



It's all about timing

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CBTtoday

Official magazine of the British Association for Behavioural & Cognitive Psychotherapies

A Peer among equals

**Helping others follow the path
to recovery**





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Welcome to the first issue of CBT Today for 2017. As part of our redesign we have made a few changes, including the introduction of short news items from around the world of CBT and mental health in general, as well as a new feature, and also including more colour.

'BABCP and me' on page 23 is intended to be a light-hearted opportunity for members to be a part of CBT Today. If you would like to feature, then do get in touch!

As always, we welcome feedback and comments, as well as ideas for articles that you want to submit. Please get in touch at the email address below.

Peter

Peter Elliott
Managing Editor
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Disclaimer

The views and opinions expressed in this issue of *CBT Today* are those of the individual contributors, and do not necessarily reflect the views of BABCP, its Trustees or employees.

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Advertising

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President's update



We have been working hard as a Board to try and progress some key areas in BABCP. This year the membership fee has remained stable, and we are committed to making sure we provide a high quality, responsive and supportive service to all our members.

Here are a few areas that are being developed:

Accreditation: We have now approved and will shortly be moving to a new self-declaration method of recording re-accreditation applications. The feedback from members has generally been very positive, and we expect it will increase the strength and credibility of our accreditation system, by moving to an annual cycle and increasing the likelihood of audit.

CPD online recording: We have invested in ensuring our new website contains the extra database facilities to allow members to record their supervision and CPD activity. This will be launched within the next three months.

DWP and treatment of depression: We are continuing to liaise with the Department for Work and Pensions about the introduction of trials of CBT for people in job centre settings. We also had a helpful meeting with the Mental Wealth Foundation who share similar concerns to BABCP about the need to avoid coercion, the dangers of power imbalances, the threat of sanctions and issues around privacy and consent.

We share those concerns, though where we would depart is we as an organisation are keen to ensure such issues are addressed in the service design and through evaluation/feedback, whereas the Mental Wealth Foundation are more fundamentally concerned that addressing depression etc. in such settings is never appropriate. A good two-way open discussion was most helpful however.

Complaints and disciplinary processes: A clear plan has been agreed to refine and simplify our approach, while continuing to focus on practitioners who have no employer and no statutorily regulated profession. We will still take into account the decisions of statutory and also other voluntary regulators. Our focus will remain on determining the two things we can control for

our members - membership and accreditation. We will consult with the membership regarding any proposed changes before bringing these forward to the Annual General Meeting in Manchester.

AGM: We are planning to have this again in the middle of the day at conference to keep it accessible to members. To avoid time overruns, Fellowship and Branch awards will be made at the Welcome event.

Senior Clinical Adviser: We have offered the post of Senior Clinical Adviser and hope to confirm an excellent appointment shortly. This will be a key appointment for furthering our external communications.

Membership and Branch Liaison Manager: This other critical appointment has recently been advertised. This post is focused on building good communications and support with members and branches and managing the membership services we provide.

Branch training events: The Board has agreed an upper limit for workshop presenter fees at BABCP events, and also limiting the number of free places for committee members.

Flexibility is available in exceptional cases but a case needs to be made to support such a proposal. Branches do a great job in advertising events. However please be reminded that all events need approval by the office so they can be advertised in good time and so we can also report on how the organisation is meeting its charitable objects.

An updated process has been discussed in the branch liaison meetings and will be distributed to all branches shortly. Going forwards, the Board is looking at providing an online event organising resource to take on the advertising and administration of training events.

Do keep letting us, the Board, know your thoughts on BABCP as it continues to grow and develop!

Chris Williams
BABCP President



This year the membership fee has remained stable, and we are committed to making sure we provide a high quality, responsive and supportive service



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

in brief...

Government Five Year Forward View for Mental Health released

The Government has published its response to the recommendations outlined in the 2016 Five Year Forward View for Mental Health and has announced that it will accept all of them in full. Prime Minister Theresa May has said that – among other initiatives – training will be provided for teachers to spot signs of mental health problems in schoolchildren, and that employers will be supported to help staff.

Mad about The Pill

BBC Woman's Hour partnered with *Debrief* magazine in January to launch "Mad about The Pill" - an investigation into understanding the link between hormone contraceptives and mental health.

A survey by the magazine revealed 45% of women who took the Pill have experienced depression, while there have been reports about the psychiatric reactions to Desogestrel and Levonorgestrel hormones, which are found in several types of hormone contraceptions. The investigation is aimed at raising awareness and encouraging debate around the topic, and calling on the NHS to conduct research necessary to allow women to make more informed decisions about their contraception. The NHS is also challenged with providing support for young women.

Outstanding North East NHS Trust recognition

A North East NHS Trust has been chosen by NHS Improvement to lead the way in developing new ways of working in mental health.

Staff in the Northumberland, Tyne and Wear NHS Foundation Trust (NTW) engaged with over 2,000 stakeholders, held 27 workshops and explored 720 patient journeys so they could create a map to enable them to calculate the resources required. New ways of working were introduced, including the 24/7 Initial Response Service and the Street Triage Team.

The introduction of these services saw improvements, with a typical week seeing the Initial Response Service receiving more than 1,500 telephone calls, carrying out rapid response visits, crisis assessments, and home-based treatments, as well as providing advice and support to callers.

The Street Triage team, an initiative where police and mental health services work together, has seen a significant reduction in the number of inappropriate detentions to both hospital and custody, as well as enabling staff to follow up those who can be difficult to engage after initial contact with the police.

John Lawlor, NTW Chief Executive said: "We're delighted that NHS Improvement have seen our work in action and have chosen us to be their strategic partner in developing their mental health improvement programme. This is a great opportunity and we hope that our work will benefit the wider NHS as well as the people we serve in the North East."

CBT in Ireland *save the date!*

The inaugural CBT in Ireland conference will take place in Dublin's Hilton Hotel on 5 May 2017 to promote CBT as the evidence-based treatment of choice for a wide range of conditions. This IABCP event will market and promote CBT in Ireland, and enable networking opportunities with other practitioners and policy makers.

This event will also raise the profile of IABCP as an organisation with decades of experience in supporting CBT members across diverse settings including health and social care, education and research.

IABCP Chair Stephen Herron said: "This one-day event will be of strong interest to multidisciplinary researchers and clinicians in CBT, along with mental health professionals, GPs and policy makers in health and social care".

Confirmed speakers for the day include Rodney Morton (Service Improvement Lead at Health and Social Care in Northern Ireland), Anne O'Connor (HSE Ireland), Professor David Clark (University of Oxford), Professor Chris Williams (University of Glasgow) and Dr Harry Barry (GP).

There is also a poster competition, with deadline for submission of 3 April. **Email iabcp@babcp.com for further details.**

 **More information and registration details will be available in due course at www.babcp.com/IABCP/**



www.babcpconference.com

BABCP Annual Conference & Workshops

Manchester University, 25 - 28 July 2017

Confirmed Workshop and Keynote speakers so far:

Arnoud Arntz, University of Amsterdam

Stephen Barton, Newcastle University

Rachel Calam, University of Manchester

Peter de Jong, University of Groningen

Barney Dunn, University of Exeter

Colin Espie, University of Oxford

Daniel Freeman, University of Oxford

Lars-Göran Öst, Stockholm University

Sarah Halligan, University of Bath

Emily Holmes, Karolinska Institutet, Sweden

Nusrat Hussain, University of Manchester

Andrew Jahoda, University of Glasgow

Steve Kellet, University of Sheffield

Helen Kennerley, Oxford Cognitive
Therapy Centre

Colin MacLeod, The University of
Western Australia

Kate Rimes, King's College London

Roz Shafran, University College London

Blake Stobie, South London and Maudsley
NHS Foundation Trust

Ed Watkins, University of Exeter

Submissions are now open

Submission for Open Papers and Posters will close on **1 March 2017**

Full details will be available at www.babcpconference.com

The **2017 BABCP Annual Conference** will take place at the **University of Manchester** - a familiar and always popular venue. The pre-conference day Workshops will take place on 25 July, and the conference itself will run from 26 - 28 July (ending on the Friday lunchtime).

Following the success of our conference in Belfast in 2016, we plan to build on the positives that we had there. This includes a stronger emphasis on depression and medically-related symptoms, as well as our traditional strength in depth relating to anxiety disorders.

The invited keynotes and one-day workshops include an impressive array of speakers, covering different clinical groups, disorders, and approaches.

Whether your interest is in younger cases, depression, psychosis, anxiety, psychopathology, supervision, cultural adaptations, perfectionism, personality disorders, sleep problems, positive mood interventions, or basic skills, there is plenty for you in this meeting.

Submissions for Open Papers and Posters are still open until 1 March 2017, so head over to the website to submit your proposal if you would like to be a part of the Conference programme. Last, but not least, there is the social side of things... Manchester is well known for having a culture that is all its own. We will be dipping into that culture, to make Manchester 2017 an entirely memorable experience. See you there.

The 45th
annual
conference &
workshops
takes place at
the University
of Manchester
on 25 - 28
July 2017



Visit www.babcpconference.com for more information on the programme and for details on submitting an Open Paper or Poster for the 2017 annual BABCP Conference.

Accreditation

Update on change from Reaccreditation to Maintaining Quality and Standards of Practice (MQSP)

As we enter 2017 we thought it might be useful for the accreditation team to give a general update on progress; provide some reassurance based on queries received to date and provide some detail about the new process of Maintaining Quality and Standards of Practice.

Why the change?

Through clearly highlighting individual practitioner's responsibility and accountability for their own practice, the new process is intended to clarify accreditation and listing on CBT Register UK as being about each listed practitioner's commitment to doing what is needed to support their own ongoing practice. An additional aim is to remove any impression of BABCP acting like a statutory regulatory body; unlike regulation for doctors, nurses and psychologists, BABCP accreditation is a voluntary process.

What this means for you

Rather than being a statement of ongoing practitioner competency, accreditation and listing on the register is about having met Minimum Training Standards in CBT - and subsequently committing to meet standards which support good practice. Failure to engage in the process will mean that you have opted to self-remove from the CBT Register. As reaccreditation certificates are no longer being issued, current accreditation status of members can be verified **only** from the Register listing on the BABCP website.

What is happening now?

To date, all reaccreditation processes have ceased with work ongoing preparing the way for an online system which will enable members to make annual declarations of commitment to keeping their own records of supervision and continuing professional development. After the new process is launched in May this year, it is planned that each practitioner listed on the register will be contacted one month prior to their annual accreditation date with an invitation to make their first online declaration.

What happens next?

Prior to the launch of MQSP, the accreditation team will provide a guidance document recommending that practitioners continue to meet the standards for supervision and continuing professional development encapsulated within the discontinued reaccreditation process. It will be for individual practitioners however to decide how best to uphold standards within their own context.

Within this guidance document, there will also be full details of the intended quality audit which is scheduled to commence one year after launch of MQSP.

What should I do now as an Accredited member?

The most common type of query the accreditation team have had from members to date has been for

CERTIFICATE UPDATE

- The changes in re-accreditation mean that we also need to change certificates
- There will be no more re-accreditation certificates
- Full Accreditation certificates will now only state the date of accreditation award – with no ongoing period of accreditation – hence a certificate is no longer proof of current accreditation
- An online Accreditation Check on the CBT UK Register on the BABCP website is now the recommended means of verifying accreditation
- BABCP will be attempting to correspond with as many NHS Trusts, private health insurers and medico-legal companies as possible to let them know of these changes
- We may not reach everyone, so keep this article and refer anyone who needs to know to the BABCP website



RE-ACCREDITATION CHANGES - THE HEADLINES!

- Re-accreditation will be replaced by new annual system of maintaining accreditation – Maintaining Quality and Standards of Practice (MQSP)
- New system starts on 1 May 2017
- Fully accredited practitioners will make an annual online declaration of maintenance of CPD and supervision
- Therapists will keep their own records of suitable supervision and CPD
- No need to submit records to BABCP unless selected for audit
- A percentage of accredited members will be randomly selected each year for audit
- If selected for audit, you will be given three months to provide a summary of supervision and details of CPD
- Failure to make online declaration or submit satisfactory details at audit will result in self-removal from the CBT Register UK
- Full guidance, recommendations and examples of forms available after 1 May 2017
- All accredited therapists remain accredited until new system starts – no reaccreditation applications required

clarification as to what needs to be done between now and being contacted.

Essentially, we suggest you continue to use the existing forms and records. What has changed is the process of responsibility and evaluation.

For the avoidance of doubt - please be assured that all those listed on the register will remain listed throughout this transition - without any action being required on the part of the individual. Ongoing status can be checked on the register at any time – and if any member who should be listed finds they are not, please contact a member of the team who will follow up appropriately.

How will the audit work?

For audit, a percentage of those listed on the register will be randomly invited to submit summary details of previous 12 months of supervision session dates, duration of sessions and supervisors' names.

There will be a check list of methods used within supervision over that year (which could include use of live samples as one recommended, though not mandatory, method).

Those audited will also be invited to list their CBT CPD over the previous 12 months – with evidence of engagement (which could include reflective statements as one possible, though not mandatory, form of evidence).

Failure to respond to a request for audit materials – or providing a submission which does not meet the minimal standards - will result in removal from the register.

What will BABCP do with the audit data?

The quality audit is designed to give the accreditation team – and ultimately the Board – feedback on how MQSP is working regarding members following up on commitments made in online declarations.

It will differ from the discontinued reaccreditation process within which there was evaluation of the detail within records maintained by practitioners - in that only summary information will be sought and scrutinised for quality feedback purposes.

Changes to Supervisor and/or Trainer Accreditation

Finally, there have also been changes made within Supervisor and Trainer Accreditation.

Separate application processes – with Practitioner accreditation and reaccreditation elements removed - are being developed for both Supervisor, and separately, Trainer accreditations - so that they can be applied for online once the new portals are available.

In the meantime, a paper version of Supervisor accreditation only has been made available to cover the period between now and May 2017.



After the new process is launched in May this year, it is planned that each practitioner listed on the register will be contacted one month prior to their annual accreditation date with an invitation to make their first online declaration



OTHER ACCREDITATION NEWS...

- At present, no changes to PWP Accreditation
- No changes to current Provisional or Full CBT Practitioner Accreditation
- Supervisor and Trainer Accreditation will be separate forms with no Practitioner or Re-Accreditation elements within them
- Supervisor and Trainer Accreditation will also be renewed using specific MQSP declarations
- Supervisor Application process is now available on the website. Trainer Application process will be available online from May 2017

It's all about timing

Rob Griffiths (pictured) writes for *CBT Today* to consider the use of service-led scheduling to improve the experience of people receiving psychological therapy.



Imagine the following scenario. It's Saturday night and you're in the mood to watch a film at the local independent cinema. Maybe there's a new sci-fi film that you have been looking forward to for months and it's just been released.

Anticipation building, you phone the cinema to book a ticket. The member of staff who answers your call says, unfortunately, you will not be able to watch that film tonight. Instead you will be placed on a waiting list. The cinema will write to you in due course, he says cheerfully, letting you know when you can watch a film.

Six months pass and you hear nothing from the cinema.

Then, seemingly out of the blue, you receive a letter from the cinema manager to say you have been allocated a seat for a film screening. 'Finally, I'll get to watch my film', you think. Unfortunately, the long wait was actually just the start of your problems.

Instead of the sci-fi film you wanted to watch, you have been sent tickets for a romantic comedy, and rather than the local independent cinema, the film is being shown at the multiplex on the other side of town. The letter goes on to say that there are no showings on a Saturday night, so you've been allocated a seat on a Tuesday afternoon.

Also the only snacks available will be hot dogs, even if you would prefer popcorn with your movie. And despite the fact you prefer to sit at the back of the cinema, the seat you have been allocated is on the front row. Understandably, you decide not to take up the offer of watching the film.

A few days later you receive another letter from the cinema manager to say he is sorry you didn't attend the film screening. He regrets to inform you that you have now been removed from the film waiting list. The letter concludes by asking you to contact the cinema again if you want to watch another film in the future.

It's easy to imagine the effects of running a cinema in this way. For one thing, it's likely that your customers are going to be pretty irritated about not having their preferences respected. Having the cinema dictate what film you watch, not to mention when, where and how you watch the film, is likely to be an unsatisfactory experience for most people.

From the cinema's perspective, they are likely to discover that many people simply do not turn up for the film they have been allocated, resulting in lots of empty seats at each screening. Consequently, the waiting list grows and the cycle perpetuates itself.

If this all sounds a little far-fetched, it is worth remembering that many mental health services, including those offering psychological therapy, operate on just this basis. Service users are often unable to refer themselves directly to mental health services, requiring a health professional to do this for them. Once referred, people often have a long wait to be seen.





When people are finally offered an appointment, the date, time and venue of the appointment are frequently dictated by the service. It is not surprising then that people often choose not to attend their appointments. This is usually seen as a problem with the service user 'not engaging' with the support being offered. The service user is said to have DNA'd (short for 'did not attend') the appointment.

A recent report from the We Need to Talk coalition found that over 50% of people surveyed had been waiting longer than three months for psychological therapy, and 10% had been waiting over a year. Seventy-five per cent of people surveyed had not been given a choice over where they received therapy, 58% had not been given a choice of treatments, and 50% felt like they had not received a sufficient number of sessions. This is all sounding a bit familiar. Maybe the cinema example was not so fanciful after all.

Is there another way of doing things that provides service users with more choice and control over the support they receive? In a recent *Patient Experience Journal* article, Tim Carey describes how mental health services and practitioners need to shift their focus from patient-centred care to patient-perspective care.

However well intentioned, simply placing the patient at the centre of care, Carey argues, is not enough to stop clinicians making decisions on behalf of the patient. Patient-perspective care, on the other hand, requires clinicians to avoid making assumptions based on what they think the person needs.

What is actually required is an acceptance that we can never truly know what another person needs. Adopting a stance of genuine curiosity and humility, however, gives clinicians the best chance of delivering services in a way that is acceptable to the people who are using them.

Part of taking this new perspective might include the use of service user-led appointment scheduling. This has been used successfully in settings as diverse as Fife and rural Australia to deliver a transdiagnostic cognitive therapy called Method of Levels (MOL). Rather than the service dictating the timing, frequency and number of sessions, as much control as possible over these decisions is given to the service user.

It is based on the principle that the service user is best placed to make decisions about how many sessions of therapy they need, how often the sessions should occur and how long they should keep attending therapy. This approach was found to be as effective when compared to equivalent practice-based studies, but was significantly more efficient.

Funded by the National Institute of Health Research (NIHR) the Next Level trial is currently evaluating the feasibility of Method of Levels therapy for people experiencing a first episode of psychosis, and it uses a service user-led approach to appointment scheduling. It will be fascinating to find out how participants utilise the therapy sessions when they have control over appointment scheduling.

With healthcare budgets becoming ever more stretched and the demand for psychological therapy increasing, maybe what is needed now is a fundamental shift in the philosophies underpinning the way mental health services are delivered.

Details of the Next Level trial can be found at www.isrctn.com/ISRCTN13359355
Rob Griffiths is a psychological therapist and Clinical Doctoral Research Fellow at the NIHR



So long to SUDS

Exposure is not about fear reduction... it's about new learning and flexibility



Clinical psychologist and researcher Dr Eric Morris looks at the power and effectiveness of exposure – a classic method of behaviour therapy with more than four decades of research to support its use.



Whatever approach to working with cognitions and inner experiences a cognitive-behavioural therapist takes in helping clients with anxiety, (a cognitive approach, such as Beckian CBT; or contextual one, like Acceptance and Commitment Therapy), there will usually be the use of exposure.

While it would seem that we should know how exposure works, recent research suggests that there is still a lot more to discover about the best ways to engage clients in this approach.

Does habituation matter?

Many therapists have been trained in using exposure based upon a *habituation rationale*. Typically, sessions are conducted where the client is asked to rate their distress (using a SUDS – Subjective Units of Distress Scale) while doing exposure over the course of the session, with the aim of having distress reduce by the session end (typical treatment protocols suggest at least a 50% reduction in distress).

What is also tracked are reductions in distress between sessions. The process of exposure is thought to be successfully occurring if these reductions in distress (habituation) are happening.

However, there is not much support for habituation being the process of change in exposure. For example, it has been found that:

- 1) people don't have to experience distress reduction in session for exposure to be effective
- 2) people don't have to experience distress reduction between sessions for exposure to be effective

If reductions in distress in exposure sessions seems unimportant to outcome, then what should the therapist focus on instead?

Learning from new models of exposure

The contemporary empirical literature gives some indications, from an inhibitory learning perspective, and the psychological flexibility model (based on Relational Frame Theory, which underpins ACT).

The inhibitory learning model hypothesises that fear learning is not extinguished when people participate in exposure. Instead, what happens is that people learn new associations with what they

fear, and this new learning inhibits old learning (such as fearful responding). From this model, the aim of exposure therapy is to maximise the ways that this new learning occurs. This could be done by:

- 1) violating the client's expectancies of what will happen when doing exposure (i.e., learning is focused on whether the expected negative outcome occurred or not, or was as 'bad' as expected), and the degree of 'surprise' a client has about the exposure practice. In this model new learning is impactful by the degree of a mismatch between what the client expects, and what they experience; sessions focus on this goal, rather than distress reduction;
- 2) increasing uncertainty associated with learning, by occasional reinforced extinction (the client experiencing occasional negative outcomes, such as social rejection if socially phobic, through 'shame attack' exercises or deliberately doing things that will invite criticism from others), which may strengthen inhibitory learning if the client is later in contexts that would risk a relapse of fearful responding;
- 3) removing safety signals and safety behaviours, as these interfere with new learning. The therapist paying attention to the development of any new safety signals, such as the client learning that distress reduction reliably occurs during exposure;
- 4) the use of variable exposure, where exposure is conducted to items from the hierarchy in random order, without regard to distress levels or distress reduction (usually starting with the least anxiety producing item to avoid drop-out), and for variable lengths of time (again, with client agreement);
- 5) deepened exposure, where multiple cues are combined (that have previously been used in isolation in exposure sessions), such as the use of in-vivo (e.g., contamination with an 'unclean' environment) and imaginal exposure (e.g., imagining someone becoming sick due to the contact with the client's contaminated hands) together in an exposure session.
- 6) conducting exposures in multiple contexts – being creative about the range of occasions where exposure can be done, such as when alone, in unfamiliar places, or at varying times of day or varying days of the week. This reduces the risk of new learning being 'context bound' (risking

increased chance of relapse), such as if exposures were only done in the therapist's clinic.

- 7) broadening contact by engaging in affect labelling, with the therapist asking the client to state their emotional responses, without attempting to change these responses, in the midst of exposure.

The psychological flexibility model emphasises helping the client learn how to pursue a values-based living regardless of anxiety, fear and urges (such as escaping or avoiding). For this model, the focus is on maximising client actions that are personally meaningful, whether in the presence of life-narrowing stimuli or not.

The functions of anxiety and fear are transformed by experiencing them in the context of values, so that these experiences are responded to with qualities of openness, curiosity and compassion. The connection to values can mean that the client is reinforced for being in contact with fear and anxiety, in the context of acting in personally meaningful ways:

- 1) Engaging in exposure is explicitly linked to the client's values, with meaningful (values-linked) activities chosen for the exposure sessions. Thus, there is a clear relationship with the stimuli and tasks chosen for exposure, and the kind of life that the client wants to be living;
- 2) Exposure sessions reflect the ACT approach: instead of monitoring ratings of distress levels during exposure (SUDS), the client is asked to provide ratings of their willingness to experience anxiety and other inner experiences (urges, unwanted thoughts, feelings) throughout exposure tasks. Over exposure sessions, work is done to increase willingness (through using exercises linked to acceptance, defusion, present moment contact, and flexible perspective-taking);

- 3) It does not matter whether the exposure task is easy or difficult (in a level of distress sense); rather, it is about how open and accepting the client is to what shows up while doing exposure;

- 4) Exposure provides an excellent opportunity to practice experientially, the skills of psychological flexibility that ACT promotes;

- 5) Following a session, the client should be encouraged to reflect on being willing and open during exposure, to strengthen experiential learning; if a client is starting to respond in a rule-bound way to doing exposure (e.g., "I just need to allow that feeling to be there and not fight it"), then the therapist should encourage curiosity, in light of workability (Therapist: "how has it worked in terms of your goals? How has this worked compared to other things you do?")

Implications

Considering the recommendations from both these models of exposure, you can see that we are long way from the traditional, habituation-based approach. While the models have theoretical differences, there are commonalities.

For the ACT therapist, I think this can inform how to engage clients in exposure that maximises learning and flexibility, by:

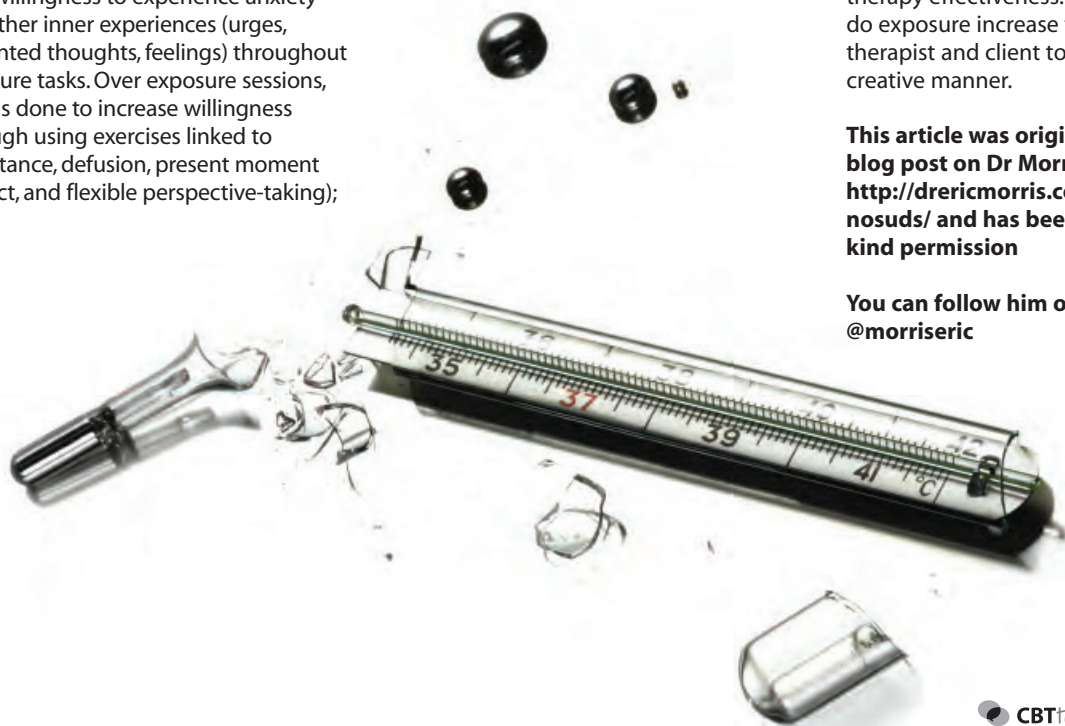
- having a focus on willingness and noticing the experience of fear and anxiety, without working to reduce distress within or across sessions

- linking exposure with 'ultimate outcomes', by engaging the client in approaching exposure within the hierarchical framing of values
- strengthening therapist and client willingness for exposure sessions to have variability in the intensity of distress, without controlling or avoiding this (and having sessions where distress may vary, including times when it remains high at the end of the session)
- promoting present-moment awareness and expanded contact by affect labelling during exposures
- working with the client to be in contact with feared outcomes (in-vivo, imaginal) as part of openness to experience and discovery
- encouraging client curiosity about what they are learning during exposure, without focusing on there being a 'right' or 'definitive' view to take
- moving away from using hierarchies as means of structuring of exposure, and introduce more variability into exposure sessions in terms of exposure difficulty (while ensuring that the client is choosing to engage in exposure)
- expanding the contexts where exposure is practiced, so that new learning is not context-bound

It is an interesting time to be practicing exposure therapy, with increased empirical interest in the processes that strengthen learning, and discovery of new ways to conduct sessions that may increase therapy effectiveness. These new ways to do exposure increase the options for the therapist and client to work in flexible and creative manner.

This article was originally published as a blog post on Dr Morris' website at <http://drericmorris.com/2017/01/13/nosuds/> and has been reproduced with kind permission

You can follow him on Twitter @morrseric



A peer among equals

Nick Marlow talks to *CBT Today* about overcoming OCD and becoming a peer support worker, helping others follow his path to recovery



You are ill.
You are not
alone. You
can recover



**These words
changed my life.**

It was September 2012, and I was sat opposite a psychiatrist in a rehab clinic. I was being treated for addiction, and had just been diagnosed with acute Obsessive Compulsive Disorder. For the first time in a very long time, I no longer felt isolated. Just as importantly, in the midst of what I now knew to be an illness, I had a sense of hope for the future – a glimmer of light at the end of a deep, dark tunnel. Armed with a diagnosis, and fuelled by the gift of desperation, I jumped into recovery.

Fast-forward to February 2015, and I found myself on a NHS Peer Support Worker training programme in Nottingham. I had been in recovery for over two years, and something had become very clear to me during that time. Peers had played - and continue to play - an intrinsic part in my journey.

I was reminded of a quote from a recovery text: “the... past thus becomes the principal asset. This... may be of infinite value to others... still struggling with their problem”. My story could be of practical use to others. Like many before me, I could become a source of experience, strength and hope to those still struggling with mental health.

I began volunteering with organisations rooted in recovery, determined to turn the course of my illness into a positive force for change. This culminated with my enrolment into – and subsequent graduation from – the ‘Peer Support School’ run by the Nottinghamshire Healthcare NHS Trust.

Once formally qualified, I was excited to be asked to join a new team with a remit to improve patient pathways post-OCD diagnosis, in line with NICE recommendations. A bespoke client assessment would be introduced, along with two groups – a two-week information course, focusing on delivering an understanding of the disorder (with signposting to recovery opportunities), and an eight-week treatment group, whereby cohorts of clients would be guided through a therapeutic course of action.

Both groups would be led by an experienced Cognitive Behavioural Therapist, and supported by me, as a Peer Support Worker. Both also enabled clients to undertake intensive, personalised therapy both within, and adjacent to, the weekly group. Whilst only a pilot scheme, and not intended to fully replace existing one-to-one therapy, this clearly demonstrated the NHS’s commitment to improving services and exploring new opportunities for therapeutic interventions. I had heard of the Trust’s pioneering use of Peer Support Workers in dynamic, recovery-orientated

roles. Here it was in action, and I was privileged to play a part.

As I write this, we are approaching the end of the project, having successfully developed and delivered two information groups and two treatment groups, alongside multiple opportunities for focused, individual exercises. Underpinning the objectives of improving treatment pathways sat two key recovery models – therapy via group sessions, and peer involvement in the process. There were risks associated with both models. Would individual needs get lost in a group environment? Would clients be uneasy sharing personal information in front of others? Would clients be able to relate to a peer, and would this strengthen or diminish the impact of therapy?

My experience during the process suggests that, correctly managed, these concerns were unfounded, that both the group setting and peer involvement had added value for the clients. Watching a room of clients burst into spontaneous applause when one of their number shook hands with the therapist spoke volumes. They understood that the client had avoided contact with people over many years, for fear of contamination. They understood the fear and anxiety that this had caused for so long. They understood the bravery needed to reach out his hand. They understood the leap of faith that this required, faith that had been earned by both the therapist and the peer. They understood all this because they felt all this. They felt part of something bigger than themselves, motivating each other to push onwards, to challenge their illness, to share their recovery. Like me, they no longer felt alone.

As peers had given hope to me, so I passed it on to others. I watched hope turn into faith, and faith turn into trust, and trust turn into action. We were determined that these groups would be so much more than generic support groups. They were designed to instigate change, and I was honoured to be witnessing individuals’ change as the courses progressed. They began collating their own recovery experience, experience which is priceless.

If the group format had proved to be successful, it was apparent that the peer role had also demonstrated its value. This professional position validated my recovery experience. This doubtless aided the impact of my words, and demonstrated that I could ‘walk the walk’ as well as ‘talk the talk’.

Seeing eyes widen as experiences were shared, and the realisation slowly dawn that they were not the

Findings

- Groups experienced around 85% attendance rates
- 100% of clients felt they benefited from the information groups
- Four assessment tools and measures were used in treatment groups to assess change in clients' OCD presentation (OCI, PHQ9, GAD & WAS). Overall mean scores demonstrated a decrease of 14.1% - a notable recovery rate
- 87.5% of clients found the treatment groups to be a helpful option instead of waiting for individual therapy
- 100% of clients felt that the treatment group would enable them to continue working on their OCD independently
- 100% of clients found the involvement of a Peer Support Worker to be beneficial



only one, was humbling and testament to the power of peerness in recovery. You could almost see the hope developing. My role as peer helped validate the therapy team's suggestions, as though I was providing proof of concept to their therapeutic theories. It felt very much like a team effort. We were all pulling together and we were all pulling in the same direction.

The groups drove individual action, and individual action further consolidated the group's strength. This proved as effective a tool for change as one-to-one therapy. The format instilled hope, and provided ample opportunity for each client to test their experiences within a safe therapeutic environment. There was a growing sense that individuals were slowly clawing control of their lives back from this debilitating condition. Hope, opportunity and control – the watchwords of recovery.

An analysis of the second treatment group is ongoing. However, analysis of both information groups and the first treatment group has been completed. Key quantitative and qualitative results are highlighted elsewhere in this article.

The pilot thus demonstrated a successful model for improving patient pathways in the treatment of

OCD. A decision is pending as to the future of these pathways. However, it should be noted that care was taken to ensure the process is both replicable and scalable. There is no reason to suggest it couldn't either be expanded in its current format, or rolled out to other areas.

I am extremely grateful that I have been able to put into practice all that I was taught on the Peer Support Worker training course. More importantly, I have witnessed peer work in action, and seen the positive change it can drive. It has proven to be an extremely effective resource for recovery, and demonstrated its value alongside both individual and group therapeutic practice. Much of the content of the courses was derived from the Salkovskis model of treatment, and it seems appropriate to conclude with an extract from his co-authored text *Break Free from OCD* –



To be restored to health does not mean not having a past, but we can use our experiences of getting better to stay better.



Feedback from users of the group

- "Talking to other people who have had similar experiences – realising that my experiences are part of a disease, a disease that can be treated"
- "(the PSW) was very good at sharing their experience, and offered valuable insight into how to overcome OCD"
- "(the PSW) understands the reality of living with OCD as much as he understands the theory"
- "It has given me many tools to experiment with in fighting OCD"
- "I think that groups like this are essential for people like us"
- "Being able to share my experiences in a safe and supportive group helps to reduce the feelings of isolation"

in brief...

Mental health form charges to be reviewed

The Prime Minister has announced a review of the charge currently levied by GPs in completing the Debt and Mental Health Evidence Form.

The form was introduced by advice organisations and credit firms to enable people with mental health conditions to request easier repayment terms or reduced charges on debt.

Charges typically varied between £20 and £50, but with the charges left to GP's discretion, there had been reports of some charging £150 to complete the form.

Announcing the review, PM Theresa May said: "Despite known links between debt and mental health, currently hundreds of mental health patients are charged by their GP for a form to prove they have mental health issues. To end this unfair practice the Department of Health will undertake a formal review of the mental health debt form."

“

charges varied between £20 and £50... at GP's discretion

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giftaid it

Did you know that you can choose to Gift Aid your BABCP subscriptions? If you haven't done so already, get in touch with the office to request your fees to be registered for Gift Aid contributions.

Funds raised through Gift Aid are put directly into the BABCP Research Fund, which provides researchers with much-needed funds to further develop research in CBT.

Applications for grants from the Research Fund will open again soon.

You can email babcp@babcp.com with your membership details to register for Gift Aid.

Three awards were made in 2016, funding research in the following areas:

- A pilot study of group intervention for couples affected by Chronic Fatigue Syndrome
- Identifying and overcoming barriers older people face in accessing CBT for severe mental health problems
- Families' experiences of therapy for depression, anxiety and behaviour problems when a child has a long-term physical illness.

Banks called upon to tackle 'unfair disadvantage'

Research published recently by the Money and Mental Health Policy Institute has shown that financial capability is affected by periods of poor mental health.

Among its findings, the report states that people experiencing bipolar disorder or ADHD often struggle to resist impulses, perhaps leading to dramatic spending sprees, while depression, substance dependence, borderline personality disorder and psychosis can make it more difficult for people to plan ahead, while serious anxiety can cause difficulty in making telephone calls or opening mail.

The consequences of all these situations can be financially harmful, with the Institute's Director, Polly Mackenzie saying: "For too long, it's been assumed that when people with mental health problems get behind on bills, or struggle to stick to

their budget, it's because they're lazy or incompetent. Our research proves beyond doubt that's just not true.

"We have assembled all the evidence to prove that mental health problems can severely affect consumers' ability to stay on top of their finances, shop around, or manage a budget. It's time for the financial services industry to adapt its services to help support people when they're unwell – just as they do to help people with physical disabilities who struggle to access a branch or engage on the phone.

"One in four of us will experience a mental health condition in any year, so this is not a niche problem: it should be core business. Today's report should be the starting gun in a new race to the top for banks, energy companies and everyone else who supplies essential services. This is a significant chunk of their market, who are currently left under-served."

Spring Conference

The 2017 Spring Conference will be held in Cardiff on 6th and 7th April at the Wales Millennium Centre.

Final touches to the programme are being made, with workshops by Lance McCracken, Paul Salkovskis and Trudie Chalder already confirmed.



Registration is now open, with more information at www.babcpconference.com



Working as a BME CBT therapist

Saiqa Naz is a cognitive behavioural therapist from Sheffield, and is a committee member of the BABCP Equality & Culture SIG. Here she gives her response to Andrew Beck's thought-provoking article in September 2016 about service users' experiences of racism.



The NHS England website states that one of its priorities is to increase the number of adults accessing care within IAPT services from 900,000 to 1.5million by 2020/21.

The majority ethnic group in England and Wales according to the 2011 Census in was White British (80.5%). The next largest ethnic group was Any Other White (including Irish and Irish travellers) with 4.4%. Indians (2.5%) and Pakistanis (2%) were the next two largest ethnic groups.

I have been unable to find statistics on the percentage of the Black and Minority Ethnic (BME) community currently accessing IAPT. However David Clarke, Richard Layard and Rachel Smithies state in their 2009 report *Improving Access to Psychological Therapy: initial evaluation of the Two Demonstration Sites* that 49% of all patients came from BME groups. This data is based on the Doncaster and Newham sites only, so it would be interesting to see what the current figures show.

According to the 2015 Adult IAPT Workforce Census Report produced by NHS England, the majority of the IAPT workforce is White British (83%) and Female (79%). These figures include Low Intensity workers and High Intensity workers (trainees and qualified), and supervisors. Eight per cent of the IAPT workforce are Asian or British Asian. So the IAPT workforce in terms of its ethnicity is largely representative of the population it serves.

Although this is positive, I feel IAPT services can do more to do more to reflect the diversity of their workforce to represent the local population they serve, for example employing more BME therapists, older therapist and male CBT therapists in proportion to the local demographics. For a long while, in one of my previous roles, I was the only BME CBT therapist working in a community where at least 20% of the population belonged to the BME community.

CBT has been developed by white therapists for white populations, therefore, generalising CBT to different cultures and communities requires consideration.

BME communities have less access to early interventions or preventative mental health services, often only presenting to services when their mental health problems become acute or serious. If we are to seriously work on reducing this figure, then the status quo needs to change. However, this paper is not looking at how to increase access of the BME community into IAPT. You can look at the BME positive Practice guide to read more on that.

This paper will consider two areas when working with the BME community; at a service level and issues that may arise in therapy when working with this community.

There is a general assumption by services I have worked for, that because you're from a particular BME background, that somehow you're an expert in the field of working with BME communities. Therefore, in my experience, it is the BME therapists who are pulled together to form working groups to look at working with individuals from the BME community.

Some of the challenges other BME therapist I know and I have experienced from a service perspective include:

Lack of resources

Often, although not always, many people have literacy problems. The literature that is available is often in English. Appointment letters sent to service users are in English. No extra concessions are given to therapists to have time to adapt therapy. Sometimes any translated materials given to people have been found via completing a Google search! In my experience, services take a therapist telling them they are bilingual at face value. No measures are in place to check therapist's competency. One way around this (as was being discussed in one of the previous services I worked in) is to give bilingual therapists interpreter qualifications.

continued overleaf



Incorporating religious values and behaviour into therapy can promote mental health as you are then working within a service users own framework



Lack of training for all clinicians and lack of culturally sensitive supervision

We are encouraged to work within a client's own framework. You can't do this if you have no knowledge of what that framework is and don't know what questions to ask. Given these constraints, we are still expected to get the same outcomes for BME service users as their English speaking and literate counterparts. Talking of outcomes, the mandatory IAPT measures are also not culturally adapted. There have been many times when I have given up trying to explain how the scoring works for WASAS and the Phobic questionnaire. Often completing the PHQ9 and GAD7 can take up half the session.

Lack of support from management

Setting up a BME working group is just the beginning of the work. Having the correct clinical and management support in place is integral if the work of the BME working group is to develop and deliver desired outcomes. The BME lead in one of my previous employments lacked knowledge and interest in the work, and would very rarely turn up to meetings. The working group also spent time outside of their contracted working hours to complete their work as the time allocated to them was not sufficient to complete their work. Having a BME lead who knows the values of diversity is important, otherwise, progress will be stalled. Some of the challenges we face from service users include:

The boundaries of the therapeutic alliance can be different

The service users want to know the name of your parents, their country of origin. In my case it's Pakistan. They then want to know where exactly in Pakistan. My age, my marital status, why am I still not married, why do I not wear the Islamic headscarf and do I pray? I always find these conversations awkward and I tend to give vague answers so as not to compromise the therapeutic alliance, but at the same time not wanting to blur the professional boundaries.

A service user once figured out who my father was by asking his first name and the mosque my family attended. When he found out I was going to Mecca on a pilgrimage, he wanted me to pray for him and bring him back dates and holy water. I apologised and said I would not be able to that, but would pray for him. Deep down I felt guilty for saying no to his request. I recently asked a young Pakistani male how he found disclosing personal information to me. His stated that he was not initially keen on seeing me after reading my name on his appointment letter. He had done some research about me online before deciding to keep his appointment. It is awkward feeling like my personal life was being intruded upon. Guidance around handling such issues would be helpful. Self-disclosure can be helpful as it can enhance the therapeutic alliance. By holding back too much, it

may create barriers in therapy. In both of the examples above, I found the service users engaged really well and I did not need to divulge in much more self-disclosure once therapy had started. How much a therapist discloses about themselves is up to them. Whatever makes them feel comfortable, therefore, it is perfectly acceptable to tell service users you would rather not answer a question as you are there to help them or ask them how knowing that information about you will make a difference of your work together.

My experience of working with older South Asian women who have often been caring for others throughout their lives (their own parents, husbands, in-laws, children and grandchildren) is that their needs have often been overlooked. Many of them are not used to asking for help. I have found that these women prefer a more didactic approach. Someone not aware of these issues will not be able to reasonably adjust their work to meet the needs of these service users.

Role of religion in therapy

How much of it is acceptable to bring into therapy? Incorporating religious values and behaviour into therapy can promote mental health as you are then working within a service users own framework. Ghazala Mir's work on adapting the Behavioural Activation approach to incorporate the Islamic faith is one way in which we can address this issue specifically when working with the Muslim community. The BA manual and self-help booklet produced by Ghazala and her colleague's is available on the University of Leeds Faculty of Medicine and Health website.

Working with interpreters

Working with interpreters has its own challenges. On one occasion, I asked an interpreter to complete the IAPT measures with a service user. The interpreter clearly struggled with it because she read out the questions in English, and the session did not flow as well as it had with our usual interpreter. I made a polite request to the surgery not to book the same interpreter again. As I am writing this, I am wondering if interpreters need to be given some basic mental health training before they can start interpreting for us?

Cross-cultural therapy and the BABCP Standards of Conduct

The BABCP's Standards of Conduct, Performance and Ethics says:

'You are personally responsible for making sure that you promote and protect the best interests of your service users' (1.1).

Is trying to somewhat impose a white Western therapy and the IAPT model on the BME community ethical? Surely not? Hence the importance of adapting therapy.

'You must ensure that any intervention procedures adopted will be based upon evaluation and assessment of the service user...' (2.1).

Are the CBT interventions and IAPT measures the best way to measure how depressed an individual is given that they may not be culturally appropriate? How much adapting should therapists do so as not to deviate too much from the CBT evidence-based interventions, but also meetings individual needs of the service users?

'...you should only practise in the areas in which you have appropriate education, training and experience' (7.1).

When I trained as a CBT therapist, we received no more than two hours of training of the importance of working with diversity. Talking about the importance of working with diversity is one thing, showing people how to practically implement that is another!

'People who consult you or receive treatment or services from you are entitled to assume that a person with appropriate knowledge and skills will carry out their treatment or provide services' (9.1).

In the past I have provided peers with support, but what about the therapist who does not have such a resource in their service? They are not supported to feel confident in working with the BME community.

'You must always continue to give appropriate supervision to whoever you ask to carry out a task. You should not put the safety of the service user in danger' (9.2).

This highlights the importance of continuous supervision. Services should not assume that because they have bilingual staff, that they do not require support. I would argue that they require more support. Trying to fit people into a Western model in another language and often with the use of an interpreter isn't an easy task.

When working with BME service users, both clinicians and services need to ensure they are adhering to these standards. The full document can be found on the BABCP website. The Five Year Forward Review of Mental Health report published in 2016 states: "Delivering Race Equality programme concluded in 2010 that there had been no improvement in the experience of people from minority ethnic communities receiving mental health care. Data since shows little change. These inequalities must be prioritised for action...". I strongly feel BABCP has a role to play in ensuring these are being adhered to and that BME service users are receiving the same quality care as those from the White British community.

Moving forward, the book by Andrew Beck *Transcultural Cognitive Therapy for Anxiety and Depression - A practical guide* is the closest attempt

someone has made to help address some of the issues I have raised. *Cultural Adaptation of CBT for Serious Mental Illness: A guide for training and Practice* by Rathod, Kingdom et al. is another attempt to adapt therapy for the BME community.

There is a need to develop and standardise materials and approaches including giving therapists access to culturally sensitive supervision (including live supervision) to ensure quality of care is not compromised and that clinicians are supported and protected.



CBT Today volume 44 number 3, September 2016

Coming back to Andrew Beck's article in the September 2016 issue of *CBT Today*, asking service users about racism has never occurred to me as I'm often too preoccupied with the above issues. However, I don't have to look far to find an answer - services themselves are discriminating against the very people they should be serving! BME work should be everybody's business, not only those who are BME therapists.

To this day, I do not think I have asked any service user, whether from the White British or BME community about any incidents of racism they have experienced, and I certainly haven't shared any of my personal experiences. Moving forward, now that Andrew has highlighted this, and given the rise in hate crime, I think it is only appropriate to start asking our service users about their experience of racism.

It would be interesting to hear from other clinicians about the challenges they experience of working with BME service users.

For more information on the work of the SIG, or to join, please email equality-sig@babcp.com You can follow Saiqa on Twitter at @saiqa_naz



When I trained as a CBT therapist, we received no more than two hours of training of the importance of working with diversity.



What is Schema Therapy?

Originally developed by Dr Jeffrey Young, founder of the Cognitive Therapy Centers of New York and Connecticut, Schema Therapy (ST) is one of the third-wave cognitive behavioural psychotherapies. **Susan Simpson**, a clinical psychologist at NHS Lothian, looks at the current evidence and applications behind it.



Schema therapy is particularly useful for those clients who become 'stuck' in traditional CBT.



The ST model systematically and coherently integrates theory and techniques from a range of therapeutic approaches, including CBT, psychodynamic, object-relations, person-centred and gestalt. It draws heavily on research from attachment theory and developmental psychology. The ST model has expanded on CBT by elaborating the concepts of schemas and modes. Early Maladaptive Schemas (EMS) refer to patterns or pervasive themes of internal experience, and include beliefs, emotions, memories, and sensations that drive self-defeating behaviours. It is proposed that EMS develop through the interaction between a person's temperament and their early environment.

When emotional needs are persistently unmet during childhood, this naturally shapes the child's view of themselves and their relationships with others. Coping mechanisms (modes) develop as an adaptation to those circumstances during childhood, but become dysfunctional in adulthood, as they perpetuate the EMS and prevent the person from getting their needs met in healthy ways.

The Schema Mode Model is the most recent development to the model and is generally used with those who have more complex presentations, and more than 5-6 EMS. Schema modes are the moment-to-moment emotional states, coping responses and healthy behaviours that are currently active for an individual. Modes are activated by life events linked in some way to experiences in childhood or adolescence, to which we are overly sensitive (our emotional buttons).

A wide range of techniques are used to address cognitions, emotions and behaviours in the here-and-now, both in therapy and current relationships. The goal of therapy is to help clients develop self-compassion and resilience through strengthening their 'Healthy Adult' mode, whilst weakening coping modes that drive dysfunctional behaviours (e.g. Detached Protector).

Why Schema Therapy?

A significant proportion of clients who seek help suffer from characterological disorders which interfere with the application and effectiveness of traditional CBT. Those with rigid characterological difficulties have more rigid cognitions and behaviours, tend to experience difficulties identifying thoughts and emotions, and often do not follow through with traditional CBT techniques

(e.g., thought records, homework assignments). In addition, there is a more substantial gap between cognitive & emotional change for this client group.

In ST, techniques are employed to enable clients to move beyond intellectual change (e.g. "I understand that I am not worthless, but I still feel worthless"), in order to experience a shift at a deeper 'core' level.

What are the components of Schema Therapy?

ST has four main components: cognitive, behavioural, interpersonal and experiential.

Cognitive techniques are directed at shifting core beliefs through a range of structured exercises such as Reviewing the Evidence, flashcards and schema diaries. Clients are encouraged to track schemas and modes in their daily life, and challenge them through accessing their Healthy Adult mode.

The therapeutic relationship is a key mechanism for change in the ST model, whereby clients are encouraged to increase awareness of their emotional needs and reduce coping behaviours to enable them to get these needs met. Transference and countertransference reactions are utilized as a compass to help identify and address coping modes within the therapeutic setting. Experiential techniques, including imagery rescripting and chair work are used to challenge EMS at an emotional and felt-sense level, through externalising self-destructive messages learned from past experiences, and internalising new corrective emotional experiences.

There is a heavy emphasis on behavioural change work in ST, whereby techniques such as role-play and empathic confrontation are used to help clients reduce avoidance and other maladaptive coping mechanisms, and increase healthy coping. Without changing coping responses, the underlying EMS will continue to be reinforced and perpetuated.

Who is it suitable for?

ST was originally developed for those with personality disorders (PD) and other chronic, treatment-resistant disorders. However, it has recently become more widely used for a range of psychological difficulties, including chronic depression, chronic and complex anxiety disorders,

eating disorders, ruminative disorders, substance misuse and alcohol dependence and forensic populations. In addition, the ST model is increasingly being developed and utilized with children, families, and couples therapy.

ST is particularly useful for those clients who become 'stuck' in traditional CBT. Although cognitions may have shifted at an intellectual level, their problems may remain entrenched and ego-syntonic. ST employs a range of powerful techniques that challenge their EMS in order to facilitate cognitive and emotional change.

What is the evidence-base?

A seminal randomised controlled trial (RCT) by Giesen-Bloo et al. (2006) found ST was more effective than transference-focused psychotherapy

for Borderline PD across a range of measures, including Borderline PD-specific and general psychopathologic dysfunction, and quality of life. Attrition rates were significantly lower in the ST condition. These results were replicated in a RCT implementation study that compared ST with/without crisis support (Nadort et al., 2009). In addition, a RCT by Farrell, Shaw and Webber (2009) compared 30 sessions of group ST with Treatment-as-usual for borderline PD, and found that 94% of ST as compared to 16% of Treatment-as-usual no longer met diagnostic criteria for Borderline PD at end of treatment. In addition, ST has been found effective in a RCT with Cluster C and Narcissistic PDs (Bamelis et al., 2014).

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the therapeutic relationship is a key mechanism for change

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A summary of the most recent evidence is available at www.schematherapyscotland.com/evidence-base-for-schema-therapy/

BABCP Spring Conference

Cardiff Millennium Centre, 6 and 7 April 2017

(BABCP)

www.babcpconference.com



Extending the application of CBT

Full Day Workshops on 6 April

- **Worried Sick? Extending the application of the CBT from health anxiety to Medically Unexplained Symptoms (MUS) and Long Term Medical Conditions (LTC)**
Paul Salkovskis, University of Bath
- **Persistent physical symptoms: something old, new, borrowed and blue**
Trudie Chalder, King's College London
- **Truly Functional Contextual Applications of Psychological Flexibility for Chronic Pain and Related Conditions: The Eyes, Ears, and Heart of ACT**
Lance McCracken, King's College London
- **What to do when the manual runs out? Using CBT when working long-term or with complexity with people with eating disorders**
Vicki Mountford, King's College London

Conference day on 7 April includes Keynote Addresses from

- **David Clark, University of Oxford**
Thrive: How better psychological therapy provision transforms lives and saves money
- **Paul Salkovskis, University of Bath**
Empirically grounded strategies for improving mental health in the context of general medical presentations
- **Trudie Chalder, King's College London**
Persistent physical symptoms: something old, new, borrowed and blue

For more information and to register for a Workshop or the Conference go to www.babcpconference.com

BABCP: Special interest group versus profession

BABCP President **Chris Williams** and Honorary Secretary **Kate Davidson** write exclusively for members about why BABCP cannot act as a professional regulator

The BABCP has always been a multi-disciplinary interest group for people involved in the practice and theory of behavioural and cognitive psychotherapy. Its main aims are to promote the development of the theory and practice of behavioural and cognitive psychotherapies in all applicable settings in accordance with our Standards of Conduct Performance and Ethics. Members include mental health practitioners, social workers, teachers, interested members of the public and others.

Who are members of BABCP and who regulates these members?

BABCP currently has more than 10,000 members. The majority have a core profession such as nursing, social work, medicine and clinical psychology or counselling psychology. These individuals are regulated by one of the statutory regulatory bodies. For example, those with a nursing profession are regulated by the Nursing and Midwifery Council (NMC), the General Medical Council (GMC) for medicine and Health and Care Professions Council (HCPC) for psychology, occupational therapy and some others. Statutory Regulation is a legal process requiring professionals to abide by nationally agreed standards in order to use a protected title, such as nurse, clinical psychologist, health psychologist, doctor or music therapist.

The terms 'Psychotherapist' and 'counsellor' are not protected titles and are unregulated by law. Likewise 'cognitive behavioural therapist' and 'cognitive therapist' are not protected titles. This means there is no restriction on use, and therefore anyone could call themselves a CBT therapist in adverts or on a brass plate on their door. There is no regulator for those without a regulated core profession.

What is a health and social care regulator?

Regulatory bodies such as the HCPC are set up under the authority of Parliament to protect the public. There are currently nine health and social care regulators, including the Health and Care Professions Council, the General Medical Council and the Nursing and Midwifery Council. The Professional Standards Authority regulates the regulators.

Regulators set out standards of conduct, performance and ethics that guide clinical practice. Regulators describe the behaviour that is required of registrants. The function of the regulator is also to keep a register of health professionals who meet their standards and who have been trained by educational programmes that are approved by them. The regulator will take action against practitioners who fail to meet the regulator's standards.

Figure 1: Differences between Regulatory bodies, professional bodies and BABCP

Regulator	Professional Bodies	BABCP
Examples of regulators: General Medical Council (GMC) Nursing and Midwifery Council (NMC) Health and Care Professions Council (HCPC) General Dental Council (GDC)	Examples of Professional bodies: British Psychological Society, British Medical Association, Royal College of Nursing, British Association of Occupational therapists.	Interest group Membership association
Public protection	Promotes interest of one profession	Interest group for those involved in practice & theory of one type of psychotherapy (CBT)
Sets mandatory standards	Facilitates members to meet standards e.g. CPD	Facilitates members to meet standards in training for CBT
Has power to hold registrants to account	Can expel members from being a member of professional body (but has no legal power to stop member from practicing)	Can expel members from being a member of organisation (but has no legal power to stop member from practicing)
Has legal powers	Has no legal powers	Has no legal powers

In the past some professional organisations operated voluntary registration schemes in an effort to protect the public. This role has now passed to the statutory regulator for many organisations. However many healthcare professionals, as well as paying fees to a regulator, also belong to professional bodies who support and develop their practice. In addition, some bodies such as BABCP, UKCP and BACP maintain their own voluntary registers to list people they define as appropriately trained practitioners, and have also separately run their own complaints procedures.

Accreditation provides an important service to employers and the public. However, there needs to be a discussion about whether it is appropriate for BABCP - like UKCP - to continue to offer a formal complaints system. To justify this, any system would need to be done well, in a timely fashion, and not mislead the public or employers in what it can and cannot achieve and what powers it has over individuals to determine who practices.

In contrast to BABCP and UKCP, statutory regulators have legal powers that associations like ours do not have. For example, when investigating a complaint, regulators such as the HCPC has legal power, due to the Health and Social Work Professions Order 2001, to demand information and can require individuals or organisations to supply information or produce documents. It also has the power to override the provisions of the Data Protection Act. They can require witnesses to attend a hearing or produce documents. Such regulation of professionals is expensive. For example, the HCPC has a budget of approximately £6 million per year. This allows it to regulate effectively – as effective regulation is an expensive business.

This is in contrast to a non-statutory organisation - like BABCP - that has no statutory powers of investigation, and limited funding to regulate, the process often being co-ordinated by an office that is at times over-stretched and working often using volunteers whose time is again limited and not fully focused on the complaints process leading to delay. BABCP is not a statutory health and social care regulator and it is our concern it does not have the money, time or resource to adequately deliver this function. As such, we question the benefits of continuing a wide ranging complaints process, rather than a smaller scale process focused on membership and accreditation alone.

Figure 1 describes some of the main differences between regulatory bodies, professional bodies and associations such as BABCP.

Why is BABCP not a professional body?

A professional body is profession specific and acts on behalf of the professional

interests of their members. BABCP is not a professional body and is a special interest group for people interested in CBT. In the same way that the British Medical Association (BMA) as the trade union representing doctors would not be an appropriate regulator, as a special interest group it is also inappropriate for BABCP to take on regulatory activities.

BABCP is a multi-disciplinary interest group for people involved in the practice and theory of behavioural and cognitive psychotherapy. BABCP sets high standards of training and has an accreditation process. This may give the appearance of CBT therapists having a profession but this is not recognised by any of the regulators as a core profession. Instead, it represents a strong statement of training, a commitment to supervision and CPD.

What does BABCP accreditation mean?

Accreditation is a valuable label that provides assurance about training in CBT to the public and employers. Accreditation means that the practitioner has submitted evidence that they have attended and reached a level of proficiency in core CBT training, and subsequently have committed themselves to Maintaining Quality and Standards of Practice through a commitment to CPD and appropriate clinical supervision.

It does not in itself guarantee patient safety, nor does it provide any professional standing, but it is still a valued and important statement of training and a commitment to keep updated. BABCP accreditation stops short of statutory registration.

continued overleaf

“ Accreditation is a valuable label that provides assurance about training in CBT to the public and employers. ”



EMDR Therapy

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If a CBT therapist or other practitioner is not regulated, are they free to practice as they wish?

All BABCP members who belong to a core profession are regulated by that profession (e.g. medicine, nursing etc.). Some BABCP members practice as CBT therapists but do not have a core profession - typically they are either members only, or may be accredited members. BABCP members are not free to practice as they wish. As a member they have committed themselves to BABCP's Maintaining Quality and Standards of Practice.

Can the BABCP complaints procedure protect the public?

Our complaints procedure should in our view be focused on addressing whether a member can continue as a member or as an accredited member. We have no statutory power to prevent them practicing. BABCP's *raison d'être* is not to provide protection to the public; but rather to be a multi-disciplinary interest group for people involved in the practice and theory of behavioural and cognitive psychotherapy.

Why can BABCP not act like a regulator, particularly for those without a core profession?

This is a legal matter. BABCP does not have the power in law to regulate its members by providing, for example, legally enforceable suspension, censure or prohibition from acting in the chosen profession. Similarly, we cannot also legally force a member to attend or provide evidence in response to a complaint. BABCP cannot determine who calls themselves a CBT therapist as this is not a protected title in law.

There may be other external bodies that act to regulate in some way. So, for example workers employed by the NHS or other employer are also subject to governance and disciplinary/complaints processes through their employer.

Our options as an organisation

BABCP has various options regarding complaints:

1) Withdraw completely from any complaints. However organisations such as BABCP do need to retain the ability to control who is, and who is not a member, and additionally, to withdraw accreditation if necessary.

- 2) Put significant time, staff and money into developing a process to match HCPC or other statutory regulators – but without the key powers to do this well. The latter would require a law to be passed.
- 3) Leave as is.
- 4) Modify and clarify our processes so they are fit for purpose, and we are clear about the purpose and processes being used, and deliver it consistently and well.

How we think our complaints process should be delivered

BABCP's lawyers recommend we do not aim to act as a regulator as firstly, we are not a professional body, and secondly we have no statutory power to take on this role. Also from an organisational point of view, to fund a parallel full system would be very expensive with significant new resources (and increased membership fees) required to do the job. And even then with the weaknesses already identified.

However, we do need to have a simpler process to address membership and accreditation complaints about our members.

We therefore have argued we focus our response for clinical practice in the following way:

- If the member has a core profession we ask the complainant to complain to the member's professional regulator and do not accept the complaint ourselves.
- If they have no core profession but have an employer we will ask the complainant to pass the complaint to the employer (e.g. the NHS, Social Service etc.). Again we would not accept the complaint ourselves.
- This still leaves a significant group – those who are accredited but have no employer or a core profession. Typically such workers are independent (private) practitioners – an important and valued membership group in BABCP.

BABCP already has a long-standing policy to lobby for the regulation of psychotherapy so that this important group of practitioners is effectively regulated by statutory regulation. However, little has been done by BABCP in terms of such lobbying. We will look again at this at an upcoming Board meeting, but advocating that psychotherapy and

counselling are taken into HCPC seems logical and compelling from the perspective of protecting the public.

In the meantime our lawyers suggest that we require such practitioners to adopt a complaints process which they provide for their clients to address clinical complaints should they wish to remain members of BABCP. We believe our accredited members should also be required to hold professional liability insurance.

Finally, we will still need to maintain an internal process to address issues concerning membership and accreditation. We have the right as an organisation to set rules to decide who is a member and who is accredited. This will act on the outcomes of these externally completed investigations, as well as responding to inaccurate or misleading membership or accreditation applications, and acting on the results of audit as part of the MPSQ.

BABCP should follow the conclusions of a regulator's investigation of a complaint about a practitioner

Once the primary regulator (like HCPC, GMC or NMC) has considered the matter and reached a conclusion, then BABCP will take this into account and act on this decision in its own consideration of the complaint. If the regulator exonerates our member, the Conduct Committee may still consider whether the member has breached the BABCP Standards of Conduct, Performance and Ethics. If the regulator sanctions or expels our member, this will be taken into account in determining whether the member should also be sanctioned or expelled by the Association.

Next steps

The Board is a number of months into a process of working with the existing complaints committee to revise and update our regulations. This may lead to the need for changes to our articles of association, in which case the changes will be brought to the AGM in 2017.

The views in this article are those of the authors and do not necessarily reflect the views of the Board.

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

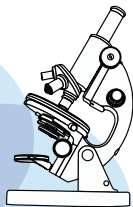
A. There are so many reasons for this! I think it was following some volunteer work in a mental health hospital, seeing the amazing patients and staff there influenced my decision to switch career paths. We can all suffer from poor mental health and seeing those patients as well as some of my close friends and family go through really difficult times I felt I wanted to understand more and be able to help them.



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

A. That it continues to grow in strength but that there is investment in other Talking Therapies so evidence base can be supported to grow for other modalities. I think we are facing tough times with talking therapy services and we need to work more in collaboration with external agencies and secondary care to provide a more robust service to all our clients and prevent people being lost who don't fit OUR remit.

Q. What other job might you have done?



A. Forensic science and analytical chemistry was my under-grad – I would like to think I was going to be Columbo. Realistically I would have worked in a laboratory and on reflection I'm more suited to working with people than DNA samples.

BABCP and me

Taryn Whitley
is a Cognitive
Behavioural Therapist
and Step 3b Lead at
Talking Matters
Northumberland

Q. And fears?

A. Oops I started to answer this already so I'll continue. My fear is that all services and therefore therapy services are put under continued pressure and which may mean therapy is diluted through demand/ priorities and therefore is no longer evidenced based.

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

A. I'm sure I should say lots of fancy and impressive people current and historical but really I would like nothing more than five of my closest friends.

Q. When did you join BABCP and why?

A. Following my CBT course, I think I initially joined as I felt I had to but there is so much more to it that I'm now sure I would never not be involved.

Q. Who is your biggest hero?

A. Columbo - obviously!



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

A. Stay curious, invest in your future and your modality and join the BABCP. I would also say prioritise how you are going to maintain self-care and resilience. For me this vocation is very rewarding but also harrowing at times and we need to protect ourselves to help others.

Q. What has been your best working moment?

A. There are so many otherwise we couldn't do the job we do but recently it was working with a client who had given up on himself to see him start to value himself again. I was so humbled by all he had been through and the strength he had developed.

Q. How would you like to be remembered?

A. As someone who cared.



London Branch & DBT SIG
presents



Using DBT to treat young people with suicidal and self-harming behaviours

with Dr Michaela Swales

Friday 31 March 2017
London



Registration fees

BABCP members: £95 Non-members: £130 AREBT members: £95

London Branch
presents



Functional Imagery Training

with Jackie Andrade and David Kavanagh

Thursday 16 March 2017
London

Registration fees

BABCP members: £95
Non-members: £130
AREBT members: £95



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

Medics SIG
presents



Medics SIG Conference

Friday 17 March 2017
Leeds

Registration fees

BABCP members: £60 Non-members: £70 Students: £50*

*Evidence of student status must be provided with application



South East Branch
presents



CBT and the treatment of compulsive sexual behaviour

with Dr Thaddeus Birchard

Friday 12 May 2017

Using behavioural experiments in cognitive therapy

with Dr Nick Grey

Friday 7 July 2017
Both events are in Sevenoaks

Registration fees (per event)

BABCP members: £65 Non-members: £75

Supervision Training - Cinderella no more!

Linda Bean provides readers with an update on the Supervision SIG's work and plans for the new year

We all know how important effective and ethical supervision is to our professional development. Whether it is for a trainee needing instruction on what to do next when working with patients for the first time, a newly qualified therapist taking the first steps towards independent practice or an experienced clinician feeling burnt out.

A good supervisor can challenge us, develop our skills, knowledge and understanding, help us negotiate the local, national and global context we work in and provide vital restorative functions.

It is then perhaps surprising how little training has been available on the topic of supervision compared to other areas of CBT practice. Nonetheless, interest in supervision and training has been growing.

The Supervision Special Interest Group was set up in 2014 by a group of members with a special interest in Supervision in order to meet this challenge. We now have more than 150 members, with our committee of six chaired by Emma Scott. We are now running specialist supervision focused training regularly across the year. In the past year our training programme has included clinicians and researchers of international standing, such as Michael Townend and Stirling Moorey, and feedback from participants has been consistently outstanding. We are also working with BABCP to improve the accreditation process for supervisors and ran a session at the Belfast conference to improve understanding of how to get accredited under the current system. We are keen to hear your views about the process of accreditation, so please do get in touch.

Increasing Access

In addition, we have plans to improve access for people with disabilities to our training and to this end we are working with disability organisations to find a suitable template for venue access information that can be included in publicity materials. We plan to share this with other SIGs once we have an effective working model.

We have also submitted a proposal to BABCP to ask that they explore the feasibility of recording training via Video on Demand or Webinar in order to make more training available at a lower cost to a wider range of clinicians. We envisage that this would have additional benefits as it would make training more accessible to those in remote areas, people with caring responsibilities who cannot travel far from home and people with disabilities.

Call for members

As you can see we are small group running training across the UK. We would like to co-opt two new members from the Northern, Central and Western areas of the UK to fill the roles of Treasurer and Ordinary Member to help us set up and run training. Currently we have members located in London, Devon, Newcastle upon Tyne and Scotland.

We have monthly to bi-monthly meetings via Skype so location is no barrier.

Would you be interested in joining us? We are a friendly and welcoming group and you will quickly become part of things. I can vouch for that as I only joined a few months ago! I am also disabled and have found the committee thoughtful and accommodating.

Creating a peer network

Obtain advice, support and information or share your views by emailing us at supervision-sig@babcp.com

Keep up to date with relevant training, research and good practice by following us on Twitter @BABCP - don't forget to tweet us interesting stuff too!

Meet us at Conference, attend a training course, join our mailing list or apply to join the Committee. We hope to work with you soon.

The New Year promises further interesting and thought-provoking workshops:

Training Programme 2017

Ethnicity and Gender in Supervision, in conjunction with the Equality & Culture SIG (Presented by Andrew Beck), date TBC - London

Using the Assessment of Core CBT skills (ACCS) for Feedback and Reflection in Supervision (Presented by Sarah Rakovshik and Helen Muse), date TBC - Oxford

Enactive Supervision: Using Video and Role Play (Presented by Mark Latham in conjunction with the Glasgow Branch), date TBC - Glasgow

For the latest information on Supervision SIG events, go to www.babcp.com/Membership/SIG/Supervision.aspx

Southern Branch
presents



CBT for older adults

with Professor Ken Laidlaw

Friday 19 May 2017
Southampton

Registration fees

Early Bird (up to 17 March)
BABCP members £75 Non-members £85 Students £55*
Full fee
BABCP members £90 Non-members £100 Students £70*

*Evidence of student status must be provided on application

CBASP SIG
presents



Three-day intensive training in Cognitive-Behavioural Analysis System of Psychotherapy (CBASP)

with John Swan, Marianne Liebmg-Wilson and Bob MacVicar

Wednesday 17 to Friday 19 May 2017
Dundee

Registration fees
BABCP members: £280
Non-members: £300



Couples SIG
presents



Treating Couples with Infertility

Thursday 8 June 2017

Emotion Focused Interventions for CBT with Couples

Friday 9 June 2017

with Misa Yamanaka
London

Registration fees (per day)
BABCP members: £95 Non-members: £110



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

Chester, Wirral & North East Wales Branch
presents



Delivering Group CBT

with Michael Scott

Friday 10 March 2017
Chester

Registration fees
BABCP members: £65
Non-members: £70



Devon & Cornwall Branch
presents



Trauma-Focused Cognitive Therapy for complex PTSD

with Dr Nick Grey

Thursday 1 June 2017
Buckfast Abbey

Registration fees
Early bird (up to 24 March)
BABCP members: £60 Non-members: £70
Full fee (from 25 March)
BABCP members: £80 Non-members: £90



A Quality Framework for Supervision of CBT with children, young people and families

Quality in supervision is a key factor in provision of quality therapy, therapist skills progression and workforce development. Despite CBT being a key evidence-based intervention for core presentations to child and adolescent mental health services, it remains the case that many therapists offering CBT within mental health services for young people still have difficulties accessing appropriate supervision. Furthermore, where such supervision is available, service structures or requirements can at times also constrain best practice.

We at the Children, Adolescents and Families Special Interest Group (CAFSIG) aim to promote quality therapeutic practice, supervision and research into CBT with children, young people and families and so would ask BABCP members to support us in compiling a best practice statement for supervision of CBT with children, young people and families that will support supervisors, therapists and service managers enhance quality of CBT

supervision and therapy with young people, therapist development and ultimately workforce development.

We propose a framework of four interacting domains, or levels, that influence quality of supervision and its transmission into quality in therapeutic practice, positive outcomes for young people and therapist skills and development.

- 1 Contextual domain: (National and local e.g. service context, organisational arrangements, national guidelines, etc)
- 2 Supervision of supervision level: (What processes or practical arrangements are most helpful, what contracting arrangements, evaluation, documentation, etc)
- 3 Supervision level (What models are helpful, what sessional process, contracting arrangements, evaluation, documentation, etc)

4 Therapy level (What models are helpful, what process, contracting arrangements, evaluation e.g. ROMs or specific symptom or behavioural measures, documentation, etc)

We would therefore be interested to hear from anyone working therapeutically with young people, or supervising those that do, about the things that have been most helpful in supervision you either provide or receive to support CBT with children, young people and families.

For example, there have been some very useful developments in outcome monitoring and service transformation. How for example have these factors affected quality of supervision and what insights can be usefully be integrated? What models of supervision do you use, what session structure, contracts, etc?

You can email the CAFSIG lead for supervision, Nicky Dummett at nicola.dummett@nhs.net

What is the future for CBT and technology?

Sarah Bateup introduces what will become a regular look in *CBT Today* at the use of technology in the delivery of CBT.

cCBT, iCBT, eCBT, IECBT, eMental health, apps, Big White Wall, Silvercloud, Ieso Digital Health, MoodGym, Fearfighter, Skype, Buddy, Sleepio, avatars, virtual reality exposure, video, electronic cue cards, tape-to-tape CTS-R feedback, and so on.

It is little wonder with such a myriad of terms, definitions and products that many of us remain a little confused about the use of technology in CBT. However, there is little doubt that the future of CBT will involve using technology in a number of ways in order to offer choice and widen access to evidence-based interventions.

As emerging health policy supports the use of technology to bridge the gap in provision of evidenced-based psychological interventions, such as CBT, there is a growing need to investigate and understand the efficacy, mediators and moderators of online interventions.

As a therapist, supervisor and lecturer I have developed a special interest in technology and CBT. My interest grew

from excitedly observing how technology can be used to support CBT trainees to develop clinical skills both in the classroom and through self-directed learning. I quickly became interested in how technology might be used to enhance face-to-face sessions for my own patients and for my supervisees. More recently I have been drawn to understanding how CBT can be fully delivered online and how this method also enables therapists to reflect 'in action' and improves their clinical skills.

The future?

Whilst I do not believe that online CBT is a panacea and that it will replace face-to-face CBT, I do feel that technology has a great deal to offer. Whether we choose to incorporate technology into our face-to-face sessions, as a tool to facilitate learning, helping a patient make an informed choice about how to access CBT or working as an online therapist, technology can be used to assist us in the important work we do.

In my experience, one of the barriers to adopting technological interventions is lack of knowledge or experience in how to use new methods or a lack of confidence in what works.

In order to address the increasing requirement to understand the use of technologies, a Special Interest Group (SIG) was set up to enable BABCP members to access specialised training and knowledge about this emerging field. The SIG brings together those with expertise in this area and those with an interest in learning and sharing skills with the aim of creating a vibrant environment in which we can all learn together.

If you want to learn more about the IT SIG we will be at the Annual Conference in July. Please come and meet us to learn more about our first CPD event which will be held in London this autumn.

You can contact the IT SIG by emailing it-sig@babcp.com

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Ieso Digital Health is the UK's leading provider of online CBT, and is commissioned on behalf of the NHS to deliver CBT to patients with depression and anxiety disorders.

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Schema Therapy Scotland is a specialist provider of workshops, consultation & certification throughout Scotland & north of England.

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- Edinburgh: February 23-25th
- Newcastle: April 27-29th
- Manchester: Oct 19-21st
- Edinburgh: 16-18th Nov
- Bali 26-28th June

Workshop 2: Beyond the Basics

- Edinburgh: Oct 5th, 6th, 7th

Specialist workshops...

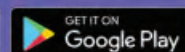
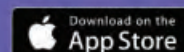
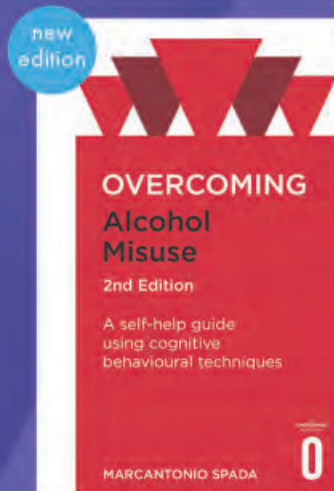
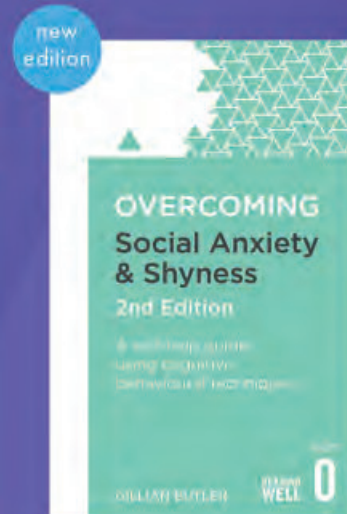
- 'Schema Therapy for Complex Eating Disorders'
- 'Therapists' own Schemas: Preventing Burnout'

O

New publications from **OVERCOMING**

For over 20 years, the *Overcoming* series has provided essential CBT self-help guides for mental health conditions. These thoroughly revised new editions come with a contemporary new look for 2017 and are now supported by a CBT homework app that allows users to log their problem thoughts, emotions and behaviours on their mobile device.

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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.

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 Isbun.*

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 choosing to have close supervision of a session and evaluation of a case report will fulfil the requirement for BABCP accreditation outstanding after successful completion of the PG Diploma.

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

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