Spot the Difference

Volume 46 Number 1 • February 2018

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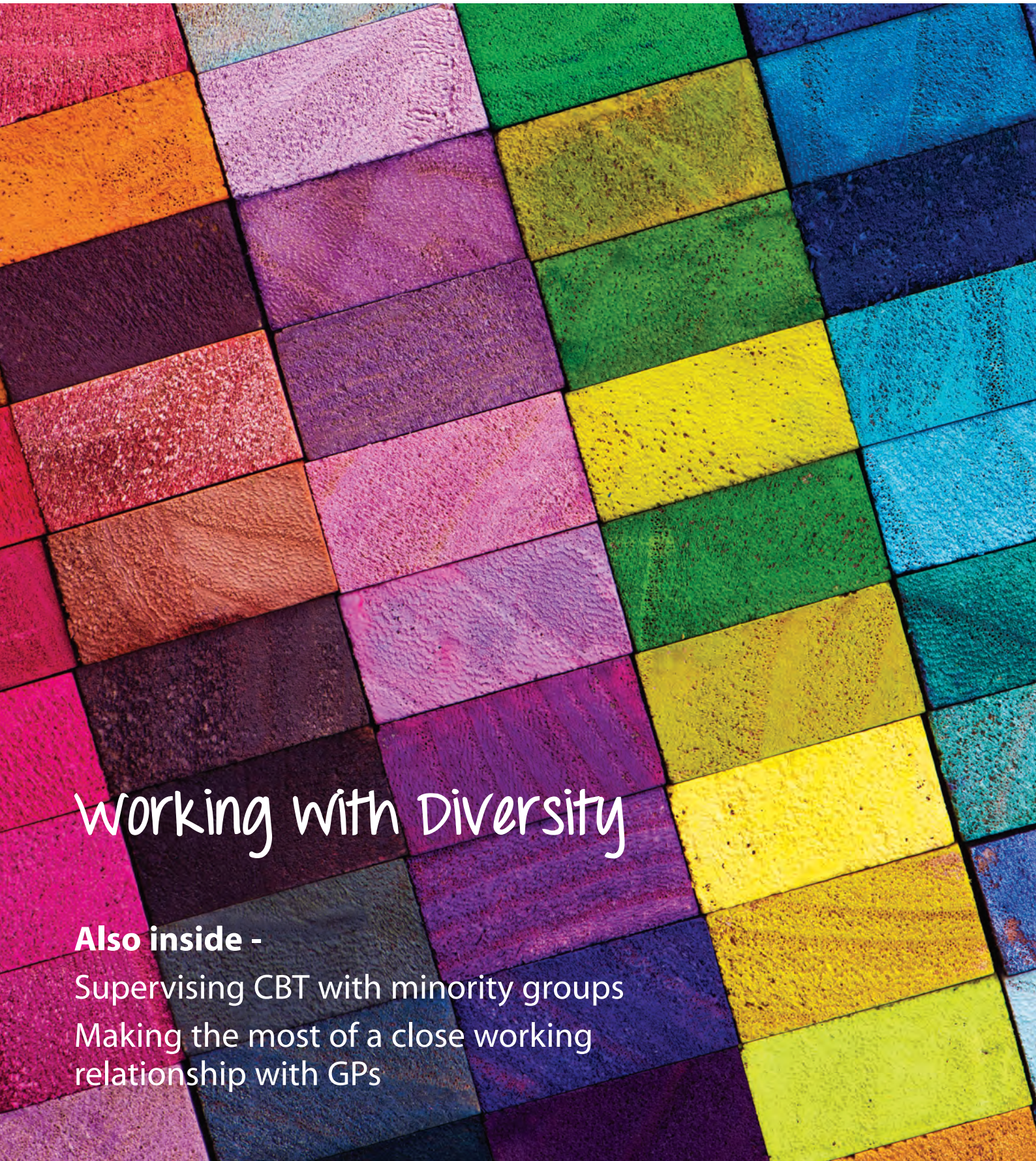
CBT today

Official magazine of the British Association for Behavioural & Cognitive Psychotherapies



Working with Diversity

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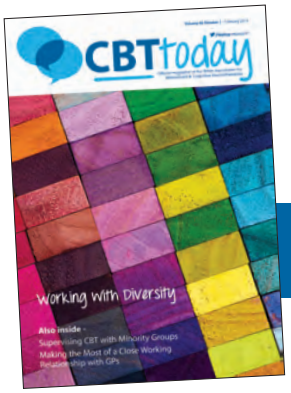
Making the most of a close working relationship with GPs



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Volume 46 Number 1
February 2018

Welcome to our first issue of the year. As always we have a range of topics in this issue, with a heavy emphasis on working with diversity.

There are a few updates in the news section, with the recent release of our podcast 'Let's talk about CBT' among them. A listen to the first episode is well worth 45 minutes of your time.

As always, thanks go to all our contributors – if you have an idea for inclusion in a future issue, please do get in touch.

Peter

Peter Elliott
Managing Editor
peter.elliott@babcp.com

Contributors

Mark Addis, Andrew Beck, James Bennett-Levy, Elaine Davies, Isabella Foustanos, Rob Griffiths, Emily Holmes, Ruth Lawrence, Saiqa Naz, Chris Williams

CBT Today is the official magazine of the British Association for Behavioural & Cognitive Psychotherapies, the lead organisation for CBT in the UK and Ireland.The magazine is published four times a year and posted free to all members.

Back issues can be downloaded from **www.babcp.com/cbttoday**

Next deadline
9.00am on 9 April 2018 (for distribution week commencing 4 May 2018)

Advertising
For enquiries about advertising in *CBT Today*, please email advertising@babcp.com.

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Main Feature

Features

Also in this issue

From the President:

Well, doesn't time fly…

It's now February and only a few months until we welcome delegates to our Annual Conference in my home city Glasgow in July. It will be my last event as President before Paul Salkovskis takes over the role.

Last year's conference was amazing with a fantastic mix of clinical and academic content, and as always, a great social programme. So do think of joining us.

Also, consider doing more than being an attendee alone. Why not put yourself forward to participate? For example, yesterday I was contacted by a Scottish low intensity worker (called CAAPS for those outside Scotland). He had done a fantastic project on one of the Scottish islands, where the initial appointment letter for LI-CBT had been altered to focus on conveying relationship and engagement rather than just the facts and practical details of the appointment. They were noticing marked differences in attendance rates, engaging more individuals plus spontaneous contacts being received by those declining the assessment explaining why – something that was new to the service. I suggested he consider putting this forward as a possible poster presentation at conference.

I'm sure many readers have themselves – or via colleagues, taken part in all sorts of interesting innovative and good work this year. Why not share it with others? You can still submit posters and oral presentations, but you will need to be quick, as the deadline is on 12 March.

I reported in the last issue of *CBT Today* that we would be examining different options about how we describe ourselves as an organisation.

The intention was to develop three possible cases for the future: maintaining the status quo – i.e. we are an interest group largely of practitioners; we make a formal change to become a professional body; or a hybrid approach where we emphasise our role in providing the professional delivery of CBT – pointing to our role in course accreditation, individual accreditation and complaints/ disciplinary work.

I think those tasked with writing these three options papers for Board were surprised to find common ground. The solution was in providing clarity about what we are - and what we are not as an organisation. It has been agreed at Board to consult on a change where we would move to describing ourselves as a Professional body.

There are definite advantages to many members – and if a forthcoming consultation supports this change, the changes to our Memoranda and Articles would actually be quite small (a few lines of text). You will hear more on this as the consultation begins over the next months.

We are also in consultation with our Branch and SIG committees to work with them in delivering high-quality CPD workshops for members – this includes looking at how we can best support our valued volunteer committee members as well as continue to act in accordance with Charity Commission regulations and our own organisation aims.

We have now responded to a consultation on the issue of statutory regulation and possible changes to health regulation in the UK. Our full response (including all our answers to the consultation) is available on our website at https://tinyurl.com/y7scqvxf

Finally, I am aware that some people are concerned that there has been a change to our Minimum Training Standards required for practitioner accreditation. Please note there has been no change.

Chris Williams, BABCP President

Let us know your thoughts by emailing **babcp@babcp.com**

in brief...

Going Greener

Thanks to recent feedback we have received, we have taken the decision that from this issue onwards, your copy of *CBT Today* will be posted in a paper envelope rather than the normal polywrapping you will be familiar with.

Long-Term Health Conditions SIG

The latest BABCP Special Interest Group was launched at the end of January.

The Long-Term Health Conditions and Medically Unexplained Symptoms SIG held their inaugural meeting at the University of Sheffield, where founding member Helen Macdonald opened the meeting before speakers Philip Kinsella and Saiqa Naz were joined by other BABCP members who work in the field of helping those with long-term medical conditions and medically unexplained symptoms.

More information was unavailable at the time of going to press, but those interested in joining the SIG should email the office at babcp@babcp.com.

To contact the SIG itself, you can email them at longterm-sig@babcp.com.

Accreditation logo

All BABCP-accredited members are now able to display their status by using the new 'BABCP Accredited' logo, which has been designed for use on websites and stationery such as letterheads and business cards.

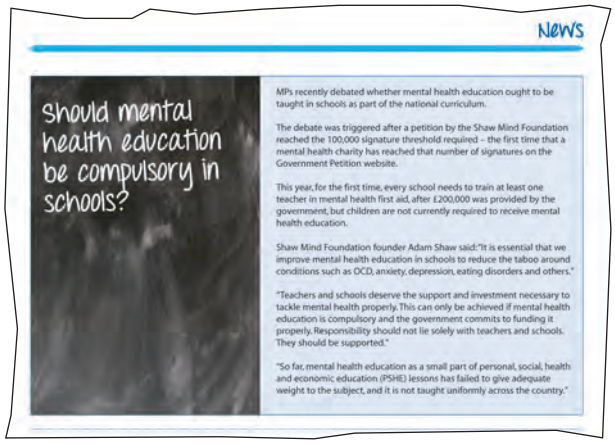
Guidelines for its use and instructions to download the logo itself has been emailed to all currently accredited members.

BABCP Accredited

Mental health in schools

We revealed in the last issue of *CBT Today* that MPs were due to debate the issue of making mental health a compulsory topic in schools.

The Shaw Mind Foundation - who campaigned to have the debate heard in parliament - reported that MPs from all parties showed overwhelming support for improved mental health education in the debate held on 6 November.


News

Should mental health education be compulsory in schools?

MPs recently debated whether mental health education ought to be taught in schools as part of the national curriculum.

The debate was triggered after a petition by the Shaw Mind Foundation reached the 100,000 signature threshold required – the first time that a mental health charity has reached that number of signatures on the Government Petition website.

This year, for the first time, every school needs to train at least one teacher in mental health first aid, after £200,000 was provided by the government, but children are not currently required to receive mental health education.

Shaw Mind Foundation founder Adam Shaw said: "It is essential that we improve mental health education in schools to reduce the taboo around conditions such as OCD, anxiety, depression, eating disorders and others."

"Teachers and schools deserve the support and investment necessary to tackle mental health properly. This can only be achieved if mental health education is compulsory and the government commits to funding it properly. Responsibility should not lie solely with teachers and schools. They should be supported."

"So far, mental health education as a small part of personal, social, health and economic education (PSHE) lessons has failed to give adequate weight to the subject, and it is not taught uniformly across the country."

CBT Today - December 2017

But there is still some way to go before making this a reality, as although Education Minister Nick Gibb assured the chamber that mental health is a key Government priority, he did not commit any additional funds to mental health education or recommend its inclusion in the curriculum.

Shaw Mind Foundation founder Adam Shaw said: "The point needs driving home that if it isn't compulsory it isn't good enough. They [the Government] must take a step back and restructure the curriculum to put mental health education in from the start, it should be on the syllabus for the next generation of teachers as part of their training and qualification."

Comms Committee

Are you interested in ways to help shape the communications within BABCP?

If so, the Communications Committee would love to hear from you.

The committee ordinarily meets twice a year to review and develop our communications with members and external stakeholders.

If you have experience in writing articles, being involved in communications strategy or the use of business or organisational social media accounts, please email **editorial@babcp.com** for more information.

Let's talk about CBT

BABCP www.babcp.com
Let's Talk About **CBT**

Our new podcast was launched last month with the release of Episode One, where Lucy Maddox spoke with experts in the field and service users, as well as explaining CBT jargon and busting myths around CBT.

Future episodes will be announced via our Twitter feed, and can be downloaded on iTunes for Apple devices and is also available for Android devices.

More info is available at http://letstalkaboutcbt.libsyn.com/website

46th BABCP Annual Conference and Workshops

University of Strathclyde, Glasgow
17-20 July 2018

Workshop Leaders and Keynote Addresses confirmed:

Frederike Bannink, Private Practice, Amsterdam
Linda Clare, University of Exeter
Michelle Craske, University of California, Los Angeles
Ray di Guiseppe, St John's University, New York
Barney Dunn, University of Exeter
Chris Ecclestone, Bath University
Anke Ehlers, University of Oxford
Alice Gregory, Goldsmiths, University of London
Andrew Gumley, University of Glasgow
Ian James, Northumberland, Tyne and Wear NHS Foundation Trust
Freda McManus, Stirling University
Richard Meisser-Stedman, University of East Anglia
Rory O'Connor, University of Glasgow
JD Smith, Northwestern University Feinberg School of Medicine, USA
Gail Steketee, Boston University, USA
Michaela Swales, Bangor University
John Taylor, Northumbria University
Hannah Turner, Southern Health NHS Foundation Trust
Glenn Waller, University of Sheffield

BABCP GLASGOW2018

Submissions are still open for Open Papers and Posters. The closing date is 12 March.

For more information on the Conference programme or to submit an Open Paper or Poster, please visit www.babcpconference.com

Low Intensity worker survey

The issue of how best to support those working in the low intensity workforce has been one that BABCP is continually developing

The withdrawal of PWP Accreditation in 2017 was a decision met with mixed responses, but we acknowledge that the work carried out by PWPs in IAPT is a vital role.

The launch of the Low Intensity Cognitive Behavioural Interventions Special Interest Group (LI SIG) was very much welcomed, and work has taken place with their committee to consider how to provide the support they need.

An online survey was created to gather feedback from this workforce. This was disseminated to BABCP members and also more widely to networks for this workforce including Rebecca Minton, IAPT Workforce Development and Wellbeing Manager in the NHS.

There were more than 450 responses to the survey, the majority of which were non-members (80%). Almost all participants were from England with limited responses from Scotland, Wales and Northern Ireland.

The key topics of focus for the survey were to understand their roles and responsibilities, supervision practices, views on accreditation and how BABCP could support this workforce.

In recognising the number of different low intensity settings and roles, a question was included to find out what title this group of workers preferred. While not the majority, 46% of respondents chose "low intensity therapist", followed by "wellbeing practitioner" (22%). Of the other categories; the main phrases used were Psychological Practitioner (32%), psychological therapist (17%), PWP and low intensity therapist.

On the question about whether accreditation from BABCP would be important, more than 90% felt that this was important; with accreditation needing to offer "clear expectations of CPD attendance and content", "clear expectations of fidelity to the low intensity model and professional boundaries" and "clear expectations of supervision". BABCP accreditation of the low intensity workforce was felt to be important in order to promote and maintain high standards in the workforce, recognise and respect the role within the wider psychological workforce, and provide an ability to maintain and demonstrate professional competence.

Finally, we asked for any other recommendations on areas of support from BABCP. With more than 100 responses to this particular question, we are unable to use this space to list them all, but to summarise, there was disappointment that BABCP withdrew PWP Accreditation; a wish for BABCP to work closely with IAPT England; for BABCP to be more involved in defining the low intensity role; more mention of the workforce as part of the BABCP magazine and in the wider media; while in a more general sense, there were multiple mentions of burnout in the sector along with the desire for recognition of the role as a core profession.

Our Membership and Branch Liaison Manager Michelle Livesey has contacted her equivalent at the BPS to discuss their work taking place in this area. The outcomes of the survey as well as recommendations was presented to the BABCP Board. Further developments in this area will continue to be discussed further, including specific CPD provision, in particular with the LI SIG. The full report will be made available on the members section of the website.

Ann Hackmann

All at BABCP were saddened to hear of the loss of Ann Hackmann in December 2017. Tributes to Ann and her work came from far and wide, with two tributes posted here, thanks to ***James Bennett-Levy*** *and* ***Emily Holmes.***

Ann had an absolute heart of gold, someone who inspired and taught as much through her being as through her wealth of knowledge. As a friend – and as a therapist – she was so embracing, so willing to see the light in others, even where there were a lot of dark spaces.

As a work colleague, Ann was inspirational. She taught me and countless others so much. She was an innovator extraordinaire. Her work on imagery was revolutionary. She was truly the leader in the field when it came to bringing imagery into mainstream cognitive therapy, and conceptualising its role. Her clinical prowess was amazing. So was her teaching, full of wonderful stories to illustrate and inspire.

She was also a great supervisor! I had the very good fortune to spend about a year being supervised by Ann. Another part of her shone in that role – she was insistent on behavioural experiments between supervision sessions, insistent that you try things out and report back.

I always said that if I were allowed to recommend just one therapist in the UK, it would have been Ann. Her capacity for empathy, to put herself in the shoes of the other, her warmth and overwhelming desire to be on your side and to help were just some of her hallmarks.

She knew CBT inside out. How fortunate those patients were who came in touch with her. With Ann and Melanie working on clinical trials, it was scarcely surprising the results from the Warneford CBT research team were so great!

Then there was writing the Imagery book together. We were really ploughing a new field, working out how best to frame all of Ann's acute clinical observations about different forms of imagery, and strategies for working with imagery.

It's a work which I feel honoured and proud to have been a part of – a testimony to Ann's amazingly innovative mind. Ann's thinking inspired Emily and me, and countless others. The memory of our workshop and launch of the book in Byron Bay remains as one of the happiest occasions of my working life.

I shall miss Ann so much – her wisdom, warmth, humour, intelligence and extraordinary generosity. But she will remain with me while ever I live – her spirit permeated my soul.

James Bennett-Levy

Like an explorer, you helped us to find the haunting images within our minds.

Like a magician, you help change their nature, elegantly conjuring ways to dispel them.

Like the sense of relief on finding something that has been lost, you helped others discover feeling at peace.

You shared ways to find calming images and ways to find meaning.

Setting up signposts along a road including fun and occasional chaos – the best road to be on.

Thank you Ann, imagining a hug, you in your flowery scarf, the colours you choose, and your hair at that angle it takes, your way of being you.

Emily Holmes

Making the most
of a close working relationship with GPs

The Islington IAPT Service, otherwise known as 'iCope', is dedicated to the provision of high quality CBT as well as other NICE Guideline adherent psychological approaches in the treatment of anxiety and depression for adults living in Islington or with a GP in the London Borough of Islington, writes **Isabella Foustanos**

We are a service that prides ourselves on our service user involvement and innovations for which we have received several awards, as well as our research links with universities and on our continuing commitment to provide an evidence-based service within the Camden and Islington NHS Foundation Trust.

We work in GP surgeries and community settings in order to be accessible to the local population.

iCope serves a population of 206,100 people (according to the 2011 Census) , and our referral rates are substantial (e.g. 8,885 in 2016-2017). Referrals are a widely cast net, with any person living in Islington or with an Islington GP being able to be referred or to refer themselves by telephone or via our well established website (www.icope.nhs.uk).

With a substantial proportion of referrals to iCope coming from GPs (42%), we know how important it is to work closely with them.

We started by looking closely at one particular GP surgery, where recovery rates were higher. One important contributing factor seemed to be the carefully considered referrals to iCope made by those GPs, which was cultivated over time in mutual feedback and learning between the iCope clinician and the referring GPs.

Based on what worked well, the following ideas are those that were put into action at this surgery to establish good working relationships with the GPs. The aim has been clear about what we do so that the GPs are in the best position possible to identify and refer people to iCope who can best make use of the service.

Establishing the working relationship

Approaching new medical staff in the surgery to introduce our roles and the service itself can only be helpful. Often trainee GPs appreciate a brief teaching session on the different psychology services at primary and secondary care. Both new and established GPs may wish to hear a refresher of our inclusion and exclusion criteria guidelines, and the wider mental health system in which the psychology service is positioned.

GP team meetings provide another opportunity to ask questions. We are encouraged to ask to attend the occasional GP team meeting, where we can inform GPs of new groups and workshops running. We are also able to discuss an IAPT case that is going well or even an example of an IAPT appropriate referral compared to a referral best referred to secondary care at the first instance. Increasing referrals of Older Adults, BME clients, clients with long term health conditions or learning difficulties, pregnant clients and veterans can all be promoted in this forum in the spirit of 'increasing access'.

Maintaining the working relationship

A great deal of the most useful talking can take place informally to discuss potential referrals and progress with cases. This can really enable you and your referrer to get to know each other and of course to help communicate who best to refer.

An open door approach involves simply having your clinic room door open between client sessions, sitting where the GPs have their lunch, working on computers where the GPs do their administrative work, informing the GPs of a time when and where you are available in the surgery for a drop-in informal discussion, such as in the middle of the day when they are between clinics.

All of this helps to create a culture of joint working at primary care level. You might have to take the lead in dropping in on the GPs between their patients or at the start or end of their clinics to discuss cases, while communicating that GPs and nurses are welcome to do the same. Keeping it brief helps too, as this fits with their culture of brief consultation times that they apply for patients in their surgeries.

If you see clients at their GP surgery, then with the client's consent, write a short note on GP's electronic notes system (EMIS) regularly to briefly outline the progress in the therapy and what approaches are being used can help to demystify what we do. Just three sentences leaving out anything sensitive would be enough, and using non-technical language such as 'mood-lifting activities' rather than 'behavioural activation' can make it more accessible. Where EMIS is not at hand, the assessment and discharge letters are going to be the next best step for communicating something about what we do and how this maps onto meaningful change for the client.

Making the most of the working relationship

In being easy to refer to and located on site at GP surgeries, it is possible that some clients with more complex needs and higher risk may be referred to iCope in the first instance, where primary care mental health may in hindsight not be the safest first step.

If this is the case, then use of inclusive language can help to highlight how the responsibility for risk in primary care is shared between the GP and iCope clinician. An example of how to say this would be to ask the GP if they think the client is safe to manage together with them in primary care and planning how to do this together if appropriate and necessary.

Some referrers who tend to refer clients in crisis

Continued overleaf

“With a substantial proportion of referrals to iCope coming from GPs (42%), we know how important it is to work closely with them.”

Making the most of a close working relationship with GPs *(continued)*

can also be reminded that those are not necessarily the best candidates for an IAPT approach, whereas those being overlooked may be instead.

Clients with health anxiety (who seek GP reassurance) and clients with blood-injury-needle phobia (who try but struggle with following through with medical investigations) offer an opportunity for joint working with the GP.

As they are often already more involved with clients in these situations, working with the GP to manage these cases holistically in primary care can be empowering for them and it is informative about what we do.

Drawing on a real example of joint working, a client consented to a triad of co-working between them, myself and the GP, whereby the GP was shown how to spot overt and subtle reassurance seeking, and the client agreed different ways that the GP could help the client to reduce this, with good effect for all.

This kind of working assumes that the client is usually seeing the same GP who knows them reasonably well. Generally, encouraging clients to see the same GP at their surgery facilitates better mental and physical health care.

Impact

We continue to share these key ideas of joined-up working in our induction for each new member of staff, as well as reminding and supporting staff in this integrated approach via individual supervision, team meetings and Recovery Consultations.

The greater proportion of CBT-ready clients with manageable risk levels that we have, the more able we have been to complete helpful pieces of therapeutic work effectively and in a shorter time-frame.

Staff who have taken on these ideas have noticed that the initial extra time and effort employed can enable a greater satisfaction from joined-up working and mutual support in their relationship with their referring GPs.

What Next?

There is currently a national and local drive to move services out of hospital settings and into primary care wherever possible. This is reflected locally in Camden and Islington NHS Foundation Trust's plans to roll out further mental health resources in primary care in Islington in the form of multidisciplinary 'Practice-Based' mental health teams.

We are pleased to be working alongside these mental health professionals within GP surgeries and are endeavouring to work with the new services in primary care as closely and collaboratively as possible. We have significant learning from our experience of having been in GP practices in Islington for many years and are working to share this knowledge with our new colleagues.

With valued contribution from Dr Josephine Morgan, and with thanks to iCope clinicians Dr James Gray and Rebecca Minton.

For more information on Recovery Consultations, see Case Study 'Islington iCope - An IAPT Service with a Strong Focus on Recovery' at https://www.england.nhs.uk/mental-health/case-studies/mh-islington/

BABCP and me

Mark Addis has worked in mental health for almost 30 years, is an accredited practitioner, supervisor and trainer, and has worked as an Accreditation Liaison Officer with BABCP since 2011

Q. What made you want to work in talking therapies?

A. As a mental health nurse working in a hospital environment I was specifically impressed by the practical no nonsense active approach of CBT towards clients' difficulties – and how CBT therapists actually went out with their patients and tried things out in the real world.

It being empirical and collaborative as well only added to the appeal.

Q. What other job might you have done?

A. Well I did work for Customs and Excise at first so being a VAT inspector! (I think fortune favoured me in in going into mental health nursing instead!)

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Member

Q. When did you join BABCP and why?

A. I joined in 2001 whilst completing the MSc in CBT at The University of Derby on the recommendation of the course team. Derby went on to be the first fully BABCP Accredited course in the country.

Q. What advice would you give someone starting working in CBT?

A. Always look for quality, in training and supervision, strive to be an autonomous professional practitioner, continue to implement the principles of empirically grounded practice and collaboration, listen to and respect your clients and – think for yourself! Live, sleep and breathe CBT.

Q. Who is your biggest hero?

A. I don't have heroes but if there was anyone who impresses me quite a bit it is Joss Naylor the most famous and successful fell runner ever – a farmer from the Lake District – Google him!

Q. What are your hopes for talking therapies over the next five years?

A. I hope for professional regulation and greater recognition and availability to all – especially children, adolescents and young adults in the near future.

Q. And fears?

A. That evidence-based therapies such as CBT will be reputationally eroded by poorly funded implementation to problems caused by social and environmental factors. Without adhering to the evidence base.

Sociology recognises the tendency to focus on the individual not the cause in this regard – the Pathologisation of environmental distress.

Q. What has been your best working moment?

A. Those would be the ones where you do genuinely help ordinary people overcome previously 'unsolvable' serious problems that have blighted their lives for years. Knowledge is power – power to the people. True CBT is a genuinely seditious act!

Q. Name five people (dead or alive) that you would invite to a dinner party?

A. Joss Naylor
Dr John Cooper-Clarke
Tony Benn
Jocelyn Bell
My wife

Q. How would you like to be remembered?

A. Don't care – I will be dead so…..No really – think about it.

CBT as part of a Weight Management Service

Data shows that in the UK that more than 68% of men and 58% of women are either overweight or obese, writes ***Ruth Lawrence***

People with obesity often experience concurrent psychological difficulties, such as depression, with some studies showing that obese people are 25% more likely to experience a mood disorder such as depression compared with a non-obese population. Added to this, patients will often also experience poor self-image, low self-esteem, social stigma, social anxiety and feelings of shame and worthlessness. They are also likely to experience physical health problems including diabetes and high blood pressure. Other individuals experience problems with mobility, self-care tasks, sleep difficulties and many other increased health risks (eg poor fertility, cancer, heart disease etc).

In order to help patients manage their weight, some are referred to a Local Specialist Obesity Service (LSOS), of which there are many across the country. These services may take different forms, but should all be multi-disciplinary and incorporate psychological intervention as part of offered interventions.

As a recently qualified CBT therapist, I joined a Local Specialist Obesity Service in April 2007 – I have now worked there for more than 10 years, and feel passionately about my work and the patients I work with. Our service helps people in Knowsley in Merseyside, where public health outcomes for weight, smoking etc. are generally below the national average. We see patients who have a Body Mass Index (BMI) of 35 or above, thereby classed as 'morbidly obese'.

Our team is run by qualified dietitians, specialised in working with patients with obesity. In addition, we have Lifestyle Advisors who deliver group intervention programmes and exercise classes.

As one of a team of four CBT and psychological therapists working in the service, we take referrals directly from our dietitians (patients having initially been referred into the service by their GPs, another

health professional or via self-referral). Working directly within the weight management team alongside the dietitians means that joint care plans based on individual needs and formulation can be shared and worked towards, and it helps that all dietitians have received training in behavioural change and CB approaches.

Having assessed each patient once referred, CBT provides input for patients on a range of issues including Binge Eating Disorder, low self-esteem, disordered eating, secret eating and emotional eating. Treatment is generally delivered via one-to-one therapy sessions over a number of months based on a formulation of needs and how these link with their eating and weight.

We have also delivered group interventions and stand-alone workshops in the past for topics such as Mindful eating, relapse prevention and self-esteem. We have close ties with local IAPT and Eating Disorder services in order to help patients access the correct level and type of support, but overall we see approximately a third of the patients who are accessing the Weight Management Service at any one time.

ACT, CFT and Mindfulness have proved excellent approaches to use with this client group where shame, guilt and self-criticism are frequently a strong maintenance factor in their difficulties with food and eating.

As therapists, one of our major job roles is in assessing the psychological suitability of patients to undergo weight loss (bariatric) surgery – a treatment option recommended for and sought out by many patients. NICE guidance for obesity recommends weight loss surgery for patients with a BMI of over 35 (where they have certain health co-morbidities) or over 40 (without co-morbidities) as it can have significant positive outcomes on weight and health problems such as diabetes and sleep apnoea.

Weight loss surgery, whether it be gastric bypass, gastric sleeve or a similar procedure, will require the individual to make major lifestyle changes in order to achieve and then maintain long-term weight loss after the procedure. Therapists in the service work hard to prepare patients for these changes, addressing cognitive and behavioural changes that need to be made before and after the surgery.

Over the past two years, a study was undertaken in the service of the effectiveness and helpfulness of the Weight Management Service in preparing patients for their surgery. Patient feedback was sought at the end of the programme and 12 months after their referral on to the surgical team. Outcomes for patients were significant, in terms of their weight loss and quality of life, and it was clear how much they also valued the team (and CBT) intervention to enable them to prepare for and cope with life after surgery.

This area of work has been my professional home for the past 10 years and I feel passionately that CBT can offer a great deal to this complex and rewarding client group, which makes up so many within our population.

Ruth Lawrence is the CBT Professional Lead for Weight Management at North West Boroughs Healthcare NHS Foundation Trust.

Patient feedback

"Thank you for your understanding and support through our sessions together. You have helped me to discover a more positive body image and a renewed self-confidence when I thought both were lost"

"I've found CBT extremely helpful in making me understand my eating habits and be open and not ashamed. I learnt how to think about my eating and implement strategies when things might get a bit out of control"

> "ACT, CFT and Mindfulness have proved excellent approaches to use with this client group where shame, guilt and self-criticism are frequently a strong maintenance factor in their difficulties with food and eating."

Supervising CBT with minority groups

You don't need to be an expert in the Cultural Adaptation of therapy, says **Andrew Beck**

> This article is meant to start supervisors thinking about what they have to offer in terms of helping therapists adapt CBT and to encourage supervisors to give this a go even if they do not believe they are expert in CA-CBT.

CBT was largely developed for and by white, middle class, heterosexual communities but the past 20 years has seen an incredible amount of work by clinicians, service users and researchers to adapt this useful and flexible therapy model to a wide range of populations.

Much of the initial work was done in HIV services in the late 1980s and 1990s where therapists were employed to meet the mental health needs of people with HIV and also to support them with difficulties such as adjusting to their new diagnosis, keeping to often complex and unpleasant medication regimes and managing relationships with partners with a different HIV status to themselves.

Predominantly these clinical populations were gay men and Sub-Saharan Africans and as many of the therapists were using CBT the adaptation of this approach to take into account culture, religion and sexuality was paramount. There were also developments at this time that began to look at what needed to be adapted when working with refugee and asylum-seeking service users from a variety of cultural backgrounds in the field of trauma and subsequent work with migrant groups in North America and Europe whose mental health needs had been overlooked historically.

Over the past 10 years CBT in Low and Middle Income Countries has also developed with its own challenges in terms of adaptation and implementation with limited resources.

We are now at a point where the curriculums of many CBT training courses include some consideration of cultural adaption and where a solid body of evidence is suggesting that this adapted therapy is effective. There are also training modules and workshops available through BABCP and other training providers that skill staff up in adaptation, but one area that remains poorly developed is in the area of providing supervision for Culturally Adapted CBT (CA-CBT).

It is important that therapists who work across cultures and with diversity have the chance to think about these processes in supervision as this adaptation is an ongoing process and new ideas and approaches will be constantly found by therapists. Having a safe space to think about these, practice them and check out the feasibility of these approaches will support the development of these skills in the same way that supervision supports other skills.

In many ways supervision for CA-CBT is similar to supervision for CBT. The same core skills are used to understand where the supervisee is at in terms of their current learning and expertise, where they might realistically get to given the appropriate support and what mechanisms might be needed in supervision to get them there.

There remains a national shortage of supervisors in CBT (though the IAPT programme has increased numbers in recent years) and there are even less people who would consider themselves to have expertise in supervision and CA-CBT but in many ways supervisors do not need to be an expert in this area in order to be helpful.

First of all the supervisor needs to establish an environment where diversity is valued and respected. This can be done by developing and maintaining knowledge of the local communities and populations and promoting a team philosophy which places a high value on respect for and curiosity about new cultures. This is an important point in terms of supporting this culturally sensitive work. This flexible and adaptive use of CBT is embedded in a team that is in itself diverse and that values that diversity.

By prioritising these issues in team discussions, policies and practices the supervisor is able to support this work and develop high standards of reflective practice in case discussion and supervision. Cultural competence and reflexivity is therefore not something that is simply added to CBT as usual in the service, it is a part of the core values and practice of the team. Once this is established a number of supervisory approaches can be added.

Although space means that all the approaches a supervisor might draw on can't be looked at in detail here, some of the main points to get people started are detailed below.

The most useful thing for supervisors to start with

is developing a safe setting for these discussions, which can be seen as risky or problematic by therapists worried about getting things wrong when it comes to diversity. A lot of this work is part of the core supervisory process but this can be enhanced by giving clear messages when setting contracts or agendas that discussions about adaptation are welcome and that it is okay to not get things right all the time. This can involve supervisors reflecting on their own work in CA-CBT and the challenges this might have brought or acknowledging that 'sometimes it is hard to talk about in case we get it wrong'. Supervisors might look out for discomfort or anxious arousal where these topics are discussed and collaborate with the supervisee to decide how best to manage this.

These supervisory discussions sometimes highlight unhelpful beliefs about particular minority groups. It is generally not helpful for supervisors to challenge these in a way that makes the supervisee uncomfortable or defensive. It is better to take a Socratic position and allow further exploration of these in a non-judgemental way to increase the chance that they can be modified. Supervisees might also be reluctant to discuss these issues at all and in these circumstances the supervisor has to think about what approach is in the best interest of the service user in terms of leaving ideas unmodified or working explicitly with them.

There may be technical issues about specific adaptations that therapists might want to try. It is unlikely that even a supervisor who is expert in CA-CBT will be familiar with all adaptations and in many ways it is not necessary to be in order to provide good supervision around this. Providing a thinking space to plan, rehearse and trouble shoot adaptations will do a lot towards improving practice and this will be further enhanced by using recorded material to review how the intervention was received and to reflect on what might be done differently next time. Again expertise by the supervisor is not necessary to use the Kolb cycle as a reflective tool, just the willingness to try and consider what needs to be different and how this might be done.

Lastly I want to consider that some aspects of this work might make therapists and supervisors uncomfortable. There might for example be beliefs, practices and values that minority groups hold which are not in keeping with the values of the therapist and supervisor. There is no easy solution to this other than to highlight the importance of being able to articulate this in supervision, to be able to do so without being judged and in recognising this to accept the values of another in a way that does not interfere with the therapy. It is also likely that members of minority groups have experienced prejudice and discrimination and that the mental health problems that have brought them into therapy are linked to these experiences. If your own life has not brought you

into much contact with what it is like to be discriminated against it can be distressing to hear about this in the detail that might be needed to work with this therapeutically. Acknowledging this to the service can be useful in the same way that acknowledging difference can be but also thinking about this with a supervisor can provide an opportunity to think about this.

This article is meant to start supervisors thinking about what they have to offer in terms of helping therapists adapt CBT and to encourage supervisors to give this a go even if they do not believe they are expert in CA-CBT.

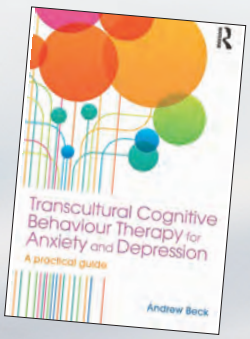
There are BABCP workshops that also provide the chance to try out these and other related skills run through the Equality and Diversity and the Supervision SIGs. The workshops are intended to create a safe and open space to help supervisors build their own confidence in delivering suitable supervision for CA-CBT. This will enhance the experience of service users, supervisees and supervisors.

Supervisors are encouraged to contact the Equality & Culture SIG and Supervision SIG if they identify any training needs. Both SIGs are happy to develop and deliver more workshops.

A detailed chapter on this issue can also be found in Andrew's book *Transcultural CBT for Anxiety and Depression*.

The Equality & Culture SIG can be contacted at equality-sig@babcp.com, while the Supervision SIG can be contacted at supervision-sig@babcp.com

You can follow Andrew on Twitter @andrewbeck45



Working with Diversity -

whose responsibility is it and what needs to change?

Living in an ever-changing diverse and multicultural society, it is important that therapists and mental health services are able to respond quickly to these changes. In this article, **Saiqa Naz** discusses who is responsible for ensuring the agenda of diversity remains at the forefront of any mental health services

Accreditation bodies across mental health care provision, in this case the BABCP, need to ensure measures are in place to implement the Equality Act and the BABCP's own equality policies. They can do this by reviewing existing courses and ensuring a minimum standard is set for accredited courses to teach about diversity on their syllabus. This may include requiring courses to have a minimum number of hours of teaching on diversity and requiring attendees to present at least one case of diversity under close supervision. Accredited supervision courses should also have sufficient teaching on equality and diversity.

There are commissioning guidelines about services for BME services. Without the right resources and support from commissioners, these may fail to deliver the equality agenda in their services. Commissioners may need to have uncomfortable conversations with services if they are not meeting standards as well as exploring ways in which they can be supported to be more accessible to different populations.

The connection between staff and commissioners is where the main change needs to happen within many services. Service managers need to take ownership and ensure that diversity and equality are embedded in to their services. Too often we hear about therapists not feeling confident or supported when working with diverse communities, in particular the BAME community.

Expecting staff to work with service users without adequate resources and supervision is unethical and can inadvertently cause more distress if, for example, the therapist struggles to work with more complex presentations like PTSD with asylum seekers and refugees.

It is important for services to support their staff to work with all communities by providing allocated time, resources, ongoing training and supervision. A good example of this is the Sheffield IAPT service. The service is taking a whole team approach and has formed a BAME strategy group. The service manager, the Quality Improvement Manager, team leaders, CBT Therapists, Counsellors and Psychological Wellbeing Practitioners from various backgrounds, including White British backgrounds, all form part of the strategy group. The strategy group is also being supported by staff from within the wider Trust including the Trust's Head of Equality and Inclusion.

As the link between staff and service managers, clinical leads and supervisors are vital in identifying training needs of the staff they support and relaying the information back to the service managers. They need to ensure any issues regarding working with diversity are not ignored,

> As the link between staff and service managers, clinical leads and supervisors are vital in identifying training needs of the staff they support and relaying the information back to the service managers.

and make sure that staff are as capable of providing therapy to BME services users as they are to white service users. Clinical leads and supervisors also need to take ownership of their own learning needs and actively seek out any training to help them deliver culturally competent supervision.

Therapists themselves have to take responsibility and ownership of seeking support and delivering the equality agenda in their individual work, within their teams and the wider profession. They need to have discussions between themselves and management to discuss ways in which they can implement the recommendations given in this article to give equal access and deliver high quality care to their different service users.

Therapists are encouraged to adopt positive non-judgemental attitudes when working with different communities. This can sometimes be lost when therapists do not feel confident when working with different user groups either through lack of experience or lack of understanding of service users' culture or faith. Allowing themselves to feel vulnerable and like a novice practitioner can understandably be quite anxiety provoking for many therapists. It is important to use supervision to discuss their anxieties.

What about third sector and faith organisations roles?

There is a move towards some voluntary sector and faith organisations now being commissioned to deliver mental health services. Although this is a step in the right direction to reaching out to underrepresented communities, the organisations need to have experience and sound understanding of mental health including stringent policies before being commissioned to deliver mental health work. Ideally, they should work alongside existing NHS mental health services to help provide access into the community. This is to prevent the quality of care from being compromised.

People are only hard to reach when services are not taking responsibility and adapting the right approach. A collective approach needs to be adopted. If everybody in the chain embraces and commits to the Equality Act 2010 and the BABCP codes of ethics, take responsibility and ownership for themselves, their services, and support their colleagues, only then will true equality be achieved in mental health services and the psychology profession. Without these you cannot deliver high quality patient-centred care. Anything less, for me, is a tick box exercise.

The BABCPs Equality and Culture Special Interest Group (SIG) delivers workshops to support therapists develop their confidence when working with diversity. The SIG currently has a number of workshops they can deliver. These include Exploring Race, Ethnicity and Culture, Delivering Culturally Competent Therapy, Working with Asylum Seekers and Delivering Culturally Competent Supervision. The SIG is happy to organise more workshops if further training needs are identified.

Saiqa Naz is a CBT Therapist working for Core IAPT in Sheffield and Sheffield IAPTs integrated Health and Wellbeing Service and is Chair of the BABCP Equality & Culture SIG. You can follow her on Twitter @saiqa_naz.

You can contact the equality and culture special interest group at equality-sig@babcp.com

> Therapists are encouraged to adopt positive non-judgemental attitudes when working with different communities

the difference:

Comparing three approaches to CBT

The idea of comparing different approaches to therapy is not new. Famously, in 1965, Carl Rogers, Fritz Perls and Albert Ellis took part in the *'Three Approaches to Psychotherapy'* films. Here, each therapist provided an overview of their chosen therapy (Client-Centred Therapy, Rational Emotive Therapy, and Gestalt Therapy, respectively) before giving a practical demonstration of their approach with the same client. The films provide an insight into how therapy might be delivered in the 'real world'.

At the 2017 BABCP Conference, we used a similar format to explore the similarities and differences between three approaches to CBT: Acceptance and Commitment Therapy (ACT), Motivational Interviewing (MI) and the Method of Levels (MOL). The therapists, Joe Oliver, Rory Allott and Sara Tai, are all experienced practitioners and trainers of the approaches they demonstrated.

While it was not possible to recreate the conditions of everyday clinical practice, every effort was made to ensure that the demonstrations were as realistic as possible. For example, the person taking on the role of the 'client' discussed a real-life issue, creating more authentic demonstrations than the use of role plays would have allowed.

Here, Joe, Rory and Sara reflect on their experience of the clinical roundtable. The person who took on the 'client' role for the demonstrations also gives his feedback on receiving these three different approaches to cognitive-behavioural therapy.

Joe Oliver – Acceptance and Commitment Therapy (ACT)

ACT is a transdiagnostic model of behaviour change. It uses mindfulness and acceptance processes to facilitate psychological flexibility in order to instigate behaviour change towards chosen values.

In this demonstration, my aim was to set a context that was likely to increase psychological flexibility in relation to the problem the client wanted to discuss.

I opened the interaction by asking about values related to the problem described - "who or what is important here?". This question was designed to widen the client's perspective from a narrow focus on the problem, to include important life domains. I then asked the client what thoughts and feelings show up in relation to the values described that 'hook' him. Throughout, I invited the client to mindfully notice the degree to which any of these thoughts and feelings showed up as we were speaking, to help increase a sense of present moment awareness.

From here, I asked how he typically responds when hooked by these experiences (experiential avoidance). Here I was aiming to help the client discriminate between automatic behaviour and the sources of control of this behaviour, drawing attention to the workability of such responses.

Finally, I asked the client to consider what a values-based action could be when such unwanted thoughts and feelings arrive. This question was explicitly designed to contrast behaviour governed by cognitive fusion and experiential avoidance with a mindful choosing of behaviour (values and committed action) that didn't require the elimination of thoughts or feelings (defusion and acceptance) in relation to the problem.

Rory Allot – Motivational Interviewing (MI)

Unlike MOL and ACT, which are based on theoretical models, MI was developed by William Miller following observation of his successful practise with heavy drinkers. Based largely on Rogerian counselling, it aims to build rapport with the client through empathic understanding and build momentum for change by selectively reinforcing client talk in favour of an identified change goal.

The client had already spoken to an ACT therapist about his problem. There was no obvious target for behaviour change. Instead, the focus seemed to be the possibility of enjoying what he had, without ruminating over what he had lost.

I first engaged the client by attempting to understand his 'stuckness' through reflective listening, a core skill of MI - "You are doing a lot of planning in the future and each time this conversation comes up you get stuck". For the client, empathy seemed to be at the heart of this interview.

I then tried to establish a shared focus for our conversation and began the task of directing the client to talk about the possibilities for change. Unlike MOL, which relies exclusively on questions, MI pays careful attention to the balance between reflections and questions to elicit and reinforce

The ever-increasing number of different psychological therapies raises an interesting question: "What are the theoretical and practical differences between these various approaches?" asks **Rob Griffiths**

client talk about their values and the discrepancy with their current behaviour - "It sounds like kicking the ball and having all this open space and being this free guy who could do that sort of stuff is still important to you".

The aim is to help the client ask themselves a question; 'how would I like to live my life and how am I living it right now?'.

Sara Tai – The Method of Levels (MOL)

MOL is an application of Perceptual Control Theory, a functional model of human behaviour based on principles of control, conflict and reorganisation.

Control over important life goals is fundamental for mental health, acknowledged in psychological literature under terms like 'regulation' and 'self-determination'. Conflict arising from trying to control two incompatible goals simultaneously causes psychological distress.

Reorganisation is the process of therapeutic change through which new perspectives, insights, and solutions are generated. MOL therapy involves keeping clients focused on a problem until awareness of the conflict between goals is generated. Reorganisation follows awareness whereby potential solutions are developed to successfully balance competing goals.

In the demonstration, I aimed to do two things. Firstly, I kept the client talking about his problem; expressing it externally for long enough to connect with the emotion associated with the problem.

I used only terminology generated by the client (e.g. "Can you tell me a bit more about the 'moving forward'?") and focused exclusively on the present moment to connect with emotions as they occurred ("Are you getting the feelings of sadness and frustration now?"). Secondly, I watched for signs of the client experiencing background thoughts, which I asked about to facilitate a shifting of perspective to a different evaluative level. For example, when the client laughed, I asked about the last thing he said - "What's funny about not knowing which way to move forward?" - to facilitate exploration of potential solutions - "Are you getting a sense of what's important now?".

In conclusion…

Everyone involved in delivering this clinical roundtable agreed that it was a really fascinating experience. The live demonstrations provided a real sense of how these three therapies are delivered in 'real life', in a way that therapy manuals and academic articles are often unable to convey. Conference delegates who attended the session also seemed thoroughly engaged, evidenced by the lively discussion that followed the demonstrations.

Given the positive reception to the roundtable – with one delegate describing it as the best thing he had ever seen at a conference – we think that planning similar live demonstrations at future conferences would be worthwhile.

If you would like to explore this subject in more detail, audio files of the demonstrations, as well as Joe, Rory and Sara's overviews of the three therapies, are available at [insert web address].

Client's reflections

My experience of ACT was of Joe standing alongside, aligned but providing no pressure. Rather offering me space and time to reflect on my choices, and greater freedom to make choices I had been unaware of.

MI with Rory felt more emotional. Together we explored many avenues that brought me into contact with sensitive domains important to me, which we embraced.

MOL immediately felt different. Faster, more intense, and, initially, less comfortable. Then, when the experience overtook my ability to overthink, it became fun, freeing, and I came into contact with sensations I had been looking for but had long forgotten.

ACT and MI felt similar, but MOL felt very different. Each approach, though, felt unique, providing distinct outcomes for me. ACT left me feeling avoidance of the issue was no longer needed, MI helped place the issue within the broader context of life goals, and MOL helped trigger the state I unknowingly wanted to achieve as I sought to address the problem. The collective result was a resolution of the issues raised.

Rob Griffiths

Joe Oliver

Rory Allot

Sara Tai

There is a plethora of literature recognising that CBT supervision is an ethical and professional requirement. It facilitates model fidelity, aids better therapeutic outcomes and helps to develop the practitioner. Supervision is held to be important by every therapeutic tradition and in other people practitioner helping professions.

There is no reason to argue that supervision is central to the effectiveness of low intensity CBT within the IAPT model. The subject of low intensity PWP supervision has been discussed over a substantial period of time with the purpose and focus of case management supervision being agreed by eminent writers.

The strength of the current model lies in weekly case management giving PWPs the opportunity to talk about each new case, risk clients, reviewing patients and those patients that need stepping up to high intensity intervention.

Supervising the Psychological Wellbeing Practitioner

Is it time for a newer version of the existing model?

Supervising PWPs in an IAPT Primary Care Service with a high volume of client turnover comes with its rewards as well as its fair share of challenges. In this article - which is timely following the critical conversations on IAPT practitioner burnout - **Elaine Davies** addresses the current model and make arguments for the model to evolve and to incorporate new tasks of supervision

Monthly skills sessions allow PWPs to roleplay or participate in enhancing skills such as problem solving, cognitive restructuring and behavioural activation.

However, the way in which this model is currently structured with weekly case management, time often runs out in the supervision session before all cases have been addressed. Of late this is mainly on account of most services requiring PWPs to overbook patients to meet national targets. For PWP caseloads in some services this is between 40-50 patients. If we do the maths, in hourly supervision with the greatest of skill gives just over one minute per patient.

The reason that time runs out in case management supervision is often due to ethical and organisational dilemmas impacting on patient work. Issues of risk, safeguarding, complex presentation often outside the eligibility criteria for IAPT and sometimes material emerging from the practitioner life experience.

In the current model if these extraordinary issues arise the supervisor at this juncture has a decision to make. The supervisor can carry on regardless ignoring the emotion in the room; move on with the case management and come back to the issue possibly when the heat of the moment has gone; abandon the current model of case management supervision and explore these pertinent issues in the presenting moment and letting some patients go without discussion; adopt a tick box exercise and give the practitioner direction for therapy or wellbeing services when personal issues arise, or use the idea of the monthly skills practice to discuss pertinent issues.

All of these listed above except carrying on regardless have their advantages. PWPs would state that there is an underlying theme of not being listened to, they have no time to reflect and grow, and they are talked at rather than being encouraged for self-discovery. There are supervisors who are trying to do it all and this is having an effect on their wellbeing and on all the other tasks and client work they themselves have to account for in the working day. If we now have a model where both supervisee and supervisor are less than competent due to external pressure it is indeed time for a review.

If we agree that supervision is a good practice then case management and skills ought to be one of the same. There are many aspects to developing the practitioner. If we agree that good supervision has the potential to reflect good therapy then time constraints for PWP supervision are leaving out some important tasks.

The building of relationships, doing rather than being with a person, less time for discussion on values, power, equality and difference. Our supervisor is the person we turn to for support in a complaint or for a reference.

Currently what is the supervisor basing this knowledge on? How do we assess clinical competence in PWPs? We could just assume that reducing outcome scores will cover this competence but working with a human being who is distressed is more.

The task that is missing from the current model is restorative supervision. Where are the PWPs being restored? Where or what are they turning to for their restoration? In supervision a safe and trusting relationship is an important factor. It is a place to discuss our errors and successes, our feelings and thoughts towards clients, a freedom to discuss organisational issues, to understand our own values, morals and judgements all of which are important in the work of helping others understand themselves.

With primary care low intensity services currently undergoing significant change, it is time to think about the supervision of PWP's.

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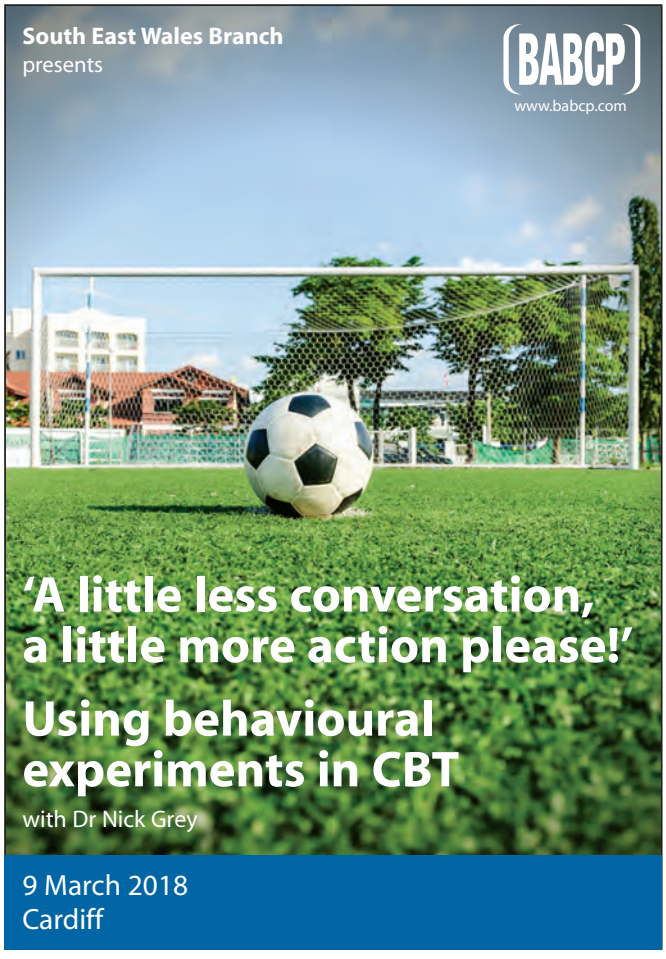

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Dr Mary Welford

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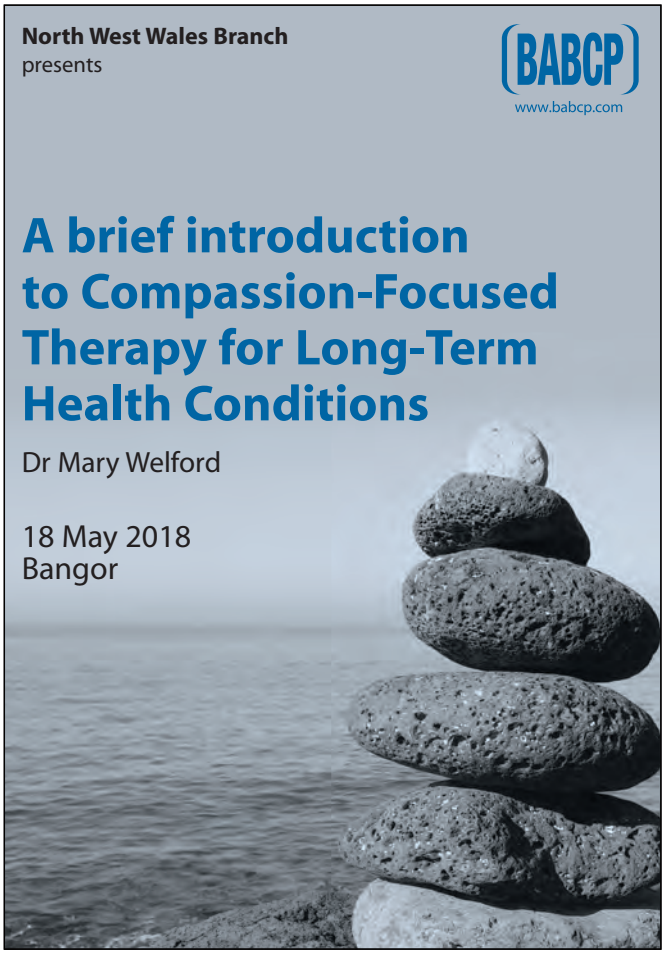

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All Cards on the Table

The Equality & Culture Special Interest Group (SIG) delivered a workshop in November titled 'All cards on the table - Developing cultural competence for CBT Therapists: Exploring Race, Ethnicity and Culture' *and was delivered by SIG committee members* ***Romilly Gregory, Meera Bahu*** *and* **Saiqa Naz** *at the Reading International Solidarity Centre*

This was the current SIG committee's first workshop since being elected earlier in 2017 and it gave us an opportunity to meet other BABCP members. The workshop was very interactive and generated a lot of discussion which demonstrates the richness of the topic.

Getting this training higher up on therapists' priorities for CPD would require more thought, for example, there needs to be more management commitment and determination to ensure diversity training in their counselling services; there is a need for more diversity training as part of diploma courses for CBT therapists in training; it was striking that most of the participants at the workshop themselves had diverse identities, and were able to draw on and share their own varied experiences at the workshop; and it may be especially important for therapists with White British heritage to have opportunities to explore these issues in a safe and non-judgemental setting.

Sian Johnson, Cognitive Behavioural Psychotherapist

The training helped me to reflect on what it means to be 'White British' and take a step back from this. Experiential exercises also helped me to think about how it feels to be in a minority population and prompted more questions to reflect on following the training such as what 'white privilege' means to me and how this may transpire in my practice.

Having the space to think about the topics of race, ethnicity and culture, along with training with a group of people from a range of backgrounds themselves enabled us to openly share personal and professional experiences and resources to develop our knowledge further. It was useful to bring concepts from past learning back into my awareness and highlight new ones such as process including how 'acculturation' and 'assimilation' can play out in real life experiences.

Most importantly, the take home message was that it is acceptable not to know everything about a particular culture and how important it is to be open about this in our practice with patients.

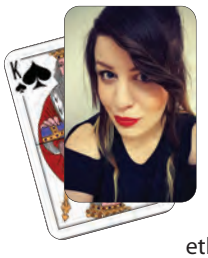
Rebecca Joyce, Psychological Wellbeing Practitioner

Attending All Cards on the Table was an eye-opening and positively challenging experience. We had an opportunity to discuss our knowledge and experiences of diversity without judgement. For me it was an opportunity to express that someone's race isn't always communicated by their skin tone.

The best part of the day was the 'footsteps' exercise

where we were allocated a vignette and asked to take steps forwards for 'positive' (socially valued) characteristics and take a step back for adverse or diverse characteristics. It was very illuminating to consider that a person's experience could be so dictated by elements that are in no way related to their value as a human being.

The learning I will take through to my practice will be to always consider those holistic elements that a patient is contending with and how their mental health could be just one challenge in an entire spectrum. As a PWP I have the opportunity to develop a holistic care package with other services rather than treating what may be a symptom of a larger societal issue.

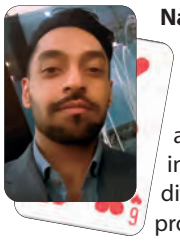


Nia Gkizounidi, Psychological Wellbeing Practitioner

It is great to go to a learning opportunity and leave not only feeling that you shared some positive practice but also developing ideas and putting plans in place to improve the quality of work with people from different ethnic backgrounds.

An important learning moment was to understand better the importance of privilege through discussion but also through activities. Through this activity we had the opportunity to be "in someone else's shoes" for a moment which helped me not only grow as a person but also understand the needs of our community and demographics that we work with.

We talk about change in therapy but we need to understand that some barriers can be difficult to shift due to different contributing factors. However, if we put all cards on the table and achieve transparency and a better understanding of the individual's values and culture we can then talk about making meaningful changes and working together towards the patient's goal.



Naheem Hakim, Psychological Wellbeing Practitioner

I learnt how important gender, colour, religion and race are in shaping up future prospects for individuals. We did an exercise looking at differences such as religion, metal health problems and parent's earnings. This was any eye opener for me as I saw how skin colour could either be a privilege or disadvantage. I was able to reflect on my own community and how we further segregate ourselves by focusing on caste and religious sect.

Sadly we live in a society where differences are still looked down at rather than being celebrated. I learnt a lot of useful things which I will take forward when working with my patients.

I learnt when a patient is being resistant to treatment or focusing on my race or religion, to have an open conversation with them and address any biases. This will clear any misunderstanding and help with patient engagement. I will also not be afraid to ask questions when I am not sure or need more information as fear of offending the patient can be a barrier.

The training was really useful and I hope this will become mandatory in the healthcare system.

We would like to thank all the delegates who attended for their contributions to the workshop on the day and to those who have contributed to this article - we look forward to meeting you all at our future workshops.

We would also like to thank Dr Andrew Beck for being the chair of the SIG for the past three years, and to acknowledge his contributions to the SIG and profession as being invaluable including, and not limited to his book *Transcultural Cognitive Behavioural Therapy for Anxiety and Depression: a practical guide*. We are pleased that Andrew will continue to be involved with the SIG and help disseminate best practice within BABCP and the wider CBT community. We wish him all the best with his new endeavours.

The new committee is:

Saiqa Naz (Chair) is a CBT therapist who has previously worked with people with brain injuries and has been working with people with common mental health problems in IAPT services since 2009. Saiqa is also a trained Mindfulness teacher and lectures on how to deliver culturally competent therapy. She has an interest in working with BAME communities and looking at ways in which to bridge the gap between services and different populations to ensure all have equal access to mental health services.

Saiqa has been active in the community for many years, using her understanding of psychology to support grass roots organisations, for example, the homeless community and Save the Seven Sisters social housing campaign in Rochdale. She currently works in Sheffield in the core IAPT service and the integrated IAPT Health and Wellbeing service where she is also overseeing the BAME strategy across both services.

Romilly Gregory (Treasurer) works for the Oxfordshire IAPT service Talking Space Plus as a Primary Care counsellor, is an accredited CBT therapist in private practice, and the in-house CBT therapist for staff at Oxford Brookes University. Romilly previously worked as a senior manager for both Amnesty International and Oxfam. She has many years of experience at facilitating interactive events with diverse groups of participants, most recently at Oxfam and Oxford Brookes University.

Meera Bahu (Secretary) works as a senior CBT therapist at Camden and Islington NHS Trust. She is also Mindfulness Teacher and supervisor at Mindfulness Network CIC. Meera provides CACBT (culturally adapted CBT) to meet the needs of the local client population and she is an accredited RECC (Racial Equality and Cultural Capability) trainer and in her previous role she provided training to NHS staff in Holistic Assessment and Planning. The training provided the staff the learning of the key principles of a holistic approach to BME mental health service provision and so they could use the principles of a holistic approach to evaluate an assessment system in local mental health services for BME people. She has further developed a culturally adapted model by integrating Eastern psychology to work with Tamil refugees and asylum seekers in her previous service.

The SIG can be contacted at equality-sig@babcp.com

Devon & Cornwall Branch
presents

BABCP
www.babcp.com

Integrated CBT and Third Wave therapies

with Dr Fiona Kennedy

26 & 27 April 2018
Buckfast Abbey

North West Wales Branch
presents

BABCP
www.babcp.com

CBT for Social Anxiety

with Professor David M Clark

5 October 2018
Bangor

To find out more about these workshops, or to register, please visit www.babcp.com/events or email workshops@babcp.com

North East & Cumbria Branch
presents

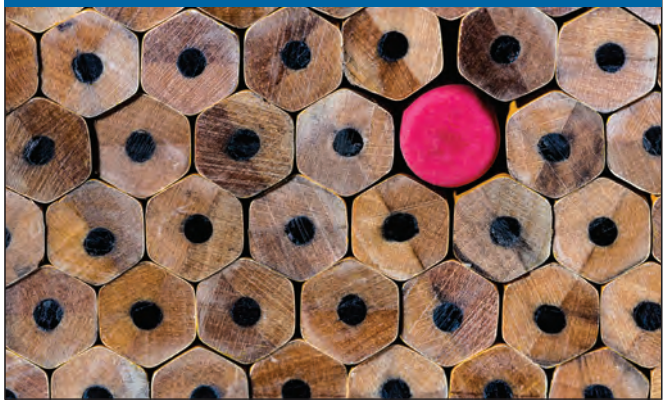
BABCP
www.babcp.com

Doing it better:

A masterclass in the understanding and treatment of Obsessive-Compulsive problems in adults and children

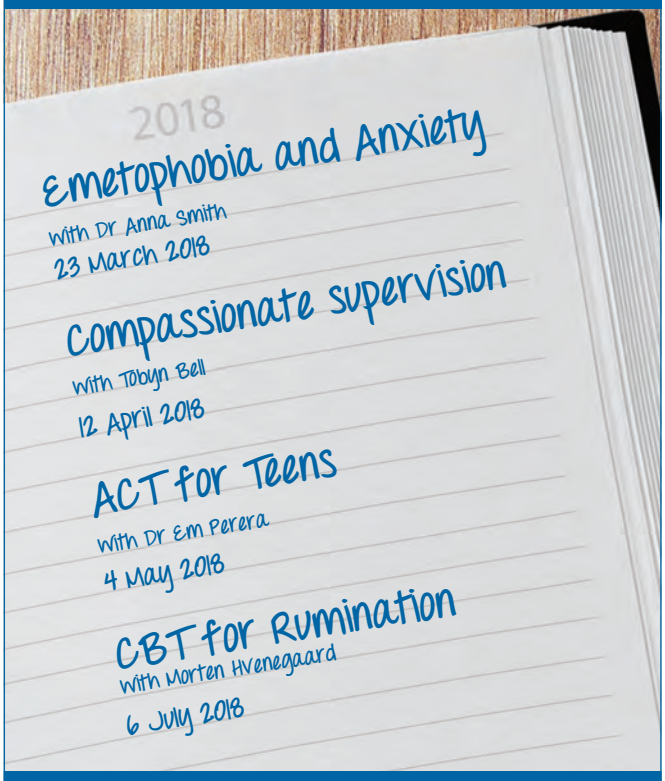
with Professor Paul Salkovskis

22 & 23 March 2018
Grasmere



South East Branch
presents

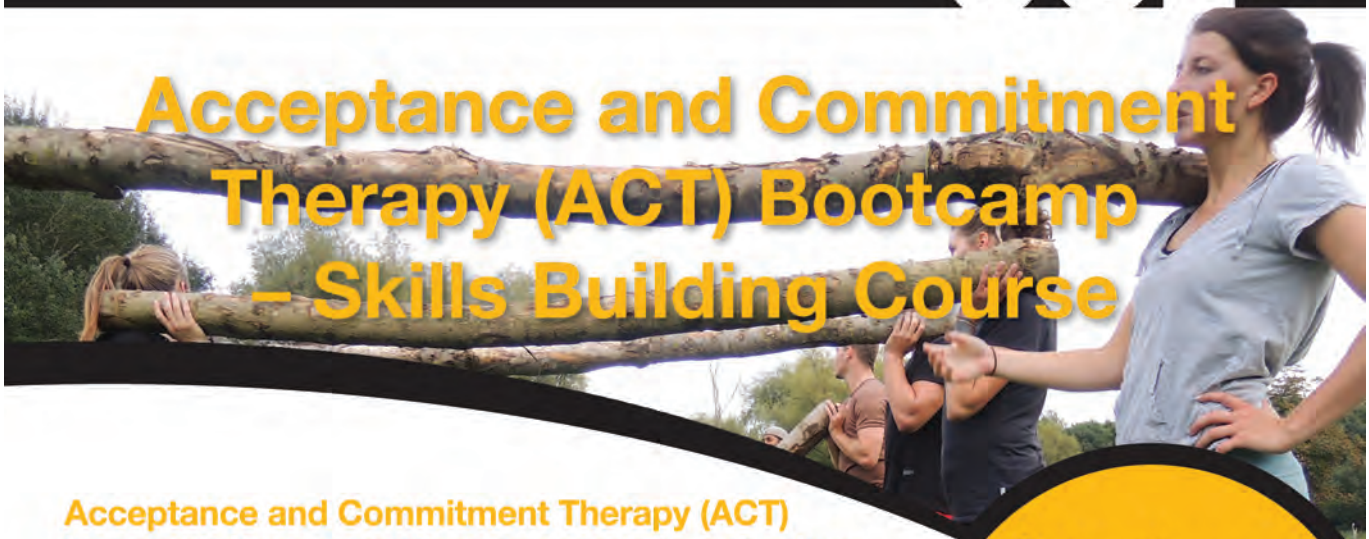
BABCP
www.babcp.com



All events will be held in Sevenoaks

LONDON'S GLOBAL UNIVERSITY

UCL



Acceptance and Commitment Therapy (ACT) Bootcamp – Skills Building Course

Acceptance and Commitment Therapy (ACT) is a revolutionary, modern approach to behaviour change, combining mindfulness and values-based action to transform lives.

This course is designed as a "bootcamp" to intensively build your ACT practitioner skills, across 4 days of training, along with focused reflective practice supervision groups.

You will be taken from the basics of the ACT model, through to advanced skills building training. This bootcamp aims to put you through your paces to enhance your skills in a super practical way to help you move from "slow and clunky" to "fluid and flexible".

If you just want to dip your toe in the water, you can join for only the Introductory workshop. If you go all out, you can sign up for the Bootcamp, which includes the Introductory workshop, the Intermediate Skills workshop and two reflective supervision groups, facilitated by ACT experts.

The workshops will include live demonstrations, videos of therapy sessions, and a wide range of experiential exercises.

Joe Oliver is a Consultant Clinical Psychologist and course director at UCL. He is a peer reviewed ACT ACBS trainer and is a engaging speaker who presents ACT in a very practical, accessible and inspiring style. He is author of several ACT books, including the popular self help book, **ACTivate Your Life.**

Central London, University College London

18th & 19th June 2018

11th & 12th Sept 2018

Register early for discounted rates. Full 4 day course early bird fee - £380

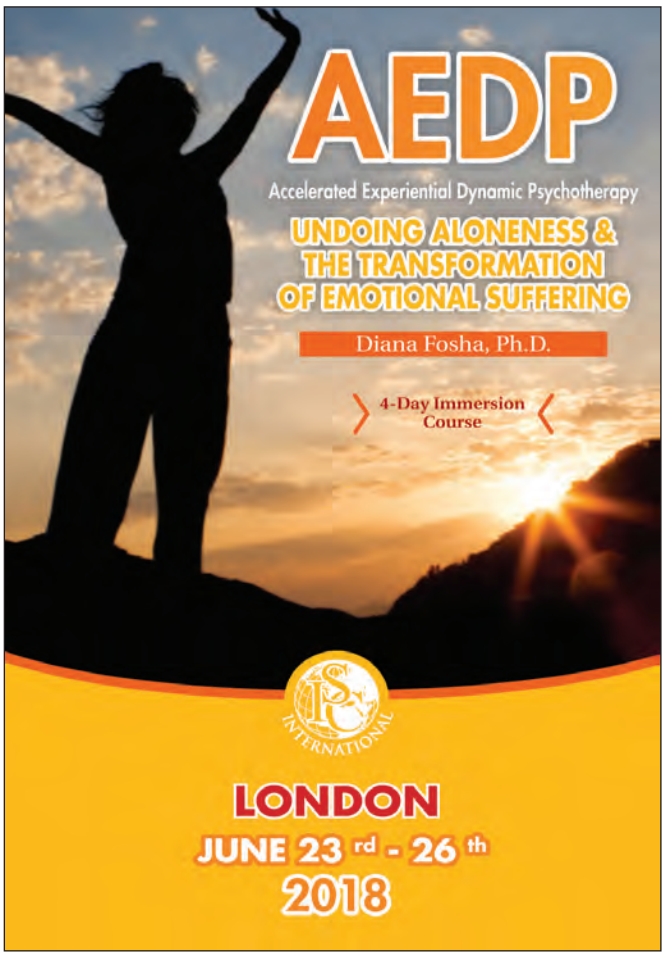
This event is jointly hosted by UCL and Contextual Consulting

For more workshop information, rates, venue locations and how to register go to:

www.ucl.ac.uk/lifelearning/courses/act-bootcamp

Dr. Joe Oliver

Contextual Consulting



2018 ACT Workshops
with Dr Russ Harris

Contextual Consulting

Dr Russ Harris returns to the UK in 2018 to deliver two highly acclaimed workshops

His best-selling ACT Made Simple workshop and, new to the UK ACT for Trauma. Russ Harris presents ACT in a truly accessible style, seamlessly weaving together theoretical knowledge and practical application. His workshops are entertaining and inspiring, brimming with thoughtful experiential exercises presented with clarity and authenticity.

ACT Made Simple workshop
Central London on 10th & 11th July

Boost your current practice with this extremely accessible popular 2-day workshop.

This INTERMEDIATE level workshop will cover case conceptualisation in both clinical and non-clinical populations: how to conceptualise any client problem in terms of the ACT model, from clinical disorders such as depression, anxiety, addiction to non-clinical issues such as work stress, performance anxiety, fear of failure and low self-confidence. It also covers working with mandated or coerced clients; getting unstuck (for both clients and therapists); 'selling ACT' to your clients; getting to values when your client says 'I don't know'; overcoming resistance and motivating the unmotivated; anger and resentment; compassion and forgiveness.

This workshop is full of experiential exercises and shares fantastic tools for trans-diagnostic case conceptualisation, interrupting disruptive in-session behaviour, staying on track and using the model flexibly.

ACT for Trauma workshop
Central London on 12th & 13th July

An in-depth, integrated approach to healing from trauma

If you want to help your clients find safety and security in their bodies, unlearn old physical responses to trauma, overcome hyperarousal and hypoarousal, shift from self-hatred to self-compassion, work mindfully with body memory, break free from dissociation, and learn how to build develop rich and meaningful lives... this 2-day masterclass is for you.

In this workshop, you'll go deeper into the ACT model and learn how to adapt and enhance it to effectively address all the common problems of trauma therapy: dissociation, flashbacks, numbness, nightmares, hyperarousal, hypoarousal, fractured sense of self, shame, self-hatred, aggression, addiction, hopelessness, social withdrawal, intimacy issues, emotional dysregulation and more.

For more workshop information, rates and special discounts for booking both workshops, venue locations and how to register please see:

www.contextualconsulting.co.uk

Check out our other 2018 workshops!
Available also by Webcast...

Advanced ACT Robyn Walser *March*

ACT for Health Problems Ray Owen *April*

ACT for Self Esteem Joe Oliver & Richard Bennett *June*

Compassion Focused Therapy Paul Gilbert *November*

Supercharge Your CBT Practice Fiona Kennedy *November*

Oxford Cognitive Therapy Centre
www.octc.co.uk

OCTC/University of Oxford Courses

Collaborations between OCTC and the University of Oxford,

UNIVERSITY OF OXFORD

Our new programme provides an accessible and flexible format of CBT training, well suited to the needs of contemporary mental health practitioners, whilst maintaining the 'gold-standard' delivered over the past two decades.

Oxford Cognitive Therapy Centre

Postgraduate Certificate in Cognitive Behavioural Studies

Course Lead: Dr Sarah Rakovshik

This course aims to equip researchers and practitioners with knowledge of the models and theories used in CBT treatment and supervision; it comprises 20 days of teaching over two years. The course does not aim to prepare students to practice, teach or supervise CBT. Instead, the emphasis is on acquiring and understanding of the theory and practice of CBT treatment and supervision, within an explicit theoretical framework in relation to associated empirical research.

Postgraduate Certificate in Cognitive Behavioural Therapy

Course Lead: Dr Sarah Rakovshik

The course aims to equip practitioners with the CBT skills necessary to implement evidence-based treatment for the most common psychological disorders. The course is open to all mental health professionals with at least one year's experience of supervised clinical practice. It comprises 20 days of teaching over two terms, including weekly supervision groups.

Postgraduate Certificate in Enhanced Cognitive Behavioural Therapy

This course is open to mental health professionals with at least 2 years of supervised clinical practice and the equivalent of the University of Oxford Postgraduate Certificate in CBT.

Choose from one of the following four areas:

Complex Presentations — *Course Lead: Dr Sarah Rakovshik.*
Psychological Trauma — *Course Lead: Martina Mueller.*
Psychosis & Bipolar — *Course Lead: Dr Louise Isham.*
Supervision and Training — *Course Lead: Dr Helen Kennerley.*

Postgraduate Diploma in Cognitive Behavioural Therapy

Course Lead: Dr Sarah Rakovshik

Having successfully completed the Postgraduate Certificate in CBT or the Postgraduate Certificate in Enhanced CBT, you can apply to progress to the Postgraduate Diploma in CBT. To complete this, you will take one of the courses not taken as part of the Postgraduate Certificate: Complex Presentations; Psychological Trauma; Psychosis and Bipolar; Supervision and Training. For further information on BABCP accreditation of the Postgraduate Diploma CBT, please see: http://www.babcp.com/Training/BABCP-Level-1-Accredited-Courses.aspx

MSc in Cognitive Behavioural Therapy

Course Lead: Dr Sarah Rakovshik

The course offers clinicians who have successfully completed the Postgraduate Diploma in CBT an opportunity to carry out high quality research and contribute to the evidence base for CBT. This two-year, research based award provides the foundation for carrying out research and publishing an academic paper. On successful completion the MSc will subsume the Postgraduate Diploma in CBT where already received.

Short Courses in Advanced Skills:

Research Skills

Course Lead: Dr Sarah Rakovshik

Clinicians wishing to acquire a foundation in research design and methodology may attend the preparatory module of the MSc. Teaching and discussion will prepare students to develop a comprehensive proposal for research that can be carried out in their clinical setting.

Advanced Clinical Practice

Course Lead: Dr Kate Rosen

The course offers clinicians the opportunity to refine advanced clinical skills and to be brought up to date with the latest advances in practice. Masterclasses include 'Anxiety', 'Depression' and 'Assessing and treating more challenging presentations'. It comprises seven workshop days over two terms. Students may choose to have close supervision of a session and evaluation of a case report thereby contributing to the BABCP minimum training standards for accreditation.

Short courses can be taken for a University of Oxford "Attendance only" certificate, or as an assessed course for 15 CATS points.

OCTC
Warneford Hospital
Oxford OX3 7JX

Tel: 01865 902801
www.octc.co.uk

For more information or bookings, & the rest of our programme, see the OCTC website.