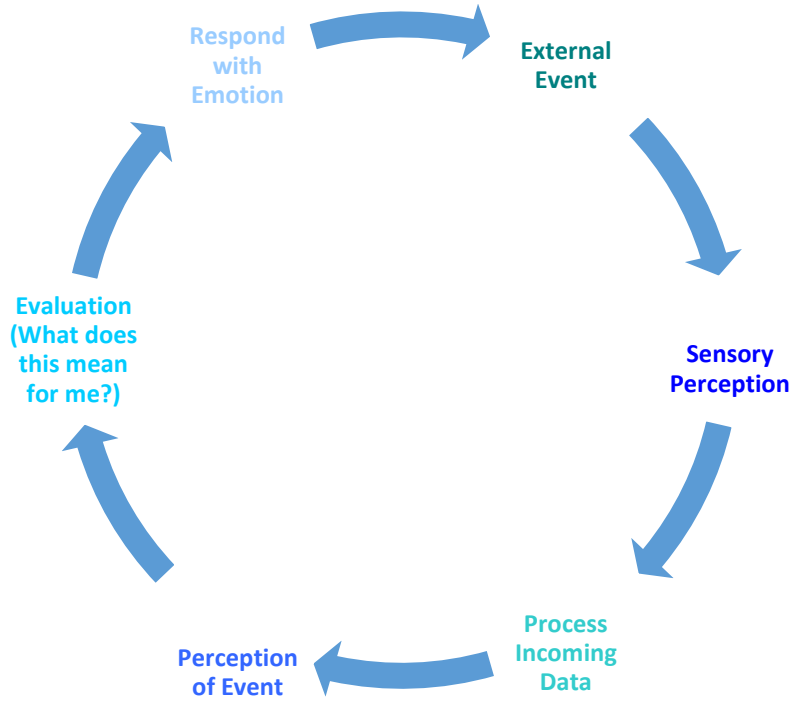
"When we experience an emotion, such as fear or happiness, this is the end result of a complex series of processes, usually starting with an external triggering event. Our senses (sight, sound, touch, taste, smell) relay this data to various parts of our brain where we interpret the incoming information and form an impression or perception of the event. Depending on what information we receive and the perception of it that we form, we make an evaluation or judgement concerning the meaning of this event. Once we have established what the event means for us, we then start to generate an emotion in response to the situation."

Instructions:
Use the diagram below and the following scenario as an example of how the cycle, from external event to response of emotion, can work. (N.B. It is worth checking if patient has experienced a road traffic accident before using this example.)

"Imagine you are walking across a zebra crossing and, suddenly, a bus comes hurtling towards you and does not look as though it is going to stop. What do you do?"

Go through the flow diagram to show how we process information from the environment.

Emotional Processing Cycle



Emotional Processing Cycle: Additional exercise to embed connection between thoughts and emotions

Reflections:

"We have little or no control over how our senses work and how our brain processes data but we do have some control over how we perceive events and evaluate what they mean to us. This means we only have influence over the latter stages of the processing cycle. The kinds of evaluations we make are heavily influenced by our previous experiences and our evaluations impact the kinds of emotional responses we experience. This helps us understand why different people can have very different responses to the same event.

Now let's try to identify a few different evaluations people might make and which emotions they might experience as a result. So, let's imagine the person has made it safely to the other side of the road. What different kind of thoughts might go through their mind and what different kinds of emotions might these lead to? For example, someone who evaluates/thinks that they had a lucky escape and are safe might experience the emotion of relief."

e.g. *I can't even cross a road safely on my own > fear/anxiety*
That bus driver is an idiot, they should have been paying attention! > anger
Phew, that was close! > relief

Exercise 4: Emotions and our bodies

Aim:

This part is about informing the patient about the physiological sensations associated with emotions. The aims are to introduce how the body is involved in producing emotions and that listening to our bodily sensations can inform us about our emotions. This is important to integrate the brain and body and to recognise that they are not functioning separately.

The therapist can also use this opportunity to reassure the patient that emotions and the associated bodily sensations are not to be feared; they are helping us to understand ourselves and our world. We need them for survival and it is perfectly normal to experience different emotions in different ways.

Instructions:

Explain to the patient that bodily sensations are crucial in helping us to understand what's going on around us and provides us with vital clues and indicators as to the emotion we are experiencing.

Ask the patient to think about times when they have noticed bodily sensations. For example, when they are feeling anxious, nervous, panicky, distressed or worried, do they notice where they experience this in their body? If the patient is finding it difficult to come up with anything suggest everyday examples including: before an exam, during a driving test, doing a presentation etc.

Using the 'body and emotions diagram' choose a particular emotion, i.e. anxiety, and with the patient discuss and write down what effects the emotion has on different parts of the body. If there is time you could also complete another diagram with an opposite emotion such as calm, relaxed.

Reflections:

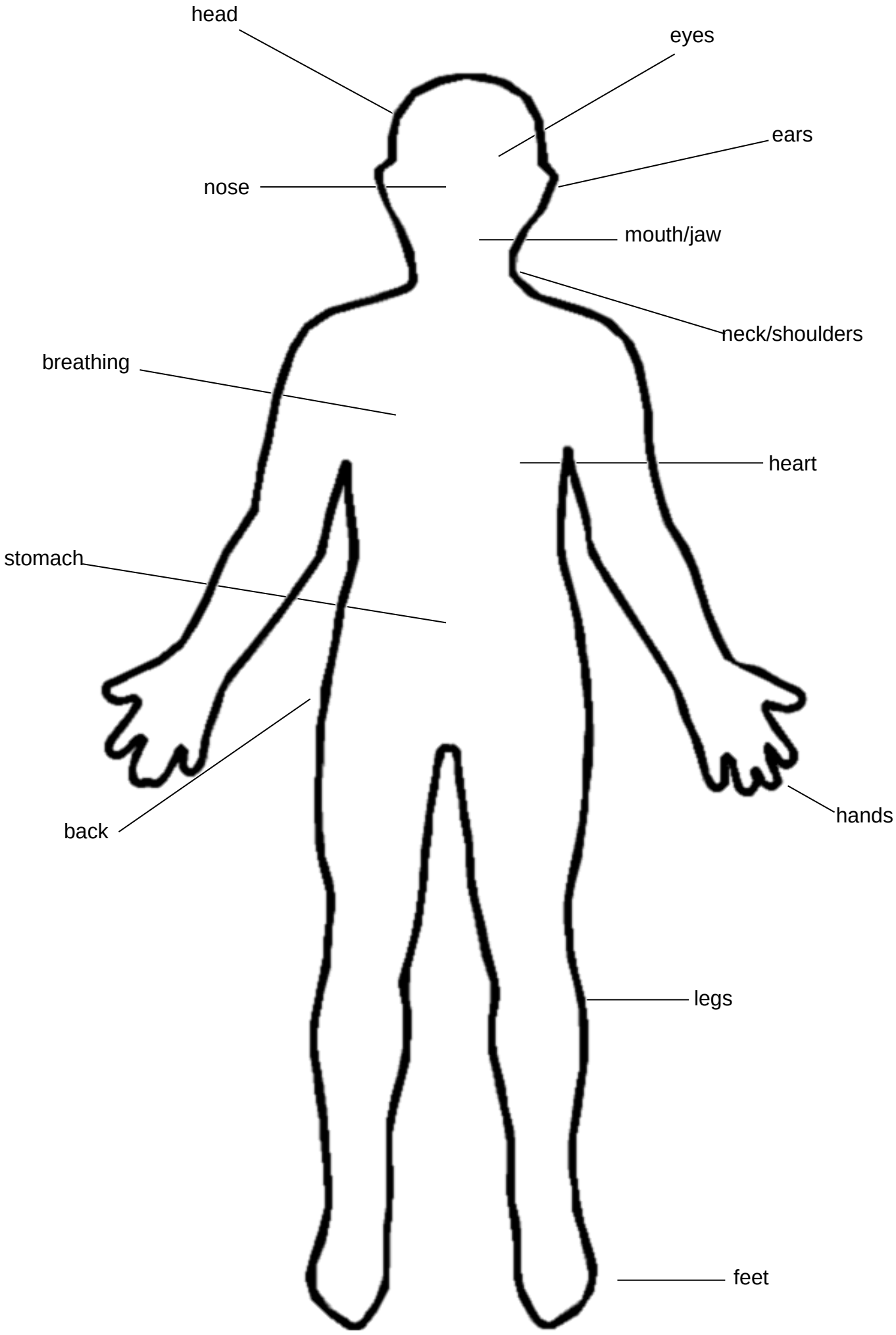
- If you think about your day to day life is it difficult to link bodily sensations with emotions?
- Do you listen to your bodily sensations?
- Do you notice that your bodily sensations differ depending on how you are feeling, where you are, what you are doing?
- How does it feel to experience bodily sensations, is it pleasant or unpleasant?

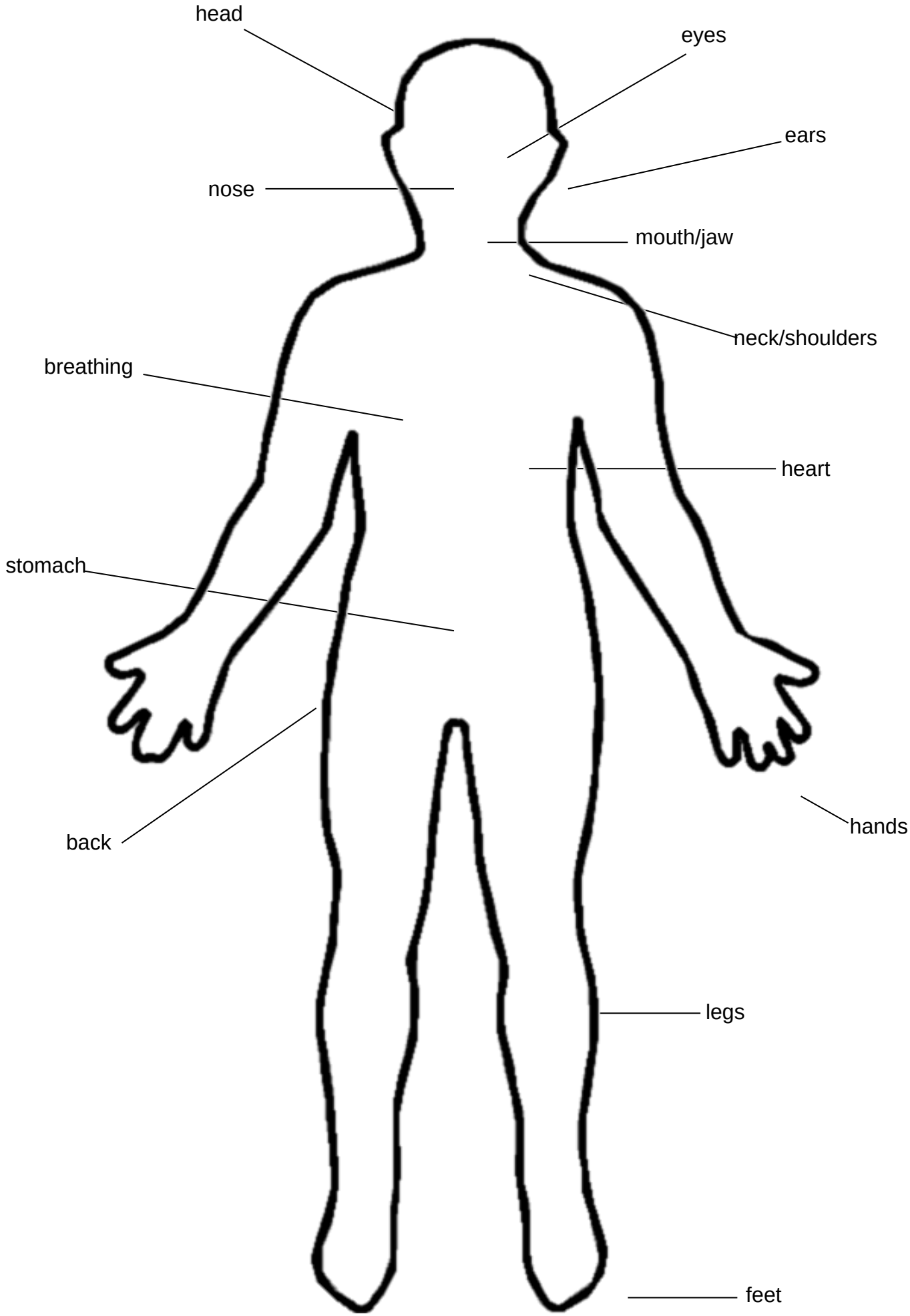
Discuss the body's arousal system in terms of 'positive' and 'negative' emotions (i.e. negative emotions are not bad, they are just saying something about our environment or internal state).

If this is an area of particular difficulty you can offer to use the body diagrams to help the patient explore:

- An emotion they find easy to identify and one they might struggle to recognise if they felt it
- Two emotions they might struggle to differentiate between e.g. anxiety and excitement
- Always end by focussing on a positive emotion!

Therapist tip: describe also how **you** experience this emotion physiologically in the body and notice both similar and differing sensations to the patient, thereby acknowledging that people can experience emotions in different ways and that there is no right or wrong in this.


head
eyes
ears
nose
mouth/jaw
neck/shoulders
breathing
heart
stomach
hands
back
legs
feet


head
eyes
ears
nose
mouth/jaw
neck/shoulders
breathing
heart
stomach
back
hands
legs
feet

Exercise 5: Emotion questionnaire

Aim:
The purpose of this questionnaire (on p.19) is to help increase the patient's awareness and understanding of their own thinking and emotional styles. By completing the questionnaire CREST will become more personalised to the patient as you can reflect with them after each session on whether there have been any changes in how they understand, approach or deal with emotions. The aim is that the patient will learn healthier ways of managing and expressing emotions.

Instructions:
Explain that the purpose of the emotion questionnaire is to help the patient gain a greater understanding and awareness of their current thinking and emotional style.

> *"This questionnaire outlines the themes that we will cover in CREST. This is based on evidence from research that these are areas that some people find difficult. You might find that some of these areas are a problem for you too. It is helpful for us to identify together what these are at the beginning of our sessions. We are then in a better position to help you think about other ways of understanding emotions."*

Complete the first two columns of the questionnaire with the patient.

Homework: Session 1

Instructions:
Ask the patient to fill in the third column of the questionnaire with examples of how the problem does or does not manifest in day-to-day life.

Prompts for the CREST questionnaire

These are aspects of emotional processing that we are going to be focussing on over the next sessions, so it will be useful at this early stage to explore and reflect on aspects of this that you feel more confident in and areas that may be more problematic or challenging that we can focus more fully on.

1. We have completed some exercises focused on thinking about thinking in our first session(s). Do you think you are more aware of your thinking styles? Can you tell me a little more of what you have learned? Are there ways you can continue to make small changes in your day to day routine?
2. We have been considering the theme of 'thinking about feeling in this session. Let's summarise what we have learned. (Explore together whether this is an area of difficulty, what makes it so and the impact it may have on daily life).
3. We will be moving on to explore the power of positive emotions, and focusing on exercises that will support you in working toward a more positive bias. Do you think this is an area of emotional processing that will be important for you to explore? How much do you think this impacts on your day to day experience?
4. We will then be moving forward to explore emotion management, focussing on recognising, expressing your emotions to yourself and others. What are your immediate thoughts when you consider your relationship to your emotional experience? Is it straightforward or quite challenging to recognise, manage and express your emotions? Are certain emotions more or less acceptable to you? What impact does this have on your day to day experience?
5. Finally, we will be doing exercises focused on recognising emotions in others. Thinking about this now, what do you think helps you in identifying others' feelings? Does this impact on your daily life?
6. For homework, it will be really helpful to explore this further, and reflect on specific examples from your daily life. This will help in gaining greater awareness of how this impacts on you personally, and can help inform our later sessions.

***Therapist note*:** please retain a copy of the questionnaire and keep with the patient's records as part of the ongoing manual evaluation.

CREST QUESTIONNAIRE **Your thinking and emotional style:**	**Problem for you? Y/N**	**How much does this interfere in your day-to-day life?** **(0 = Not at all, 10 = Extremely)**	**Give a recent example of how this problem manifests itself**
Thinking about emotions			
Recognising your own emotions			
Thinking positively			
Managing your emotions			
Expressing your emotions and communicating positively			
Thinking about thinking			
Recognising and interpreting others' emotions			
Evaluation and summary			

Core Module 2

Recognising your emotions & focusing on positives

Session 2

Reflect on homework

At the beginning of the session spend some time going over the 'emotion questionnaire' that the patient has completed for homework. Explain that throughout CREST you will be revisiting the questionnaire as the hope is that there will be some changes in awareness and understanding of emotion acceptance, management and expression by the time they have completed CREST. It may also help to reflect on the emphasis on 'problems' and 'negative emotions' and that sometimes we need help to recognise the opportunities to experience positive emotions.

Session 2: Identifying and describing emotions

Exercise 1: Emotion word list

Aims:

1.) To think about recognising specific emotions within ourselves in the here and now, making identifying and labelling emotions more relevant and personal to the patient.
2.) To provide the patient with a broader emotion vocabulary

Instructions:

"Researchers believe there to be six basic universal basic emotions:
JOY – DISTRESS – ANGER – FEAR – SURPRISE – DISGUST
There are also hundreds of other words that people use to describe how they're feeling. On this sheet are some of the many words that we can use to describe emotions. We will use this to think about emotions that you may be feeling. There may be some missing which we can add too.

"Our emotional states can seem like shapeless clouds of experience; by trying to label or name our experiences we start to give them some shape. Eugene Gendlin, an American philosopher, has written about a process called "focussing" where you pay attention to your emotional state and try different labels and descriptions until you sense a fit – it is as if there is a slight click into place when you find the label which resonates most."

Using the emotion word list overleaf, ask the patient to underline which words they are drawn to that reflect different feelings at different times. If the patient is comfortable to do so, they can describe how they are feeling now. If they find that too challenging, ask them to describe how they felt during a recent event. Encourage the patient to look out for the "click" or other body sense that the label fits their experience:

1) How do you/did you feel?

- What has drawn you to those particular words?
- Do you think these are more positive or negative emotions?

- What is it like to be able to share something of what you are feeling? (We include this as patients have disclosed that they can feel quite exposed and uncomfortable.)
- How does it feel in your body? (Use body and emotions diagram if needed to prompt patient.)
- Have you ever felt like this before?

2) How would you like to feel?

- Can you think of a time when you have felt like that before?
- How did that feel in your body?
- What is usually happening around you when you feel this way?

Reflections:

Ask the patient how it felt to do the task – was it hard? Why? Were they surprised by how many words we have to describe emotional experience?

Therapist tip: It can be useful to start every CREST session with a check in – how are you feeling today? This enables repeated practice at labelling here-and-now emotions. If labelling emotions is an area of particular difficulty, you can experiment with the patient choosing different ways to describe how they feel on different days e.g. using the emotion word list; describing mood as weather/music; trying spontaneously with no prompts.

- To keep it playful you might use these prompt questions:
  - What is today's weather report?
  - What soundtrack would be playing to fit your mood today?
- Remind and reassure patients that emotions do not come out easily in tidy sentences, so it is ok to stumble a bit or take a few goes to describe them.
- Encourage them to look for the sense of "clicking into place" when a description feels accurate.
- Repeat it back to them and ask for confirmation that it feels accurate. If not try to adapt it with them until a good enough fit is found.
- NB This also models non-judgemental curiosity towards emotions – what exactly is it that you are feeling?

Emotion word list

Abandoned, Abrasive, Accommodating, Adored, Affectionate, Afraid, Aggressive, Agreeable, Awkward, Alienated, Altruistic, Amused, Angry, Annoyed, Anxious, Avoidant

Betrayed, Bitter, Blessed, Bored, Bothered, Brave, Bursting, Blue, Belittled, Bad, Brilliant, Blamed, Blissful, Beautiful

Calm, Careless, Caring, Celebrating, Charming, Cheerful, Cherishing, Cold-blooded, Comfortable, Compassion, Competitive, Confused, Cool, Creative, Crucified, Crushed, Cheated, Controlled

Defensive, Delicate, Delighted, Depressed, Desirable, Discontented, Disgust, Distracted, Dull

Eager, Earnest, Easy, Enjoying, Enthusiastic, Excited, Euphoric, Energised, Elated, Effective, Energetic, Empowered, Empathic, Edgy, Embarrassed, Envious

Fascinated, Fear, Frustrated, Funny, Furious, Fearless, Fortunate, Fragile, Fidgety, Fulfilled

Giggly, Glad, Glee, Gloomy, Grateful, Guilty, Gentle

Happy, Hectic, Hilarious, Hopeful, Horrific, Humorous, Hurt, Heroic, Helpful, Hostile, Heartless, Hateful

Impressed, Impulsive, Inflexible, Insensitive, Inspired, Interested, Intimidated, Irritated, Incensed, Infuriated, Irate, Intelligent, Influential

Jealous, Jittery, Jolly, Jubilant, Joyful, Jumpy

Lively, Lonely, Lost, Loved, Lovely

Mad, Manic, Melancholic, Merry, Mindful, Miserable, Moved

Nervous, Numb

Optimistic, Overwhelmed, Out-of-control

Passionate, Passive, Panicky, Pleased, Proud, Petrified, Peaceful, Positive, Paralysed, Powerful, Pissed-off

Reckless, Refreshed, Romantic, Restless, Resistant, Ruthless, Resigned, Rejected, Receptive, Relaxed, Revitalised

Safe, Satisfied, Scared, Secure, Seduced, Selfish, Sentimental, Shamed, Shy, Strong, Self-reliant, Serene, Soothed, Sympathetic, Surprised, Shocked, Stressed

Tolerant, Tranquil, Troubled, Twitchy, Thrilled, Talented, Tender, Terrified, Tense, Threatened, Tentative, Tolerated

Uncomfortable, Unhappy, Understood, Unpopular

Victimised, Vulnerable, Vigorous, Vivacious, Vehement, Vindictive, Violent

Warm, Worried, Worthless, Wise, Worthy, Wild, Wanted

Exercise 2: Describing emotions

Aim:

The aim is to continue identifying and recognising emotions in ourselves by using new strategies. In particular, the focus of this exercise is to provide an alternative way of identifying and recognising difficult emotions with the use of a mental imagery exercise.

Instructions:

Return to the emotion list and ask the patient to pick out the most difficult emotion to recognise in themselves. This can then be further explored using the exercise below which looks at the emotion if it were an animal, colour and so on.

Continue to explore other emotions and identify with them using the following questions. Ensure that there is a focus on positive emotions as well as negative. (Reminder of the 10 positive emotions: **joy, gratitude, serenity, interest, hope, pride, amusement, inspiration, awe and love**)

If _____ were a type of weather, what would it be?

If _____ were an animal, what would it be?

If _____ were a colour, what would it be?

If _____ were a flower, what would it be?

If _____ were a sound, what would it be?

If _____ were a pop song/piece of music, what would it be?

If _____ were a character from a fairy tale/book/movie, what would it be?

Going back to the emotion list, pick out the most pleasant emotions – how they would like to be feeling. Again, use the exercise comparing to animal, etc. to explore this emotion

Reflections:

- Do you find some emotions easier to recognise than others? Which were they?
- Are there some emotions you feel more often than others? Which are they?
- Think of an emotion. What is it that makes it easy/difficult to recognise?
- Can you distinguish between emotions?
- What strategies could you use to help you recognise emotions?

> ***Therapist tip*:** always try to end with focus on a positive emotion as this provides a reminder that we want to manage the negative to get into the positive.

Exercise 3: Switching scenarios

Aim:
The aim of the following task is to encourage the patient to see emotions as transient and temporary.

Instructions:
Ask the patient to imagine a scenario and really try to explore the emotions that may arise; how we may be thinking, what are our emotional responses, and how is this experienced in our bodies? It is up to the therapist to judge whether the patient will be ready to engage fully, imagining themselves in the scenario, or whether they would prefer to think about a character and how this person would experience the scenario. Read through the following scenarios together.

> ***Therapist tip*:** The task can also be used to model the ability to find positives in any situation, for example using the 3:1 positivity ratio (see page 37) and/or to model a range of emotions as normal with both patient and therapist naming how they might feel at each reflection point.

Now, first let's imagine we are out for the afternoon. We're in a park and it's summer time. The sun is shining brightly and there are just a few wispy clouds in the sky which create a very gentle breeze like a fan. We're lying under a shady tree and just listening to the sounds around us. There are some birds singing. We can hear the gentle rustle of leaves in the trees and there is a small stream nearby so there's the gentle trickle of water going over pebbles. The warmth of the sun is pleasantly caressing our skin and there is the faint scent of freshly cut grass in the air.

Reflections:
- What thoughts are going through your mind?
- What are you feeling?
- What do you notice about your facial expression?
- What do you notice in your body?
- Is it a familiar feeling?
- Is it easy of difficult to feel like this?

Suddenly and quite dramatically the winds picks up and dark, threatening clouds move in. We hear the distant rumble of thunder and realise we need to move quickly. We're in thin summer clothes and start to feel cold as we pack up our things as quickly as possible and start running to find shelter. We are only half-way across the park when the heavens open and the rain begins to pour down, completely drenching us.

Reflections:
- What thoughts are going through your mind?
- What are you feeling?
- What do you notice about your facial expression?
- What do you notice in your body?
- Is it a familiar feeling?
- Is it easy of difficult to feel like this?

We keep moving, freezing cold now. There is so much surface water that the roads are quickly becoming flooded. The traffic is starting to build up and people are angrily blasting their horns to get each other to move more quickly. As we are making our way toward the bus stop, somebody purposely swerves their car, thinking it would be funny to drench us further. We are completely soaked by a wave of water and we can see the person and their friends laughing in their car, giving each other a high five to have 'got' us.

Reflections:

- What thoughts are going through your mind?
- What are you feeling?
- What do you notice about your facial expression?
- What do you notice in your body?
- Is it a familiar feeling?
- Is it easy of difficult to feel like this?

We are now freezing cold and soaking wet. There is water cascading down from our heads to our toes and our shoes are sodden, slowing us down. We can see our bus pulling into the stop just ahead of us and run, waving our arms for it to wait for us. Just as we think we are going to make it; the bus pulls off and we see it disappearing into the traffic. We are now stranded, no umbrella, no means of getting dry and warm.

Reflections:

- What thoughts are going through your mind?
- What are you feeling?
- What do you notice about your facial expression?
- What do you notice in your body?
- Is it a familiar feeling?
- Is it easy of difficult to feel like this?

We are shivering and our teeth are chattering and must look a right sight, standing there in thin summer clothes and getting wetter by the second, people laughing and waving at us as they go past in their cars. Then, suddenly, a car pulls up. It's one of our friends who knew our plans for the day and thought she'd drive by on the off chance, knowing we wouldn't be prepared for the sudden storm. She gets us into the car, where she has brought warm towels, and drives us home. Once we are home, we run a long hot bath with some scented bubbles and relax into it. After, we put on some cosy, warm, dry clothes, sink into our favourite sofa with a big duvet and put on our favourite movie.

Reflections:

- What thoughts are going through your mind?
- What are you feeling?
- What do you notice about your facial expression?
- What do you notice in your body?
- Is it a familiar feeling?
- Is it easy of difficult to feel like this?

Exercise 4: Emotions Snap

Take a pack of emotions playing cards and play the game ‘snap’. Each player has half a pack of playing cards each holding the cards face down. Take it in turns to make a pile of cards face up. When two cards are the same both players have to try to put their hand on the cards first, the winner being the one who manages this. When you make a snap, fully explore the emotion that has been landed on.

Reflections:
Is this a familiar emotion?
Can you recall a time when you experienced this emotion?
What kinds of situation cause this feeling?
How does it feel in your body?

Continue until you ‘snap’ on another emotion and fully explore this.

Homework: Session 2

The purpose of this homework is to assist the patient in increasing positive experiences in their life. The strategies described here and in the positivity handout can also be introduced as antidotes to a negative bias – to help achieve a more accurate perspective and prevent low mood persisting or being amplified. The homework is something which the patient can continue to do in their lives and is not just a one-off piece of work. With the patient, decide which of the following exercises they would like to do for homework.

Portfolio of positive emotions:
The aim is for the patient to collect positive images, metaphors, anecdotes and mottos, which they will log in their book. The portfolio helps in the process of shifting attention toward aspects of life that make them feel more positive.

Bank of positive experiences:
The bank of positive experiences (see worksheet below) is useful in helping the patient recognise that, even when they are feeling particularly negative, there are and have been positive experiences which will recur.

Three good things:
This is based on Martin Seligman's positive thinking research (e.g. "Authentic Happiness"). The idea is that if you if you can think about and reflect on positive things regularly, it can move you into a more positive mind state. The three good things exercise is especially useful for those who have a bias toward negative emotions, and so highlighting that even when 'having a bad day', there can be positives within this. Thus, this can make patients aware of this bias and also see that emotions can and do fluctuate, but that sometimes we may fail to pay attention to the positives.

Ask the patient to think of a good experience that has happened during the day. It can be as seemingly inconsequential as it needs to be. For example, it could be somebody smiling at them when they feel low. As they become more accustomed to finding one good thing it can be expanded up to three good things (see handout in Appendix 2.7).

> ***Therapist tip*:** this is a good opportunity to recommend that the patient have a notebook or journal to keep a record of the work they are doing in CREST and to keep information they are given.

In order to start preparing for the next session, also ask the patient to find a picture, drawing, piece of artwork of a favourite person, place or thing, indeed anything that makes them feel positive. Ask them to bring it to the next session. In order to work within the collaborative framework, the therapist can also contribute their own photo.

Bank of positive experiences

Finding ways of keeping hold of positives emotions is crucial. One way is a 'bank system' using the log book below. You may experience more positive experiences than you think…..

Day	Positive action or experience	New or unusual?	Tick each time that you revisit the positive feeling it gave you

Session 3

Reflect on homework:

Ask the patient to discuss what they did for homework and to reflect on what they noticed and learnt. Encourage them to continue to practice noticing when they have positive emotions and experiences.

Session 3: Finding and focusing on positive emotions

Aim of session:

1. To recognise and identify positives in everyday situations and in ourselves.
2. To provide the patient with a range of strategies that encourages them to notice and amplify positives, shifting from a tendency to focus on negatives.

> ***Therapist tip***: we found it useful to explain that positive people automatically look for positives in their environment and hold on to these, amplifying them and remembering them after the event. The patient needs to *learn* how to do this. The tasks and exercises help to shift focus onto the positives as well as showing what it feels like so we know what we are aiming for.

Instructions:

Discuss the positive psychology experiments/interventions described below with the patient. Explore which ones would be easier, which would be most helpful, which ones would they like to try. Use the taster tasks to break up the discussion.

The following text provides background information and supporting evidence from the positive psychology literature. Please use your own judgement as to whether it would be beneficial for your particular patient to share with them the scientific basis for the exercise in this session.

Positive Psychology: Pleasure from being with people and positive thinking

Read the following text, which forms an overview of the more detailed information on the following page:

"For many years, psychologists have studied the negative emotions which, of course, are vitally important. However, more recently, psychologists have also recognised the importance and power of positive emotions.

"For example, a simple experiment in which you are asked to remember something that made you feel happy during the past month, is an easy and effective way of positively influencing mood. Let's give it a try. Right now recall one good thing that has happened over the past month.

"Barbara Fredrickson, a researcher in positive psychology and author of very interesting books based on years of experiments, developed her Broaden and Build theory of positive emotions. The broadening effect of positive emotions relates to their ability to open our minds and help us to 'think outside the box', giving a bigger picture view of our current situation, enabling us to become more creative in finding solutions. Fredrickson highlights a list of ten important positive emotions: joy, gratitude, serenity, interest, hope, pride, amusement, inspiration, awe and love."

Try and recall a time when the patient has experienced one of these emotions. Discuss the experience with the patient in as much detail as they are able.

"Let's have a look at some other exercises from positive psychology."

***Therapist tip*:** the more detailed version on the following page can be provided as a handout for patients who are interested.

Studying positive emotions

For many years, clinical and experimental psychologists have studied negative emotions such as anger, sadness, fear, and disgust. All of these emotions are vitally important for survival, but positive emotions are as important and psychologists have begun to focus more on understanding and appreciating the power of positive emotions.

This work has been collected together under the field of Positive Psychology, a branch of psychology which focuses on strengths, resources, resilience, optimism and hope, rather than a deficit model of human experience. The most notable proponents of this field of psychology have been Martin Seligman, Mihaly Csikszentmihalyi and Barbara Fredrickson. For example, a simple experiment in which you are asked to remember something that made you feel happy during the past month is an easy and effective way of positively influencing mood. Mood relates to 'free-floating or objectless' experience that is 'long-lasting and occupies the background consciousness' (Fredrickson & Losada, 2005; p121), whereas emotions focus on a specific event (past, present or future), are shorter in duration and the individual experiencing the emotion tends to be acutely aware of it at the time (Peterson, 2006).

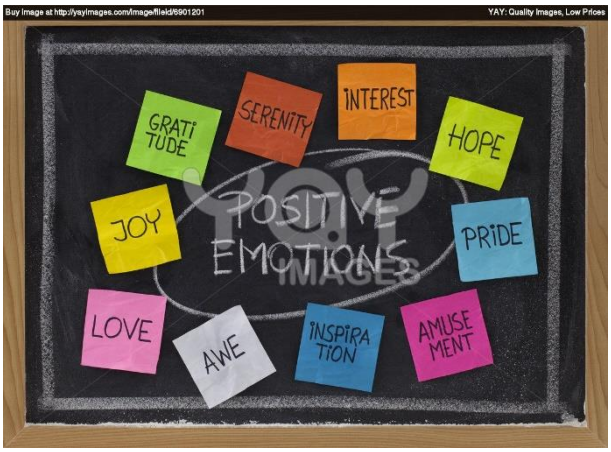
Based on many years of laboratory experiments, Professor Barbara Fredrickson (2001) developed her Broaden and Build theory of positive emotions. In summary, her work demonstrates that positive emotions broaden our thought-action repertoires, they can undo, or counteract negative emotions and they build resilience (Fredrickson, 2001; Cohn & Fredrickson, 2009). More specifically, the broadening effect of positive emotions relates to their capacity to open up our minds which helps us to 'think outside the box,' giving a bigger picture view of our current situation enabling us to become more creative at finding solutions.

Several experiments have shown that dwelling on positive emotions enhances performance in verbal creativity tasks. More specifically, the building effect relates to the capacity of positive emotions to build personal resources which can be accessed now or in the future. These include intellectual resources such as problem solving and openness to new learning, physical resources such as cardiovascular health and coordination, social resources such as the ability to maintain relationships and make new social connections, and psychological resources such as resilience, optimism, our sense of identity and our drive to achieve personal goals. As we develop these resources, they generate more positive emotional experiences and these positive emotions continue to build the resources further in an upward spiral. Some new evidence is emerging that demonstrates that positive emotions have the potential to build religious and spiritual resources as well as the other personal resources highlighted in the literature above (Saroglou et al., 2008).

Fredrickson's work has led to the development of a list of 10 important positive emotions. These are; **joy, gratitude, serenity, interest, hope, pride, amusement, inspiration, awe** and **love** (Fredrickson, 2009). Enhancing our experiences of these emotions can lead to greater psychological (and physical) **well-being**. Through CREST we would like to encourage thinking about and noticing positive emotions: "Think, be, do positive things…"

Empirical/experimental research shows that we can improve wellbeing by:
writing letters of gratitude, counting blessings, performing kind acts, cultivating strengths, visualising an ideal future, meditating (Lyubomirsky & Layous, 2013).

Focusing on positive emotions



Helpful Strategies:

1. Being mindful of positive experiences

Try just 'being' in your environment and notice its effect on your mood. This means trying to pay attention, non-judgementally, and purposely to your current surroundings. If you have ever tried mindfulness before, you can use your experience of learning how to do this. Research shows that being present in your environment helps you to focus your attention on what's around you, rather than ruminating, and this can lead to a positive emotional experience.

You could try paying attention to positive events/items/experiences during the day by keeping a positive event diary. At the end of each day, write down three positive things (no matter how small) that you saw, experienced, thought about or planned that day.

We have learnt that when we're feeling depressed, it is difficult, if not impossible to see the positives in life. However, with practice, by keeping a positive log, over time, you will train yourself to see more of the positives in life.

TASTER TASK... Complete with your therapist: Think of three good things that have happened to you in the past 24 hours and share them with each other. How does it feel to explore this?

We know that people can often have a glass 'half empty' approach, but there is lots of evidence to suggest that people who see the glass as 'half full' have healthier, happier, more successful, balanced lives and the positive event log is one way to practice experiencing the 'glass half full' approach to life.

The service users in our unit have developed a toolbox of simple pleasures and positive resources to remind them what they have available to them when they are experiencing negative emotions or negative mood states.

Simple pleasures
These include: smiles, personal treats (massage/facial/nails), reading a book, watching old films, losing yourself in a city, walking in the park, by a lake or river, or on the beach, watching ballet/dance, spicy food, candles, crafts, writing a wish list for travel, being with positive people, visiting museums, looking at photos, taking a bath, writing a diary, having a conversation, standing on grass with bare feet, people watching, card making, knitting, playing music or listening to it, company of people/animals, making jewellery, pottery, posters, art, glass painting, having a 5-minute time out.

This list was generated by patients in the Emotions Group and individuals are free to add their own ideas and resources to their own copy of this simple pleasures toolbox. They are also encouraged to share new ideas with the Group, where relevant. Having these positive strengths and activities written down is one way to access positive strengths and emotional states when your mood is so low that your problem-solving skills are reduced. There is a copy of the toolbox we have developed in Appendix 2.5.

2. Being with others

Spending time with others is an excellent way to boost positive emotions. This works especially well if you are sharing interesting and novel activities. This might mean you need to try a new hobby or go along to an event that you wouldn't normally try in order to share the experience with others there.

Kahneman et al., (2004) used an experience sampling method and asked people to write down what they were doing during the day and how much positive or negative emotion they were experiencing. The results indicated that people were happiest when they were doing activities that meant they were with others, and they were least happy when they were doing mundane activities on their own. This suggests that if you have the choice, it would be wise to choose an activity that means you are going to be spending time with others.

3. Favourite person exercise

Look at a picture of your favourite person, pet or place. Matsunaga et al., (2008) found that simply looking at our favourite person produced enhanced immune function, improved mood states, improved experience of positive emotion and the feeling of invigoration.

TASTER TASK... Share with your therapist the photograph or artwork of a favourite person, place or object and tell them a little about it. Your therapist will also share their image with you. If you forget to bring one, your therapist will ask you to tell them about what you would have brought with you and/or ask you to talk about someone or something which you really like.

4. Savouring

This means doing things or having thoughts that amplify and intensify positive experiences of any sort. This can be in the form of anticipation – looking forward to enjoying a future positive event; being in the moment – thinking and doing whatever intensifies and prolongs a positive event as it actually happens (for example, don't leave an enjoyable party or meeting if you are really enjoying it); and reminiscing – looking back at a positive event to experience and awaken the positive memories, thoughts and feelings from the event. Here are some ideas suggested by Bryant, (2004; 2005) whose research has shown that savouring offers heightened positive experience:

- sharing with others
- taking mental photographs to build positive memories
- congratulating yourself
- comparing your current experience with what you have felt in other circumstances
- sharpening your senses through concentration
- becoming absorbed in the moment
- expressing yourself through your behaviour, such as laughing out loud, shouting, putting your arms or fist into the air
- realising how fleeting and precarious an experience can be
- counting your blessings (writing a list of all the good things about you or in your life)

TASTER TASK... With your therapist, explore a positive memory together and really engage with what this felt like. What sensations did the patient experience in their body? Use the emotion word list to describe which emotions were present, which ones were most intense? Does talking about the memory bring back those same emotions?

5. Getting into the 'flow'

Do activities that are high on the following dimensions, i.e. activities that:

- are structured and have clear goals and immediate feedback
- have a balance of challenges and skills

- absorb your full attention
- make you lose track of time, requiring complete concentration where everything else but the activity is irrelevant at that moment in time
- give you a sense of control
- make you want to do the activity again just for the sake of doing it (not for any material reward it might give)
- provoke curiosity in life

By participating in an activity that offers you many of the above factors, you will achieve 'flow.' This has been described by the positive psychologist Mihalyi Csikszentmihalyi (2009, p349) as 'the intense experiential involvement in moment to moment activity which can be either physical or mental. Attention is fully invested in the task at hand and the person functions at their fullest capacity." This is an experience where you start to do something, and you become so lost in it that you lose track of time and become completely absorbed in the task. It is different to persisting with something to get it perfect. Rather, it is about the positive experience of 'being in the zone,' and the research shows that activities which are most likely to lead to the experience of flow include **sports, dance, creative arts, sex, socialising, studying, listening to music, reading and working**. Activities that prevent the experience of flow from occurring include housework, watching TV and being alone and these experiences were more likely to produce emotional states of apathy and boredom (Csikszentmihalyi, 2002; Delle Fave & Massimini, 2004).

6. Optimal positive to negative emotions ratio

This experiment encourages people to look for a balance of 3 positive emotions/experiences/interactions to 1 negative emotion/experience/interaction.

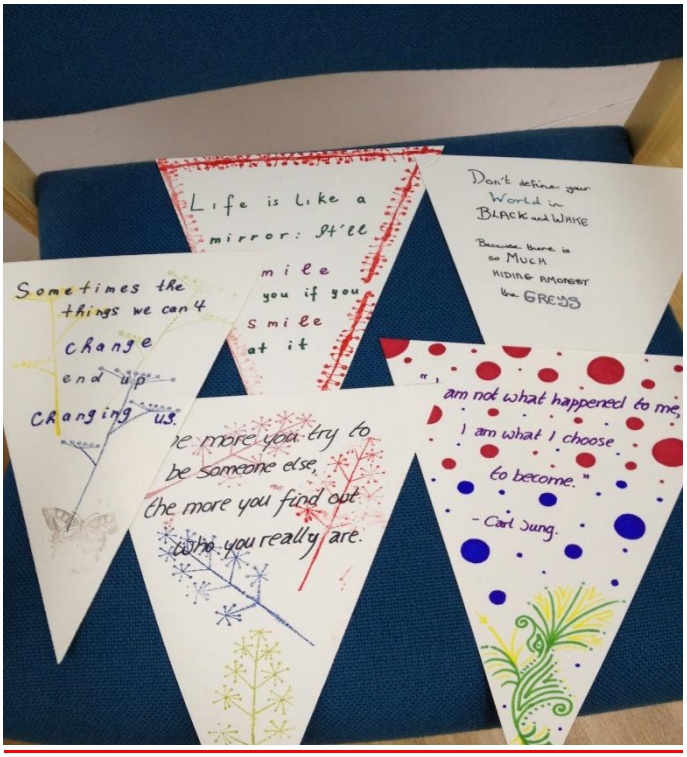
TASTER TASK... Complete the 2-minute online calculator on Fredrickson's website: www.positivityratio.com together. You could come back to this in a later session to see if the positivity ratio has changed.

Fredrickson and Losada (2005) initially looked at the performance of 60 business teams and explored the ratio of positive to negative interactions. The research showed that those with the best balance of positive to negative emotions had 3 positives to every 1 negative. Fredrickson and Losada concluded that this ratio offers the optimal balance for 'human flourishing.' Therefore, if you train yourself to notice more positive emotions/experiences/interactions in life, then you will achieve a better emotional balance and improved well-being.

7. Just smile!

Smiling more often, in private or in public, is one way of improving the experience of positive emotions. If you try to smile in public, it will offer more opportunities for you to have positive interactions with others because a smile is welcoming and invites others to talk to you.

Johnson et al., (2010) have carried out an experiment using a facial muscular tracking device that showed that when people smiled genuinely, their thought patterns were immediately broadened, meaning that they had better access to a wide range of problem solving and personal resources with which to approach difficult situations. Furthermore, Harker and Keltner (2001) found that simply finding the time to smile about small things in the period after bereavement was negatively correlated with the duration of grief experienced after the bereavement. This study also found that giving genuine smiles was related to better social functioning and higher life satisfaction and well-being in a group of females followed up over a 12-year period.



Homework: Session 3

The purpose of this homework is to put into practice the strategies discussed in session. With the patient, decide which of the tasks they would like to do for homework. Also, remind them that their homework from last week (Portfolio of positive emotions / Bank of positive experiences) is ongoing and can be continued alongside the new tasks.

Instructions

Choose one or two of the strategies we have talked about today and experiment with introducing them into each day.

1. **Being mindful of positive experiences** *(can be integrated into log-book/bank)*
2. **Being with others**
3. **Favourite person exercise**
4. **Savouring**
5. **Getting into the 'flow'**
6. **Optimal positive to negative emotions ratio** *(List three good things each day)*
7. **Just smile!**

How could you experiment with introducing some of these strategies into your daily life? Which one seems possible to start with? How could you begin to use it each day?

"Managing the negative to get to the positive"

The strategies explored in this session should be encouraged throughout the remaining CREST sessions, fitting in with the objective of 'managing the negative to get to the positive.'

If the patient finds a strategy that works for them, encourage them to keep this going and integrate it into their weekly routine. If they do not find a strategy useful, prompt them to return to the list of positive psychology exercises and try a different one.

***Therapist tip*:** See Appendix 2.5 to 2.8 for additional exercises/worksheets which can be given to help elicit positive emotions and embed positive strategies in daily life (Simple Pleasures Toolkit; Pay it Forward Quotes; Three Good Things; Letter of Gratitude).

Session 4

Reflect on homework:

Ask the patient to discuss what they did for homework and to reflect on what they noticed and learnt. Which of the 7 strategies did they try? If they chose the favourite person exercise, ask if they are willing to share their picture with you and discuss this. Remind them that these strategies are always available to them and encourage them to continue practising on a regular basis.

***Therapist tip*:** encourage the patient to fully engage in describing how this made them feel, using the emotions word list from session 3 as an additional tool if this would be deemed helpful.

Session 4: Identifying and using personal strengths

"We are going to think about what you consider your personal strengths. So, what qualifies as a personal character strength, and how do you know if one is really yours? In 'A Primer of Positive Psychology' (2007), a researcher in this field, Peterson, explains:

'I believe that people possess signature strengths akin to what Allport (1961) identified decades ago as personal traits. These are strengths of character that a person owns, celebrates, and frequently exercises. In our interviews with adults, we find that almost everyone can readily identify a handful of strengths as very much their own, typically between two and five'."

Exercise 1: List of personal strengths

Aim:
The aim of this exercise is for the patient to identify positives in themselves. The therapist should support the patient to think about which aspects of their personality they value and should be proud of.

Instructions:
Read **a précis** of the following information for the patient:

Peterson goes on to present a list they used in 2004 summarising their "possible criteria for signature strengths" including:

- *A sense of ownership and authenticity ("this is the real me") vis-à-vis the strength*
- *A feeling of excitement while displaying it, particularly at first*
- *A rapid learning curve as themes are attached to the strength and practiced*
- *Continuous learning of new ways to enact the strength*
- *A sense of yearning to act in accordance with the strength*
- *A feeling of inevitability in using this strength, as if one cannot be stopped or dissuaded from its display*
- *The discovery of the strength as owned in an epiphany*
- *Invigoration rather than exhaustion when using the strength*
- *The creation and pursuit of fundamental projects that revolve around the strength*
- *Intrinsic motivation to use the strength.*

Give the patient the list of strengths and ask them which ones they recognise in them self. If they have difficulty with this, ask them to think of a single time where they have shown one of the strengths. Emphasize that this is not a wish list of desirable qualities, character strengths are qualities we demonstrate without anyone asking us to – they are just part of us. Listen out for the patient dismissing any of their personal qualities and gently name this – I notice you have dismissed every quality because you do not show them 24 hours a day but that criterion is too strict – no-one consistently demonstrates any quality every day or all day long!

***Therapist tip*:** again, and in the spirit of collaboration, the therapist can express one of their strengths and describe how it feels for them when fully involved in this strength.

The list of personal character strengths is not set in stone. Like other scientific theories it is subject to change as evidence is evaluated over time. On the following pages you will find the 24 strengths of character at present, grouped in 6 categories of virtue:

Personal character strengths

Strengths of WISDOM AND KNOWLEDGE: cognitive strengths that entail the acquisition and use of knowledge

1. ***Creativity (originality, ingenuity):*** thinking of novel and productive ways to conceptualise and do things
2. ***Curiosity (interest, novelty seeking, openness to experience):*** taking an interest in ongoing experience for its own sake; exploring and discovering
3. ***Open mindedness (judgment, critical thinking):*** thinking things through and examining them from all sides; weighing all evidence fairly
4. ***Love of learning:*** mastering new skills, topics and bodies of knowledge, whether on one's own or formally
5. ***Perspective (wisdom):*** being able to provide wise counsel to others; having ways of looking at the world that make sense to oneself and to other people

Strengths of COURAGE: emotional strengths that involve the exercise of will to accomplish goals in the face of opposition, external and internal

6. ***Bravery (valour):*** not shrinking from threat, challenge, difficulty or pain; acting on convictions even if unpopular
7. ***Persistence (perseverance, industriousness):*** finishing what one starts; persisting in a course of action in spite of obstacles
8. ***Integrity (authenticity, honesty):*** presenting oneself in a genuine way; taking responsibility for one's feelings and actions
9. ***Vitality (zest, enthusiasm, vigour, energy):*** approaching life with excitement and energy; feeling alive and activated

Strengths of HUMANITY: interpersonal strengths that involve tending and befriending others

10. ***Love:*** valuing close relations with others, in particular those in which sharing and caring are reciprocal
11. ***Kindness (generosity, nurturance, care, compassion, altruistic love, 'niceness'):*** doing favours and good deeds for others
12. ***Social intelligence (emotional intelligence, personal intelligence):*** being aware of the motives and feelings of other people and oneself

Strengths of JUSTICE: civic strengths that underlie healthy community life

13. ***Citizenship (social responsibility, loyalty, teamwork):*** working well as a member of a group or team; being loyal to the group
14. ***Fairness:*** treating all people the same according to notions of fairness and justice; not letting personal feelings bias decisions about others

15. ***Leadership:*** encouraging a group of which one is a member to get things done and at the same time maintain good relations within the group

Strengths of TEMPERANCE: strengths that protect against excess

16. ***Forgiveness and mercy:*** forgiving those who have done wrong; accepting the shortcomings of others; giving people a second chance; not being vengeful
17. ***Humility/modesty:*** letting one's accomplishments speak for themselves; not regarding oneself as more special than one is
18. ***Prudence:*** being careful about one's choices; not taking undue risks; not saying or doing things that might later be regretted
19. ***Self-regulation (self-control):*** regulating what one feels and does; being disciplined; controlling one's appetites and emotions

Strengths of TRANSCENDENCE: strengths that forge connections to the larger universe and provide meaning

20. ***Appreciation of beauty and excellence (awe, wonder, elevation):*** appreciating beauty, excellence, and/or skilled performance in various domains of life
21. ***Gratitude:*** being aware of and thankful for the good things that happen; taking time to express thanks
22. ***Hope (optimism, future mindedness, future orientation):*** expecting the best in the future and working to achieve it
23. ***Humour (playfulness):*** liking to laugh and tease; bringing smiles to other people; seeing the light side
24. ***Spirituality (religiousness, faith, purpose):*** having coherent beliefs about the higher purpose, the meaning of life, and the meaning of the universe

***Therapist tip*:** Link to the next exercise by explaining that negative emotions are a normal and inevitable part of life, but it is important to not dwell on these and to recognise that they are temporary. Being aware of your own positive strengths as well as having a 'toolkit' of strategies that highlight the positives in everyday life will help to shift the automatic bias from a negative to a positive perspective of situations.

Exercise 2: Emotion Switching

Aim:

The aim of the following exercise is to explore with the patient how emotions are transient and tell us something about our environment at the time rather than being fixed and permanent. It also helps to demonstrate how we can shift our focus of attention, which can sometimes help to change our mood or prevent a "bad" mood from worsening.

Instructions:

Place a selection of word cards on the table (words facing upwards). Ask the patient to select a word at random and to try to identify with that emotion. To assist with this, the therapist can ask them to describe a time when they felt this emotion, what it was like for them, how they experienced it in their body. The therapist can also be involved and reflect on the same emotion in themselves. Once the patient has managed to do this, ask them to find a contrasting emotion word and repeat the exercise. Do this a few times. **Always end with the patient describing a positive emotion.**

Reflections:

- How was it experienced?
- What did you learn about yourself?
- Could you see it is possible to switch between one emotional state and another?
- Do you think that people can also have different experiences of the same emotion?

***Therapist tip*:** Start slowly. Remember the patient must be properly eliciting each emotion so it may take some time initially. Try to help the patient speed up in switching between emotions.

Homework: Session 4

Aim:

To encourage your patient to practise noticing emotions in a variety of situations. This will highlight the transient nature of emotions even within a short space of time. This exercise will also encourage patients to consider their emotions as part of the bigger picture by asking them to consider the context and physical sensations associated with their emotions.

Instructions:

See homework sheet on following page.

"Managing the negative to get to the positive"

Don't forget... if the patient has found a strategy that works for them, encourage them to keep this going and integrate it into their weekly routine. If they do not find a strategy useful, prompt them to return to the list of positive psychology exercises and try a different one.

Session 4 homework: Emotions Log

Instructions:
Before the next session try to record a few situations when you experienced an emotion. What was the emotion? How did it feel in your body? Try to include a variety of experiences. Please use the *emotion word list* and *emotion diagram* from your previous sessions to help if needed.

Situation (what was I doing)	Emotion(s)	What did this feel like in my body

Core Module 3

Managing your emotions

Session 5

Reflect on homework

Spend a few minutes going through the patient's emotion record and ask some of the following questions:

- How easy/difficult was this homework? Why?
- Did you notice anything about your emotions?

Session 5: Managing difficult emotions

Exercise 1: Managing difficult emotions

Aim:
To discuss with the patient how they currently manage difficult emotions and to explore the advantages and disadvantages of their current strategies (using the worksheet on the following page).

After completing the managing difficult emotions worksheet, it can be useful to provide some psychoeducation:

"We learn about emotions in early life, usually from our families and caregivers. Some families are comfortable with anger and conflict but struggle to show each other vulnerability or sadness. Other families are comfortable showing vulnerability or sadness but not anger. Some families prefer to hide emotions, other than happy ones, from each other."

Questions for reflection:

- What do you think you learned about your emotions from how they were dealt with in your family/childhood?
- How do the different members of your family/caregivers show their emotions?
- How do the different members of your family/caregivers deal with their emotions?

Managing difficult emotions worksheet

What do you do to manage difficult or upsetting emotions?

Do you bottle them up perhaps? Or squash them?

Which feelings do you bottle up? Do you ever express them? How do you do this?

BOTTLE UP	**AVOID**
EXPRESS	**FREEZE**

***Therapist tip*:** if deemed helpful for your particular patient, a more playful exercise could be to reflect on the past two weeks, asking the patient to recall as many times as possible occasions they have suppressed their emotions, actively filling up a jar and reflecting on what would happen.

Learning to manage extreme and overwhelming emotions

How does dealing with your emotions in this way help?

.....

What are the problems with dealing with your emotions like this?

.....

What alternative ways can you try to help you deal with your emotions?

.....

How do you deal with positive experiences? Can you think of one example we can discuss?

Exercise 2: Pink giraffe

Aim:
To demonstrate to the patient that using avoidance as a strategy for dealing with emotions can be counterproductive.

Instructions:

- For one minute, let's both try to think of a pink giraffe.
- Let's imagine what it would look like, what shade of pink it is, whether shocking pink, piglet pink or any other kind of pink; really conjure it up in your mind's eye.
- Now, for another minute, let's try very hard NOT to think of a pink giraffe. What do you notice?

Reflection:

- What have you learnt from this exercise?
- A lot of mental effort is involved in suppressing thoughts and feelings!
- If you ignore a thought or feeling, it is more likely to come back again, and likely to be more intense when it does come back.
- Can you think of any times when you have experienced this?

Remember the analogy about how emotions come knocking on your door? If we don't open the door they just knock louder and feel stronger and more difficult to cope with. They also become more difficult to ignore the more we try.

Research evidence:
Wegner and colleagues in cognitive psychology first reported this interesting experiment finding that when they asked patients "not to think about a white bear" all of them did just the opposite. Avoiding thinking about something was not very helpful (e.g. Wegner, 1989).

"Remember the information from Compassionate Mind Therapies? If our emotional self is like a young child/animal how might it react to being ignored or turned away from?

"It is likely to feel neglected and try harder to get your attention, just like a child tugging on your apron or a puppy who jumps all over you. They really want and need you to notice and acknowledge them. It might feel scary but paying attention to emotions rather than avoiding them usually reduces their intensity rather than increasing it."

Homework: Session 5

The 'Self' exercise

Aim:
For the patient to gain some insight regarding the discrepancy between how we feel and what we express. The homework will require the patient to do a 'self' exercise where they will create two images, one of how they want to appear to others and another of how they feel inside.

Sometimes people hide their true feelings from others. There may be a number of reasons why people do this but not expressing our feelings can make them harder to manage and they can grow in strength. A difficulty in labelling and recognising emotions accurately could be in part due a discrepancy between emotion identification and emotion expression. **The greater the discrepancy the greater the internal stress, for anyone, not just people with eating disorders or other psychiatric diagnoses, but for everyone!**

Instructions:
This will involve getting pieces of A4 paper. Ask the patient to create two images. The first image is to show how they would like to appear to others and the second is to show how they actually feel on the inside.

With regards to the images suggest that the patient can either draw their own images or could use pictures from magazines, the internet. Suggest they could also write words or cut out words from magazines to include on their image.

It is important to let the patient know that they are not expected to share their images with anyone, including the therapist. Reassure the patient that there is no right or wrong way of doing this exercise and their artistic ability is not being assessed. The exercise is an opportunity for the person to think about how they want to appear and how they actually feel and to see if there is any discrepancy. Explain that a difficulty in labelling and recognising emotions accurately could be partly due to a discrepancy between emotion identification and emotion expression.

"Managing the negative to get to the positive"

Don't forget... if the patient has found a strategy that works for them, encourage them to keep this going and integrate it into their weekly routine. If they do not find a strategy useful, prompt them to return to the list of positive psychology exercises and try a different one.

Session 6

Reflect on Homework:

Discuss with the patient how they found the 'self' exercise and ask if they are happy to share their images with you.

Reflect and discuss the following:

- Did you learn anything about how you express your feelings?
- Do you feel one thing and say another?
- What are the advantages/disadvantages of emotion suppression?
- What are the advantages/disadvantages of emotion expression?
- What would be a more effective way of managing and expressing your feelings?

Session 6: Managing difficult emotions – cont.

***Therapist note*:** The following two tasks inform each other. The 'emotion word map' lays the foundations for the 'emotion thermometer' exercise in the following way. The 'emotion word map' explores a strong emotion and the associated emotions. This exercise can then be used in developing the 'emotion thermometer'

Exercise 1: Emotion word map

Aim:

This exercise aims to introduce the concept that emotions vary in strength and intensity. This exercise will enable patients to think about and identify varying levels of emotions within themselves. It also encourages patients to find the right describing word to fit the emotion.

Instructions:

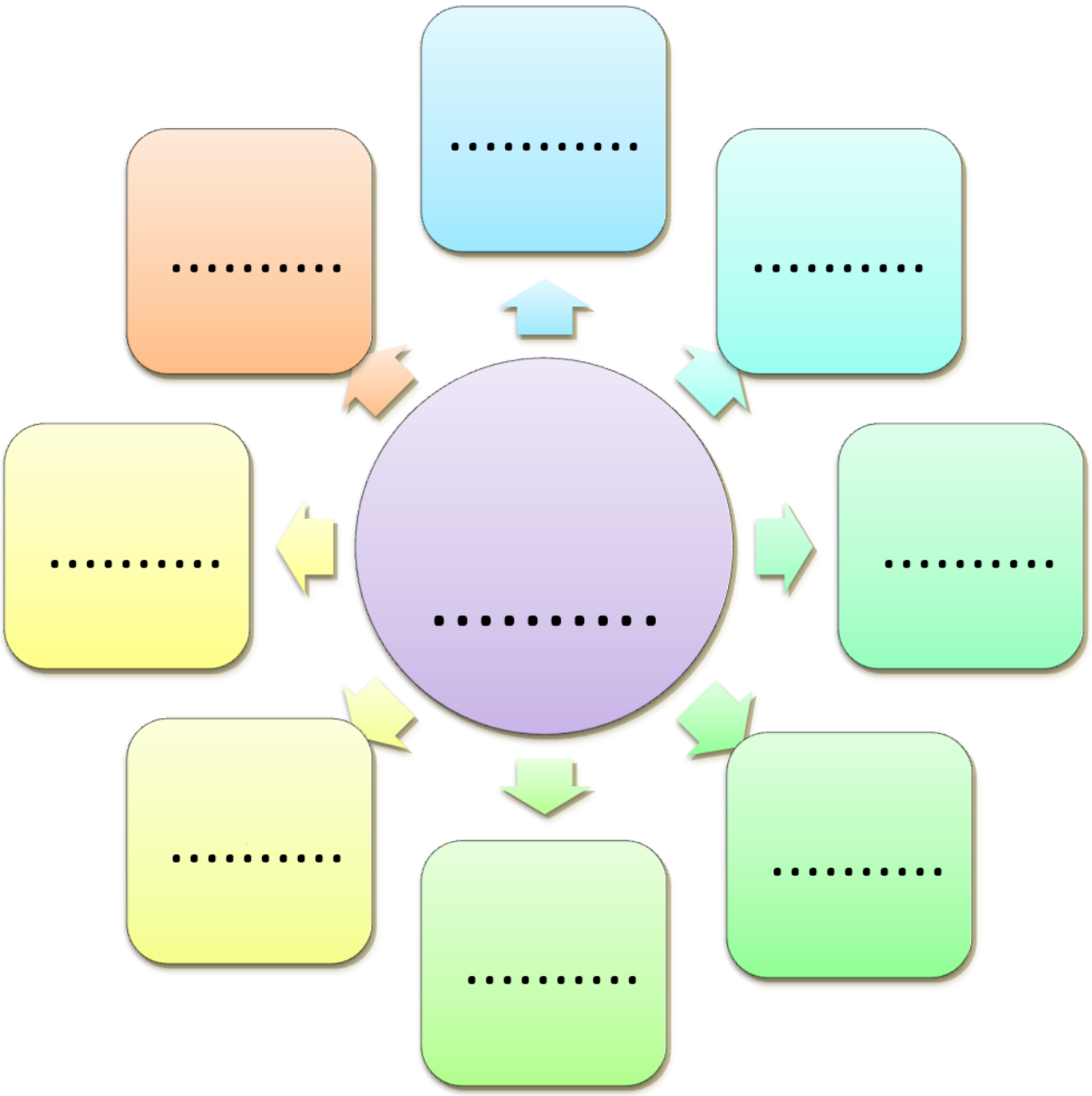
Introduce to the patient the idea that emotions are on a continuum and vary in intensity. For example, 'fury' and 'irritation' may be on the same continuum but they have very different levels of emotional intensity. Irritation may be an easier emotion to manage and do something with rather than fury. **Ask the patient if they can identify with this?**

Using the 'emotion word map' start with an intense feeling in the middle and then ask the patient to name associated emotions. It may be useful to refer to the emotion word list.

Discuss in the session that if we have a greater understanding of the language of emotions, we are in a better position to express our emotions accurately and get the right support or help in return as others will have a clearer understanding of what it is that we are feeling.

***Therapist tip*:** The emotion word map task can be extended to become a mind map exploring features associated with each emotion word. Use the outer words to branch off into communication styles, physical signs, thinking styles or anything the patient can think of that is related to that particular emotion.

Emotion word map



Exercise 2: Emotion thermometer

Aim:

This exercise introduces the idea that if our emotions vary in intensity then our physiological response and behaviour will also vary. This can also tell us something about how we are feeling. If we can be aware of the emotion, the physical sensations and how we are behaving we are then in a better position to manage emotions more effectively and catch them before they become overwhelming. This awareness can help us to manage or diffuse difficult emotions.

Instructions:

Using the emotion thermometer identify an emotion (perhaps from the emotion map) that is very strong and place at the top of the thermometer. Go down the thermometer identifying associated feelings that are lessening with intensity. Note the physical sensations and any behaviour changes these emotions produce on the other side.

Discuss the following with the patient once you have completed the 'emotion thermometer':

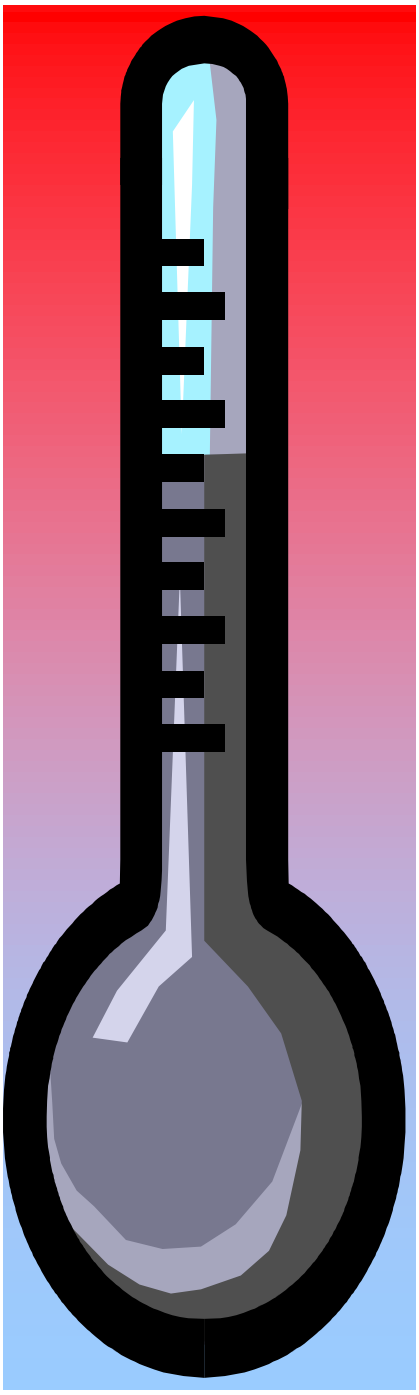
- Do you notice anything about this?
- At what point on the emotion part of the thermometer would it become difficult to express or manage the emotion? Is this the point that you need to do something with the emotion before it continues to escalate and you then feel unable to manage it?
- What could you do at this point to help you manage or express the emotion?
- Is there anything you could do to prevent the emotion from intensifying?
- If you find yourself easily overwhelmed by an emotion would it help to look out for sensations in your body? This may give you clues to how you are feeling and help you to manage the feeling before it becomes overwhelming? *For example: if someone is getting angry they may notice that their shoulders are tensing and their heart rate is increasing. At this point the person may be able to take themselves away from the situation to cool off.*
- Would it help to look out for certain behaviours as these may also give you a clue? *For example: if someone is getting angry they may notice that they start to fidget or pace around. At this point the person may be able to take themselves away from the situation or use a relaxation exercise to calm themselves down.*

> ***Therapist tip*****:** *Therapist tip*: See Appendix 2.9 for useful links which can be used in a discussion about body language. This is related to the part of this task in which patients think about the sensations/behaviours associated with emotions. Furthermore, the body language links emphasise positive emotions so may help to shift the balance if the patient has focused primarily on negative emotions so far.

Emotion thermometer: Intensity of emotions

Emotions:

Sensations: how does it feel, what are you doing?



Exercise 3: Dimensional emotions

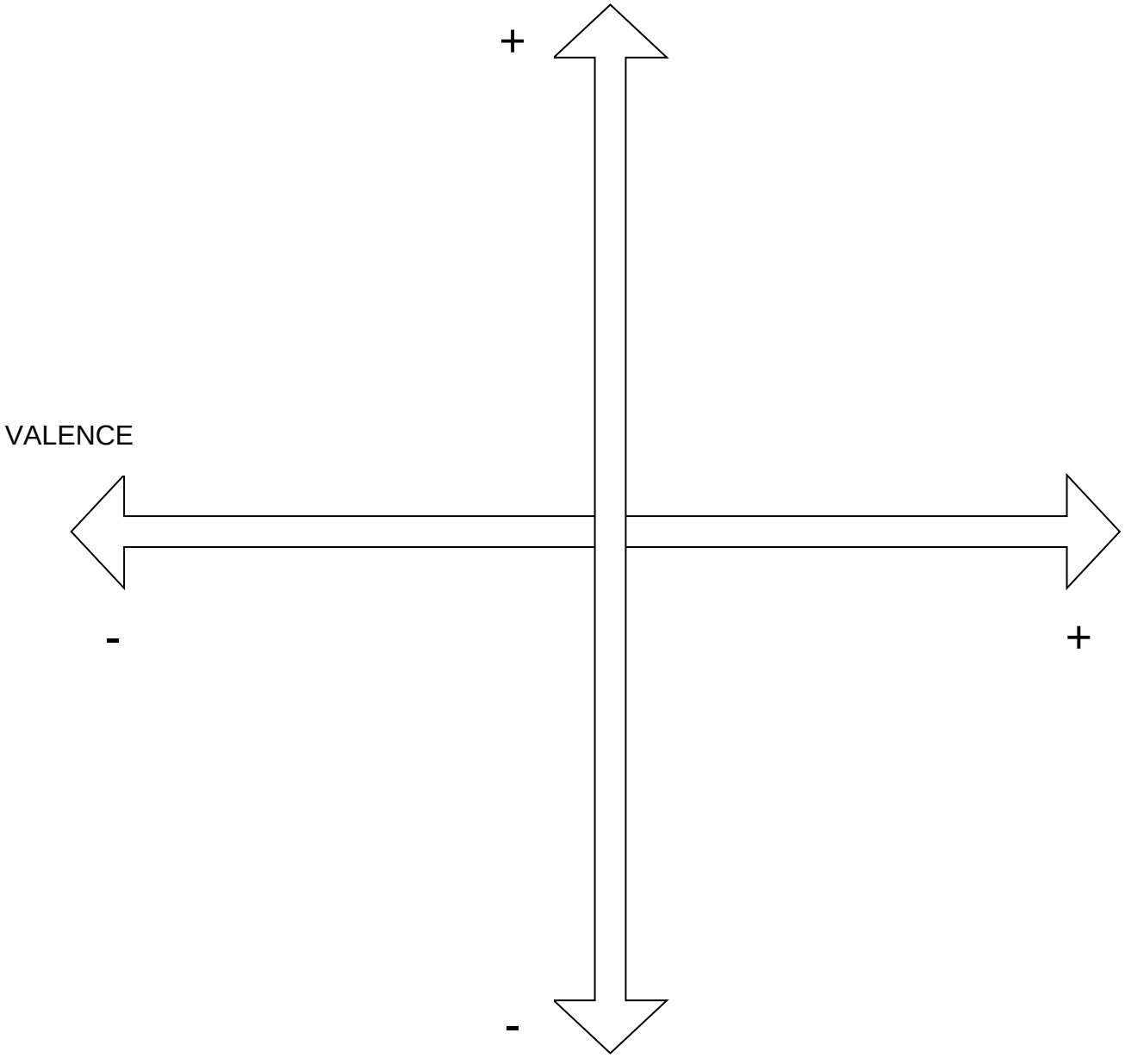
Aim:

This exercise will explore how emotions vary in intensity and valence. This awareness can help us to distinguish between similar emotions enabling us to better communicate how we are feeling.

Instructions:

Place emotion words on the chart below according to valence (how positive or negative an emotion is) and intensity (how strong the emotion is). For example, where would surprise be placed; is it a strong emotion? Is it positive or negative?

Discuss whether they found it easier to rate words on one dimension rather than the other. Picking two words that are in a similar place on one of the dimensions, ask how they can tell the difference between these two emotions? What are the similarities and differences?



Homework: Session 6

Managing difficult emotions

Aim:
The following homework task is to encourage the patient to use some strategies to manage emotions before they become overwhelming.

Instructions:
Give the patient the following hand-out '*What helps me to manage difficult emotions?*'. Ask the patient to be mindful of their emotions, including physiological responses and behaviours. Suggest they use some of the strategies outlined to help them manage difficult emotions before they become overwhelming. It will be helpful to give the patient a copy of their 'emotion thermometer' to help with this task.

If there is time it would be helpful to spend a few minutes deciding which exercises the patient is willing to try before the next session.

"Managing the negative to get to the positive"

Don't forget... if the patient has found a strategy that works for them, encourage them to keep this going and integrate it into their weekly routine. If they do not find a strategy useful, prompt them to return to the list of positive psychology exercises and try a different one.

What helps me to manage difficult emotions?

- Speak to someone (staff, friend, family member).
- If unable to express the feeling it may help just to be with someone.
- Imagine a cloud in your mind (what type of cloud – small, large, fluffy, rain cloud; what's the sky like – blue, grey). Then place the emotion you are experiencing on the cloud and watch it float away. As the cloud floats up and further away from you imagine the emotion lessening in intensity until you feel more comfortable with your feeling.
- A relaxation exercise – deep breathing. See attached handout.
- Ask yourself: 'what would I say to a friend who was feeling this way?'
- Ask yourself: 'what would a friend say to me right now?'
- Ask yourself: 'am I giving myself a hard time here, is there another way I could think about this?'
- If it's difficult to work out what the emotion is, try to imagine what it would be like (animal, plant, monster, etc.), what colour is it, what type of voice does it have (quiet, angry, shouting).
- Keep a feelings diary – sometimes it can help to write down how we are feeling as this is a form of emotional expression.
- If the emotion is really powerful and upsetting, try writing down the feeling or your thoughts on a piece of paper. Then tear the piece of paper up and throw it away. What does that feel like?
- Put some music on.
- Get some fresh air or go into another room; a slight change in scenery/environment can sometimes diffuse an emotion.
- Use distraction – puzzle, games, knitting – something that will hold your attention for a few minutes, and return to the emotion when it is less intense.
- Draw what your emotion looks like.
- Create a collage of everything that makes you smile.
- Get involved in a board game with others.
- Play music that reflects the feeling and then its opposite.
- Use one of the positive psychology exercises that you have found helpful.

- Create a self-soothing box or bag including items that stimulate each of the senses.
- State the emotions you are experiencing to yourself in a non-judgemental manner.
- Squeeze a stress ball or your pillow to release some of the tension.
- *Are there any other ways you can think of that would help to manage difficult emotions? What has worked in the past to help lift or change your mood when you have felt down or anxious? Make a note below.*

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Breathing Exercise

1. Get yourself into a comfortable position and gently start to focus on your breathing.
2. As you breathe, try and allow the air to come down into your diaphragm. Feel your diaphragm, the area underneath your ribs, move as you breathe in and out.
3. Focus on the sensation of the rise and fall of your breathing. You may want to place your hand on your tummy and feel the rise and fall of your hand as you slowly breathe in and slowly breathe out.
4. Breathe in for three and out for three slowly.
5. Gently practice breathing a little faster or slower until you find a breathing rhythm that suits you and feels comfortable and relaxing.
6. Continue with this exercise for a few minutes until you start to feel calmer and more relaxed.

There are now many apps for your mobile devices which can guide you through simple breathing exercises. One of the simplest is the 'Breathe Ball', where you breathe in time to an image of a ball inflating and deflating. Try a few apps and see which work for you.

Session 7

Reflect on homework:

Ask the patient how they found the homework and reflect on:

- Have there been any occasions since the last session where they have used any of the strategies from 'what helps me to manage difficult emotions'?
- Which strategies did they use?
- Were any particularly helpful?
- Did they come up with any other strategies?

Session 7: Making emotions work for you

Exercise 1: Making emotions work for you - the function of emotions

Aim:

The aim of the following exercise is to encourage the patient to think about emotions as being important signals that we need to listen to as they are communicating something to us about ourselves, our environment and they can help us to communicate with others.

The following exercise helps the patient to think about how emotions can help us, in particular we will be looking at 'negative' emotions and their positive intention. If the patient finds it too difficult to think about their emotions, you can start by thinking about "people's" emotions and

Instructions:

Go through and complete the following handout with the patient.

> ***Therapist tip*:** It can help to verbalise your thought processes as you try to answer the questions alongside the patient – they often value opportunities to hear how other people think, especially about emotions.

Making emotions work for you: The function of emotions

Do you remember that right at the beginning of this workbook we talked about why we have emotions?

We said that emotions are important signals worth listening to:

1. They tell us something about *ourselves,* about what is happening in *the world* around us, and they *organise us* to act.
2. They help us to *communicate with others* about our current state, needs, goals and inclinations. They can also influence other people's behaviours.

Let us think a bit more about how emotions can tell us something about ourselves and our world.

For example, think about:

Happiness

Being happy can give you a sense of contentment

What positive things does happiness do for you?

_____

Even the emotions which are sometimes considered to be 'negative' emotions can be useful to us.

For example, think about…

Anger

Anger can give you the power to stand up for what you believe in.

What positive things does anger do for you?

_____

Shame

If you feel ashamed about hurting someone, it can help you remember to be more considerate of people you love

What positive things does shame do for you?

_____

Sadness

Sadness can help you reflect on life and move on

What positive things does sadness do for you?

_____

Can you think of other emotions and the positive and negative aspects to them?

Emotion = _____

How does this emotion help you?

_____

Emotion = _____

How does this emotion help you?

_____

Emotion = _____

How does this emotion help you?

_____

Emotion = _____

How does this emotion help you?

_____

***Therapist tip*:** If your patient gets stuck trying to identify the function of an emotion, you could try this thought experiment with them:
Let's try to imagine this emotion does not exist and no-one in the world has ever felt this emotion:

- What would the world be like if no-one ever felt this emotion?
- What would be different about how people interacted with each other?
- How would society be different?
- Does this help us think about what is useful about this emotion?

Exercise 2: Making emotions work for you (cont.) - emotions and needs

So, emotions communicate something about our world to ourselves. However, they also communicate our needs to others. Let's take a look at this second function of emotions.

Complete the following sentences:

People experiencing….

- **Happiness** are communicating that they need……

  ……

- **Sadness** are communicating that they need……

  ……

- **Anger** are communicating that they need……

  ……

- **Shame** are communicating that they need……

  ……

- **Fear** are communicating that they need……

  ……

- **Disgust** are communicating that they need……

  ……

- **Envy** are communicating that they need……

  ……

- **Guilt** are communicating that they need……

  ……

Reflections:
Try to link some of the instances where emotions can help, to real life examples experienced by the patient. Try to get the patient to think of a time in their life when they felt each of the emotions. Ask them:

- Where were you? Who was with you? What was happening in your life?
- Consider how this emotion was trying to help you out.
- Finally, think about what this emotion tells you that you needed.

Reflections on this session:

- What are the key points that you think you can take away from this section of the module?
- In what ways do you think you have improved in the skills that are focussed on in this section?
- Can you think about how you can implement what you have learnt in this section in your day-to-day life?

"In the following sessions, we will think about how you can meet your emotional needs."

Homework: Session 7

Making emotions work for us

Aim:
The aim of this homework is to encourage the patient to continue with what they have learnt in the session with regards to emotions being important signals that we need to listen to.

Instructions:
Read through the following handout with the patient and ask them to complete the exercises for the next session.

"Managing the negative to get to the positive"

Don't forget...if the patient has found a strategy that works for them, encourage them to keep this going and integrate it into their weekly routine. If they do not find a strategy useful, prompt them to return to the list of positive psychology exercises and try a different one.

Making emotions work for me

Think about your work so far and write down what you are learning about the link between emotions and needs:

e.g. The positive intention of my anger is to give me the power to stand up for what I believe in and it tells me that I need to explain to someone else the effect that their actions/words are having on me.

The positive intention of my _____ is_____

_____

and it tells me that I need_____

_____

The positive intention of my _____ is_____

_____

and it tells me that I need_____

_____

The positive intention of my _____ is_____

_____

and it tells me that I need_____

_____

(It might be useful to refer back to the previous worksheet for ideas about what others need when experiencing an emotion)

Core Module 4

Expressing your emotions and communicating positively

Session 8

Reflect on homework:

Review with the patient how they found the homework and help with any difficulties they may have had.

Ask if they feel that they can use what they are learning about emotions in everyday life.

Session 8: Expressing emotions and communicating positively

Exercise 1: How do you signal what you feel and need?

Aims:

The aim of the following exercise is to reflect with the patient how they currently communicate their emotions and needs. This will highlight that there will be times when the patient does not signal their needs in the most effective way.

Instructions:

Complete the following questionnaire with the patient and then ask the following questions:

- What do you notice from your answers above?
- Which of these approaches do you use most?
- What are the advantages of this style of getting your needs met?
- Are there any downsides?

***Therapist tip*:** see Appendices 2.3 and 2.4 for other tasks and worksheets practising communication skills, including being *direct and clear* and *using 'I'* to communicate thoughts/needs.

Practising to recognise what you feel and what you need

Try this short quiz to see how you go about getting your important needs and feelings met by people close to you.

For each statement below indicate how often you act in each way by ticking rarely, sometimes or mostly.

How I signal my needs	Rarely	Sometimes	Mostly
I ask assertively by explaining my feelings and asking for what I need.			
I wait for others to see into my mind and know what I feel and need.			
I give up on any hope that others can meet my needs and sink into sadness.			
I bottle up my feelings, but secretly show how unhappy or angry I am with little signals like refusing to speak or not eating and leaving others to guess what I need.			
I rebel against the injustice of being ignored by letting rip with my anger and demanding that my needs are met.			
I don't really know what I feel or need, but I know what I don't want and hope that others will guess for me.			
I don't feel anything and don't know how I signal my needs.			

Exercise 2: Assertiveness vignettes

Ask the patient to reflect on how they would usually respond to the following situations and how they would be feeling. Then explore how these could be managed more assertively and how they would be feeling.

1. You want to be able to go out for a gentle walk in the grounds of the hospital by yourself and someone asks if they can come with you.

2. You are tired and somebody is playing their music quite loudly in the room next to you.

3. Somebody admires a project you are working on in OT.

4. Somebody thanks you when you have done something kind for them.

5. You are engrossed in a really good book and a friend phones for a chat.

Exercise 3: What might work better for you?

Aim:

The aim of the following exercise is to support the patient to think of ways that they can start to communicate their feelings and needs in an open and assertive manner. By looking at how patients currently deal with feelings and needs this will show that they often do not communicate themselves in a way that gets their needs met and the outcome can be an intensification of negative emotion. By using the 'scripting approach' (see handout: What might work better for you? on p.74) patients will be able to think of new ways of signalling their needs which will lead to a more positive outcome and a likely reduction or change in negative affect.

Instructions:

Using the 'scripting approach' identify a recent time when the patient did not recognise an emotion or signal their need and complete the boxes in the handout on p. 74. Then revisit the same situation and complete the exercise as if they had signalled their emotions and needs, how they would do this and the outcome.

If the patient struggles to identify a specific situation, the following vignettes can be reflected on instead.

Vignette 1

Sarah goes out with a group of friends most weekends and Angie is part of this group. The problem is that Angie often makes fun of Sarah and puts her down. For instance, quite often when Sarah joins in a conversation, Angie will roll her eyes to the rest of the group, making it clear that she has missed the point. Sarah is finding it increasingly difficult to cope with the

situation but has no idea what to do. She enjoys spending time with the group but finds she is increasingly self-conscious and continually replays these conversations in her mind during the week to try to prevent further 'mistakes'.

Vignette 2

Arabella has recently moved in with two flat-mates. They get along quite well, regularly socialise together and enjoy similar hobbies. Arabella has a busy job as a PA and a very demanding boss who regularly contacts her outside of working hours to request extra things she needs done. As a result, Arabella is never without her work diary or mobile, which annoys her friends as she will have to answer her phone in the middle of a conversation. Although she likes her flat-mates, she finds them extremely untidy and, after a busy day, she will feel compelled to clear up as she cannot relax until she is in a tidy and comfortable space.

Vignette 3

Louise and Jodi are on holiday together on a beautiful Greek island. They have saved up and are staying in a fabulous hotel right on the beach. They are gently strolling along the beach, looking around and admiring the incredible scenery, the crystal blue water, bright sunshine and stunning, fragrant and vibrant flowers native to the island.

What might work better for you?

You have begun to identify your own feelings and started to recognise how they are trying to help you or to indicate what you need. Now you may want to take the next step and think about how you would use these pieces of information to help you make things different when faced with a situation.

To help you learn how to do this we use a technique called the ***scripting approach***. Many people find this approach helpful – let's give it a go.

1. Let's start by thinking about a situation in which you found it difficult to identify needs or feelings or where you ignored them:

EVENT:

Where were you?

Who were you with?

What happened?

FEELINGS:

What was the main feeling?

What other feelings were there?

How did this feel in your body?

NEEDS:

What do you think these feelings were telling you that you needed?

Did you meet any of these needs? Which ones?

Did you ignore any of these needs? Which ones? Why did you ignore them?

CONSEQUENCES:

What was the outcome?

How did you feel afterwards?

2. Now, let's think about how the situation might have turned out if you had recognised and listened to your feelings and needs. What might you have done to help those needs be met?

Reflections:

- What do you notice about the differences between the two ways of dealing with the scenario that we have sketched out?
- What is good/bad about each of them in the short term/long term?
- Do you feel able to have a go at applying this technique in practice? What might be difficult about doing this? What might help it go well? Remember that it doesn't need to be perfect!

> ***Therapist tip*:** Practice this exercise with as many scenarios as possible, particularly situations that the patient has found very difficult or those that occur frequently. Use the reflection above each time.

Homework: Session 8

What might work better for you?

Instructions:

1. Choose one of the examples of a scenario that happens frequently, that you have scripted in the session. Ask the patient to reflect on this exercise and have a go at practising 'being assertive' the next time this situation arises: for example, by expressing needs and seeking for them to be met in the positive way you have planned (see communication skills exercises in Appendices 2.3 and 2.4).
2. Use the boxes and prompt questions above (they are provided as a handout on the following page) to keep a record of what happened, how they felt, what their needs were, how they tried to get them met and what the consequences and outcomes were.
3. Make a conscious effort to use the words 'I feel' more often when interacting with others.
4. When asked 'how are you?' try to say something other than 'I'm fine'; try taking a moment to ask yourself how you feel then answer based on this. E.g. 'I feel tired'/ 'I feel worried about…'

> ***"Managing the negative to get to the positive"***
>
> Don't forget...if the patient has found a strategy that works for them, encourage them to keep this going and integrate it into their weekly routine. If they do not find a strategy useful, prompt them to return to the list of positive psychology exercises and try a different one.

What might work better for you?

EVENT:

Where were you?

Who were you with?

What happened?

FEELINGS:

What was the main feeling?

What other feelings were there?

How did this feel in your body?

NEEDS:

What do you think these feelings were telling you that you needed?

Did you meet any of these needs? Which ones?

Did you ignore any of these needs? Which ones? Why did you ignore them?

CONSEQUENCES:

What was the outcome?

How did you feel afterwards?

Reflect on homework:

Review with the patient how they found the 'scripting approach'.
Discuss the following:

- What are the key points that you think you can take away from this section of the module?
- In what ways do you think you have improved in the skills that are focused on in this section?
- Can you think about how you can implement what you have learnt in this section in your day-to-day life?

If more help or strategies are needed for communicating emotions, see additional worksheets in Appendices 2.3 and 2.4.

Ending CREST and Feedback

Aims:

The aim of this part of the session is to provide a reflective space in which to think about and consolidate what the patient has learnt during CREST. In particular, revisit the CREST questionnaire from session two with the patient to see if there have been any changes in their understanding or awareness of their own emotional processing. Complete the evaluation questionnaire and give feedback to the patient about your experience of working with them.

Instructions:

Reflect with the patient that this is your last session together and you would like to spend some time thinking about their experience of CREST and what they feel they have learnt. Revisit the CREST questionnaire from Session 1 and go through and discuss whether the patient has a greater understanding or awareness of the themes discussed. It is not expected that the patient would have made actual changes but if they have this should be congratulated. What is important is their understanding of how they label and express emotion. This is the first stage of being able to think about possible change.

Ask the patient to complete the evaluation questionnaire and give them positive and constructive feedback of your experience of working with them.

> ***Therapist note*:** please remember to take a copy of the CREST questionnaire as in session 1 for ongoing manual evaluation.

CREST QUESTIONNAIRE **Your thinking and emotional style:**	**Problem for you? Y/N**	**How much does this interfere in your day-to-day life?** (0 = Not at all, 10 = Extremely)	**Give a recent example of how this problem manifests itself**
Thinking about emotions			
Recognising your own emotions			
Thinking positively			
Managing your emotions			
Expressing your emotions and communicating positively			
Thinking about thinking			
Recognising and interpreting others' emotions			
Evaluation and summary			

End of therapy reflection

What have you learnt about yourself from this therapy?

Were there any aspects that were especially helpful?

Were there any aspects that you felt were unhelpful?

What do you think could be improved?

Have you learnt any strategies that you could use in the future?

Optional Modules

5. Thinking about thinking
6. Recognising and interpreting other people's emotions

Optional Module 5

Thinking about thinking

Thinking about thinking (optional)

Aims of session

1. **Establish relationship**
   The collaborative nature of the cognitive exercises and the simplicity of these tasks will hopefully aid engagement with the intervention and help build a therapeutic relationship.

2. **Reflect on thinking styles**
   The purpose of the exercises is to raise awareness of thinking styles and to encourage patients to reflect on their own thinking styles. This can be done by "thinking about thinking" and consciously learning new strategies which can be reused and practised.

3. **Relating thinking styles to everyday life**
   A third aim is to link this material (thinking styles and strategies) to real life behaviours and examples.

The aims, therefore, are to use practice, reflection and guided discovery to improve thinking style, change behaviours in a flexible way and discover alternative ways of doing simple things (e.g. organising the room in a different orientation, watching different TV programmes, changing fonts on the PC, taking different routes to the clinic, school, and sitting in different places during mealtimes, etc.). Making these simple changes serves to develop confidence in ability to change and hopefully leads to more significant changes.

There are a number of exercises for the therapist to choose from. These exercises focus on different aspects of cognitive styles such as bigger picture thinking, attention to detail, prioritising, flexibility and switching as well as looking at perfectionism traits (e.g. estimating rather than doing things perfectly). It is unlikely there will be enough time to complete all exercises in the session so the therapist can choose which to complete.

Most importantly, this session is a great opportunity to engage the patient in the treatment programme. The two main ingredients of CREST (content and process) will hopefully provide a safe and motivational starting point.

> ***Therapist note***: it may be necessary to spend two sessions completing and reflecting on these cognitive exercises if your patient requires longer to engage with this way of working together, especially if they did not complete CRT prior to this.

Instructions to patient

In this session, we will do a few pencil and paper tasks. After each one we can talk about the exercise and reflect on any particular issues it raised for you. This intervention is based on our research in eating disorders, cognition and emotion. Every person is different, and we will have the opportunity to explore how you think and feel and how would you like to use this knowledge in further psychological work here in the sessions and your day to day life.

Exercise 1: Main Idea – addresses 'bigger picture thinking'

Aim of the task:

The aim of this task is also to encourage patients to see the context of the information rather than focussing on the details only. Patients are presented with large amounts of written information in the form of a story and are required to summarise the main points.

Instructions:

Choose one of the stories on the following two pages. Read the story and try to summarise it in a couple of sentences. If your patient is comfortable doing this, you can then ask them to write the story in the format of a text message and finally to make up a title for the text. If they find it difficult leaving out information, try summarising a paragraph at a time and then in later sessions increase the amount of information that should be summarised.

Helpful hints for patients:

- Start by making a few bullet points
- Try to identify the main points and the details – what is important and what is not important; maybe underline the main points in the text.
- Imagine you are above the information – try to get 'helicopter vision'
- Talk to yourself by starting and finishing the sentence, 'The main idea is…'
- Try to give a headline to each paragraph (or summarise the paragraph in one word)
- Imagine a lens that helps you zoom in on information and zoom out from information – where could this technique be useful?

Ask for patient's reflections:

- What drew you to the information you chose to summarise the piece?
- Were you able to hold the whole story in mind or did you get stuck on certain aspects of it?
- How did you summarise the information as you read through?
- How can you relate this task to day to day life? For example,
    - Are you able to follow what a person is talking to you about or do you get side-tracked on one piece of information?
    - Are you able to follow the plot of a film or book or do you get side-tracked by certain parts?

Story 1: “Maybe”

(There are a number of versions of this story in Taoist and Zen philosophy. This version was retrieved from: http://www.myrkothum.com/the-10-very-best-zen-stories/ on 04/07/13)

Maybe

Once upon the time there was an old farmer who had worked his crops for many years. One day his horse ran away. Upon hearing the news, his neighbours came to visit. “Such bad luck,” they said sympathetically.

“Maybe,” the farmer replied.

The next morning the horse returned, bringing with it three other wild horses. “How wonderful,” the neighbours exclaimed.

“Maybe,” replied the old man.

The following day, his son tried to ride one of the untamed horses, was thrown, and broke his leg. The neighbours again came to offer their sympathy on his misfortune.

“Maybe,” answered the farmer.

The day after, military officials came to the village to draft young men into the army. Seeing that the son’s leg was broken, they passed him by. The neighbours congratulated the farmer on how well things had turned out.

“Maybe,” said the farmer.

Useful questions:

What do you think about the farmer’s reaction to the various situations?

How does the farmer's embracing of uncertainty by remaining open minded help him cope with a fluid situation?

What might be helpful and unhelpful about this approach?

Story 2: "The Professor's Lesson"

(retrieved from http://www.dailylifesinspiration.com/life-in-a-mayonnaise-jar on 17/07/13)

A professor stood before his class with some items in front of him. When the class began, he picked up a large empty jar and proceeded to fill it with golf balls. He then asked the students if the jar was full? They agreed that it was.

So, the professor then picked up a box of pebbles and poured them into the jar and shook it lightly. The pebbles rolled into the open areas between the golf balls. He then asked the students again if the jar was full. They again agreed it was.

The professor picked up a box of sand and poured it into the jar. Of course, the sand filled up everything else. He asked once more if the jar was full. The students laughed and all agreed that it was.

The professor then produced two cups of coffee and poured the entire contents into the jar, effectively filling all the empty space between the sand.

"Now," the professor said, "I want you to recognise that this jar represents your life. The golf balls are the important things - your family, your partner, your health and your children, your passions - things that if everything else was lost and only they remained, your life would still be full. The pebbles are the other things that matter like your job, your house and your car. The sand is everything else - the small stuff."

"If you put the sand into the jar first, there would be no room for the pebbles or the golf balls. The same goes for your life." He continued, "If you spend all your time and energy on the small stuff, you will never have room for the things that are important to you."

"Pay attention to the things that are critical to your happiness: play with your children, talk to your family, keep that doctor's appointment, take your partner out dancing, go shopping - treat yourself"

"There will always be time to go to work, clean the house and fix the car. Take care of the golf balls first - the things that really matter. Set your priorities. The rest is just sand."

One of the students raised her hand and asked what the coffee represented. The professor smiled, "I'm glad you asked. It just goes to show that no matter how full your life may seem, there is always room for a couple of cups of coffee with friends".

Useful questions:

What do you think is the main message the professor is trying to teach his students?
Can you think what the golf balls are in your life? And the grains of sand?
Do you think that you currently fill your time with the golf balls in life or the grains of sand?

***Therapist tip*:** it can be really useful to complete separate mind maps of the golf balls and grains of sand and then reflect on how the patient felt completing each of these, and perhaps ways that they may be able to start to build a bridge toward their 'bigger picture'.

Exercise 2: Embedded Words – targets 'switching' ability

The aim of the task:

The aim of this task is to practice identifying particular categories of information amongst irrelevant information e.g. circle cold and hot objects when you go through the page. This task practices thinking which requires seeing the bigger picture and the detail. It also practices flexible thinking by encouraging switching between different sets of information swiftly and accurately.

Task instructions:

Hand the piece of paper with text to the patient. Follow the instructions at the top of the page.

Ask for patient's reflections:

- Was there a time you noticed you were stuck and the old rule got in the way of the task in hand? How did you move past it?
- When might it be useful to do two things at the same time or use two rules at the same time?

***Therapist tip*:** For more tasks to practise switching, try looking at visual illusions together. Some examples have been provided in Appendix 2.2, along with useful questions to reflect on the task. Websites such as http://brainden.com/optical-illusions.htm also have many more illusions to try.

Embedded word task

Instructions:

Underline words describing clothing and at the same time **circle** words related to cold temperature

snow slacks newspaper top crisp freezer skirt books editor
shoes incur trousers licence change vest doors font drawing
sitting underpants icicle revolve pyjamas chilly sweatshirt t-shirt
shout tonight ice cooker even costume happen nippy sleet
assumption gate gloves temperature freeze point camera attire
dress flower notification past slippers coat leave shudder garden
pants swim blue danger socks pathway insert hat jacket suit
trainers retainer glacier jeans hover shelves swing shorts sweater
game raincoat slacks week permafrost December pushchair fridge
winter sell shirt wonder frostiness outfit glasses type Antarctic
giving cool bus box roof underclothes hustle iceberg ivy scarf
chill gown regent avalanche undershirt stockings tie envelope
stitch Melbourne red premises stove charge talent telephone
hammer icy shelter icecap frost icebox mouse hail face bitter
cabinet party boil boots medal money cap shiver belt cassette
remote cable quiver closed garment fight

Exercise 3: Estimating task – explores perfectionism in action

Aim of the task:

The aim of this task is to encourage patients to practice:

- Estimating and approximating
- Thinking on a continuum rather than dichotomously
- To consider things as being 'good enough' rather than perfect

It is essential that this task be focussed on balancing speed and accuracy, rather than achieving one at the expense of the other. The therapist's target is to minimise performance demands and focus on how the individual patient approaches this task.

Task Instructions:

Place the page directly in front of the patient. Ask them to place a mark where they think 50% is on each of the lines. Explain that the mark does not need to be exact, but rather a 'rough' estimate. Direct your patient to start at the top (for horizontal lines) or the left (for vertical lines) of the page and not to miss any lines.

If they do this very easily, then the task can be made more difficult by marking different percentage points on the line e.g. approximately 25%, 75%. Always encourage approximations.

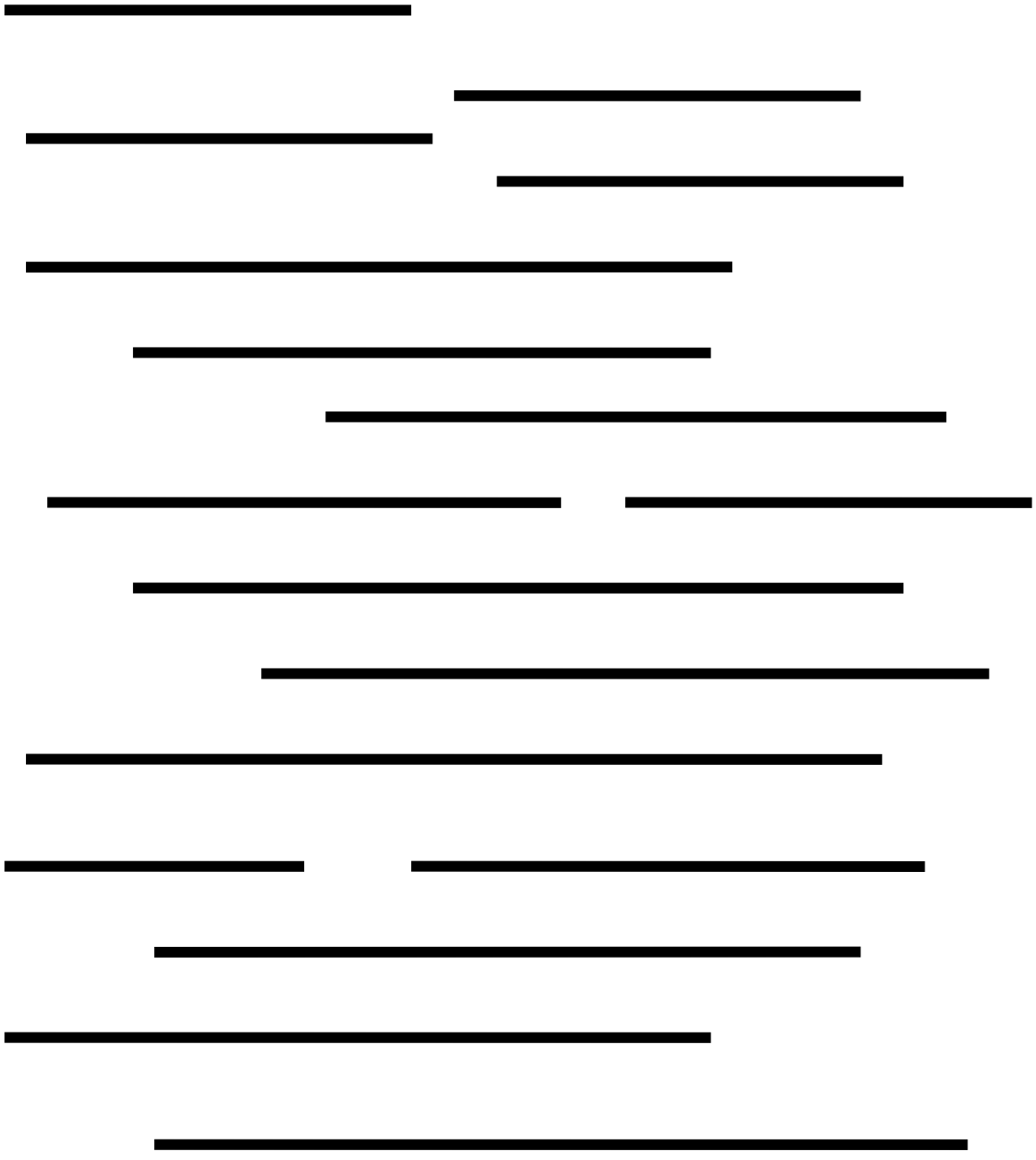
Ask for patient's observations:

- How did you approach the task? Did you use any technique to guide where you placed your mark?
- Did you have times when you felt you were making a mistake? What did you do?
- How do you feel about guessing at things? Do you like knowing more than guessing? When can that be useful? When might it not be useful?
- Do you look for the right answer or spend time focussing on the details, instead of choosing something imperfect, but acceptable?
- How can you use this experience in everyday activities?

  For example, estimate the size of the parking space when parking your car; estimate the amount of washing powder to use; estimate the time rather than looking at clock

If patients take the task too seriously and spend longer on it than they should, enquire about spending excessive time on small or inconsequential tasks. Ask if they often find themselves spending more time than they need to on details or making certain things are exact, rather than focussing on getting a task done in a way that is 'good enough'.

Estimating task



Homework:

Aims:

1. To encourage the patient to introduce a small change to their daily routine thus encouraging flexibility and challenging rigid behaviours.
2. To avoid the possibility of disengagement, reassure the patient that the homework is optional and their performance is not being assessed. This intervention is an opportunity for the patient to learn about and explore different aspects of their daily functioning.

Instructions:

Reflect with the patient on any rigid routines or rituals that you may have identified during the session. Ask the patient to make one ***small*** change to their daily routine, for example not making their bed before breakfast; brushing teeth before shower instead of after; reading a different newspaper at the weekend. These changes need to be relevant to the individual patient and should be decided in the session. There are some ideas for behavioural changes on the handout on the following page.

Ideas for behavioural tasks

Changing routine

- When you get dressed, put on your clothes in a different order than usual
- Brush your teeth with your non-dominant hand.
- Wear different make up or less make up.
- Change the colour of your nail polish/lipstick/rouge.
- Wear your watch on the other wrist for a day.
- Wear your hair differently (put your parting on the other side, wear it up or down, in plaits or blow-dried in a different way).
- Choose a different ring tone on your phone.
- Listen to a different radio station.
- Experiment with a different newspaper or TV programme.
- Change around a small item of furniture or lamp in your room.
- Choose different brands whilst shopping e.g. a different brand of washing up liquid, moisturiser, breakfast cereal.
- Change cleaning routines (e.g. have breakfast before cleaning the house, cleaning rooms in a different order, etc.).
- Change routines in the morning e.g. clean teeth before/after shower – same for bedtime routines.
- Change routines for journey from house to work/college/hospital (e.g. use different buses, walk a different route.
- Change your favourite plate/mug.
- Sort out your wardrobe and take items you will never wear to the local charity shop.
- Instead of keeping old newspapers, magazines etc., cut out favourite sections and throw away the rest.
- Leave the house untidy when going to work and tidy up in the evening; the same with laundry/ironing.
- Sit in a different place at mealtimes.
- Add one extra ingredient to your shopping list (not bulk food but e.g. a herb, spice, garlic).
- Estimate the amount of washing powder to use rather than using a measuring cup.
- Estimate the time rather than wearing a watch.
- Change the clock on your phone to 12 hour / 24 hour setting.
- Use a different internet browser.
- If working with text on the computer, use a different font for the day.
- Change the background picture on your mobile phone or computer.

Relaxing

- Read a different newspaper, or your usual newspaper but in a different order from your usual routine.

- Skim through or read some parts of magazine rather than reading the entire magazine from cover to cover.
- Read something you wouldn't normally consider. It doesn't matter whether it's an obscure book or a trashy magazine.
- Go to the cinema or an art gallery.
- Go to/rent a movie that you usually would not have chosen to see.
- Borrow a CD or book from the library.
- Visit a public park or other recreational facility.
- Experiment with drawing/painting using your non-dominant hand.
- Write a short letter to a person you would like to talk to, even if you never send it.
- Play a board game e.g. draughts, chess, monopoly.
- Play a game of cards.
- Listen to the whole album on your MP3 player rather than listening to the 'favourites' list.
- Create a new playlist on your iPod (or other music device), and listen to this instead of your old one.
- Shop for a novel item not related to food, for example, stationary, flowers, bubble bath, candles).
- Try describing the route from home to school/work/the store/your favourite café' to someone else.
- Describe yourself by firstly writing a short text about yourself, then shorten it down to a few sentences, and finally, summarize the text in a few words.
- Watch a movie and describe the plot to a friend or a family member using no more than five sentences.

Optional Module 6

Recognising and interpreting other people's emotions

Aims of session

Explain to the patient that now that they have learnt to recognise and manage emotions more effectively within themselves we are now going to spend a little time thinking about how we recognise emotions in other people. Recognising emotions in others can be complicated and involve a number of factors. Recognising and interpreting emotions in others can be important for our relationships and our ability to communicate effectively. It can also inform us of other people's intention and tell us something about ourselves.

Exercise: Facial expressions

Aim:

The aim of this exercise is to explore with the patient how facial expressions are an important source of information about how someone is feeling. Also, the aim is to see what pieces of information the patient uses to identify people's emotions.

Instructions:

Go through each of the pictures (overleaf) separately. Make sure you focus on one picture at a time and ask the patient the following questions about each picture:

- **What emotions do these people feel?**
- **What clues are you using to help you identify how that person is feeling?**

It might be useful to explore whether there are any differences in the emotions attributed by patient and therapist and to identify what might lead to different people seeing different emotions in the same face? If you have a bias towards seeing a particular emotion what might this mean for how you experience other people generally?

After going through and looking in detail at each picture, you then use these questions to reflect on all of the pictures.

- **Were some of the facial expressions easier to identify than others?**
- **Which ones?**
- **What made it easier to identify these particular facial expressions?**
- **Do you find easy/difficult to make eye contact?**
- **Is it important? Why? When is it important to make eye contact?**

Reflections:

- Is it easy to read faces?
- What helps to read facial expressions?

- What makes it more difficult to read facial expressions?
- What other information should we consider when making judgments about how someone else is feeling?
- Why is it important to read other people's expressions?
- What makes communications easier?
- If patient and therapist see different emotions in the same picture, reflect on why this might happen. What kinds of biases might be operating?
- If you were lost in the street who you would approach from the photos? Why?
- If you were at a party who from the photos would you talk to? Why?

Appendices

1. **Additional information sheet for patients –** to be offered after completing optional Module 5, “Thinking about thinking”

2. **Supplementary CREST materials for Individual and Group work:**
   2.1 Checklist of CREST exercises
   2.2 Visual illusions
   2.3 Assertive Communication Skill: Importance of Being Direct and Clear
   2.4 Assertiveness Communication Skill: ‘I’ Messages
   2.5 Simple Pleasures Toolkit
   2.6 Pay it Forward Quotes
   2.7 Three Good Things
   2.8 Letter of Gratitude
   2.9 Positive Body Language

3. **How CREST developed: research evidence**

4. **Individual case studies**

5. **CREST in a group format**

6. **How can we evaluate CREST?**

7. **Table of available evidence**

8. **References and further reading**

Appendix 1

Additional information sheet to be offered after completing optional Module 5, "Thinking about Thinking"

What is the link between cognitive skills and emotion?

Research in positive psychology shows that people who can recognise, express and manage their emotions effectively are happier and more successful in life. It is known that emotions, whether they are pleasant or unpleasant, help us: for example, to make decisions, avoid danger, or relate to people.

Cognitive and emotional skills are both important for good psychological functioning.

- In the "Thinking about Thinking" module, we used exercises and reflection to **IDENTIFY, USE**, and **UNDERSTAND** cognitive and thinking skills in order to **MANAGE** everyday tasks better.

- The first step to managing our emotions better is to **KNOW** more about emotions. We will be looking at lots of different skills around emotion, some of which you may find you're stronger at than others.

Research from our and other groups has shown that people with anorexia nervosa can experience difficulties in some or all of the following areas (the following references in the reference section capture this: Kerr-Gaffney et al 2019, 2018*): For full references see reference section.*

Reading: Some people find it harder than others to read emotions in themselves or other people. This difficulty with accurately picking up emotional signals can make it harder for people to know *what they need* themselves or *what others want* from them.

Can you think about a situation or occasion when it was hard to guess what the other person was feeling? (it could be a recent event – the purpose of the question is to generate specific material to work on).

Too much and too little: Emotions can give us problems if they are very long-lasting, intense and distressing, or if they arise and persist in response to minor triggers and/or out of proportion to the threat posed by the trigger (e.g. as might be the case in spider phobia). At the other end of the spectrum is an inability to experience any emotions, pleasurable or otherwise.

Can you think about how it applies to you?

Expression: Sometimes a person does not know how to express their emotions or finds them too frightening to express. Cultures differ in terms of how acceptable and desirable it is to express your emotions in particular social situations. For example, the English have a reputation for being stiff upper lipped whereas the Italians are known as much more

emotionally expressive. Also, within families there can be different emotional styles; some families are more expressive and others more emotionally restrained. Families may teach people rules about expressing emotions, such as “crying is for sissies”.

Do you have difficulties in expressing emotions? Does it help you when other people express emotions? Why?

Venting: Although an inability to express emotions can cause problems, venting emotions *per se* is not necessarily a good thing for a person or for those around them either. The philosopher Aristotle noted that anyone can become angry, but to be angry with the right person to the right degree at the right time and in the right way is not so easy. On the other hand, if someone always bottles up their emotions, censoring certain emotions and trying to ignore them, this can be unhelpful to their health. It isolates them from what their emotions may be telling them they need and it cuts them off from other people. This is a common problem in AN where starving can function to dampen or lessen emotions.

The good news is that research shows that emotional recognition improves with recovery. We also know that it is possible to learn to express emotions in a way that it is more acceptable and understandable to people around us; furthermore, it is possible to recognise and regulate emotions better when we are aware of them.

Appendix 2

Supplementary CREST Materials for Individual and Group Work

2.10 Checklist of CREST exercises
2.11 Thinking About Thinking Additional Exercise: Visual illusions
2.12 Assertive Communication Skill: The Importance of Being Direct and Clear
2.13 Assertive Communication Skill: 'I' Messages
2.14 Simple Pleasures Toolkit
2.15 Pay it Forward Quotes
2.16 Three Good Things
2.17 Letter of Gratitude
2.18 Positive Body Language

2.1 Checklist of CREST exercises

Use this list to keep track of which exercises you have completed by filling in the session number or date for each one.

Module 1: Thinking about emotions

- … Emotion word sorting
- … Emotions and thinking
- … Emotional Processing Cycle
- … Emotions and our bodies
- … Emotion Questionnaire
- … Homework – complete questionnaire

Module 2: Recognising your emotions and focusing on positives

- … Emotion word list
- … Describing Emotions
- … Switching Scenarios
- … Homework – choose one of 3 'increasing positive experiences' tasks
- … Discuss positive psychology exercises
- … Homework – introduce 1 or 2 strategies into each day
- … List of Personal Strengths
- … Emotion Switching
- … Homework – Emotions Log

Module 3: Managing your emotions

- … Managing Difficult Emotions
- … Pink Giraffe
- … Homework – Self Exercise
- … Emotion word map
- … Emotion thermometer
- … Dimensional emotions
- … Homework – emotion management strategies
- … Making Emotions work for you – the function of emotions
- … Making Emotions work for you – emotions and needs
- … Homework – Making emotions work for me summary sheet

Module 4: Expressing your emotions and focusing on positives

- … How do you signal what you feel and need?
- … Assertiveness Vignettes
- … What might work better for you?
- … Homework – what might work better for you?

Ending CREST and Feedback

- … Ending questionnaire
- … Feedback form

Module 5 (OPTIONAL): Thinking about thinking

- … Main Idea
- … Embedded Words
- … Estimating task
- … Homework – small change in routine

Module 6 (OPTIONAL): Recognising and interpreting other people's emotions

- … Facial expressions exercise

2.2 Thinking About Thinking – Additional Exercise

Visual Illusions

a) Aim of the task

The aim of the illusion task is for the patient to practice holding two ideas - seeing the bigger picture as well as the details, but also to practice switching between different pieces of information. For example, the first illusion task requires switching between seeing the face and the vase.

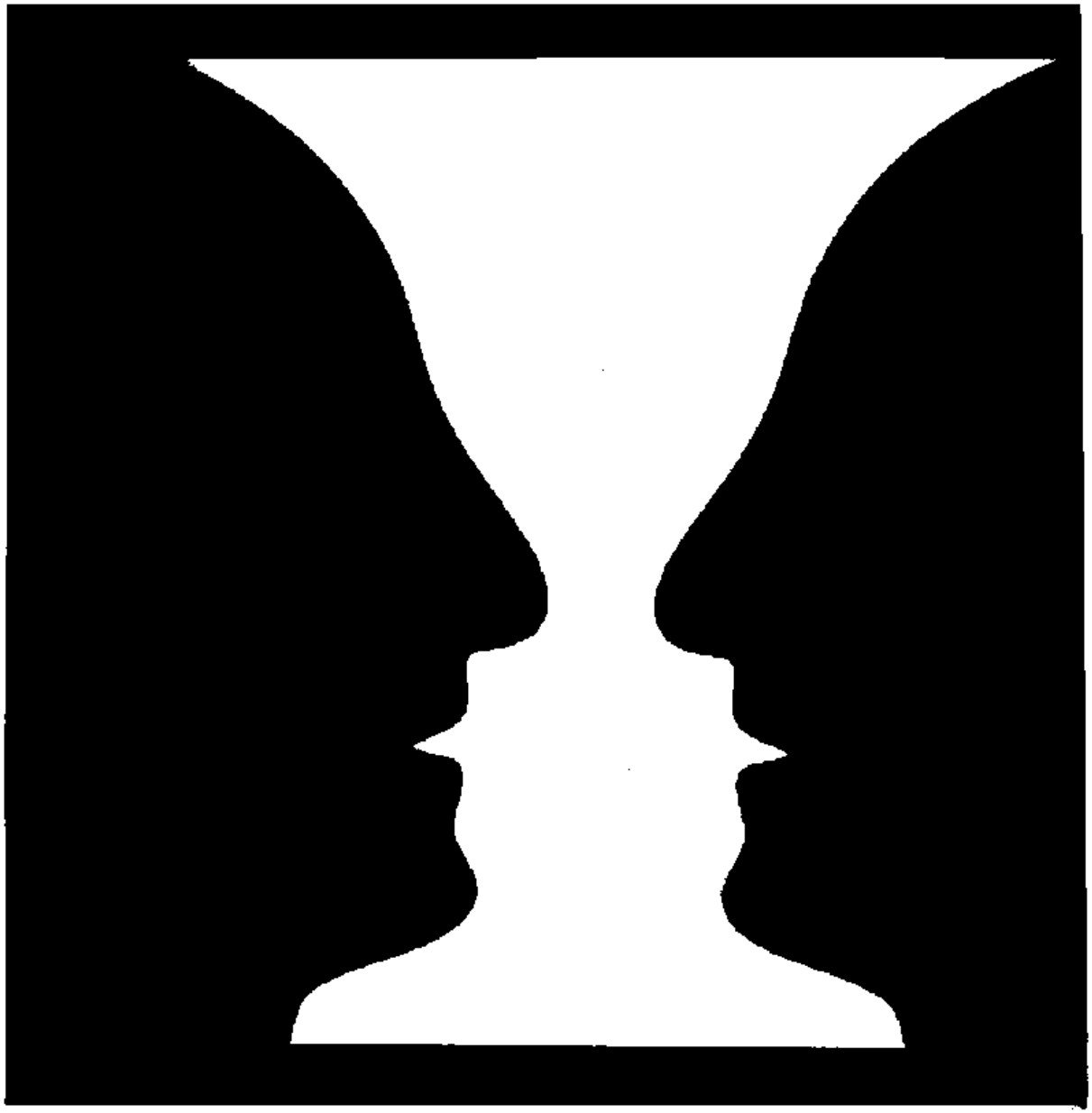
b) Task Instruction

Present the page to your patient and ask what they can see. If they can only describe one image, ask what else they can see. Leave a good time length e.g. 60 seconds for them to explore the picture. If they are unable to see any other discernible element, you may ask if they would like some help finding the image. If so you can point to specific elements of the picture. If they are able to see another image, ask them to point to different features of each image. For example, for the vase/face illusion, ask them to point to the nose, chin, base of vase, where the flowers go.

c) Ask for patient's reflections

- Did you see more than one image almost immediately?
- Did you use any particular techniques to find the other image e.g. moving the paper around?
- Were you able to interchange between the images easily?
- How can you use this experience in everyday activities? If unable to respond, please give the following examples:

    - Have you disagreed about something with somebody and been unable to see their perspective? Were you eventually able to see their point of view?
    - Is it sometimes hard to change your mind about things?
    - Is it sometimes useful to step back from a situation to see the whole situation, rather than just parts?
    - Imagine a view of something; it could be the high street near you, a view of a holiday resort or the view from your bedroom window. Think of different ways of looking at this view. Imagine you are taking a picture. Think of all the different positions you could get into to get as many different shots of the same thing.



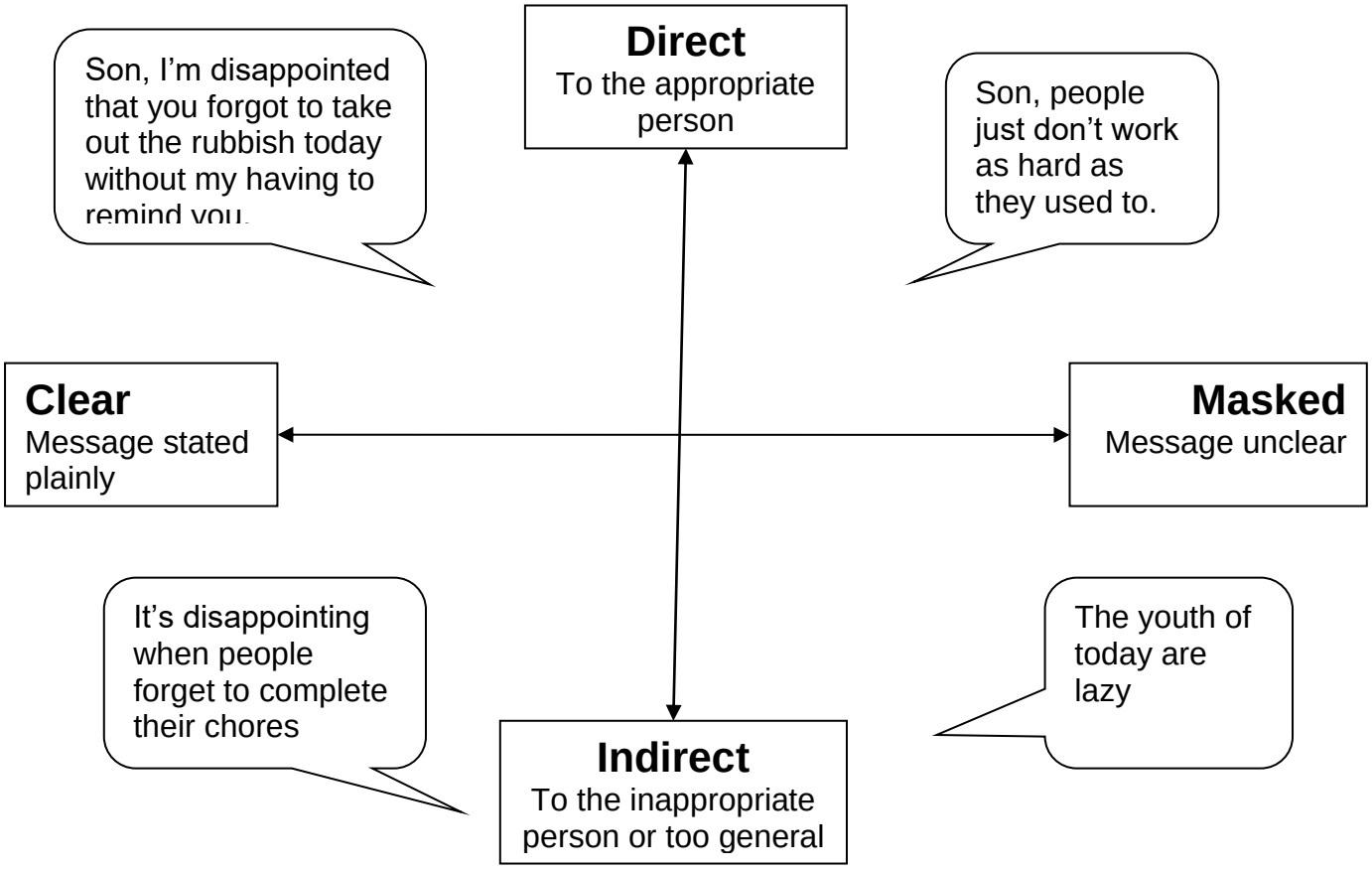
2.3 Assertive Communication Skill: The Importance of Being Direct and Clear

The healthiest form of communication is clear and direct and occurs when the message is stated plainly and directly to the appropriate person.

Miscommunication occurs when a message is masked, vague or unclear since this increases the likelihood that the other person will misunderstand or not understand at all.

Miscommunication also occurs when the message is indirect, directed to an inappropriate person or to no-one in particular since this increases the possibility the other person will fail to understand the message is intended for them.

Imagine a father is feeling disappointed about his son failing to complete his chores. Look at the different ways in which he could communicate this. All of the options might result in the son making more of an effort around his chores in future. However, notice that some of the statements require the son to guess they refer to him or to figure out it relates to his chores.



Only the statement in the Clear and Direct segment effectively communicates an accurate message to the most relevant person and therefore minimizes the possibility for misunderstanding.

We all struggle sometimes to communicate in a healthy and effective way, if there are times when you feel you have not been listened to or other people have not responded to a request you have made it is worth thinking about how you communicated with them and whether you were clear and direct enough.

By communicating clearly and directly you are helping the other person out by giving them less guesswork to do and helping yourself by ensuring that what you want to say is given the best possible chance of being heard and understood by the right person.

The next section on “I” messages will help you think about how to phrase what you want to say.

2.4 Assertive Communication Skill: "I" Messages

An "I" message is a method which allows you to assertively express your feelings. There are four components to an "I" message:

1. State exactly what was said or done that triggered your feelings.
2. State the feelings that you have.
3. Provide an explanation for why you feel the way you do.
4. If appropriate, make a request stating what you need or what you would prefer next time

Template Script for "I" Messages

You can fill in the blanks in this template to help you plan how say something assertively.

When you ……

I felt ……..

Because …….

I would appreciate ……..

Examples:

"When you are not on time, I feel worried because something may have happened to you. I would appreciate it if you would call me when you are going to be late."

"When you refuse to share any information about yourself in the groups I feel frustrated and exposed since I have revealed information about myself which you have listened to. I would appreciate you trying to say something about yourself even if it's just a little to begin with"

"At lunch when you said you thought eating the pudding would make you feel fat and greedy I felt guilty and angry because I had just finished the same pudding which is a really positive but difficult step for me. I would prefer if you could speak about those anxieties away from the meal table."

"When I suggested we could go to the cinema on Friday and no-one responded I felt hurt and confused because I did not know what everyone was thinking and wondered if my idea was stupid. I would find it easier in future if you could say what you think, if you are busy, don't fancy the plan or aren't in the mood."

2.5 Simple Pleasures Toolkit

- Winning an e-bay bid
- Positive connections with others
- Sunny days
- Contact with friends
- Writing to family, knowing they will value it
- Getting letters
- Jewellery making
- Music
- Being active/outdoors
- First signs of spring
- Flowers
- Getting your hair/nails done
- Pampering: reflexology/massage/facial
- Making others happy
- Laughter
- Shopping
- Playing games
- Singing
- Random walks
- Watching old films
- Reading a good book
- Going for a hair cut
- Going to the cinema
- Learning something new
- A drive in the country
- Cuddling a pet
- Fresh sheets on the bed
- Internet surfing
- Knitting/crochet

- Doing jigsaws/puzzles
- People watching with a friend
- dancing

2.6 Pay it Forward Quotes

"Sail beyond the horizon; fly higher than you ever thought possible; magnify your existence by helping others; be kind to people and animals of all shapes and sizes; be true to what you value most; shine your light on the world; and be the person you were born to be." Blake Beattie

_____

"I hope the fruits of my labour are ripe for many generations to come." Donovan Nichols

_____

"They say don't believe your own hype, but if you don't why would anyone else? To be great you have to believe you can do great things." Charley Johnson

_____

"Be the change you want to see in the world." Ghandi

_____

"A life lived for others, is the only life worth living." Albert Einstein

_____

"If you can't feed a hundred people, then just feed one." Mother Teresa

_____

"The only time you should look down at someone, is when you are helping them up." Jesse Jackson

_____

"If you have much, give your wealth; if you have little, give your heart." Anonymous

_____

"You may be only one person in this world, but to one person at one time, you are the world." Anonymous

_____

"An untruth kept in the heart, is a burden which weighs down the soul." Blake Beattie

_____

"There is no such thing as can't." Christopher Reeve

_____

“There are two way to live your life. One as though nothing is a miracle, the other as though everything is a miracle.” Albert Einstein

---

“I have a dream.” Martin Luther King Jr

“Every man dies, not every man really lives.” William Wallace

---

“Together we can change the world, one good deed at a time.” Blake Beattie

---

“I was angry with my friend;
I told my wrath, my wrath did end.
I was angry with my foe:
I told it not, my wrath did grow.” William Blake, The Poison Tree

2.7 Three Good Things

Each day fill in one or more of the following with a positive:

Today I appreciate ……

……

Today I value…….

……

Today I felt positive when……

…….

Today I appreciate……

…….

Today I value……

……..

Today I felt positive when…….

…….

Today I appreciate…….

……..

Today I value……

……

Today I felt positive when …….

…….

2.8 Letter of gratitude

Taking time to think about what and who you are grateful for having in your life can encourage positive emotions.

First make a list of people who have had a positive impact on you and that you are really grateful to.

I am grateful for _____

because _____

_____

I am grateful for _____

because _____

_____

I am grateful for _____

because _____

_____

Second, choose one of these people to write a letter of gratitude to, explaining how they have had a positive impact on you and why you are grateful to them. As you write the letter, try to really engage with the feelings of gratitude and thanks.

Once you are done send this letter to the person, or even better to visit them and read it aloud; however, if you are not comfortable doing this just the act of writing the letter, research shows it has positive effect.

2.9 Positive body language

Politics-body language - http://www.youtube.com/watch?v=dW9ztSUGY_Q

Body Language with Alan Pease - http://www.youtube.com/watch?v=Aw36-ByXuMw

Amy Cuddy: Your body language shapes who you are
http://www.ted.com/talks/amy_cuddy_your_body_language_shapes_who_you_are.html

We found watching these film clips together and discussing as a group provides useful information for the patients; increasing awareness of the importance of their body, face and voice in communication and giving an opportunity to set up behavioural experiments exploring positive communication with peers, staff, families and broader social networks of people.

We found it very useful to share with patients some of the links with TED talks and explore as a home task relevant materials from the webpages.

Appendix 3

How CREST developed: research evidence

There is evidence that cognitive remediation (CR) sessions for AN inpatients (working through cognitive exercises, then reflecting on thinking styles and applying them to real life) improves cognitive performance, confidence to change and ability to change (e.g. Tchanturia et al., 2008, 2014). Additionally, patients report finding this approach helpful, encouraging them to engage with treatment and to feel safe during sessions (Whitney et al., 2008).

Issues related to emotions and core symptoms such as food, weight and shape related concerns are *not* addressed in CR work. This module, therefore, can be built onto a foundation of CR work.

The content and emphasis of exercises in this manual were guided by informal clinical experience and formal feedback from focus groups with patients, carers and clinicians (described briefly here, and in more detail in the paper we reported this results - Kyriacou, et al., 2009).

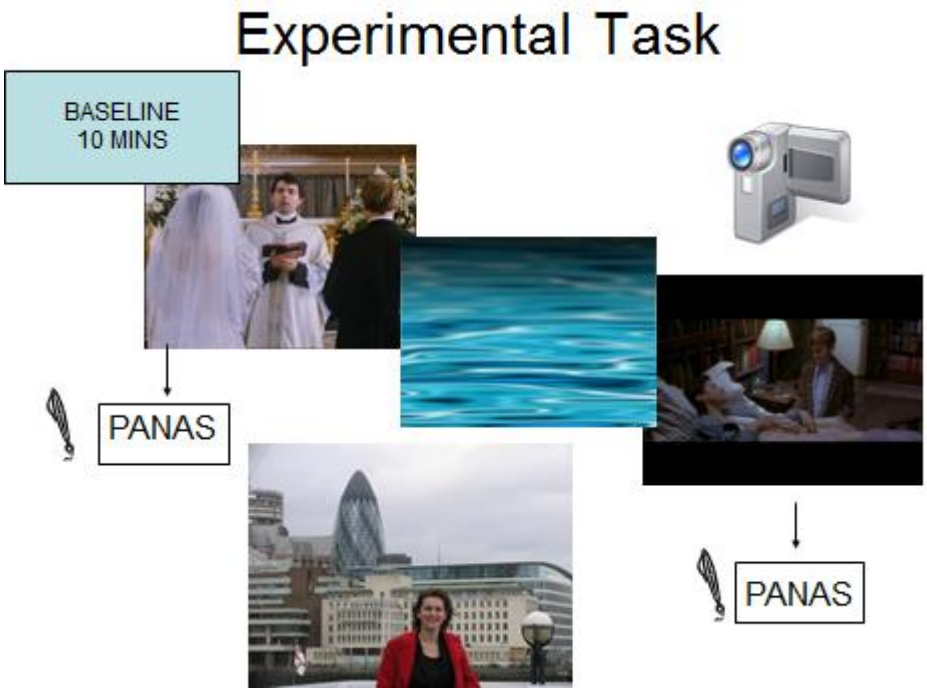
In order to make sure that we targeted the most important areas of emotional difficulties we held four focus groups with patients, carers, clinicians, and nurses respectively. These explored what each group identified as the most salient issues concerning emotions and social cognition in AN and what they thought treatment should focus on. Table 1 shows the overlapping and most frequently mentioned themes arising from these focus group discussions. This illustrates how this manual's approach matches these demands.

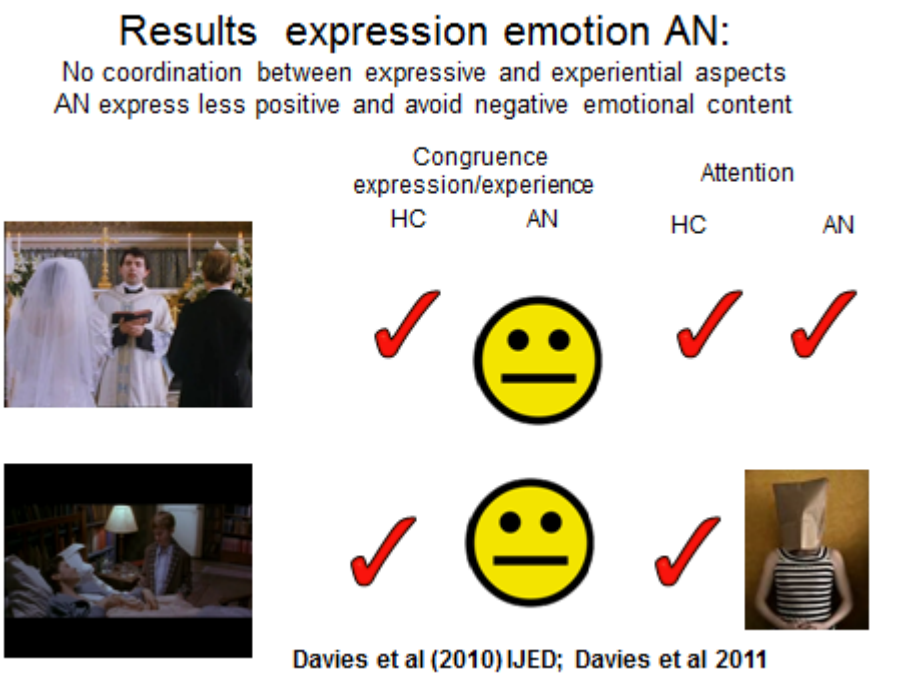
Table 1. Themes identified from focus group discussions

Themes	Clinicians Therapists	Nurses	Patients	Carers
Problems with emotions & social cognition				
Identifying emotions	√	√	√	√
Emotional Recognition & Labelling, Expression of Emotions	√	√	√	√
Lack of self-awareness of own emotions & needs	√	√	√	√
Processing and Managing Difficult/Intense Emotions	√	√	√	√
Emotional Avoidance & Intolerance of Emotion	√	√	√	√
Extremes & Erratic oscillation of Emotions	√	√	√	√

What is the research evidence for CREST?

Research evidence shows that labelling and processing emotions can be difficult for people with eating disorders. In combination with this, another big problem is the expression of emotions. For example, Helen Davies, one of the contributors to this manual, studied how people respond to neutral, positive and negative emotions. She found that people with eating disorders respond similarly to a non-eating disorder comparison group when they see a neutral film on the screen. However, when viewing positive content they show less emotional facial expressions and when viewing a negative film clip they tend to look away more often (Davies et al., 2010).





This figure illustrates the findings of the first experimental study of emotional expression in AN described above. We use this research evidence in discussions during both individual and group sessions of CREST. We ask patients how they interpret these findings. Is it similar to what they think about their own experience with expression of emotions?

How does CREST fit into the treatment pathway?

This emotional skills inpatient module aims to work with severely ill inpatients (IP) and thus exercises are targeted at a different level with different emphases to the emotion and social skills work carried out with outpatients (OP). When people are newly admitted to the hospital, typically with a number of physical complications, they find hard to concentrate and are not ready for complex psychological work. Therefore, we try to offer relatively basic psychoeducational programmes with specific exercises to facilitate therapeutic engagement while also addressing important aspects of the illness.

Table 2 shows that the inpatient (IP) module places emphasis on teaching a basic understanding of emotions and their function, as well as considering recognition of emotions in self and others. In contrast, the OP manual called "MANTRA" assumes these skills are already present to some degree and places greater emphasis on how to work with emotions, both in an individual's personal emotional life (e.g. self-compassion, beliefs about emotions) and in the context of their relationships with others (e.g. developing empathy). In this way the IP and OP workbooks aim to complement each other, enabling patients to move from IP to OP care by slowly building on and extending their emotional skills without repeating the manuals' contents.

Table 2. Summary of content of Inpatient and Outpatient work books targeting emotions and social skills. Emphasis on each learning point is described as low, medium or high.

Learning Point	*Inpatient Manual – IP- (inpatients) CREST*	*Outpatient Manual –OP- (outpatients) MANTRA*
Psychoeducation (Emotions: What and Why?)	**High V**	**Medium**
Recognising Emotions in others	**High V** *Reduced in the updated version* **Low**	**Medium**
Function of Emotions	**High V**	**High**
Managing Emotions	**High V**	**Medium**
Recognising Emotions in Self	**High V** *Pilot work indicated that patients valued this part the most*	**Medium**
Expressing Emotions	**Medium V** *increased emphasis on this part in updated manual based on experimental research findings and qualitative studies.* **High**	**Low**
Additional Work on Social Anhedonia generating ideas about Simple pleasures Positive emotions diaries Toolbox	**High** *This point was added and expanded upon in the updated manual*	
Teaching about power of positive emotions, giving tools how to facilitate positive thinking and bias	**High Materials for this section of CREST we are developing further. Research evidence and convincing pilot clinical work will be added in the next revision of the CREST manual.**	

Appendix 4

Individual Case Studies

In this section we have provided a few case reports from different therapists and patients to illustrate CREST in the individual format. We also describe some outcome measures we have used to explore the clinical and psychological benefits of this work. The case studies are presented in chronological order. The first case reflects the very early days of development of the CREST manual from Caroline Fleming (2009); followed by two cases from 2010 by Claire Money. The manual in the present form is revised and we would like to take this opportunity to thank all patients and clinicians for their reflections, creative ideas and hard work to help us to develop this next version of the CREST manual.

CREST Case Study 1

Caroline Fleming, Counselling Psychologist,
Maudsley Eating Disorder Service Inpatient Unit

The following case study describes one of the first patients we worked with to pilot the CREST individual workbook and we are very grateful to Dorothy (which was her chosen name for this case study) for giving her consent to share this.

Case introduction

Dorothy was a 30 year old female who was referred to the inpatient ED service due to severe AN. Prior to referral to the specialist service, she had been admitted to her local general hospital at 24 kg (BMI of 8.5). At that point she was unable to stand unaided. She was initially fed with total parenteral nutrition, gradually moving on to solid foods and was discharged at a weight of 31kg (BMI 11.4). However, she was unable to maintain this progress at home; she again lost weight and, a month after discharge, agreed voluntarily to be referred to a specialist ED unit. On admission to this unit her weight was 24.9kg (BMI of 9.8). She was again unable to stand or walk unaided.

Presenting complaints

She found it difficult to be continually 'confronted' by the illness in the dining room, partly because she found herself to be drawn in to the AN behaviours and partly because she was wanting to distance herself from the illness. She experienced feelings of panic and fear in response to outbursts from other patients, leaving her overwhelmed with memories of her parents' angry arguments during childhood.

History

Family. Prior to admission to her local general hospital, Dorothy had been living with her fiancé, whom she had been in a relationship with for eleven years. On discharge from her local hospital and prior to admission to this ED service, she had returned to live in the family home with both parents and her youngest sister. She has three siblings, a brother aged 32, and two younger sisters, aged 29 and 18.

Education/Career. Dorothy attended a College course in Travel and Journalism and after completion of her education, she worked as a receptionist in a Gym for three years and then as a receptionist in a security company. She has not worked formally since then but did enter various beauty contests and began training as a hairdresser.

Social. Dorothy enjoyed dancing and being out with friends. She felt very close to her fiancé, but recognised that he was overwhelmingly involved in her decisions, for example what she should wear, with whom she should socialise.

Medical and Mental Health. Dorothy had not experienced any major medical illness. There was no family history of medical, psychiatric or eating disorder. Her first symptoms of AN had emerged eight years previously at age 22. She attributed the onset of the illness to a failure to win an award in a national beauty contest. She believed that if she lost weight, she would become more beautiful and thus more successful, and this led to a cycle of restrictive eating, compulsive exercise and laxative abuse.

Case conceptualisation

Through adverse early childhood experiences, particularly witnessing parental conflicts, it seemed that Dorothy developed a belief that negative emotions are particularly dangerous, must be suppressed, and that there was no healthy means by which these feelings could be expressed. In response to these frightening early experiences, it appears she believed that she also needed to be strong and care for her mother, repressing her emotional needs, and being the 'good girl'. This developed into a stance of 'people pleasing' and 'performing' more generally, attempting to meet others expectations of her in order to be accepted (i.e. not harmed or rejected). In relation to this, only positive emotions were deemed acceptable and negative emotions were not considered valid or significant. AN developed at least partially to assist in maintaining control over affect, and she described feeling a sense of being cut off or numb emotionally, which she recognised as problematic but also relieving.

After the assessment, CREST was offered to Dorothy with the clear advice that we were developing and testing the workbook and we felt that some of the parts of the manual might be beneficial. For example, a focus on recognising positive soothing snapshots in everyday life and making a portfolio of positive emotions.

Course of treatment and assessment of progress

CREST was completed in ten face to face sessions (45 minutes each), which were conducted over a seven-week period, a minimum of 1 session and a maximum of 2 sessions were completed in any one week. The first two CRT sessions, the thinking skills exercises and associated reflection on them highlighted many areas where Dorothy struggled with a particularly rigid thinking style. She demonstrated a high perfectionism focussing on any mistakes or flaws, discounting her strengths and judging herself harshly according to a rigid set of rules. Dorothy reflected on how this thinking style impacted on her self-confidence and self-esteem. The homework tasks were developed with regard to 'breaking the rigid unreasonable rules', with small behavioural experiments such as not ironing her duvet cover and moving items around in her room.

Most of session 3 was spent reflecting on what had been learned in cognitive parts of the two sessions with a gentle introduction exploring emotional processing. Dorothy was able to identify emotions including fear, anxiety and panic, arising from her core beliefs and expectations that she may be harshly judged or criticised if she doesn't 'get things right' .

During session 4, Dorothy was able to recognise significant difficulties with managing and expressing emotion effectively, predominantly due to fears of being abandoned/rejected and due to previous experiences of having her emotional states ignored or negated. Additionally, anger was identified as a 'dangerous' emotion, seemingly in relation to the

prolonged domestic violence she witnessed during her past years. Although Dorothy did not initially perceive any difficulty in relation to recognising emotion in others, exercises concerned with identifying others emotions through photos of facial expressions, revealed a tendency to focus only on the eyes, which could lead to misunderstanding and misinterpretation. Thus, homework tasks were developed to enable practicing a 'bigger picture' perspective in relation to this. For example, looking at pictures and focussing on the context people are in and how this impacts on the emotion on their face.

The remainder of the therapeutic intervention focussed on being able to identify, label and express emotion more effectively, with particular attendance to the acceptability of negative emotional states. Sessions (before our revisions to the manual) 5 and 6 were primarily concerned with enabling Dorothy to develop a vocabulary of emotion through identifying and expressing emotions she was experiencing. For example, she was asked to choose from a word list of over 100 'emotion' words in order to explain a previous experience she had been through. Additional exercises focused on developing the capacity to switch between emotions, to assist in the recognition that emotional states are dynamic and fluid rather than fixed and unchangeable. Through reflection and a increased vocabulary on which to draw from, Dorothy seemed to find it somewhat empowering to be able to more accurately express a broad range of emotions, especially in relation to difficult situations she was experiencing during her admission. Furthermore, through the exercises which focussed on how to manage emotions, Dorothy developed an awareness of the problems associated with bottling up, suppressing and avoiding emotions, such as the resulting impact in successful communication and ability to address and resolve problems.

Through her increased awareness and understanding of her emotions and practicing self-expression in sessions, Dorothy became motivated to take the 'risk' of transferring these skills to the ward. Session 7 onwards focussed on exploring the association of emotion to corresponding need and difficulties that arise when needs are not met. Dorothy responded to these exercises well and transferred these skills to difficult situations effectively, leading to increased determination to develop these capacities further. For instance, toward the end of these sessions she described feeling alone, isolated, lost, rejected, abandoned, agitated, frustrated, angry and irritated as she did not feel her needs were being listened to or taken seriously by ward staff. Through exploration, Dorothy could recognise that she was essentially expecting others to be able to 'mind read' her emotional state without her having to verbalise her distress, and she could distinguish for herself how this was an ineffective 'communication style'. We thought through the reasons behind her emotional state and it seemed that, owing to her very lowered BMI on admission, she was still unable to leave the ward, which was becoming increasingly unbearable to manage. As a result, she was losing the motivation and determination to remain engaged in the programme. Thus, her concerns were discussed with the clinical team and it was then deemed appropriate for Dorothy to be able to be escorted by taxi to the local shops to purchase some supplies. This had a very positive impact on her and she recognised that her fundamental need in relation to sustained engagement in treatment was to work towards the themes of 'independence' and 'freedom' as 'anorexia' had taken away her dignity, to the point that she could not care for even her most basic needs.

By completion of these 10 sessions, Dorothy perceived herself to be better equipped to manage difficult situations, and more readily able to communicate her feelings and associated needs to the clinical team. This had the impact of her being increasingly able to access and utilise the supports she required. She was now engaged and motivated to begin

complex treatment with an individual therapist to extend and build on the strategies and skills learned during CREST.

Complicating factors

Dorothy was inclined to 'people please' and so needing to remain aware of her wanting to be the 'perfect patient' was always kept in sight. Despite this, she did seem authentically engaged in the material and honest about the experiences she was discussing, surprising herself on occasion as to how direct she was being in discussing 'embarrassing' or 'shameful' incidents.

Follow up

After CREST, Dorothy remained on the ward and received ongoing individual therapy with a ward psychologist, with particular focus on identity issues, self-esteem, and assertiveness with regard to expression of need. Additionally, due to the difficulties which were identified during CREST regarding flexibility and perfectionism, further work in these areas was required.

Treatment implications of the case

Baseline and end of treatment clinical measures and self-report questionnaires targeting emotion processes were completed by Dorothy.

Dorothy's clinical symptoms improved after CREST with her BMI increasing from 11.02 to 12.30. Illness related symptoms also improved with the global score of the EDE-Q decreasing from 3.30 to 2.10. Dorothy's depression and anxiety scores improved (measured by the DASS).

The self-report measures focussing on emotion processing also indicated that Dorothy ascribed a positive change in processing and regulating emotions in herself. The LSAS scores range from 55-65 for moderate social phobia to 80-95 for severe social phobia, over 95 depicts very severe social phobia. Dorothy showed a lower score after CREST of 56, thus in the moderate social anxiety range as opposed to 73 at time 1 which put her in the marked social phobia range. Two of the subscales of the TAS showed an improvement after CREST. Dorothy's total score on the Toronto Alexithymia Scale moved from the alexithymia category to the non-alexithymia category. Our hypothesis for this improvement is that the identifying and labelling of emotions exercise in CREST is very relevant for Dorothy. She had an opportunity to practice skills and label emotions with support from her therapist. Finally, on the EEQ, a score of 77 was reported after CREST, compared to 56 prior to the intervention, with a higher score corresponding to being better able to express emotion.

As well as demonstrating a change in the clinical and emotion processing domains via the self-report questionnaires, Dorothy reported on the patient satisfaction questionnaire that she valued the usefulness and positive aspect of the treatment. She also showed an increase in the ability to change via the motivational rulers suggesting that she had gained confidence to change.

Figure 1. Body Mass Index (BMI) before, during and after CREST

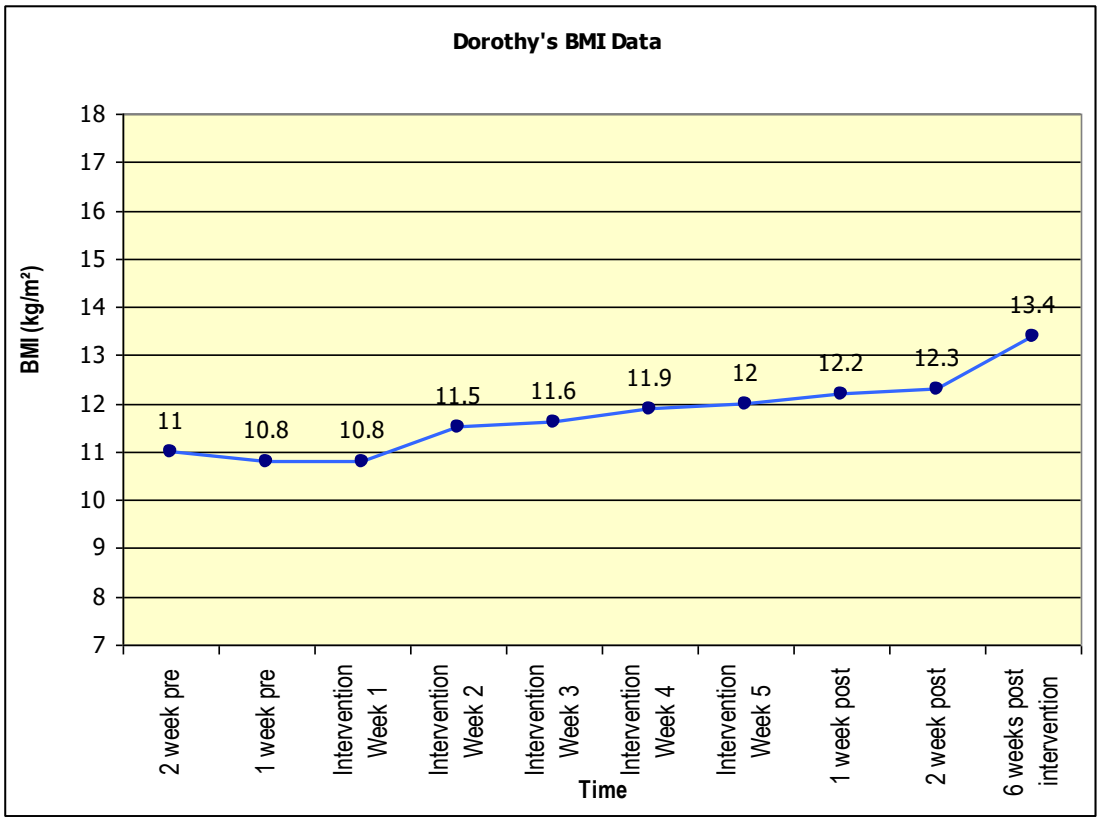


Table1. Demographic and Clinical measures

	Time 1 Before CREST	Time 2 After CREST	+ improved - got worse = no changes
BMI	11.02	12.30	+
EDE-Q (Global score)	3.30	2.10	+
DASS Stress	18	12	+
DASS Anxiety	18	12	+
DASS Depression	22	6	+

Table 2. Self Report Measures for Emotion Questionnaires and Motivational Ruler before and after treatment plus Patient Satisfaction Score at the end of treatment

	Time 1 Before CREST	Time 2 After CREST	+ improved - got worse = no change
Emotion Regulation (Reappraisal)	29	42	+
Emotion Regulation (Suppression)	17	14	+

Leibowitz Social Anxiety Scale	73	57	+
TAS (Describing feelings)	17	10	+
TAS (Identifying feelings)	31	14	+
TAS (Externally oriented thinking)	24	24	=
TAS Total	72	48	+
Emotional Expression	56	77	+
Patient Satisfaction (Mean score of all five items)	N/A	8.4	N/A
Motivational Ruler Importance to change Ability to change	 10 6	 10 8	 = +

We have been in touch with Dorothy one year after discharge from the inpatient ward. She lives a long distance from London and she is managing very well. She is back at work, maintaining a BMI of 19.5. She is currently in a relationship. She has lapses but is supported by a very good therapist in the community when required.

Dorothy's treatment had input from several members of the multidisciplinary team. She is one of the patients demonstrating a very positive outcome. She was very generous to agree to use this relatively new workbook with her and then to allow us to write up this work as a case example. In reflection, as therapists and clinicians, we learned a lot from this case.

Case study 2

Claire Money, Counselling Psychologist,
Maudsley Eating Disorder Service Inpatient Unit

History

Emily was a 19 year old female meeting the DSM – IV diagnosis for Anorexia Nervosa (restricting type). She did not have any additional Axis I or II diagnoses. Emily was admitted onto the ward with a weight of 37.3 kgs and a height 1.65metres. Her Body Mass Index was 13.7. This was Emily's first inpatient admission and prior to this she had been accessing outpatient services for approximately 18 months.

Emily began to focus on her weight approximately three years ago. There was a family event coming up and she started swimming and running regularly. Not long after the event Emily's exercise regime increased to a daily basis and she was cutting down her food. Emily and her family began to realise that she had a problem as her weight continued to decrease.

Emily was of average weight as a child until she had to take steroids for a medical problem. This led to a dramatic increase in weight, which she found difficult to lose in her early teenage years.

Emily lives with her parents and has two older brothers. She describes good relationships within the family although commented there are problems from time to time. She described her personality as ambitious, friendly and bubbly. She also described herself as being a 'control freak' before the illness. Since having AN, Emily's mood lowered and her anxiety levels increased. She reports low self-esteem and fear of failure.

Soon after the admission to the ward Emily was offered 10 sessions of CREST and attended all sessions twice weekly.

The first two sessions focused on thinking styles. The 'geometric figures task' involved Emily describing a figure for the therapist to draw. The aim was to encourage Emily to think in terms of the bigger picture. The task revealed that Emily tends to pay attention to detail, a thinking style that involves getting caught up in the detail of the figure rather than seeing the figure as a whole. In relation to everyday life, Emily talked of having a detailed focus where she focuses on having clear routines. She struggles with change and spontaneity; she described having to plan social activities in advance and finding it difficult to spontaneously go out for a coffee with a friend. Emily was able to identify advantages and disadvantages to both bigger picture thinking and attention to detail. She reported finding it helpful to look at her thinking styles and was keen to try and think more about the bigger picture. Her example was to remind herself that she was in hospital to get better rather than getting caught up in the detail of the daily menus.

In session two the focus was the 'estimating task' in which Emily was presented with a number of vertical lines and was asked to place a halfway mark on each one. Emily found this task somewhat anxiety provoking as she feared responding inaccurately. On reflection of the task, Emily related this fear to her daily life and described herself as a perfectionist who does not tolerate mistakes due to worries that people will dislike her. Another task was the 'token towers'. This involved building a tower following rules in terms of colour, shape and size of tokens. Emily was very careful and precise in building the tower. This relates to Emily's daily life in that she has lots of categories and rules for things. Emily talked about not liking uncertainty and wanting to feel in control which leads to having categories in her wardrobe for clothes or time slots for activities such as household chores. We talked about how this

maintains Emily's anxiety about uncertainty as she was not giving herself an opportunity to see how she would cope if she tried to do things differently or more spontaneously.

An inter-session task for Emily was to change one small aspect of her daily routine and she chose not to hoover at a certain time in the morning. This was a successful task and Emily talked of being able to manage the anxiety and feeling pleased that she could think about the possibility of being more flexible. One of Emily's comments about CREST was:

> "…I have found that I must be a lot more flexible in all aspects of my life. This not only means in my daily routines, but also in the way in which I express and show my emotions…I have learnt to look at the bigger picture when I am feeling anxious or worried about a certain situation"

Session four looked at recognising emotions in others. This was achieved by looking at a number of facial expressions and Emily thinking about and trying to label the emotions the person may be feeling. This exercise revealed that Emily has a bias in recognising negative emotion in others. She talked of often assuming she had done something wrong if someone around her looked unhappy. This led on to a discussion as to how Emily would benefit from thinking about the bigger picture and needing a lot of information before interpreting how someone is feeling. Emily also talked of how she struggles to show others how she is feeling and will try to cover up emotions with positive facial expressions.

Session five went on to look at identifying how Emily was feeling currently by underlining the emotions she could identify with from the emotion word list. Emily found this exercise difficult as it involved actively talking about her emotions, which were negative. Emily reports struggling to express negative emotion as she believes it is a weakness and a failure on her part. Emily related this to family life and talked of negative emotions being swept under the carpet at home. Emily became tearful talking about her emotions as she described 'numbing' herself to them and this had led to her feeling confused. It was important for Emily to hear that all emotions are acceptable and negative emotions are not 'bad' or 'wrong'. In particular Emily responded well to the 'emotion switching exercise' where she had to pick out differing emotion words and describe a time she felt that way and the associated bodily changes. This exercise enabled Emily to see that her emotions are transient and that she can experience both positive and negative emotions. Emily commented:

> "…I have learnt that emotions are fluid and change throughout the day. This has made me realise that it is ok and acceptable to feel sad at times."

After this session, I asked Emily to complete a 'self exercise'. I gave her an A3 piece of paper and asked that she create an image of how she would like to appear to others and then create another image of how she feels on the inside. Emily reported finding it helpful to do this exercise as she sometimes finds it difficult to communicate her feelings in conversation and this was an opportunity for her to think about how she wants to present herself and how she actually feels. Emily could reflect that there was a discrepancy between how she wants to be seen by others and how she feels inside. Emily was able to explore that this discrepancy often led to more feelings of stress and anxiety as people do not know how she really feels and she is not being honest about her emotions. This in turn makes it more difficult for her to manage her emotions.

> "…I find it very hard to voice my negative emotions, the picture of my personality and emotion bank really helped."

Session seven introduced the concept of emotions existing on a continuum that can vary in strength and intensity. Tasks involved the 'emotion word map' where Emily had to name a strong emotion and then think of associated emotions. This led to the 'emotion thermometer task' where Emily named a strong emotion and then graded associated emotions alongside noting physical and behavioural changes. When talking about the task Emily could see that she could intervene at a certain point on the 'emotion thermometer' and express the emotion rather than letting it build to the point that she avoids or suppresses it. Emily chose to work with the emotion of 'hopeless' and she identified that there were a number of emotions before she felt this way. Emily identified that she felt she could express the emotion of being upset and that this could prevent the emotion from spiralling to hopeless. Looking out for other signals such as behavioural and physiological changes also gave Emily clues as to how she was feeling.

It was also important for Emily to accept and tolerate negative emotions. This concept was introduced with the 'positive intention of negative emotions exercise'. This involved identifying the ways in which emotions can help us by signalling needs to ourselves and to others. Emily responded well to this task and talked about trying to see her negative emotions as opportunities to make changes in her life or to use them in a positive way. Emily talked of the emotion 'confused' and how this can make her more open to new ways of thinking and is an opportunity to learn. She also described feeling 'unpopular' and how that can spur her on to make more of an effort with people or to seek reassurance from people in her life.

Inter-session work

Emily engaged well in all of the inter-session work and found it helped to consolidate learning. In particular Emily found the 'self exercise' very valuable as it enhanced her understanding of her own emotional world. Other inter-session work involved Emily identifying and recording positive experiences to increase her awareness of positive feelings.

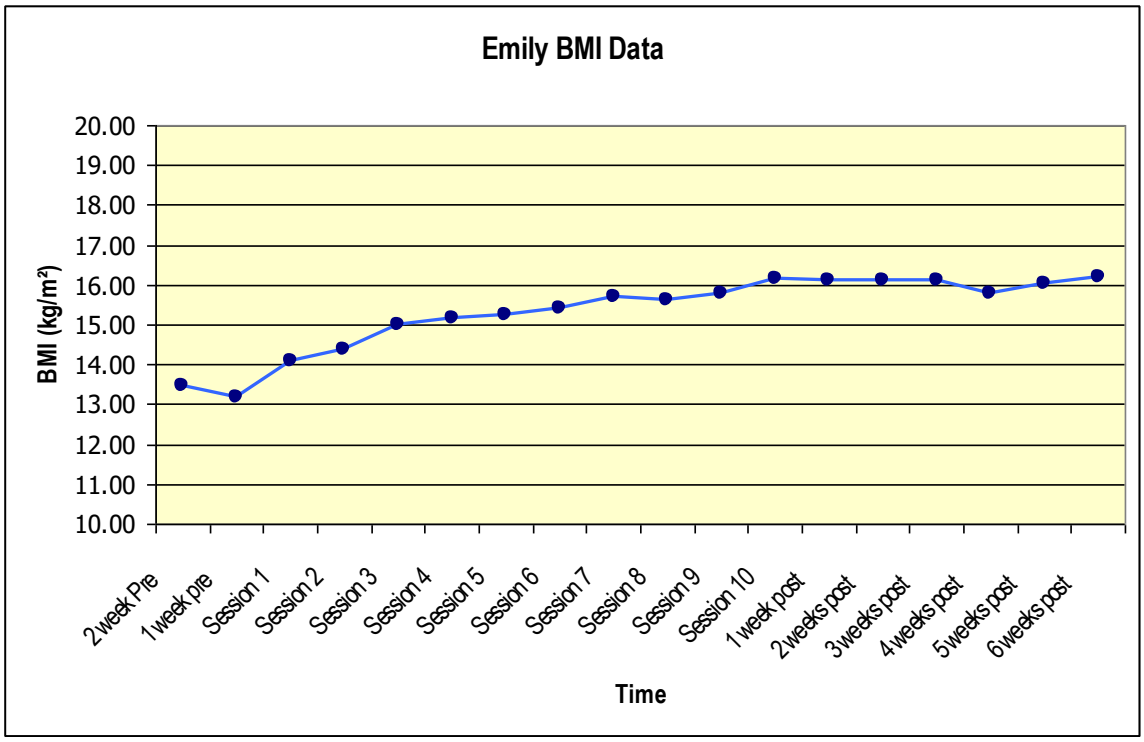
Outcomes

At the end of CREST Emily reflected that she had a greater understanding and awareness of her emotions. She was starting to communicate her emotions in an open and assertive manner although she recognised this would be difficult at times. One of Emily's final comments was:

> "…I have found the time spent looking at the way in which emotions show us what we need very helpful…I have really learnt about myself and now have a better understanding of my own emotional needs."

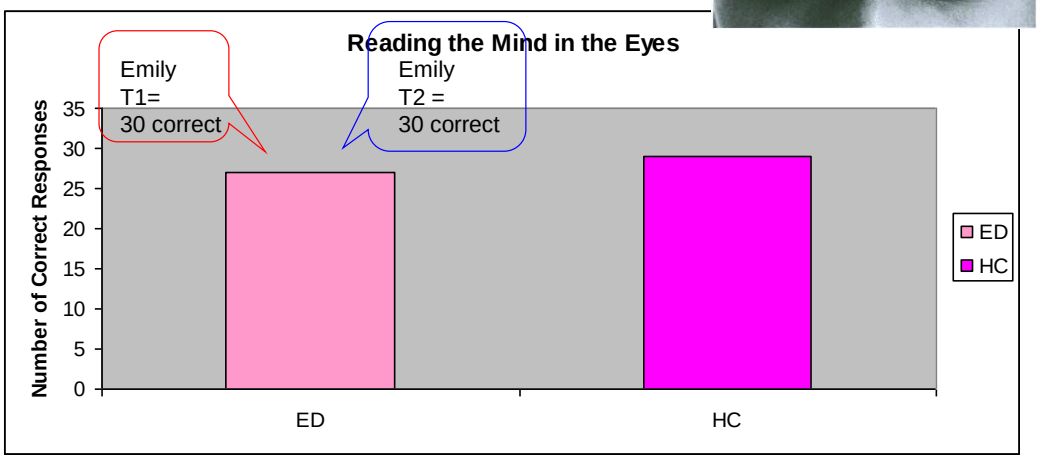
The non-threatening and non-judgemental stance of CREST provided Emily with a safe space to start thinking about her emotions.

Figure 1. Body Mass Index (BMI) before, during and after CREST



The bars in the graphs below denote average (median) scores taken from a study which used these assessments, one bar represents people with an eating disorder the other healthy controls. The speech boxes denote time 1 (before CREST), and time 2 (after 10 sessions of CREST) scores for Emily.

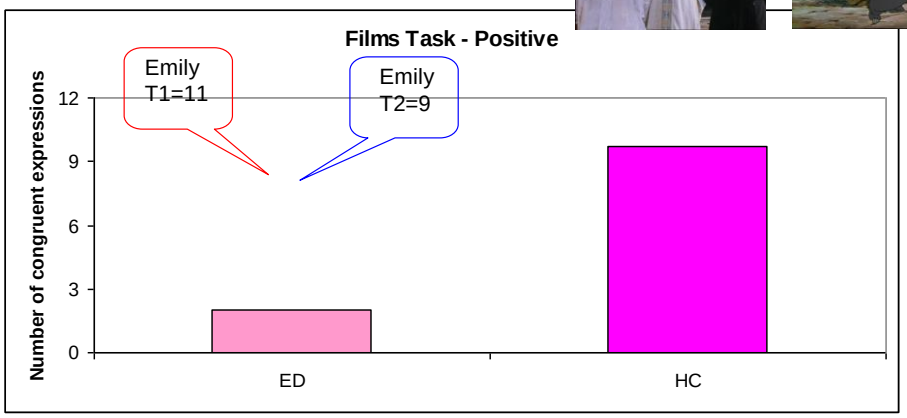
This task assesses how well people can read emotion in other people by looking at their eyes. The higher the score the better at recognising the emotion.



Emily's score remained the same at T2.

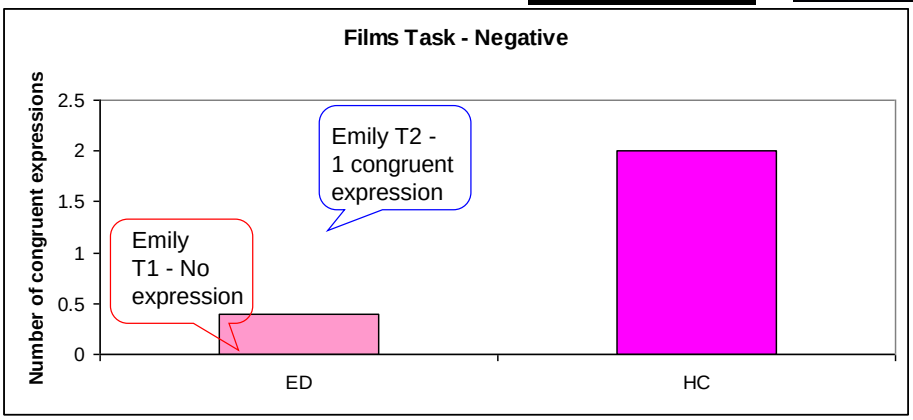
We assessed Emily's expression of emotion before and after CREST. From the results we can see an improvement in the frequency of facial expressions.

Participants are shown film clips and expressiveness is measured in response to the stimuli. Here, positive film clips are shown.



Emily showed less congruent facial expression at T2, but similar levels to HC.

Participants are shown film clips and expressiveness is measured in response to the stimuli. Here, negative film clips are shown.



Emily was more expressive at T2.

Case 3

Claire Money, Counselling Psychologist,
Maudsley Eating Disorder Service Inpatient Unit

History

Olivia is a 24 year old meeting the DSM-IV diagnosis for Anorexia Nervosa (restricting type). Olivia was admitted to the inpatient ward with life threatening AN and had been transferred from a medical ward. Her weight on admission was 34.2kgs with a height of 1.72 metres. Her Body Mass Index (BMI) was 11.5.

Olivia noticed a pre-occupation with healthy eating at approximately the age of 16 and began to restrict her diet and enjoyed the sense of control that it gave her. By the age of 19 Olivia's weight had deteriorated significantly and in 2006 she was diagnosed with AN after being admitted to a general medical ward.

Olivia has had one previous admission to an inpatient ward. This was three years ago, and lasted approximately 18 months. At this time Olivia had been in her first year of university doing a music degree. She describes herself as 'not fitting in', and is very self-critical, placing very high standards on herself in terms of achievement. She is often consumed by feelings of anxiety, panic and guilt and believes she has not achieved anything and is a burden to people. In terms of family background Olivia is the youngest of four siblings and grew up living with her mother and father.

Cognitive Remediation & Emotion Skills Training (CREST) intervention

Olivia attended all ten sessions of CREST. Sessions lasted approximately one hour and were twice weekly.

The 'emotion word sorting' exercise: This involved Olivia differentiating between positive and negative emotion words. This was a valuable albeit difficult exercise for Olivia. She talked about her difficulty in identifying positive and negative emotions as she has trained herself to be 'numb' to emotions. This exercise enabled Olivia to begin to question her belief that it is unacceptable to have a 'negative' emotion such as anger. Olivia invalidates her emotions believing that negative emotions in particular are a result of her being a 'bad' person. For example: if she experiences anger she struggles to see that she may have a justifiable reason to be angry and instead internalises the emotion believing it is a negative reflection on herself. She talked of being told from an early age that it was wrong to express her feelings or to talk about herself. It was crucial to talk about the importance of both positive and negative emotions and to point out that negative emotions are not 'bad' or 'wrong'.

Also, of benefit was the exercise that looked at the physiological response to emotion. At the end of the session Olivia reflected that she was becoming more self-aware and it had been helpful to think about how emotions can manifest in the body as it gives her clues to how she is feeling. Olivia reflected:

"if I do what I've always done, I'll get what I've always got".

We went on to talk about the alternative ways of processing and approaching emotions by listening to and working with her emotions rather than numbing and avoiding them.

Session five and six focused on Olivia recognising emotions in herself. The concept that we need to think about our emotions to enable us to process them and deal with them effectively was introduced. The specific task completed in these sessions was to underline emotions words that she could identify with currently and to explore these in terms of how they impacted on her physically as well as whether they were helpful or unhelpful. We then went on to look at how Olivia would like to feel and talked about a time when she had felt this way.

Session six looked at the fluidity of emotions highlighting that they are transient and not permanent. This was illustrated by placing a number of emotion words on the table and asking Olivia to pick out words and describe a time when she felt that emotion as well as describe the associated physiological changes in her body. Olivia was asked to alternate between positive and negative emotion words reflecting that her emotional world is transient. Olivia found it somewhat difficult to talk about and identify with difficult emotions namely anger. We used an imagery exercise where Olivia described anger in terms of an animal, what colour it would be and what sound it would make. This was a very powerful exercise for Olivia as it brought the emotion to life and she felt able to express the emotion in this way. One of Olivia's comments about CREST was that she had found this exercise helpful as it enabled her to understand what a particular emotion aroused in her. She talked of finding it impossible at times to identify emotions within herself and therefore, being able to relate to them through visual imagery and physical sensations was beneficial.

Sessions seven and eight focused on accepting, tolerating and managing emotions. Using the 'pink giraffe' exercise Olivia first closed her eyes and held in her mind a mental picture of a pink giraffe for one minute. She then attempted to not think about the pink giraffe. This was a very helpful exercise as it illustrated to Olivia that trying to suppress or ignore emotions was not effective as the emotion keeps coming back, like the pink giraffe keeps popping into your mind when you tell yourself not to think about it.

Olivia was able to look at the advantages and disadvantages of bottling up and avoiding her emotions. She was able to recognise that through emotion suppression emotions would become overwhelming and she would try to block them further. This enabled her to start thinking about alternative ways of dealing with difficult emotions such as talking to others and being kinder to herself. This would provide Olivia with an opportunity to manage her emotions and reduce their intensity.

An exercise that was particularly helpful in session eight was looking at the positive intention of negative emotions and the idea that emotions are communicating a need of some kind. Whilst Olivia found this difficult due to her belief that it is not acceptable to have negative emotions, it opened up a new way of thinking about feeling. Olivia was able to look at the positive intention of anger as a means of motivating her to stand up for what she believes in.

In the reflection session at the end of CREST Olivia commented:

> ".. the idea that each and every emotion is simply an indicator that I need something or a guide to determine how I might behave has helped me think about 'being emotional' in a different way. I've always believed expressing emotion was a weakness when in fact emotions can be valuable tools…"

Sessions nine and ten explored healthy ways of expressing emotions and looked at communication styles. Olivia was able to identify that in the past she often gave up hope that others could meet her needs and would sink into sadness and bottle up her feelings. The sessions looked at how Olivia could be more assertive and open with her emotions and we used example situations for her to think about how she could get her needs met. Olivia made plans to start talking to people about how she is feeling in an open and assertive way.

Inter-session work

After most sessions, Olivia was encouraged to do some work in her own time between sessions. Much of the inter – session work focused on identifying and recording positive experiences to increase Olivia's awareness of positive feelings. Olivia engaged with some of these tasks.

Outcomes

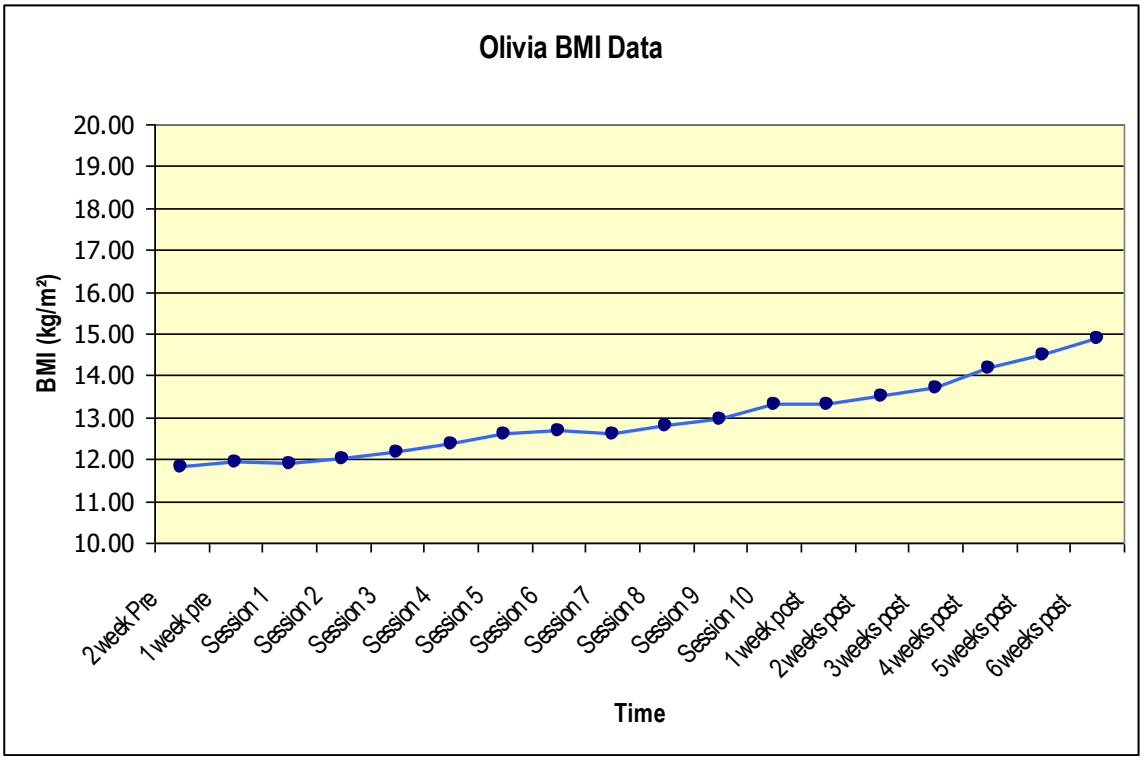
By the end of CREST Olivia reflected that she felt more able to recognise and label emotions in herself. Whilst she talked of her difficulty in making active changes in the way she dealt with emotions she reported an increased self-awareness, opening the door for potential change.

> "…I hope to keep telling myself that emotions aren't simply good or bad. Negative emotions can have a positive effect as they can alert me to the fact that something needs to change and inspire me to take a positive action…"

Olivia talked of a heightened awareness of her natural instinct to numb her feelings. CREST provided an environment in which Olivia could begin the process of challenging her beliefs and rules relating to her right to expression.

Emotions are difficult for all people to discuss at times and even more so for a patient group that have spent much time perfecting the art of emotion avoidance. Therefore, it was of paramount importance that Olivia felt she was entering a safe and non-judgemental therapeutic environment where she was able to explore her emotional world. Olivia talked of the importance of being able to talk around and reflect on the exercises she did in sessions. Providing a safe and empathic environment was integral to the engagement process.

Figure 1. Body Mass Index (BMI) before, during and after CREST



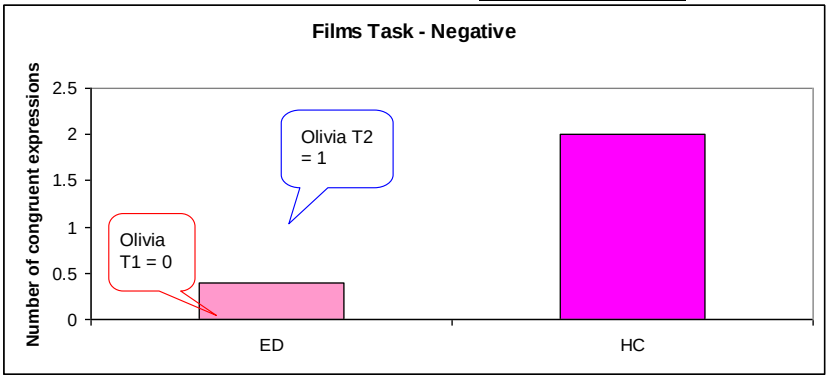
The bars in the graphs below denote average (median) scores taken from a study which used these assessments. One bar represents people with an eating disorder the other healthy controls. The speech boxes denote time 1 (before CREST), and time 2 (after 10 sessions of CREST) scores for Olivia.

This task assesses how well people can read emotion in other people by looking at their eyes. The higher the score the better at recognising the emotion.

Olivia's score improved at T2.

We see improvements in recognition and expression of positive and negative emotions in the experimental measures using the mind in the eyes task and the film clip task.

How congruent are your responses to film clips? Participants are shown film clips and expressiveness is measured in response to the stimuli.
Here, negative film clips are shown.



Olivia expressed more congruent emotion at T2.

Case study 4

Claire Baillie, Counselling Psychologist,
Maudsley Eating Disorder Service Inpatient Unit

Chrissie was an 18year old woman who met the DSM-IV criteria for Anorexia Nervosa (restricting subtype). Chrissie was admitted informally to the ward for her first psychiatric admission at a BMI of 14.4. The duration of the admission was 11 weeks with CREST offered in the second week.

History

Chrissie had been seen previously by Children and Adolescent Mental Health Services where antidepressants and weight monitoring were offered, she was discharged when weight stabilised at a BMI of 18.4. Chrissie stated psychotherapy had been attempted but she hadn't said anything in sessions, she described herself as not good at talking about her feelings. She reported having worried about her weight and size throughout life, thinking she was bigger than others and disliking her appearance. She described feeling happier and more in control when restricting food intake. Food difficulties began eighteen months prior to admission when she transferred to sixth form. She found studying difficult and felt bullied at her weekend work placement. This coincided with her older sister and sister's fiancé leaving the family home and her mother's new partner moving in. Significant events include losses related to animals, two of her horses and the family dog of sixteen years had to be put down. She experienced these losses as traumatic, perceiving them as typical of her "bad luck".

Prior to receiving the CREST intervention Chrissie described her experience as "can't feel anything, worthless, don't know, dead inside". She described herself pre-illness as "happy and lively" and thought others may describe her as "caring and lifeless", she thought of herself as a perfectionist and caregiver.

Family

Chrissie had a sister three years older than her who is reported to have had a "fuzzy spell" with food at high school which passed with counselling. Chrissie' parents divorced when she was two to three years old following an affair by her father. He maintained contact with both siblings as they were growing up although Chrissie stated she never had a strong relationship with him. He moved further away and contact became less regular. Chrissie has lived with her mother all her life describing the relationship as close. She stated she gets on well with mum's new partner who now lives with them; he has no children of his own.

CREST Intervention

Chrissie was offered CREST shortly after admission. She initially seemed reluctant to meet and created obstacles to sessions, this was resolved by an informal discussion highlighting possible concerns and inviting questions. She seemed relieved when she heard CREST had a focus and did not necessarily involve talking about her past experience.

Pre-engagement

A pre-CREST meeting was provided to look through the manual to reduce concerns and uncertainty. Chrissie identified she often froze when asked questions, going "blank", remaining silent or responding "I don't know", at these times she felt anxious and thought

she was stupid. This was normalised and possible reasons for freezing provided e.g. too many thoughts to choose from, concern about what the other will think or feeling emotionally overwhelmed by the topic. The ethos of CREST was set out, encouraging interest and curiosity rather than judgement. Chrissie was invited to contribute to this ethos by communicating what she could about difficulties she encountered in sessions. Following this meeting she attended all arranged sessions which took place twice a week for between forty-five minutes and an hour each time.

The pace of CREST was adapted to take into account Chrissie's lack of experience and familiarity with psychological thinking, more time was spent on the themes of recognising, managing and understanding emotions. Chrissie found it useful to have the list of emotions words available every time she was invited to describe how she felt in a session.

Sessions One and Two

Initial sessions involved simple tasks to identify thinking styles. Two tasks explored bigger picture vs. detail focussed thinking. The "geometric figures task" involved describing a complex shape for the therapist to draw and revealed an area of strength as Chrissie gave clear, concise descriptions based on bigger picture thinking. In contrast, she became stuck summarising a letter, the task was subsequently completed collaboratively. Post task reflection identified Chrissie knew *how* to summarise but experienced doubts and became stressed, she was able to relate this to struggles in her studies. She described copying exactly what teachers wrote, found it very hard to select irrelevant information and although she achieved good marks she found writing essays stressful and difficult. Exploring pros and cons of a detail focus Chrissie recognised it increased stress levels for some tasks but also allowed her to notice spelling errors the therapist had missed. An intersession task invited Chrissie to notice when she focused on details in different daily tasks and whether this helped or hindered. Chrissie later reported she had tried to hold this in mind but found it hard to think about and after a few days had forgotten about it.

Illusions tasks explored the ability to view the same thing from different perspectives; Chrissie could see multiple images in pictures describing her strategy of looking at different points to change perspective. She quickly related this to confusion in daily life since her perspective and anorexia's were sometimes the same and sometimes different. She described how spending time with her horse highlighted this since "anorexia" wanted weight loss, while she wanted to avoid weight loss to spend more time with her horse. Chrissie then spoke about her experiences of losing her horses and the important bonds she felt with them, acknowledging she did not allow herself face her feelings at the time.

Sessions Three and Four

The next sessions moved to thinking more specifically about emotions. Chrissie's profound focus on negative emotions was revealed by a task involving finding positive and negative words where her thinking style could even find negative aspects in positive emotions. Chrissie understood the emotion processing cycle considering how different evaluations of events (thoughts) could produce different emotions about the same incident. Working on an example of a person nearly hit by a bus; she stated "a person could think they always had bad luck which might lead to feeling unworthy". Sessions then explored different ways of recognising and labelling emotions considering descriptions of physical sensations,

alternative words, possible triggering events and building up metaphors for different emotions.

Chrissie's reported feeling of anger was utilised to explore physical sensations, she readily described tension, headache, tight chest, fast heartbeat and breathing. She also reported a confusing feeling of numbness and appeared thoughtful when numbing was suggested as one way of coping with difficult emotions. She acknowledged she tried this with anger but it did not work, tending to build until it "burst". Chrissie identified anger mainly occurred in response to feeling controlled by others, she described reacting either by feeling angry and rebellious or defeated. She named occasions when she had run away, banged her head or punched a wall when angry. CREST presents emotions as communicating needs and Chrissie identified a strong urge to get away from situations when feeling angry, this was identified as a possible coping strategy in the form of arranging "time out". Chrissie was also encouraged to channel destructive urges associated with anger in safe ways – punch pillows, rip up newspapers. In this way, the underlying needs of wanting a break and some physical release were acknowledged and addressed.

Exploring the pros and cons of emotions Chrissie identified feeling "worthless" protected her from having raised expectations of others and disappointment; "*if you tell yourself you didn't care how others treat you because you are worthless then you feel less bothered when they ignore you*". On the other hand she recognised feeling worthless could prevent someone from standing up for themselves.

Sessions Five, Six and Seven

Sessions shifted to consider how to manage emotions, including developing a more balanced emotional focus. CREST explored how to relate to positive emotions and notice them by completing the bank of positive experiences. Chrissie demonstrated considerable trouble thinking about positive emotions, as she could not relate to them. These included "proud" and "joy", despite describing positive risks she had recently taken e.g. wearing a skirt for the first time in years. Chrissie stated she could only see how she could have done them better but recognised others might feel proud if they had achieved these steps. Despite various prompt questions Chrissie was unable to identify any physical sensations related to "proud". Ideas were offered including feeling tall, looking out towards the world; strong heartbeat with energy rather than tension. Chrissie also struggled to identify alternative words or events related to "joy" but persevered and utilised prompt questions to identify joy could result from receiving something you really wanted. She was then able to contrast this with sadness by recognising sadness felt heavy, like having the weight of the world on your shoulders and joy felt light. In the subsequent session, Chrissie reported feeling excited having spent time with her mum reminiscing about her ability at training and show jumping her horses. This session included switching between being "*all or nothing*" with emotions as she found it hard to focus on "fear" when feeling excited. She completed an intersession task of monitoring daily emotions to test this idea, subsequent discussion identified she actually experienced a range of emotions in response to different situations.

Chrissie's motivation to explore anger was used to complete the emotion thermometer and consider what needs may be communicated by the feeling of anger. She

identified physical signs that her anger was becoming unmanageable including the feeling of being hot spreading throughout her body. Reviewing the kind of events which led people to feel angry resulted in Chrissie concluding anger is a sign someone needs to feel listened to, respected and acknowledged. We explored how she historically numbed anger which neglected the need to be listened to and may explain why her anger did not resolve itself. Bringing together information from various worksheets Chrissie produced this statement:

> "*Anger helps me to do things which make me listened to and communicates I need to be listened to, acknowledged and respected."*

CREST tools facilitated exploration of the underlying needs; pros and cons of Chrissie's predominant presenting emotions which were "worthless", "despairing" and "angry". This produced an important link between her emotions: "worthless" protected her from feeling disappointed by others but also prevented her from standing up for herself while anger occurred most strongly when feeling controlled by others. Chrissie gained the understanding that perpetually feeling worthless resulted in increased frequent feelings of anger as it prevented her from standing up for herself and resulted in her feeling controlled.

Sessions Eight to Twelve

Chrissie presented in session as overwhelmed after being informed discharge would occur in a few weeks, she was tearful and low in mood. The emotions list and metaphors helped Chrissie identify she felt afraid, under a lot of pressure "to get it right" and felt she had to do this alone. The level of associated distress seemed disproportionately high to the stressor of leaving treatment. In a previous session Chrissie had been unable to connect to "fear" as it reminded her of being bullied, this knowledge permitted inquiry into whether her current fear linked to how she felt when bullied. Chrissie responded it did remind her of that experience, which allowed brief acknowledgement of the enormous strain she felt at the time to get everything right in order to end the bullying.

By being curious regarding Chrissie's presentation at these times she acknowledged she "winced" internally when bullying was mentioned. She was supported to recognise this indicated discomfort and unease, encouraged to notice and communicate this in sessions so it could be understood. Chrissie began to share more of her thoughts and feelings about her experiences at the work placement. A more detailed picture emerged which suggested it took the form of psychological abuse by both adults and children. Brief trauma based interventions were interwoven with CREST sessions for a couple of weeks. This involved recognising the level of fear triggered by returning to the locality where the abuse occurred. An understanding of how the abuse triggered and maintained Chrissie's sense of worthlessness was developed as well as identifying her belief that silence kept her safe. Alternative perspectives around high levels of self-blame and guilt were offered while teaching and practising grounding techniques. This linked with CREST by considering what someone experiencing these emotions may need; how to overcome obstacles to communicating these needs and identify who to talk to and what to say. The emphasis was on acknowledging the seriousness and impact of the abuse while supporting Chrissie to identify and communicate her emotional needs so that she might feel more able to manage her emotions and possibly talk more about the abuse in the future.

Final Session

The final session involved using the end of therapy reflection worksheet to review Chrissie's experience of CREST. Chrissie identified learning how much she hated herself, and

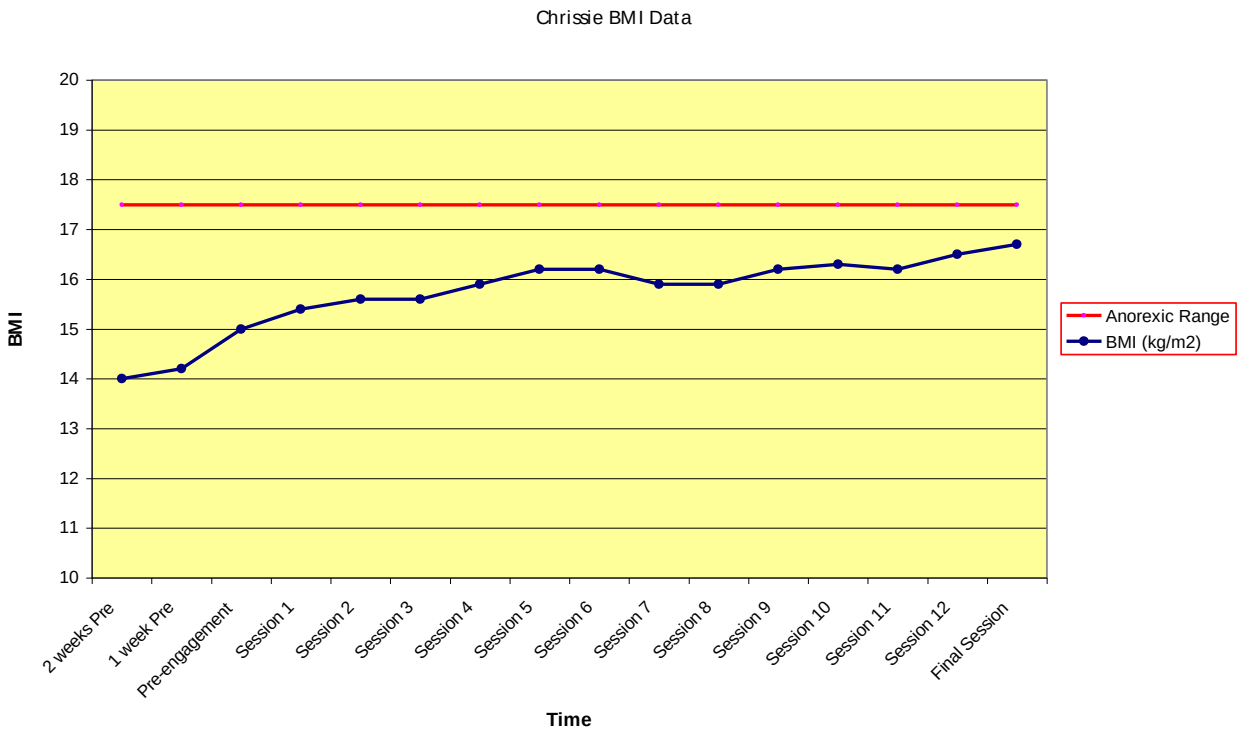
> "*how my beliefs about me influence everything I do, that I can't accept help/ask for it, that I don't meet the needs of how I am feeling*".

She stated it had been helpful to understand how her belief she was worthless linked into emotions such as anger. Chrissie described finding it helpful to learn what emotions tell her, even if she doesn't listen to them. She wanted to keep in mind that bottling up emotions kept the feeling of being worthless going. For the first time Chrissie acknowledged needing to talk about what had happened (abuse), although it was frightening she wanted to try and agreed to a referral being made for psychological therapy in the community.

Outcomes

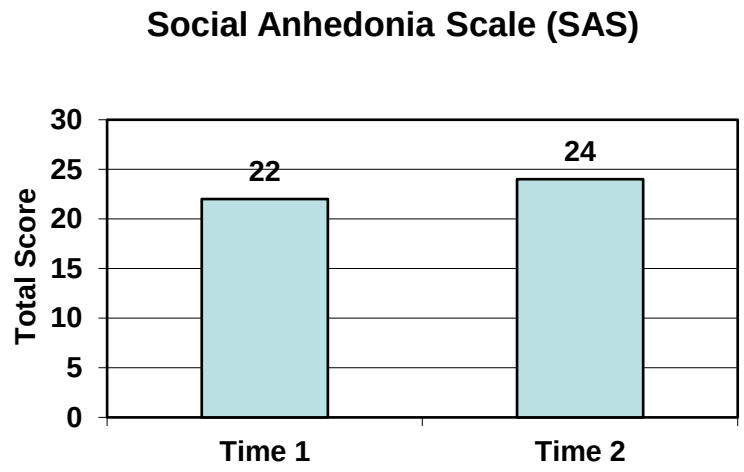
Chrissie developed increased insight into her thinking styles about herself and her emotions. CREST seemed to provide Chrissie with a way to understand and think about her experiences without having to talk directly about the abuse, the details of which emerged late in the therapy. Chrissie demonstrated considerable development from remaining silent in previous talking therapies to being able to struggle yet persist with CREST. It is significant that after CREST she presented as feeling she needed to talk about the abuse even though she knew it would be difficult and frightening. It seems CREST gave Chrissie tools to enable her to feel confident enough in her ability to understand and manage her emotions.

Figure 1. Body Mass Index (BMI) before, during and after CREST



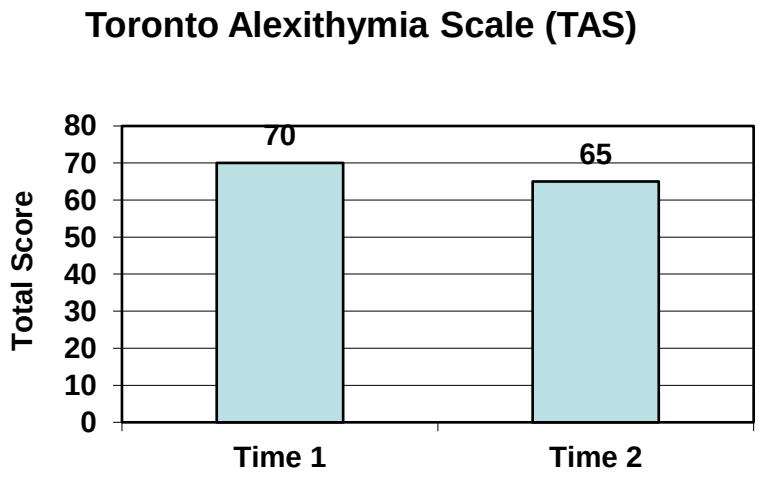
The following graph indicates Chrissie's lack of pleasure relating to social activities had increased slightly post CREST. This could be for a number of reasons, it may link to anticipation of discharge and related concerns, it may relate to an increased ability to be aware of her internal experience.

Figure 2. Social Anhedonia Scale total score before (time 1) and after (time 2) CREST



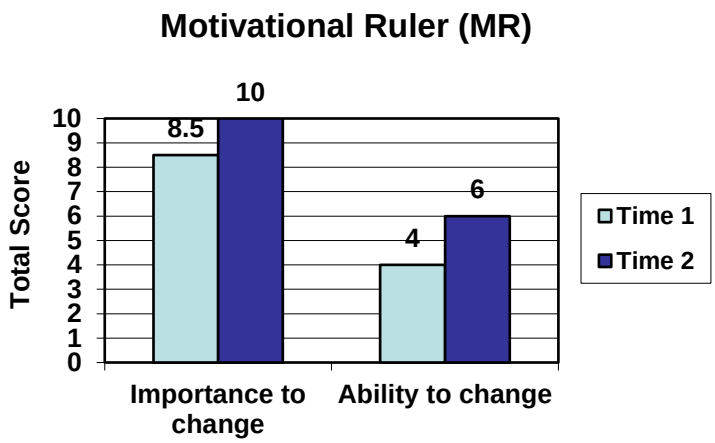
Alexithymia refers to trouble identifying and describing emotions and a tendency to minimise emotional experience/focus attention externally. The following graph indicates Chrissie's level of alexithymia decreased to a level closer to the clinical threshold of 61 meaning she had gained skills in identifying, describing and tolerating her emotional experiences.

Figure 3. Toronto Alexithymia Scale total score before (time 1) and after (time 2) CREST



The Motivational Ruler takes the form of a Likert scale ranging from 1 – 10 and asks about the person's perception of importance to change and ability to change. The following indicates Chrissie felt change was more important to her at the end of CREST, rating herself the maximum score of 10 and that she felt more able to change.

Figure 4. Motivation to change before (time 1) and after (time 2) CREST



Therapist Reflections

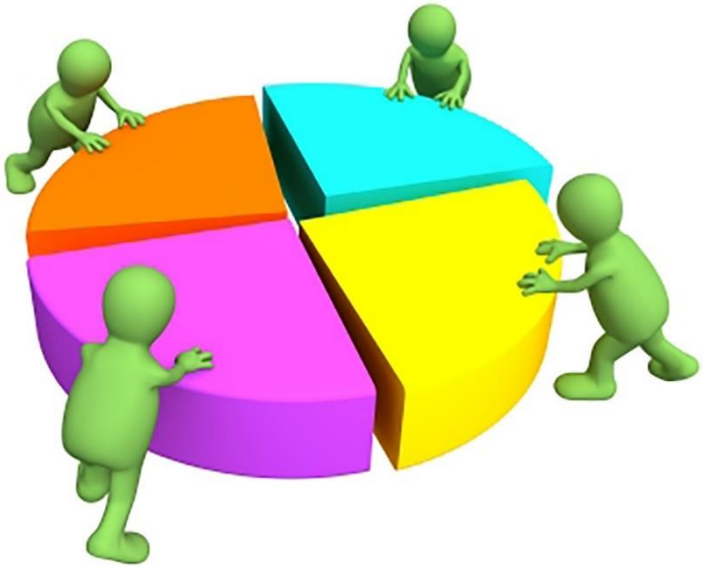
Given her history it seems likely Chrissie would have found it challenging and demoralising to be faced with another psychotherapy where she struggled to talk. Therefore, it was very useful to be able to offer her an intervention like CREST. It allowed the therapist to collaborate with Chrissie over the worksheets and offered a useful way to facilitate a *being-with* rather than *doing-to* therapeutic stance. The requirement of the therapist to struggle over questions alongside the patient, e.g. what is the function of guilt?, permitted the therapist to describe their own thought processes e.g. I try to imagine what the world would be like if no-one felt any guilt. This provided opportunities for modelling reflective thought and reduced the pressure to talk about personal issues. Importantly and potentially more than other therapies, an intervention like CREST permits the patient time to observe the therapist, their thought processes and the quality of the relationship they are offering before engaging with it. This proved very beneficial in facilitating the development of a therapeutic relationship, trust building and ultimately a secure enough sense of safety and acceptance for the patient to *choose* to take risks in beginning to share personally distressing experiences.

Appendix 5

CREST in a Group Format

Supplementary material: Handouts and useful topics for discussion
(suitable for both individual and group sessions)

THINKING ABOUT EMOTIONS GROUP/workshop



CREST in group format
(updated version 2019 August
For CREST manual:
www.katetchanturia.com)

OVERVIEW OF SESSIONS FOR CREST GROUP and GENERAL INFORMATION:

Based on intensive research using experimental studies two low intensity treatment modules were tested for inpatients– cognitive remediation therapy (CRT) and Cognitive remediation and Emotion Skills Training (CREST). Both interventions are provided in individual and group formats. Based on evaluation and clinical audit all four interventions have different benefits for the patients with anorexia nervosa. See reference section for the relevant reading.

The optimal number of participants in the group is 8-10, with two facilitators, based on existing literature. In clinical reality, the first few groups piloted with a research group led by Consultant Clinical Psychologist Professor Kate Tchanturia, her research team and experienced therapists Drs Amy Brown, Claire Baillie, Kate Tchanturia and their clinical trainees, assistant psychologists or members of multidisciplinary team in the South London and Maudsley NHS Trust). Current groups are typically delivered by one qualified therapist as group leader supported by a trainee/assistant psychologist or member of multidisciplinary team. We evaluate groups using Social Anhedonia Scale and Toronto Alexithymia Scale. Both these measures are self reported questionnaires and patients have to complete them before CREST group and after finishing CREST group. In the end of the CREST we also ask group participants to complete group satisfaction questionnaire. This measures are provided in the end of group protocol. CREST groups were evaluated and implemented in the inpatient, day care and step up services at Maudsley NHS national Eating Disorder service where this work was developed.

Please keep a record of the attendance in the group. This is very helpful information to have for audit and evaluation purposes.

Supervision is essential – group debrief after the group session should be entered in the clinical notes for each patient (gist summary) and discussed in supervision.

Related references for the group and useful psychoeducation materials and resources provided in the end of the document. Psychoeducation materials (e.g positive psychology, power of the body language, positive logbook, simple pleasures are described in detail in our CREST individual manual www.katetchanturia.com publication section.

For additional information please contact:
Kate.Tchanturia@kcl.ac.uk

SESSION 1:

THE POWER OF POSITIVE EMOTIONS

INTRODUCTION:

Welcome to the group; generate a list of rules and boundaries to be adhered to within the group so as to create a safe therapeutic space to explore often difficult issues, as well as exploring hopes, fears and expectations of engaging with a group that focuses on emotions.

Ask group participants to complete self-report questionnaires

(TAS – measuring alexithymia; SAS – measuring social anhedonia and motivational ruler. The same measures will be completed at the end of the group sessions as well as patients satisfaction questionnaire).

Start with development of a mind map of all the different ways people manage their emotions, both positive and negative. Invite the group members to think about their own unhelpful/unhealthy emotion management strategies and focus toward this for themselves personally when engaging with group materials.

Introduction to the format of the group and what will be covered within these sessions. Discuss with the group the importance and power of positive emotions and engage group in discussion:

- Do group participants attend more to positive or negative stimuli (glass half full or half empty?
- Incorporate background information and supporting evidence from session 3 of the CREST individual manual (positive psychology)

EXERCISE 1: DISCUSSION

On a flipchart explore the following questions:

- What are emotions and why do we have them?
- Why are emotions important?
- What are the positive emotions? Where and when do we experience positive emotions?
- What is our emotion word vocabulary like (handouts are prepared with a list of emotion words)

EXERCISE 2: EMOTIONS AND OUR BODIES

Diagram of the body on the flipchart (CREST manual session 1).

Question: How is positive emotion experienced in the body? Explore within this the physical reasons why it may be harder to recognise and attend to positive emotions vs negative emotions (NB reinforce throughout the group that negative emotions are not 'bad', they are just saying something about our internal and/or external environment that requires our attention).

EXERCISE 3: EXPLORING POSITIVE EMOTIONS

On the flipchart ask the group to generate a range of emotion words, developing a greater awareness of the vocabulary of positive emotions.

Ask the group to choose one of these emotion words and try to recall a memory/experience associated with this word. Explore how this felt in the body, how this emotion was communicated to self and others, body language and facial expressions associated with the emotion. Ask group for feedback, particularly in relation to the capacity to dwell on the positive and the potential impact this has within the group.

INTER-SESSION WORK:

1. Positivity self test (attendees are invited to visit the website http://www.positivityratio.com/single.php)
2. Introduce the concept of the portfolio of positive emotions and encourage group participants to engage with this process for homework (CREST manual session 3 for more details).
3. Starting to keep positive logbook options are creative (e.g positive images /photos; video messages; scrap book; positive message calendar; apps);

SESSION 2:

THE NATURE AND FUNCTION OF EMOTIONS

Welcome group participants back and review and reflect on homework, attending to and working toward overcoming any barriers to engaging with homework tasks

EXERCISE 1: DISCUSSION

Continue with the exploration of positive emotions providing psychoeducation of the research regarding 3:1 positivity ratio (http:/www.positivityratio.com). Introduce the list of personal strengths (CREST manual, session 4) and invite the group members to continue with this and positivity portfolios for homework. Explain that the remainder of the group will focus more on the negative emotions so as to be able to manage these sufficiently to attain a positive emotional state (ie managing the negative to get to the positive).

EXERCISE 2: ANIMATION

As a group watch the following you tube clip 'Alfred and Shadow' which is a short, animated story (7 minutes) focusing on the nature and function of emotions and the impact of not attending to/expressing emotional experience.
https://www.youtube.com/watch?v=SJOjpprbfeE
Reflect on this together as a group. Explain that many of us at different times have difficulty in correctly identifying how we are feeling and that we can all have struggles in tolerating and managing certain emotions, both positive and negative.
Reinforce with the group that, when we talk about negative emotions, that this does not mean that they are wrong or bad but that they can be uncomfortable and painful for people to experience. All emotions are valid and are important signals worth listening to.
Next, highlight that effective emotion management involves an awareness, acceptance and understanding of our emotions. "This group does not intend to provide strategies to eliminate emotions, the intention is to explore and change your relationship with and response to your emotions. We cannot always control our emotions but the way we behave and respond to them can either help or hinder us."
Ask the group if they have any other thoughts or ideas about the importance of identifying, tolerating and managing emotions?
Ask the group what happens if we avoid our emotions? – No accepting our emotions and avoiding them can amplify these feelings and contribute to the experience of emotions being negative and undesirable.

EXERCISE 3: VIGNETTE

Read or write on a flipchart the following case vignette:

"Jo is twenty seven and lives with her partner. They have a close relationship and have been together for three years. Jo works as a secretary in a busy office. Her boss puts lots of pressure on her to meet deadlines and often piles on the work. Jo often stays late at work not getting home until about 9pm some nights. She is feeling stressed and low but avoids dealing with the situation.

At the same time Jo is also involved in helping to plan her friend's surprise birthday party which takes up a lot of her free time. This leads to Jo feeling more stressed, tired and irritable as she does not have any time for herself or her partner.

Rather than try to acknowledge and deal with how she is feeling she ignores it and carries on.

What might be the problems for Jo if she continues to avoid her emotions?"

Prompts for the facilitators during reflection and discussion of the vignette may include:

- With regard to work, is she more or less efficient, more stressed, tired (burnt out)?
- What about her relationships, what may be the impact particularly with her partner? (eg snapping at people, arguments, social isolation)
- What about her feelings toward herself? She may feel bad about herself for not standing up to people and asserting her rights and may be very self critical as a result. She may feel taken for granted. She may berate herself for not being a supportive partner and friend etc

Explain to the group that there is a difference between emotional pain which is a part of human life, such as grief at losing a loved one, disappointment at not getting the exam results you hoped for versus emotional suffering, which comes about from an avoidance or an unwillingness to accept and respond adaptively to the emotion. Emotional suffering is the aspect of emotional experience which will be targeted in the forthcoming sessions.

Ask the group for any questions or reflections as a discussion point.

EXERCISE 4: CHALLENGING BELIEFS

Introduce that negative beliefs that we have about emotions will impact on our ability to respond to and manage them effectively.
Write the following beliefs on a flipchart:

Example from one of the groups:

People might not understand me/misinterpret
Showing emotions is weakness
I am not sure I can be happy
Do I deserve happiness?
I am burdening others if I talk about emotions
I should protect others from emotions
I should deal with my emotions
If I don't know what I feel
If I lose my temper I will lose my control

<u>Downsides:</u>

Builds up and then explodes
Feel alone

Lots of issues which are not dealt with
Letting people know might help them to understand
Might affect more people
Others will doubt less

- *Negative emotions are bad?*
- *Having some emotions is a sign of weakness?*
- *Emotions are not important?*
- *If I really think about and acknowledge how I feel I will lose control?*
- *Others?*

Ask if anyone identified with any of these beliefs. Discuss how these impact on our responses to our emotions.
Introduce facts about emotions – give the 'reasons for emotions' handout and go through this together as a group.

INTER-SESSION WORK:

1. Continue with the list of personal strengths and positivity portfolio
2. At the end of the group ask the participants to reflect on one positive experience they have had in the past 24 hours. It can be as seemingly inconsequential as it needs to be, for instance someone smiling at them when they were feeling low. Ask group members to try the 'three good things' exercise (CREST manual, session 2) before the next group session.
3. Invite the participants to bring a photo/picture which elicits positive emotions for them for next week's group (CREST manual, session 2).

SESSION 3:

HOW DO WE IDENTIFY EMOTIONS?

As with all the group sessions, the group starts with a reflection on inter-session work and exploration of any barriers that prevented participants from being able to engage with any of the tasks encouraged at the end of the previous session.

EXERCISE 1: EMOTIONS BALLS

Take in a bag of balls depicting various emotions (or other forms of emotions) and ask each group participant to choose one. Each person is asked to think about the emotion they think is depicted, a memory/situation/experience that they can reflect on when they have experienced the emotion, or a situation in which they could envisage experiencing the emotion they have chosen. When they have had a few minutes to reflect on this and engage with the associated emotion, ask the following questions on the flipchart without expecting anyone to respond verbally at this stage:

- How is this emotion experienced physically in the body?
- What kinds of thoughts are you having?
- What types of things are you doing? How do you behave?
- What situations or events prompt this emotion?
- Is this emotion easy or difficult to tolerate? What makes it so?

Ask the group participants for verbal feedback and reflection of the experience. If the group are struggling to be able to reflect verbally, ask whether they were able to engage with the exercise and explore any difficulties. So as to bring the exercise more 'live' in the room, one of the group facilitators can reflect on the emotion they are holding and respond to the questions so as to enable others to experience the exercise in action. If possible, try to end the exercise focused on a positive emotion.

EXERCISE 2: THE EMOTION CONTINUUM (PART 1)

The group are asked if they would like to explore either anger or anxiety as a group, explaining that the other will be explored further in the next session.

This exercise aims to introduce to patients the concept of emotions varying in strength and intensity. This exercise will encourage participants to think about and identify varying levels of emotions within themselves, rather than their often describing feeling nothing or completely overwhelmed. It also encourages patients to find the right describing word to fit the emotion.

"If we have a greater understanding of the language of emotions we are in a better position to express our emotions accurately and to gain the most helpful support or assistance in return as others will have a clearer understanding of what it is we are feeling. If our emotions vary in intensity then our physiological response and behaviour will also vary. This can also

tell us something about how we are feeling. If we can be aware of the emotion, the physical sensations and how we are behaving then we are in a better position to manage emotions more effectively and catch them before they become overwhelming."
Explain to the group that sometimes people feel that emotions are 'all or nothing', they either feel nothing or entirely overwhelmed. Sometimes, because people try to avoid their emotions, they can become increasingly intense and explode, so are experienced as out of keeping with the current situation. This can reinforce the idea that emotions are dangerous of just plain wrong. Introduce the group to the fact that emotions occur on a continuum and that they vary in intensity. For example, 'fury' and 'irritation' may be on the same continuum but have very different degrees of emotional intensity. Irritation may in fact be more readily tolerated than fury. Ask the group whether this is a familiar concept and their reflections in relation to this.

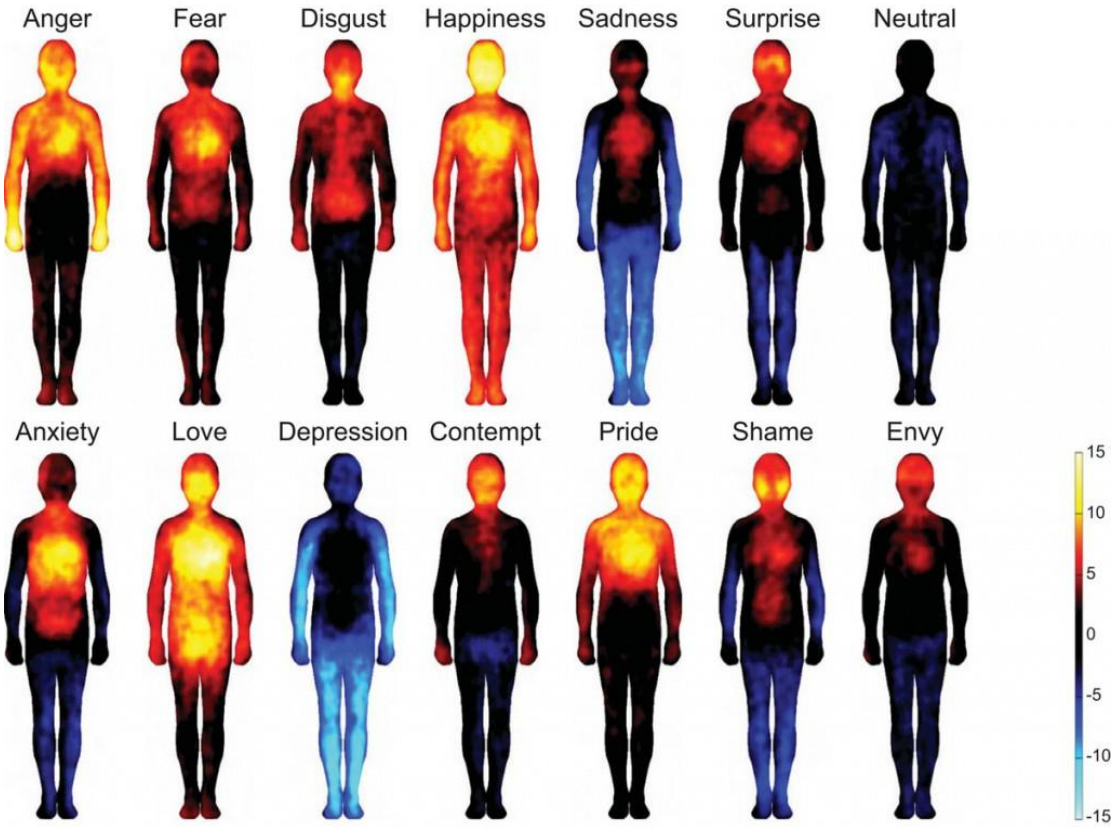
Task: Facilitators will need emotion continuum materials:

- Emotion word cards that describe varying levels or anxiety and anger
- Descriptions of the physiological sensations associated with increasing emotion
- Descriptions of behaviour changes at different levels of the emotion

Using the cards, place them on the floor and explain that one end of the room will form the least intense level of emotion up to the other side of the room which will form the most intense. Next go through the physiological sensations at the various points and finally the behaviours at different degrees of the emotion.
It can be helpful from the outset to say that different people may experience it differently and this will naturally be the case but that we are engaging with an experiential group exercise so will work toward a group consensus whilst acknowledging individual difference. It can also be useful to explore with patients how they currently engage with the emotion continuum in question and reflect on how this is experienced in daily life. Finally, it is helpful to reflect on the continuum itself and discuss with the group at which point on the continuum they may be effective in being able to manage the emotion and at which point it escalates to be too overwhelming to cope with, perhaps leading to the unhelpful coping mechanisms that had been explored at the beginning of session 1.
Reflecting on the exercise the group facilitator can summarise:
"If you find yourself easily overwhelmed by an emotion would it help to look out for changing sensations in your body? This may give you clues to how you are feeling and help you to manage the feeing before it becomes too overwhelming. *For example, if someone is getting angry they may notice that their shoulders are tensing and their heart rate is increasing or the face getting hotter. At this point the person may be able to take themselves away from the situation to cool off.*
Would it be helpful to look out for certain behaviours as these may also give you a clue to how you are feeling and give you an opportunity to do something before the emotion feels out of control? *For example, if someone is getting angry they may notice that they start to fidget or pace around. At this point the person may be able to say a few key thoughts to themselves or use a relaxation exercise to calm the system down.*"
Spend five minutes reflecting on the session and bringing it together. Finish on a positive by asking the group participants to share their favourite place/picture/person or describe this if they have forgotten to bring it to the session. It is entirely appropriate for group facilitators to share something that they find positive if this seems relevant to the group.

INTER-SESSION WORK:

1. Identifying emotions worksheet (CREST manual, session 2). As participants to start recording their emotions on a regular basis. A good time to complete this is when they notice a change in mood; they may not be able to accurately identify the mood but by completing the record it may help. Suggest that it may also be helpful to start a feelings diary.
2. Ask patients to write a letter of gratitude (CREST manual, handout in Appendix 2.8), a list of things they are grateful for, or to generate a list of emotion words associated with 'grateful' to bring to the next session.
3. Interesting link for group participants to explore on their own time linking physiology and emotions:
   http://blogs.discovermagazine.com/d-brief/2013/12/30/body-atlas-reveals-where-we-feel-happiness-and-shame/



SESSION 4

EMOTION EXPRESSION VERSUS EMOTION SUPPRESSION

Welcome to group participants back to the group and reflect on the inter-session work set at the end of the last session. Reflection questions could include:

- How did people find the emotions worksheet?
- Did they notice anything in particular about the emotions they experienced? (common feelings they encountered, a focus on a particular set of emotions, triggers identified, did the exercise support them in the identification of their emotions?)
- How did they manage focusing on the theme of gratitude? What was the experience like? What emotions did this exercise elicit?

As previously, if participants reflected that it was difficult to engage with inter-session work, look at the barriers and think together as a group how they can support one another to practice identification/acknowledgement of emotional experience between these sessions.

Exercise 1: Ice breaker

Take three different emoji/emotion balls depicting different emotions and ask the group to label each. Sit in a circle on the floor and the facilitator starts by passing one emotion ball to the next person, stating the emotion and continuing this round the group. Once the group have settled into the task set a second emotion in the opposite direction, again asking the group to state the emotion they are holding, so now there are two emotions going around the circle in opposite directions. Finally, introduce the third ball and continue this process for a couple of minutes.

Reflect on this exercise with the group, explaining that in a fun way we were just exploring how fluid emotions can be and how we can often and quickly switch between a variety of emotions depending on our thoughts and circumstances.

Introduce this session explaining that we will be focusing on the advantages and disadvantages of expressing and suppressing emotions.

Exercise 2: Discussion

On a flip chart identify with the group emotions they hold a tendency to avoid of suppress. Then generate a list of advantages and disadvantages of suppressing their emotional experience, particularly paying attention to and referencing learning from the group sessions to this point.

Next identify with the group emotions they hold a tendency to express and, again, explore both the advantages and disadvantages of expressing these particular emotions.

Exercise 3: The Emotions Continuum Exercise

Remind the group of the exercise that was completed in the previous session, exploring how emotions vary in strength and intensity and considering at which point we can be effective in managing the emotion and when the emotion becomes too 'hot' so overwhelming and feeling 'out of control'. Use the second set of emotions cards (exploring anxiety or anger, whichever was not considered in session three) and go through the exercise in the same way as described in the previous session.

Reflect on when and where the emotion may be most available to be managed and hand out the list of ways the group participants can trial managing their emotions differently.

Exercise 4: Favourite place/person/thing exercise
So as to end the group focusing toward a more positive emotional experience, invite group participants to reflect on a favourite place/person/thing for a couple of minutes. Invite them to fully gain a picture of this and allow themselves to explore and dwell on this in a very focused way. If any of the group participants are able to, they can be invited to let others know what they were thinking about and the feeling evoked. If they do not want to share the exact images they held, invite them to think about how the exercise has left them feeling. It is entirely appropriate for group facilitators to also engage with this process.

Inter-session work:

1. Handout: emotion thermometer (CREST manual session 6) – invite the group to explore for themselves an emotion they struggle with, either positive or negative and think toward how and where they could manage this more effectively
2. Ask patients to try the 'getting into the flow' exercise (CREST manual, session 3) which involved engaging fully in small pleasures, preferably with someone else if this is possible.

SESSION 5:

EMOTIONS AND NEEDS

Begin the group by welcoming participants back and asking directly that we go around the room and everyone labels at least one emotion they are feeling at this moment, either positive or negative, acknowledging and validating their experience. This can be hard for the patients to achieve but explain that this is a safe space to really practice emotion expression.

Reflect on the homework, again exploring how and in what way engagement with this can benefit participants and encourage them to continue to develop their 'tool kit' of emotion expression and management techniques once the group sessions have ended.

Introduce that today's final group session will be focused toward exploring needs that emotions communicate to ourselves and others. Highlight that emotions are important signals worth listening to as they are communicating that we may need something and can guide how we and others respond to the emotion. If relevant to the particular group you are working with, you can introduce the pink giraffe exercise to highlight the point further.

Exercise 1: Vignette
Write the following case vignette and questions on a flip chart. Read the case vignette and ask the group the accompanying questions, noting the answers on the flip chart. The aim of this exercise is to encourage people to start thinking about the needs that emotions communicate; the impact that ignoring/avoiding them may have; thinking about ways to communicate and meet associated needs.

Case vignette:

Sarah has been invited to her friend's birthday part on a Friday night. The plan is to meet in a restaurant at 7pm, have dinner and then go for drinks. Sarah really wants to see her friend but is very anxious about meeting people in public for dinner and is worried about talking to her friend about this. Sarah worries about this all week and, on the night, texts her friend saying that she has a headache and cannot go out. Sarah has now cancelled on her friend a couple of times.

How does Sarah feel after cancelling?

What is she thinking?

What does or did she need?

What was the outcome for Sarah? How about her friend? (Does she feel better or worse?)

Are there any other ways that she could have handled this situation bearing in mind her needs? What are they?

Exercise 2: Making emotions work for you

On a flip chart list a number of emotions that have been identified as difficult to tolerate within the previous four session and discuss as a group what needs these emotions are communicating and how expressing them more effectively may be of benefit in relation to emotion management. Discuss how participants could respond differently to the emotion given the need that is being communicated.

Flip chart examples:

When I feel **sad** I need ……. (eg comfort/reassurance)

When I experience this emotions I will respond to it by …… (eg ringing a friend/family member, do something that will cheer me up)

When I feel **angry** I need ……. (eg someone to listen to me, time out, understanding)

When I experience this emotion I will respond to it by …… (eg taking myself away from the situation and dealing with it later, talking to someone and not bottling it up)

When I feel **anxious** I need …….. (eg face the fear, reassurance)

When I experience this emotion I will respond to it by …….. (eg reminding myself that I can cope with this, I've managed to face the anxiety provoking situation before, speak with someone.

Remember always end on a positive emotion!!! ☺

Finally, spend time recapping the group and reiterating the importance of eliciting and attending to positive emotions, as well as the importance of thinking about the needs emotions are communicating.

It can be helpful to describe this metaphor to participants to help them think about the importance of being able to communicate more accurately how they are feeling:

Imagine a person drowning in a lake, they are shouting loudly for help and someone onshore has heard them, except the person is shouting "Help, I'm on fire!". The person onshore is now running towards them with a bucket of water shouting "Don't worry I'll put you out".

Complete the self-report questionnaire from the first session (TAS – measuring alexythimia, SAS – measuring

ASSESSMENT TOOLS

- Self-report outcome measures are administered before the first and last sessions. The 'Revised Social Anhedonia Scale' (RSAS) and the 'Toronto Alexithymia Scale' (TAS) are the group specific measures, and the 'Motivational Ruler' (importance and ability scales) is also offered.
- A written feedback form is administered to patients after the last session.
- Staff supervision (fidelity checks and evaluation of the notes from the groups).

Toronto Alexithymia Scale (Taylor et al., 1988)

	TAS						
			Disagree strongly	Somewhat disagree	neutral	Somewhat agree	Agree strongly
1	I am often confused about what emotion I am feeling		1	2	3	4	5
2	It is difficult for me to find the right words for my feelings		1	2	3	4	5
3	I have physical sensations that even doctors don't understand		1	2	3	4	5
4	I am able to describe my feelings easily		1	2	3	4	5
5	I prefer to analyse problems rather than just describe them		1	2	3	4	5
6	When I am upset, I don't know if I am sad, frightened or angry		1	2	3	4	5
7	I am often puzzled by sensations in my body		1	2	3	4	5
8	I prefer to just let things happen rather than to understand why they turned out that way		1	2	3	4	5
9	I have feelings that I can't quite identify		1	2	3	4	5
10	Being in touch with emotions is essential		1	2	3	4	5
11	I find it hard to describe how I feel about people		1	2	3	4	5
12	People tell me to describe my feelings more		1	2	3	4	5
13	I don't know what's going on inside me		1	2	3	4	5
14	I often don't know why I am angry		1	2	3	4	5
15	I prefer talking to people about their daily activities rather than their feelings		1	2	3	4	5
16	I prefer to watch "light" entertainment shows rather than psychological dramas		1	2	3	4	5
17	It is difficult for me to reveal my innermost feelings, even to close friends		1	2	3	4	5
18	I can feel close to someone, even in moments of silence		1	2	3	4	5
19	I find examination of my feelings useful in solving personal problems		1	2	3	4	5
20	Looking for hidden meanings in movies or plays distracts from their enjoyment		1	2	3	4	5

Social Anhedonia scale (Eckblad et al, 1982)

Participant Name: Participant Number:

Date:

SAS

Please answer each item true or false. Please do not skip any items. It is important that you answer every item, even if you are not quite certain which the best answer is. An occasional item may refer to experiences which you have had only when taking drugs. Unless you have had the experience at other times, mark it as if you have not had that experience.

Some items may sound like others, but all of them are slightly different. Answer each item individually, and don't worry about how you answered previous items that were somewhat similar.

Circle either: T = True or F = False

1.	Having close friends is not as important as many people say.	T	F
2.	I attach very little importance to having close friends.	T	F
3.	I prefer watching television to going out with other people.	T	F
4.	A car ride is much more enjoyable if someone is with me.	T	F
5.	I like to make long distance phone calls to friends and relatives.	T	F
6.	Playing with children is a real chore.	T	F
7.	I have always enjoyed looking at photographs of friends.	T	F
8.	Although there are things that I enjoy doing by myself, I usually seem to have more fun when I do things with other people.	T	F
9.	I sometimes become deeply attached to people I spend a lot of time with.	T	F
10.	People sometimes think that I am shy when I really just want to be left alone.	T	F
11.	When things are going really good for my close friends, it makes me feel good too.	T	F
12.	When someone close to me is depressed, it brings me down also.	T	F
13.	My emotional responses seem very different from those of other people.	T	F

14.	When I am home alone, I often resent people telephoning me or knocking on my door.	T	F
15.	Just being with friends can make me feel really good.	T	F
16.	When things are bothering me, I like to talk to other people about it	T	F
17.	I prefer hobbies and leisure activities that do not involve other people.	T	F
18.	It's fun to sing with other people.	T	F
19.	Knowing that I have friends who care about me gives me a sense of security.	T	F
20.	When I move to a new city, I feel a strong need to make new friends.	T	F
21.	People are usually better off if they stay aloof from emotional involvements with most others.	T	F
22.	Although I know I should have affection for certain people, I don't really feel it.	T	F
23.	People often expect me to spend more time talking with them than I would like.	T	F
24.	I feel pleased and gratified as I learn more and more about the emotional life of my friends.	T	F
25.	When others try to tell me about their problems and hangups, I usually listen with interest and attention.	T	F
26.	I never had really close friends in high school.	T	F
27.	I am usually content to just sit alone, thinking and daydreaming.	T	F
28.	I'm much too independent to really get involved with other people.	T	F
29.	There are few things more tiring than to have a long, personal discussion with someone.	T	F
30.	It made me sad to see all my high school friends go their separate ways when high school was over.	T	F

31.	I have often found it hard to resist talking to a good friend, even when I have other things to do.	T	F
32.	Making new friends isn't worth the energy it takes.	T	F
33.	There are things that are more important to me than privacy	T	F
34.	People who try to get to know me better usually give up after awhile.	T	F
35.	I could be happy living all alone in a cabin in the woods or mountains.	T	F
36.	If given the choice, I would much rather be with others than be alone	T	F
37.	I find that people too often assume that their daily activities and opinions will be interesting to me.	T	F
38.	I don't really feel very close to my friends.	T	F
39.	My relationships with other people never get very intense.	T	F
40.	In many ways, I prefer the company of pets to the company of people.	T	F

Initials……

Group Feedback Questionnaire

1.) Name of group……

2.) How many sessions did you attend? ……

3.) How much did you enjoy these sessions?

Did not enjoy at all		Quite enjoyed		Really enjoyed
1	**2**	**3**	**4**	**5**

4.) How useful were these sessions?

Not useful at all		Quite useful		Really useful
1	**2**	**3**	**4**	**5**

5.) Have you used any new thinking skills or strategies as a result of what you learnt in the group?

No, none		Some		Yes, lots
1	**2**	**3**	**4**	**5**

6.) What did you think about the length of the group (i.e. number of weeks)? Was this too long, too short or appropriate?

Too short		Just Right		Too long
1	**2**	**3**	**4**	**5**

7.) What did you like the most about the sessions?

……

……

……

……

.....

8.) Please give your ideas about how we could improve the group in the future:

……

……

……

……

.....

9.) What other groups have you attended on the ward?

……

……

……

……

South London and Maudsley NHS Foundation Trust

Resources from websites; YouTube:
Topic Body Language:

Politics-body language - http://www.youtube.com/watch?v=dW9ztSUGY_Q

Body Language with Alan Pease - http://www.youtube.com/watch?v=Aw36-ByXuMw

Amy Cuddy: Your body language shapes who you are
http://www.ted.com/talks/amy_cuddy_your_body_language_shapes_who_you_are.html
http://www.youtube.com/watch?v=AQENwD-QlRA&feature=related
http://www.youtube.com/user/bodylanguageexpert?feature=relchannel

Helpful References:

Tchanturia K, Doris E, Fleming C (2014) Effectiveness of cognitive remediation and emotion skills training (CREST) for anorexia nervosa in group format: A naturalistic pilot study European Eating Disorders Review. 22(3):200-5; doi: 10.1002/erv.2287
Money C, Genders B, Treasure J, Schmidt, Tchanturia K. (2011) A brief emotion focused intervention for inpatients with anorexia nervosa: A qualitative study. Journal of Health Psychology. 16(6):947-58 PMID: 21441359
Brief Group Psychotherapy for Eating Disorders: Inpatient protocols *- Routledge Mental Health http://www.routledgementalhealth.com/books/details/9781138848917/*. Edited by Kate Tchanturia, 06/2015; , ISBN: 978-1-13-884891-7

What patients told us about benefits of group format?

What was helpful?

Emotional intensity; positive emotions session.
Lot of group discussions and tasks we could all get involved in to get us thinking.
The variety of topics and the way we addressed and discussed them.
Focus on all types of emotions, not just the positive.
Interactive, pictures, different learning styles catered for.
A good opportunity to discuss emotions we feel and the reasons for them- being able to describe what we feel and identify them.

Distraction at the beginning of the group. Trying to understand the physical sensations associated with different emotions.
I found them interesting and they have made me think about my emotions and my relationship with my emotions and how to improve this.
Activities - things I can get involved with.
Group discussion- other people's insight is useful.
Practical elements; group participation; learnt connections
Listening to others about their experiences with emotions; that the group was interactive.
Interactive and dynamic
Releasing our feelings, listening to others experiences, the symptoms etc.
Hearing other peoples views
I enjoyed listening to everyone thoughts about the certain emotion. How we all think differently.
The openness and detail spoken about
Sharing thoughts, feelings, ideas
Listening to other people's perspectives of these emotions
Discussions about how to accept feelings

What can be improved? (patients' feedback)

Lock the doors! Interruptions ruin it. (late comers, staff)
More discussions and patient involvement.
More interaction
More practical exercises
Give more tools to encourage positive emotions and avoid negative ones

Appendix 6

Outcome Measures: How can we evaluate CREST?

It is hard to evaluate the immediate and long term benefits of CREST. As we can see from the case reports, BMI reflects the clinical picture, the severity of illness and dynamics of change; however, we are not suggesting that BMI is a primary outcome. All cases reported in the manual are inpatients with very compromised physical and psychological health and therefore they are receiving support from the whole multidisciplinary team.

Neuropsychological measures as outcomes need further research as experimental studies of emotional processes represent a relatively new and poorly studied topic in ED. We are still exploring the best possible measures with which to assess progress and to share with research and clinical colleagues. The reference section, including work from our team, summarises peer reviewed scientific papers on the topic.

In terms of self report measures, the Toronto Alexithymia scale is the most broadly researched and used measure in the literature; We think that the Social Anhedonia Scale (SAS) and Work and Social adjustment scale (WSAS) are also good measures to use before and after CREST (Tchanturia et al., 2012; 2013 summarises our research work to date using these tools).

And of course we administer patient satisfaction questionnaires, gather therapists' feedback from supervision and conduct focus groups with all individuals involved in CREST work.

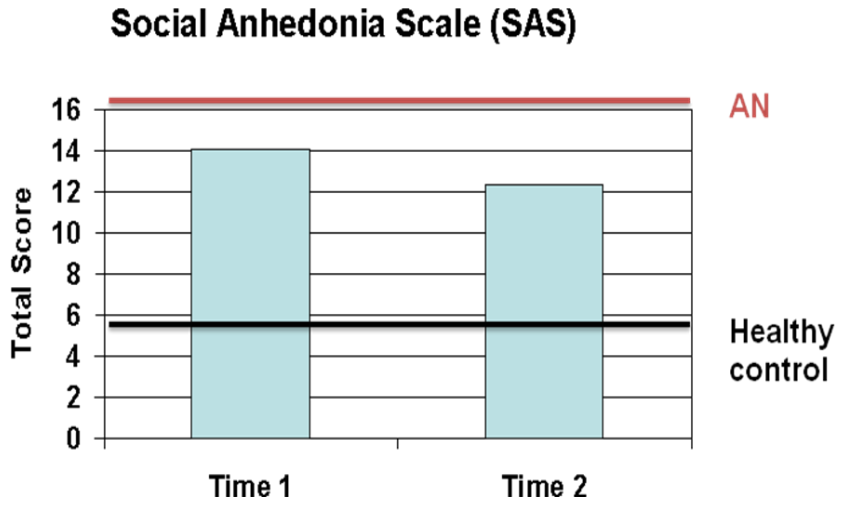
A summary of the individual and group work using these measures is shown in the graphs below:

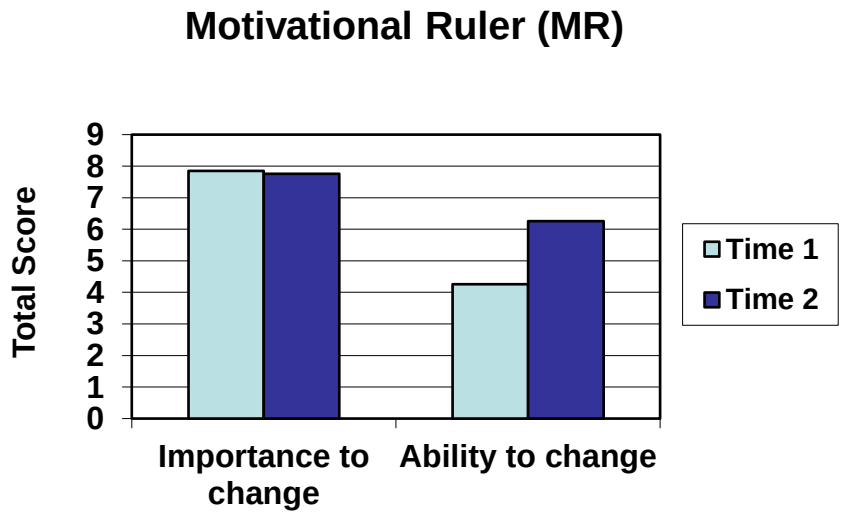
Appendix 7

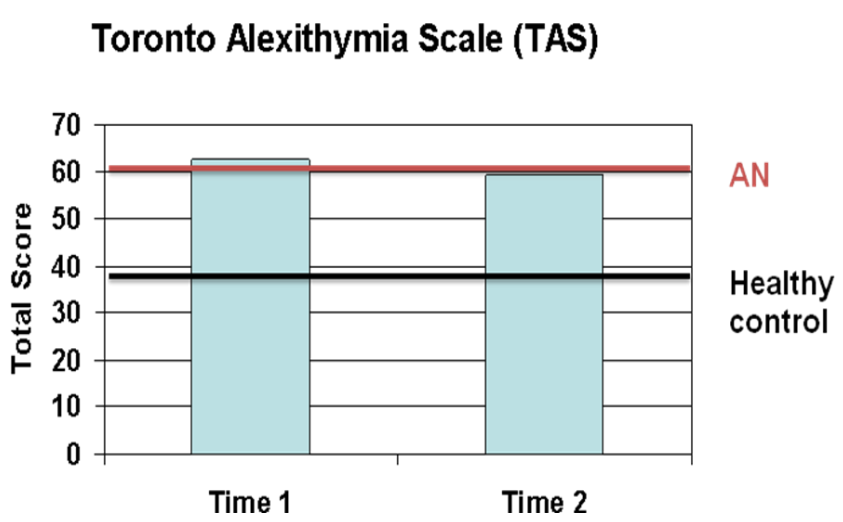
Table of available evidence

Individual CREST outcomes

- Small effect size on SAS = Increased ability to experience pleasure from everyday activities
- Medium effect size on TAS = Improved ability to identify & describe emotions, decreased tendency to minimise emotional experience
- No change on MR-I; Extremely large effect size for MR-A = Increase in perceived ability to change
- *Normative data from Tchanturia, Davies, Harrison, Fox, Treasure & Schmidt (2012)*

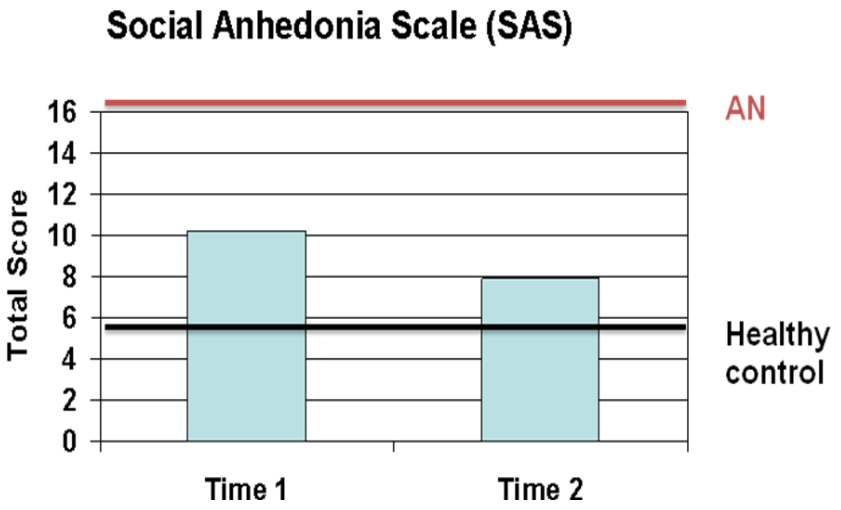


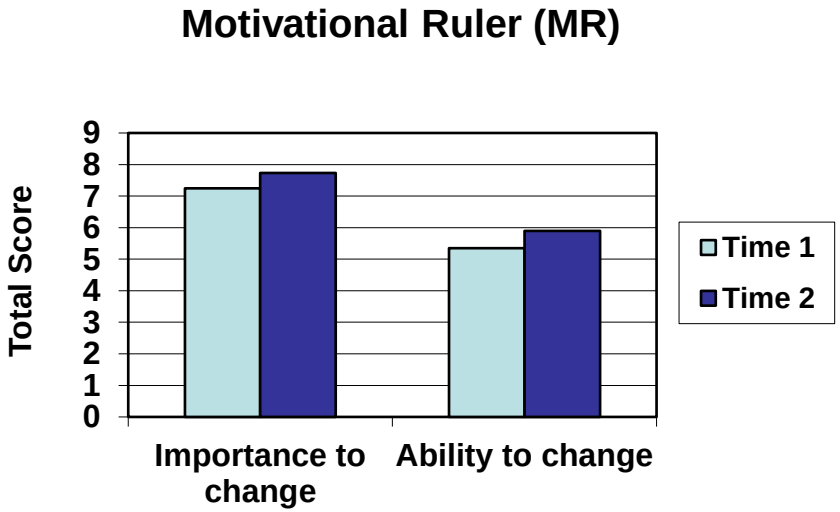


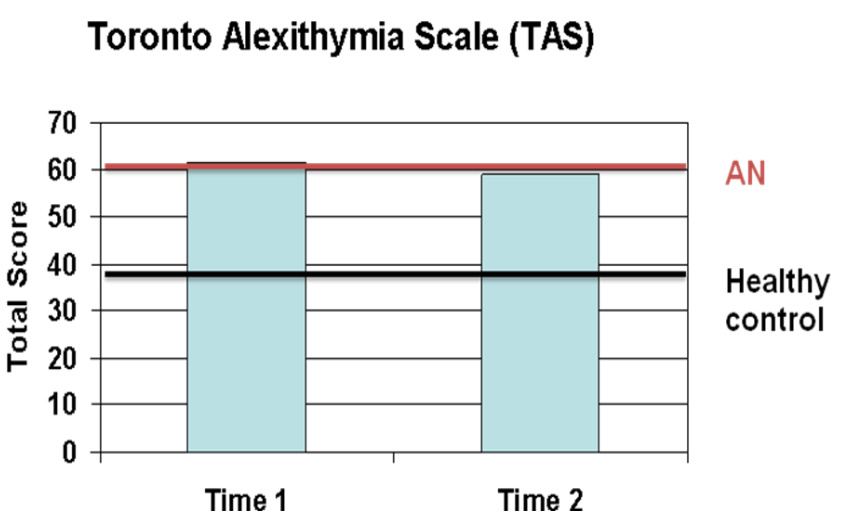


CREST group outcomes

- Small effect size on SAS = Increased ability to experience pleasure from everyday activities
- Medium effect size on TAS = Improved ability to identify & describe emotions, decreased tendency to minimise emotional experience
- Small effect size on MR-I; Large effect size for MR-A = Increase in both perceived importance and ability to change
- *Normative data from Tchanturia et al. (2012)*
-







What patients said they liked about the CREST group…

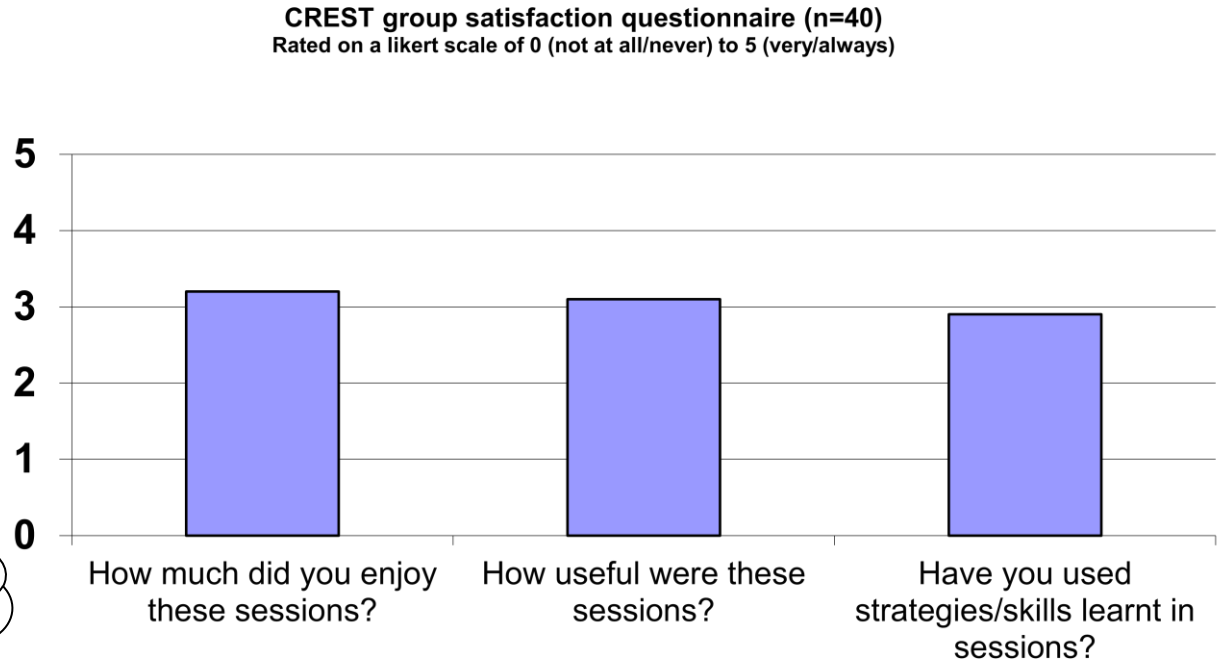
Sharing

The groups were very interactive. Being made aware of the large number of emotions people experience and identifying how we cope with them was very useful.

The sessions really got me thinking about how to notice my emotions and deal with them. They made me feel a bit more positive about my recovery.

Learning how emotions are communicating something to us. All emotions are valid and valuable - no 'good' or 'bad' feelings

Interactive tasks



Appendix 8

References

Useful materials we adapted from published resources and workbooks

Allen, J. G., & Fonagy, P. (Eds.). (2006). *The handbook of mentalization-based treatment*. Chichester, UK: Wiley.

Fredrickson, B. (2009). *Positivity: Groundbreaking research reveals how to embrace the hidden strength of positive emotions, overcome negativity, and thrive*. Oxford, UK: Oneworld.

Moritz, S., & Woodward, T. S. (2007). Metacognitive training in schizophrenia: from basic research to knowledge translation and intervention. *Current Opinion in Psychiatry*, *20*(6), 619-625.

Wegner, D. M. (1989). *White bears and other unwanted thoughts: Suppression, obsession, and the psychology of mental control*. New York: Viking/Penguin.

Wegner, D. M., Schneider, D. J., Carter, S. R., III & White, T. L. (1987). Paradoxical effects of thought suppression. *Journal of Personality and Social Psychology,* 53 (1), 5–13.

We adapted ideas from the following sources:

Action for Happiness. *Happiness Action Pack* [PDF document]. Retrieved from Action for Happiness online Web site: http://www.actionforhappiness.org/resources

Kelly, A. (2004). *A Social Communication Skills Package.* Milton Keynes, UK: Speechmark Publishing Ltd.

Kelly, A. (2005). *Building Self-Esteem & Relationship skills.* Milton Keynes, UK: Speechmark Publishing Ltd.

Powell, T. (2006). *The Mental Health Handbook (Revised Edition).* Milton Keynes, UK: Speechmark Publishing Ltd.

Roet, B. (2003). *Feelings: Exploring your inner emotions.* London: Piatkus.

Romer, D., & Walker, E. F. (2007). *Adolescent Psychopathology and developing brain: Integrating Brain and Prevention Science.* Oxford, UK: Oxford University Press.

Sunderland, M., & Engleheart, P. (2005). *Draw on your emotions*. Milton Keynes, UK: Speechmark Publishing Ltd.

Useful reading on emotions

Baker, R. (2007). *Emotional processing: Healing through feeling*. Oxford, UK: Lion Books.

Ekman, P. (2003). *Emotions Revealed: Understanding faces and feelings.* San Diego, CA: Phoenix.

Evans, D. (2003). *Emotions a very short introduction.* Oxford, UK: Oxford University Press.

Goleman, D. (1996). *Emotional Intelligence: Why it can matter more than IQ.* London, UK: Bloomsbury.

LeDoux, J. (2003). *The Emotional Brain.* San Diego, CA: Phoenix.

Evaluation and Development of CREST published peer reviewed work

Kerr-Gaffney J, Harrison A, Tchanturia K (2019) Cognitive and Affective Empathy in Eating Disorders: A Systematic Review and Meta-analysis. Frontiers in Psychiatry https://doi.org/10.3389/fpsyt.2019.00102

Kerr- Gaffney J, Harrison A, Tchanturia K (2018) Social anxiety in the eating disorders: A systematic review and meta-analysis. Psychological Medicine. doi: 10.1017/S0033291718000752

Giombini L, Nesbitt S, Leppanen J, Cox H, Easter A, Tchanturia K (2019) Emotions in play: Young people's and clinicians' experience of 'Thinking about Emotions' group. Eat Weight Disord. doi: 10.1007/s40519-019-00646-3

Adamson J, Leppanen J, Murin M, Tchanturia K (2018) Effectiveness of Emotional Skills Training for Patients with Anorexia Nervosa with Autistic Symptoms, Group or Individual Format European Eating Disorder Review. 26(4) 367-375

Cardi V, Tchanturia K, Treasure J (2018) Premorbid and illness-related social difficulties in eating disorders: an overview of the literature and treatment developments. Current Neuropharmacology; doi: 10.2174/1570159X16666180118100028

Dapelo M, Surguladze S, Morris R, **Tchanturia K** (2017) Emotion recognition in face and body motion in bulimia nervosa. European Eating Disorder Review doi: 10.1002/erv.2554.

Westwood H, Kerr-Gaffney J, Stahl D, Tchanturia K (2017) Alexithymia in eating disorders: Systematic review and meta-analyses of studies using Toronto Alexithymia Scale; Journal of Psychosomatic Research; 66-81; doi: 10.1016/j.jpsychores.2017.06.007

Leppanen J, Dapelo M, Davies H, Lang K, Treasure J, **Tchanturia K** (2017) Computerised analysis of facial emotion expression in Eating Disorders-s. Plos one 2;12(6):e0178972.doi:10.1371/journal.pone.0178972

Westwood H, Lawrence V, Fleming C, Tchanturia K (2016) Exploration of Friendship Experiences, before and after Illness Onset in Females with Anorexia Nervosa: A Qualitative Study. PLoS One. 27;11(9):e0163528. doi: 10.1371/journal.pone.0163528

Marin Dapelo M, Hart S, Hale C, Morris R, Tchanturia K (2016) Expression of positive emotions differs in illness and recovery in Anorexia Nervosa; Psychiatry Research. 30;246:48-51 doi:10.1016/j.psychres.

Davies H, Wolz I, Leppanen, F Fernandez Aranda, U Schmidt, Tchanturia K (2016) Facial expression to emotional stimuli in non-psychotic disorders: A systematic review and meta-analysis. Neuroscience & Biobehavioral Reviews; S0149-7634(15)30237-210.1016/j.neubiorev.2016.02.015

Dapelo M, Bodas S, Morris R, Tchanturia K. (2016) Deliberately generated and Imitated Facial Expressions of Emotions in people with Eating Disorders. Journal of Affective Disorders. 191; 1–7 10.1016/j.jad.2015.10.044 191:1-7

Tchanturia K, Doris E, Mountford V, Fleming C (2015) Cognitive Remediation and Emotion Skills Training (CREST) for anorexia nervosa in individual format: Self-reported outcomes BMC Psychiatry; 20;15:53. doi: 10.1186/s12888-015-0434-9

Tchanturia K, Doris E, Fleming C (2014) Effectiveness of cognitive remediation and emotion skills training (CREST) for anorexia nervosa in group format: A naturalistic pilot study European Eating Disorders Review 22(3):200-5; doi: 10.1002/erv.2287

Davies, H., Fox, J., Naumann, U., Treasure, J. Schmidt, U., & Tchanturia, K. (2012). Cognitive remediation and emotion skills training (CREST) for anorexia nervosa: an observational study using neuropsychological outcomes. *European Eating Disorder Review. 20 (3)*, 211-7.

Hambrook, D., Brown, G., & Tchanturia, K. (2012). Emotional intelligence in anorexia nervosa. *Journal of Psychiatric Research, 200(1),*12-9.

Kyriacou, O., Easter, A., & Tchanturia, K. (2009). Comparing views of patients, parents and clinicians on emotions in anorexia: A qualitative study. *Journal of Health Psychology,* 14, 843-854.

Money, C., Davies, H., & Tchanturia, K. (2011). A case study introducing Cognitive Remediation & Emotion Skills Training (CREST) for Anorexia Nervosa inpatient care. *Clinical Case Studies, 10(2),* 110-12.

Money, C., Genders, B., Treasure, J., Schmidt, U., & Tchanturia, K. (2011). A brief emotion focused intervention for inpatients with anorexia nervosa: A qualitative study. *Journal of Health Psychology, 16(6),* 947-58.

Research Evidence Supporting CREST and literature about Outcome Measures

Tchanturia K. Marin Dapelo M, Hambrook D, Harrison A. (2015) Why study positive emotions in the context of eating disorders? Current Psychiatry Reports; 17(1):537 DOI: 10.1007/s11920-014-0537-x

Doris E, Westwood H, Mandy W, Tchanturia K (2014) Patients with Anorexia Nervosa show similar friendships difficulties to people with Autism Spectrum Disorders: A Qualitative Study. Psychology Special issue Autism. 5, 1338-1349

Harrison A, Mountford V, Tchanturia K (2014) Social anhedonia and work and social functioning in the acute and recovered phases of eating disorders; Psychiatry Research, 218 (187-194) DOI: 10.1016/j.psychres.2014.04.007

Morris R, Bramham J, Smith E, Tchanturia K (2014) Social and Emotional Functioning in anorexia nervosa. Cognitive Neuropsychiatry 19(1):47-57 PMID:23697879

Marin Dapelo M, Hart S, Hale C, Lynch T, Morris R, Tchanturia K. (2015) Expressing positive emotions comparative study between people with anorexia, bulimia and non eating disorder females. Psychiatry Research 10.1016/j.psychres.2015.08.019

Fonville L, Giampietro V, Surguladze S, Williams S, Tchanturia K (2014) Increased BOLD signal in the fusiform gyrus during implicit emotion processing in anorexia nervosa; NeuroImage: Clinical; 266–273

Davies, H., Schmidt, U., Stahl, D., & Tchanturia, K. (2010). Evoked facial emotional expression and emotional experience in people with anorexia nervosa. International Journal of Eating Disorders, 44, 531–539.

Davies, H., Schmidt, U., & Tchanturia, K. (2013). Altered emotional facial expression in women recovered from anorexia nervosa. *Psychosomatic Medicine: Journal of Biobehavioral Medicine*. 13(1):2917.

Genders, R., Davies, H., StLouis, L., Kyriacou, O., Hambrook, D., & Tchanturia, K. (2008). Long-term benefits of CRT for anorexia. *British Journal of Healthcare Management, 14(12),*15-19.

Hambrook, D., Schmidt, U., Russell, T., Treasure, J., & Tchanturia, K. (2008). Empathy, Systemizing, and Autistic Traits in Anorexia Nervosa: A Pilot Study. British Journal of Clinical Psychology, 47, 335-339.

Harrison, A., Genders, R., Davies, H., & Tchanturia, K. (2011). Experimental Measurement of the regulation of Anger and aggression in women with Anorexia Nervosa. Clinical Psychology Psychotherapy, 18 (6), 445-52.

Harrison, A., Tchanturia, K., Naumann, U., & Treasure, J. (2012). Social Emotional Functioning and Cognitive Styles in Eating Disorders. *British Journal of Clinical Psychology, 51(3),* 261-79.

Lock, J., Agras, S., Fitzpatrick, K., Bryson, S., Booil, J., & Tchanturia, K. (2013). A Randomised

assessment of Novel Treatment for anorexia nervosa addressing inefficient cognitive process. *International Journal of Eating Disorders.*

Lopez, C., Stahl, D., & Tchanturia, K. (2010). Estimated IQ in anorexia: A systematic review of the literature. *Annals of General Psychiatry, 9 (1),* 40.

Russell, T., Schmidt, U., & Tchanturia, K. (2009). Aspects of social cognition in anorexia nervosa: Affective and cognitive theory of mind. *Psychiatry Research, 15:168 (3),* 181-5.

Tchanturia, K., Davies, H., Harrison, A., Fox, J., Treasure, J., & Schmidt, U. (2012). Altered social hedonic processing in eating disorders. *International Journal of Eating Disorders, 45(8)*, 962-9.

Tchanturia, K., Hambrook, D., Curtis, H., Jones, T., Lounes, N., Fenn, K., . . . Davies, H. (2013). Work and Social Adjustment in patients with Anorexia Nervosa. *Comprehensive Psychiatry, 54(1),* 41-5.

Tchanturia, K., Happe, F., Godley, J., Bara – Carill, N., Treasure, J., & Schmidt, U. (2004). Theory of Mind in AN. *European Eating Disorders Review, 12,* 361-366.

Tchanturia, K., Lloyd, S., & Lang, K. (2013). Cognitive Remediation in eating disorders. *International Journal of Eating Disorders, 46,* 492–495.

Brief Group Psychotherapy for Eating Disorders: Inpatient protocols (Paperback) – Routledge Mental Health http://www.routledgementalhealth.com/books/details/9781138848917/. Edited by Kate Tchanturia, 06/2015; , ISBN: 978-1-13-884891-7

Peer Reviewed Articles from Other Research/Clinical Centres

Jansch, C., Harmer, C., & Cooper, M, J. (2009). Emotional processing in women with anorexia nervosa and in healthy volunteers. *Eating behaviours,* 10, 184-191.

Linehan, M, M. (1993). *Skills training manual for treating borderline personality disorder.* London: Guilford Press.

Lyubomirsky, S. & Layous, K. (2013). How Do Simple Positive Activities increase Well-Being? *Current Directions in Psychological Science, 22(1),* 57-62.