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CBT today

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Official magazine of the British Association for Behavioural & Cognitive Psychotherapies

Exclusive

All together now

Meet the National Lead for Psychological Professions at NHS England, **Adrian Whittington**

Also in this issue:

Reducing isolation in private practice

Rethinking therapist drift

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Welcome to the first issue of 2020. We've been busy gathering a great range of content, including an exclusive chat with the National Lead for Psychological Professions at NHS England, Adrian Whittington.

We've been able to announce more about our forthcoming Spring Conference, with details available on page 15, along with other news from around the organisation and beyond.

As always, thank you to all our contributors. If you are interested in writing for CBT Today, please do get in touch. We are especially keen to hear from anyone who has worked with the excellent IAPT BAME Service User Positive Practice Guide which was launched last year.

Peter

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In this issue

Also in this issue

Out-of-area rehabilitation placements

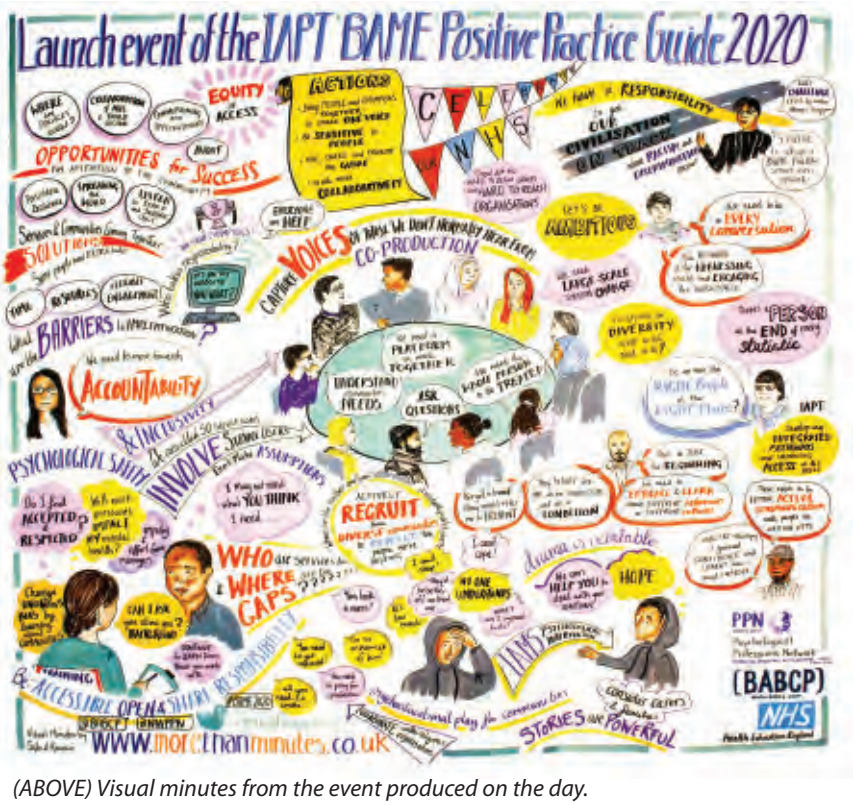
A draft NICE guideline on the rehabilitation of adults with complex psychosis and related mental health conditions says they should have access to rehabilitation services in their local area and the use of out-of-area placements limited.The draft guideline, published in December 2019, says those commissioning services should aim to place people locally and limit the use of out-of-area placements wherever possible, except for people with particularly complex needs.

And commissioners should only provide an out-of-area placement after a local placement funding panel has confirmed that the person's care cannot be provided locally.

The draft guideline recommends that when people are placed in out-of-area rehabilitation services, they (and their family or carers) should be told the reasons for this, what steps will be taken to return them to their local area, what support will be provided to help them keep in contact with their family or carers, and the advocacy support available to them.

Paul Chrisp, director of NICE's centre for guidelines, said: "Reducing out-of-area placements will result in more people receiving rehabilitation closer to home, which would improve their quality of life as well as reduce costs to the NHS.

"Evidence suggests that people placed in out-of-area inpatient rehabilitation units have a longer average stay than those placed in rehabilitation facilities closer to their homes. It also suggests that receiving rehabilitation locally makes it easier for people to maintain contact with their families, communities and local support networks or activities, such as peer support groups. This can lead to an earlier discharge when they are well enough to be move back home or live with family or friends."



(ABOVE) Visual minutes from the event produced on the day.

IAPT BAME Positive Practice Guide

The Guide – launched in 2019 – was celebrated recently in Manchester, with delegates from across the country meeting to consider how it can be taken forward in IAPT services.

Held in collaboration with the North West Psychological Professions Network and the BABCP Equality & Culture Special Interest Group, the event heard from leaders at Health Education England and NHS England, as well as moving accounts from BAME service users.

If you have used the Guide in your service, we would love to hear about it. Email editorial@babcp.com with how you are using it and tell *CBT Today* readers how it has helped your service develop.

Support needed for new Special Interest Group – Higher Education SIG

Student mental health has been an area of increasing concern over recent years. The number of students declaring a pre-existing mental health condition has doubled since 2014/15, leading to a demand on university services. Whilst the need for counselling remains, universities are now expanding to include a range of other professionals such as CBT therapists and wellbeing practitioners to manage this increase in need.

Working clinically with a student population presents a unique challenge and opportunity for therapists with work often focusing on transitions, loss and anxiety in a very fragile and developing time for many students. Therapists often find they need to work in a more flexible way whilst often also being challenged by the time boundaries due to capacity issues.

I am therefore proposing a BABCP Special Interest Group for members working in Higher Education environments to support each other via peer support, specific CPD, shared research and online discussions.

If you are interested in being involved in this group please contact Toby Chelms at T.Chelms@leedstrinity.ac.uk

Country's top mental health nurse warns of

'Under the radar' gambling

NHS mental health director Claire Murdoch recently called on gaming companies to crack down on gambling addiction risks by banning loot boxes from their products.

Ms Murdoch has warned video game firms that they risk "setting kids up for addiction" by building gambling tasks into their games.

In response to growing concerns about addiction to gaming, the NHS has confirmed the opening of a new treatment centre, alongside up to 14 new NHS gambling clinics nationwide, to address significant mental ill health linked to addiction.

The investment is part of the NHS Long Term Plan to improve mental health, backed by at least £2.3 billion extra funding within the next five years, helping hundreds of thousands more children and adults to get timely, expert care.

Concerns have been raised about children playing video games which involve spending significant amounts of money - often without parents' knowledge or consent - on so-called 'loot boxes', which are virtual collections of in-game purchases and other add-ons.

Investigations have found numerous cases of children spending money without their parents' knowledge, including a 16-year-old paying £2,000 on a basketball game and a 15-year-old losing £1,000 in a shooting game.

A report by the Royal Society of Public Health in December found that over half of young people believe that playing a video game could lead to gambling and that the link between gaming and gambling is a negative one.

Ms Murdoch said: "Frankly no company should be setting kids up for addiction by teaching them to gamble on the content of these loot boxes. No firm should sell to children loot box games with this element of chance, so yes those sales should end.

"Young people's health is at stake, and although the NHS is stepping up with these new, innovative services available to families through our Long Term Plan, we cannot do this alone, so other parts of society must do what they can to limit risks and safeguard children's wellbeing."

Ms Murdoch has called on gaming companies to:

- Ban sales of games with loot boxes that encourage children to gamble
- Introduce fair and realistic spending limits to prevent people from spending thousands in games
- Make clear to users what percentage chance they have of obtaining the items they want before they purchase loot boxes
- Support parents by increasing their awareness on the risks of in-game spending

Once referred to one of the new NHS specialist clinics, psychiatrists and clinical psychologists will work with patients who could have a range of complex problems including persistent gambling, compulsive behaviours, development disorders and difficulties earlier in childhood that underlie addiction.

Let's talk about CBT

Keep a look out for the latest podcasts which (at the time of going to press) were due to be released in early February. CBT for Self Harm and CBT for Clinical Perfectionism should be available by the time you read this issue.

You can find all our podcasts at http://letstalkaboutcbt.libsyn.com/

Open call for a special edition of *the Cognitive Behaviour Therapist (tCBT)*

TRIP: Transforming Research In Practice

(Edited by Gary Brown & Jaime Delgadillo)

CBT has always been grounded in research. The treatment methods we use every day have been developed and fine-tuned through research. The evidence base supporting these treatments has also been developed through research trials. More than for any other form of psychotherapy, research is essential to the ongoing development of CBT.

Whilst some BABCP members will take part in research during their career, whether leading research projects or collecting data, many will not. All CBT practitioners however would ideally be informed by research and one of the key aims of a practitioner journal such as *tCBT* is to bridge the gap between research and clinical practice, and produce papers that support clinicians on a day-to-day basis to remain up-to-date with the evolving evidence base and apply it to their routine work.

Since taking over as Editor-in-Chief of *tCBT*, many therapists have contacted me who are extremely keen to enhance their knowledge and understanding of current research methods used in CBT. BABCP now has a much wider membership than previously and many members have trained as Psychological Wellbeing Practitioners or CBT therapists without necessarily having a research background or training in research methods.

The Guest Editors, Gary Brown and Jaime Delgadillo, and I are keen to rectify this and publish a series of papers that stimulate clinicians' interest in research and offer insights about the process of producing and applying practice-based evidence. To achieve this, this series of articles will focus on methods; including updates on research design, psychometrics, single case research and routine outcome monitoring using relevant CBT examples from a range of patient groups.

If you are keen to produce a paper that is in line with these aims, the submission process is as follows:

- Submit your paper online at https://mc.manuscriptcentral.com/cbt
- Address your cover letter to the guest editors: G Brown & J Delgadillo
- Deadline for submissions to this special issue: 1 July 2020
- Papers that fit the scope will be peer reviewed by at least two reviewers

If you are unsure if your paper would be within the remit of this Special Issue then we are happy for you to get in touch at cbt.editor@babcp.com and detail any proposed paper. Similarly if you are a CBT therapist and are aware of any particular areas that it would be useful to cover, we are also happy to hear suggestions from you.

Richard Thwaites – tCBT Editor-in-Chief
Gary Brown & Jaime Delgadillo - Guest Editors

A **critical time** for the Improving Access to Psychological Therapies programme

The IAPT programme has, according to its official website, "transformed the treatment of adult anxiety disorders and depression in England. IAPT is widely-recognised as the most ambitious programme of talking therapies in the world".

The truth of this is clear not only from the demonstrable results, but also from the international interest it has generated, with versions of IAPT now being implemented and considered in around 10 countries worldwide, writes BABCP president **Professor Paul Salkovskis.**

Recently, the reality has been called into question (mainly in social and broadcast media). We should not be surprised, given that the programme was almost unbelievably ambitious. I would suggest, however, that the biggest surprise lies in how successful it has actually been, and the extent and accessibility of the evidence supporting it. Interestingly, the detractors of the programme have selectively drawn from the publicly available reports and detailed databases as well as open access publications and matched these with a small number anecdotal reports and stories and some highly suspect surveys, along the lines of "I was pressured to falsify the data so all the data must be false". More of that later.

As a reminder, here are the principles underpinning IAPT services. Firstly, that evidence-based therapy should be delivered by fully-trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimise outcomes, according to the evidence base. Secondly, that outcomes are routinely monitored providing individualised feedback to clinician and service user and can be used in supervision and quality improvement work. This is the data which is anonymised and published per service to promote transparency in service performance. Thirdly, outcomes focused supervision is

> Those working in IAPT are magnificent and deserve our fullest support as they strive to extend and improve psychological help

built in on a regular basis so practitioners are supported to continuously improve and deliver high quality care. These principles are both difficult to achieve and, it transpires, highly effective. (For further information about the principles and evolution of IAPT, see Layard and Clark, 2014)

On 13 November 2019, BBC Radio 5 live, Radio 4 and other BBC outlets ran a feature on IAPT, which one commentator suggested would be "dark and dirty". As it happens, it wasn't. There were helpful explanations of how IAPT works and positive comments from Mind and ex-patients. However, a handful of anonymous therapists/ex-therapists from a non-NHS provider stated that they had encouraging some of their patients to complete outcome measures more positively than they felt.

As I said on the BBC that day, if true then this is both shameful and dishonest, amounting to malpractice. NHS England made a similar comment and stated that any therapist who feels pressured to behave this way should report the matter through NHS England's or their local CCG complains procedure. It is worth reiterating the importance of the IAPT manual, which provides clear guidance on the good practice that is required of therapists, managers and services. This makes it clear (a) what good practice should look like at individual and service level and (b) what action can and should be taken for abuses of the type the critics of IAPT seek to highlight.

I also said what many of us believe about IAPT services, which is that they start with what it says on the tin (they have and are improving access to the range of evidence-based treatments), and goes way beyond in terms of ensuring that those with common mental health problems receive effective help which is appropriately monitored and refined. My view? Those working in IAPT are magnificent and deserve our fullest support as they strive to extend and improve psychological help and recognise where their limitations are. IAPT services can and do "step up" more complex problems to other NHS mental health services.

Lets briefly consider this. Improving access to psychological therapies has had the effect of putting those who would never have been able to access help, and appropriately raising their expectations of receiving such help. This of course has the effect of putting additional strain on secondary and tertiary care services for those not making a full recovery. Contrary to what some want us to believe, these services have not been shrunk (they have expanded) but they have been placed under increased pressure and we don't really know how they are doing. Why? Well, mostly they don't use routine outcome monitoring, and they don't report make outcomes publicly available. Consider the principles underpinning IAPT as set out above. These in my view should be bare minima for all MH services. And yes, it may well be embarrassing, but it would also be a stimulus for improvement.

It is so very easy to critique our NHS, our mental health services and IAPT. We need to place factors such as effectiveness, safety, accessibility and built in quality improvement front and centre. The efforts being made to make services not just accountable but also responsive should be built on. Services and individuals within them who fall short of acceptable and ethical behaviour can and should be called to account, rather than being used as a tool to undermine an extraordinary programme which is making a real difference and is on target to transform mental health care across England.

One further point, and for the BABCP and CBT this is probably the most important and exciting. The number of service users accessing IAPT in its developing form is headed towards 1.9 million people per year (NHS Long-Term Plan). We are now beginning to reap the benefits of this fantastic source of data; IAPT is not only drawing on evidence, but in a very real life way adding to it. For example, the Clark et al's (2018) Lancet paper analysing between service variation in outcomes has identified key organisational features of services that can greatly improve how much we help service users.

I am very fond of a Winston Churchill quote, which I often use with respect to our NHS, and consider applies here.

> 'No one pretends that democracy is perfect or all-wise. Indeed it has been said that democracy is the worst form of Government except for all those other forms that have been tried from time to time…'

Change **"democracy"** to **"IAPT"** and we have my view.

The IAPT website is available at https://www.england.nhs.uk/mental-health/adults/iapt/

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Adam May

2 June 1961, Bidford-on-Avon – 14 November 2019, Anglesey

First child of Sheila and Raymond May, Adam was educated in Huntingdon followed by a Master's degree in English and Psychology from Dundee University to which were later added several professional qualifications, included the Postgraduate Certificate in CBT Supervision awarded by the University of Liverpool. He worked in a number of areas primarily within the voluntary sector before undertaking further training and going into independent practice in 1989 in North Wales where he developed a thriving practice for more than 30 years.

His training and accreditation since 1998 was in CBT. His first course of study was in Rogerian Counselling, and after this his Diploma gave him a good grounding in all the major psychotherapy approaches. He was keen to keep his professional knowledge up-to-date and regularly attended courses and conferences.

In addition to practising as a psychotherapist Adam started A M Training in which his younger brother Robin joined him as a partner. For the best part of a decade they successfully delivered training courses to national voluntary organisations. They partnered with Volunteering England for several years, concentrating on developing and aiding the work of the volunteer manager. Amongst Adam's specialities were Diversity and Mental Health Awareness.

In 2009 when Dr David Baker founded the BABCP Independent Practitioners Special Interest Group (IPSIG), Adam was the first of 25 signatories to its formation. From that time on Adam supported David's chairmanship working tirelessly to help the IPSIG progress and to further his high standards for the care of those suffering with psychological difficulties. David retired as Chair five years ago and Adam took on that role leading the committee with skill, patience, and perseverance almost to the end of his life, so that the IPSIG became the largest single SIG within BABCP.

Tributes to Adam have been overwhelming both from colleagues and clients, many of whom were helped by Adam decades ago. Typical of the tributes was from a practitioner in one of the webinars Adam organised when she wrote: "We on the IPSIG pilot forum were all so saddened to hear about Adam. It is quite a shock, despite knowing about the initial cancer and I am saddened that I didn't get to say my goodbyes, so to speak. He was so helpful to me and to the group and his enthusiasm and kindness will never be forgotten". A further tribute is typical of what his colleagues thought of him and his work: "I also joined the IPSIG because of you, as I felt inspired by your work for the 'greater good' of independent practice ? and it made me want to be part of it. Your input into the IPSIG is priceless, and your relentless work towards it… made a huge contribution to developing the IPSIG into what it is today".

Adam's devoted partner for more than 20 years and husband, Rob, wrote, "Adam touched so many lives in many different ways, he was truly inspirational. He is a great loss, not only to myself, family, friends, clients, but others who knew him too. To the end he was always keen to develop whatever he was working on and still had much to give. Adam sadly died on 14 November 2019 having developed pleural effusion as a secondary to his original Metastatic carcinoma from three years ago. He was cared for throughout solely by myself at home as was his wish and it was my privilege to do so. Adam's genuine stoic learning, meant he was not frightened in sharing his cancer journey and as so he was held in high regard by many followers and they are looking to honour him by compiling some of his works in a special edition as testament to him".

David Baker

It was with great sadness that the North West Wales branch committee heard of Adam May's death. Adam was a founder member of our group when the branch came into being in 2005 and took an active role in organising and delivering branch events. Adam was a well-respected independent practitioner on Anglesey breaking new ground to offer people choice within the psychotherapy sector. He encouraged many trainee clinicians to develop CBT as their modality of practice, his clinic acting as a springboard for clinical skill acquisition and opportunity. He went on to play an instrumental role with the Independent Practitioners SIG and was a contributor to *CBT Today*.

He had a passion and a vision for good practice and was much respected by us all.

Julie Evans
on behalf of NW Wales branch

Therapist drift is said to occur when CBT therapists engage in behaviours which stray from the core aims of the approach [1]. Typically, this would include avoidance or minimal application of behavioural change methods such as exposure, writes ***Jason Roscoe.***

Rethinking therapist drift:

Incompetence or Ingenuity?

The therapist may fail to implement sufficient structure and the interaction may end up resembling a person-centred counselling session. It is proposed that the consequences of such actions lead to a watering down of the potential effectiveness of the therapy that the client receives.

We are told that CBT in randomised control trials (RCTs) should be replicated in natural settings such as IAPT services and private practice, however there are a number of known barriers to this. Client complexity is one such roadblock where co-morbidity is the rule rather than the exception. Furthermore, in contrast to RCTs where supervision is often weekly and delivered by experts, those on the front line are often only receiving the minimum BABCP requirement of 90 minutes per month, and from colleagues with similar levels of experience.

Is it such a surprise then that therapists drift from manualised, disorder specific treatment protocols in the face of such challenges? Previously, drift has only been considered as problematic and in some cases it will be, yet there might be some instances where drift is necessary or indeed beneficial. Using Generalised Anxiety Disorder (GAD) as a case in point, it is recognised in the literature that many clients with GAD have been exposed to adverse childhood experiences where they lacked stability. It is hardly surprising that they will struggle with uncertainty as adults, therefore rather than simply suggesting that they shop at Aldi rather than Lidl, time is needed to compassionately validate this.

Whilst the disorder specific protocols such as the Laval model [2] have without doubt assisted our understanding of key processes, it is often helpful for clients to tell their story – not in an unfocused way but as part of a formulation that is consistent with the core aims of CBT. Unfortunately, the current climate within CBT puts pressure on

clinicians to cut corners and to solely focus on the maintenance factors for the means of achieving a quick discharge from the service. A rigid application of CBT where only elements of the 'approved package' can be used, places therapists in a conceptual and technical straight-jacket.

It is unclear as to whether the inclusion of third wave interventions such as CFT or ACT into one's CBT treatment plan would constitute 'drift' by current definition but many clinicians are forbidden from doing so. In a straw poll that I carried out on this issue via social media 94 out of 109 respondents (86%) endorsed the statement *'I blend techniques from EMDR / CFT / ACT into CBT treatment'*. Although this is a small sample, it may well capture a national picture around the reality of CBT therapists' thinking and behaviour where clinicians are adapting their practice to meet the needs of the client in front of them.

With an ever-increasing IAPT workforce and the growing popularity of the third wave therapies in the last 10 years, perhaps a new era of integrative CBT is on the horizon. As a clinician I often find that incorporating methods from CFT and ACT enriches rather than waters down my work with clients and it does not lead to below average recovery rates. Many clients understand that their thoughts are irrational yet need to soften how they speak to themselves or make room for these 'stories of the mind'. It is by seeing the similarities between the cognitive-behavioural therapies that enables the therapist to be both adaptive and creative whilst maintaining fidelity to the core aims which is to be less controlled by one's thoughts and to behave in ways that lead to a fulfilling life.

As a trainer I often encounter anxious CBT therapists who cannot fit their client into one of the disorder specific protocols. They fear that applying ideas from CFT, ACT or even Schema Therapy is going 'off piste'. My advice is always *'What does this client ultimately need to learn about themselves and the world?'*. Once we know this, it is then *'What will be the most helpful ways of achieving this?'*.

This could be introducing them to the three drives from CFT, it could be teaching them defusion skills so as not to become so entangled with thoughts, or it could be about recognising how their maladaptive schemas play out in their relationships with others. In tandem with targeted behavioural experiments, a clear treatment plan and a solid formulation, this helps to develop their meta-competences [3, 4] and allows them to become confident, flexible and responsive CBT practitioners.

Given that so many CBT therapists appear to be drifting, it would be timely to consider if this leads to therapy-improving rather than therapy-interfering behaviours. In order for CBT not to fall victim to 'black and white thinking', further research is required to determine what is harmful versus necessary and helpful drift. ■

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Reducing **isolation** in private practice

Sarah Rees *and* **Heather Howard-Thompson**

continue their look at setting up in private practice. In the third article of this series, Heather looks at reducing isolation.

I hope you've all had a wonderful Christmas and a Happy New Year. This year also marks the start of a new decade and brings our attention to new opportunities and plans for the 10 years ahead.

It's the start of new beginnings when many of you might be considering taking the leap into private practice, so we wanted to address another popular topic that causes concern when people are thinking of working in private practice – isolation.

Often people are used to working in a team so going it alone can seem daunting.

You can rest assured that as this topic comes up a lot in the Facebook group 'CBT in Private Practice', where we share ideas that members have put forward when supporting each other.

Some ways to reduce isolation in private practice include joining an already established team of therapists, considering where you will be based, having associate therapists, peer group supervision, admin support, networking, training and social media groups.

Sarah and I have both worked in private practice for a number of years and although we have different models of working we can both honestly say we have never felt isolated.

Sarah works alone, running a busy clinic with a small virtual team, whereas I have a team of associates that work with me and I employ an Office Manager.

If you are planning on starting in private practice, it is worth considering how you will reduce isolation and which idea suits you best. People often do this as they develop their first business plan, which we discussed in the first article (*CBT Today,* October 2019).

Some therapists (like Sarah) prefer more remote working, while others (like me) start climbing the walls quickly if they are left on their own too long! So, first decide which camp you are in and what you want your business to look like in terms of who you have around you.

Let's consider the different options and you can then think about how you can reduce isolation in your own practice.

Joining an established team of therapists – When starting out in private practice you can either set up totally on your own or research local private therapy companies and contact them to see if they have space for you to join them in their practice. Joining an established team means you are likely to have a stream of referrals and possibly the opportunity for peer supervision. The service will have policies, procedures and methods for record-keeping so you won't need to set this up yourself.

Location – Giving thought to where your office will be based is a great way to ensure you're not as isolated. Being in a building with other businesses means you can mix with others and even increase your source of referrals depending on the business.

Sarah has an office and she sublets some space to other therapists, which has created a nice community.

A village or town location means you can get to know the local community. Getting to know and collaborating with other local therapists working in other fields can be rewarding. Some of the other areas that we have got to know are nutritionists, general practitioners, solicitors, reflexologists and physiotherapists.

Working from home - If you plan on working from home, consider who you will talk to when you are not with clients. You may want to ensure that your supervision arrangements are flexible in case you need an urgent chat or you have some regular peer support. I can always contact Sarah and vice versa and while it's not happened often it is invaluable having the support there. Get a list of who you can call even if it's just for a quick moan.

Working from home could mean that you end up alone for long periods, which you might enjoy, but some of us find that really difficult.

Associate therapists – Having associate therapists means that you pass work on to other therapists who work alongside you. Your colleagues are self-employed and it's a good way of having others around you and adding to your source of income if you have lots of referrals. This can be really useful for referrals that are not in your specialism (such as children or complex clients) and is a perfect way to reduce isolation. Associate therapists can work as part of your team, but ensure that you remember that the team is very different from a multi-disciplinary team (MDT) in the NHS. They are all responsible for their own workload, insurance, supervision, accounts etc.

If you have associate therapists it is useful to meet with them regularly, to agree on methods of communication and review their

caseload. This can feel like a managerial role so include some peer support in your network too.

I find it very useful to have other therapists working at the same time as me in the building. This ensures that if I need any advice or have concerns about safeguarding or risk, I have other professionals to discuss this with.

Having associates isn't all plain sailing, it can be tricky and you need to be clear from the outset how you envisage it will work.

Peer or group supervision – As CBT therapists, peer group supervision can be an excellent way of reducing isolation. There are many posts in the group about arranging this and our hope is that there are many small peer supervision groups out there as a result.

In peer supervision you have the opportunity to present and ask questions about your own cases, as well as engage in discussion about the cases of other group members. Peer supervision and groups provide a break from the isolation of private practice and an informal setting to discuss not only clients but the experiences of working in private practice. They offer valuable guidance on difficult cases and tough ethical dilemmas. They typically have between two and six members who have approximately the same level of professional experience or share a specific area of interest.

BABCP – Most areas of the country have a BABCP branch and myself and Sarah have both been active members; this can provide invaluable support and connection with other therapists who are working in a variety of settings. We had both been in the NHS for a long time and the branch meeting meant that we kept the connection with our NHS colleagues going while we transitioned out on our own. It does take up your spare time but can be very rewarding. Sarah is part of WOMGENE Special Interest Group for gender minorities in BABCP and CBT. The Special Interest Groups are full of people from all over the country so they meet virtually online.

Clinical supervision – In private practice you choose who you have as a clinical supervisor and how many supervisors you have and the amount of time you see them. This flexibility is a real perk of private practice so make the most of it. Also providing supervision can be a great way of connecting with others and feeling like you have a team around you.

Training – Regular training and attending conferences can also be a great way to keep connected, along with the training element, connection and networking is a big part of most training events.

Outsourcing – when you set up your private practice you will quickly learn that you can't do everything yourself so some of your business you will likely outsource. You may decide on having some administration support, a website designer, an accountant, a copywriter to help with blogs, or a social media manager. Choosing the right people is important as they will become vital parts of your business and you will likely have long-standing relationships with them. It might not be a MDT but you will certainly have a team around you.

Admin support – Having appropriate admin support not only helps you run your business but can reduce isolation. It helps to take some of the pressure off your business, as you have someone who can help you with administration work and organisation. They can run the business whenever you're not there as they can deal with handling invoicing, chasing payments, diary management, taking telephone calls and answering enquires, organising and answering emails, reports, social media, filing or photocopying.

Networking events – Most communities have business networking events for local businesses. They can be very hit and miss but can often raise your profile and help you get to know other local businesses in your area. Most therapists new to private practice try a few networking events while they are building up their caseload.

Social media groups – Of course we are biased, but social media groups can be a great way to connect with other therapists. There are so many groups out there now and you can always start your own. In the 'CBT in Private Practice' Facebook group we have close to 1,000 members now, which means someone is active in the group most of the time. You can post a question and get a reply pretty quickly and be kept up-to-date with common worries, wins and concerns that people are having. It's a great opportunity to share resources, work through business ideas and enjoy the therapist humour quotes. Facebook groups provide a great community for so many areas.

I hope you have found this blog useful and you have some ideas around reducing isolation depending on which approach is right for you. Our next blog will be the last in the series so if you have any topics you would like us to write about do let us know, come over and join us on Facebook or email *CBT Today* at editorial@babcp.com.

Sarah Rees is in full-time private practice in Wilmslow, Cheshire (sarahdrees.co.uk) and Heather Howard-Thompson is in private practice in Barnsley (yorkshirepsychotherapy.co.uk)

Adding value: training physiotherapists in a Behaviour Change intervention for people with **Multiple Sclerosis**

The outcomes of the iStep-MS randomised controlled trial into the feasibility and acceptability of an intervention for increasing physical activity were reported recently with promising results, write **Debbie Brewin** *and* **Dr Lee David.**

What is of relevance to CBT Therapists is the qualitative analysis of the participants' reported experiences of the trial. What were the key ingredients in both the training of those delivering the sessions and the participants' feedback on what made the intervention acceptable?

Participants received four 40-minute sessions with a physiotherapist who had been trained by a CBT therapist. The training and intervention delivery were supported by a handbook and feedback was explored through focus groups and interviews.

The handbook included brief cognitive-behavioural strategies, targeted to address perceived stress and emotional coping skills in relation to adjusting to MS, alongside change methods such as goal setting, problem-solving, action-planning and self-monitoring. These tools were well-received by participants.

Physiotherapists received three half-day training sessions which were led by a CBT therapist, and included feedback on a recorded session they had delivered. The training included video clips of the trainer delivering a session, as well as experiential skills practice. Each element of this training format was reported to be helpful. Physiotherapists' use of key skills, including empathic listening, partnership working and use of open-ended questions were rated. The programme was feasible to deliver within their usual workload, although personal study and peer-support improved their confidence to deliver the intervention.

The qualitative data analysis emphasised that time spent individually interacting with their physiotherapist was a key factor in participant's engagement and perceived acceptability of the programme. Three themes emerged:

"I can do this": Developing Competence – describes the increase in confidence and self-efficacy through goal attainment. Personal exercise boundary exploration was encouraged by breaking down goals to make targets seem achievable.

"I felt valued": The Nurturing Culture – Participants emphasised that a strong therapeutic relationship, supportive environment and sense of partnership was key. Goals were personally meaningful and tailored to the individuals' circumstances. Participants felt listened to and described how this reversed the power dynamic experienced in previous medical interactions.

Empowered Enactment – describes the transition from supported change during the trial to autonomous self-management which emerged as the result of the collaborative, values-led change methods, the therapeutic partnership and the intervention structure.

Although the study was not designed or powered to demonstrate significant change in step count, there was a positive treatment effect on fatigue at three and nine months. There was also an increase in self-efficacy, measured in terms of confidence in ability to mobilise, complete activities of daily living, and manage the symptoms of MS which are important to evaluate when determining the effects of an intervention on quality of life.

This study shows that a brief training programme can equip physiotherapists with skills to enhance their interactions. It also highlights the importance of active listening and a sound therapeutic relationship with any healthcare professional, and the impact of attending to emotions and the encouragement of personally meaningful patient-led, values-driven actions.

Isn't that what CBT therapists do so well?

Debbie Brewin is a BABCP-accredited therapist and supervisor, as well as director of a community interest company and professional advisor to a charity which supports vulnerable people to retain or gain education and employment. Dr Lee David is a GP, educator and author with a particular interest in mental health. He is currently involved with a research trial looking at strategies to improve depression in adolescents and young people using a group intervention involving high and low intensity exercise.

Further reading

Ryan J, Fortune J, Stennett A, Kilbride C, Arokye N, Victor C, Hendrie W, Abdul M, deSouza L, Brewin D, David L, Norris M. Safety, feasibility, acceptability and effects of a behaviour-change intervention to change physical activity behaviour among people with multiple sclerosis: results from the iStep-MS randomised controlled trial. *Multiple Sclerosis Journal,* 1-12, Oct 2019 DOI 10.1177/2F1352458519886231

Fortune J, Norris M, Stennett A, Kilbride C, Lavelle G, Hendrie W, et al. *'I can do this': a qualitative exploration of acceptability and experiences of a physical activity behaviour change intervention in people with multiple sclerosis in the UK.* BMJ open. 2019:e029831.

BABCP Spring Workshops & Conference

Living with Uncertainty

Thursday 16 & Friday 17 April 2020
King's College London

This year's Spring Conference will focus on understanding how and why uncertainty is a risk factor for mental health difficulties and the impact of uncertainty in the context of specific adversities.

It will bring together international and national clinical and research experts to share well-established and new CBT models and therapeutic innovations that will help individuals, families and groups overcome, manage, and ultimately thrive in the context of ongoing uncertainty.

Registrations are now open
Find out more at www.babcp.com

All together now

There are more than 20,000 psychological professionals working in NHS-commissioned healthcare in England, covering a range of psychological competencies. In October 2019, BABCP was one of twelve psychological professional groups to call for a new role of Chief Psychological Professions Officer.

Adrian Whittington, National Lead for Psychological Professions, NHS England, met with *CBT Today* to discuss the way forward in bringing all these voices together.

"For a long time it felt like the psychological professions were on the outside, shouting to be heard," he said. "The problem is, we haven't been able to speak with one voice. That makes it very difficult for policy makers to take account of us.

"Following on from the Five Year Forward View For Mental Health and the workforce plan that came from that called Stepping Forward to 2021, there were a number of ambitions for new roles in mental health of which some were psychological roles, so Health Education England wanted to push on with the new roles and get them rolled out at greater scale and speed.

"There were groups set up for the other established disciplines, like social work, nursing, psychiatry, and also for some specific new roles. I was asked to co-chair the psychological professions new roles group. It became apparent that new roles only make sense when thought about alongside existing roles in the system, and that there hadn't really been a place where that was happening. We created a work programme to look more broadly at the psychological professions workforce requirement across the Five Year Forward View, and now the NHS Long Term Plan.

"The new roles group became the Psychological Professions Workforce Group for England and we've been meeting on that basis now for about a year. That has

brought together all the psychological profession disciplines with other key stakeholders, employers, and crucially the policy leads of the key areas in NHS England and Health Education England where psychological professions are implicated. It has become a joined-up body for thinking about how we work across all the psychological professions to deliver and shape NHS policy.

"As the work has unfolded what has become apparent is that there is a huge amount to do but there hasn't been an infrastructure to lead it. I was already in a clinical advisor role with NHS England and I've been asked to extend that role to take up this position."

The National Lead for Psychological Professions role is a part-time position, until March 2021, which Adrian explained: "We have a work programme for that period of time. There will be plenty that needs to be achieved after that so part of the work we are going to be doing will be looking at the leadership needed at a national level for ensuring the psychological professions have a strong voice into policy-making and policy delivery. We will be evaluating different options around that.

"We know that many of the professional bodies have been calling for a Chief Officer and that's one of the options that we will look at. The work programme that we are undertaking has three key components to it – best described as 'Grow', 'Develop' and 'Lead'.

Grow

"This is about expanding the psychological professions and evidence-based psychological healthcare faster than ever before. If we look at the Long Term Plan, the indicative workforce to deliver the ambition requires a huge increase in capacity of the psychological professions, and faster than anything we have seen before.

"This is going to involve some concerted joined-up effort and it's about both expanding the psychological professions but also ensuring the broader workforce is psychologically informed. The other part of 'Grow' is about extending the psychological professions and psychologically-informed work beyond mental health. That's where need to demonstrate the value of evidence-based psychological healthcare across the whole of the health system.

"We've seen huge success with psychological professions working in traditional physical healthcare settings and in primary care. This is all about recognising that the body and mind are connected and make up the whole person. IAPT has been doing a lot of work in this area and with the long-term conditions programmes there's a lot more that can be done to reap the value of psychological work beyond the traditional boundaries of mental health."

Develop

"This is about helping the psychological professions to develop through having an improved training and career path, with greater equity across the different disciplines with routes both up and on through into senior clinical and leadership positions, etc. and removing some of the glass ceilings that exist for some disciplines where it's been more difficult to progress.

"There's a need to align the psychological professions training to the priorities of the Long Term Plan, to ensure that where we are training new people into this workforce, they're trained into the things that we need, and there's the element of creating clear governance requirements and structures for psychological healthcare, so that we can be clear that people delivering psychological therapies and psychological interventions have the required competence to do so and sit within a clear framework of supervision and governance."

Lead

"This is about ensuring the right leadership at all levels of the system: within each provider organisation, within the new integrated care systems across each NHS region, and at national level.

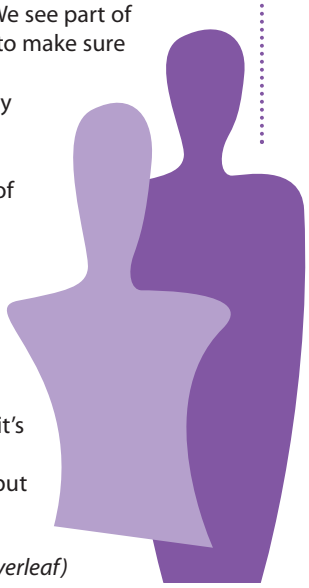
"We are going to be doing some work at the provider level to engage with all of the chief psychological professions officers in each provider organisation to move this agenda forward together.

"At regional level we are working on expanding the Psychological Professions Networks (PPN) to be the regional voice of the psychological professions. There are three currently operating and we are looking to expand that across all seven of the NHS regions. We see part of the role of the PPNs being to make sure that there's a psychological professions voice in to every integrated care system.

Developing the provision of mental health services is a costly task, which he explained: "There is significant work going on to increase investment in mental health and we are now seeing a real-term increase in investment, so it's an exciting time to be working in mental health but

(Continued overleaf)

> "There needs to be a very clear and strong voice of the psychological professions into policy-making"



All **together** now

(Continued)

I think this strand of professional leadership work across the psychological professions needs to be part of that to help these groups grow effectively and safely. That's what this strand of work is all about.

"This next planning period up until 2024 is about delivering the Long Term Plan and there are very clear ambitions for mental health. It's an exciting time to be working on this and there are some real opportunities to make a difference to patients, carers and families.

"There is a commitment within the Plan for an additional commitment of £2.3billion in mental health per year by 2024. That is a great opportunity.

"One of the key challenges we've got though is about how we expand the workforce at the rate required. We are needing to look at innovative ways of doing that with maximising the potential of new roles in the system. Some of the new children's roles are a good example of this, with Children's Wellbeing Practitioners and the Education Mental Health Practitioners can perhaps tap into groups of people who have wanted to work in health and social care and haven't always had a clear route in. These new roles could give an opportunity for that.

"There needs to be a very clear and strong voice of the psychological professions into policy-making. How that is achieved and what structures are needed is subject to further negotiation. I think there is absolutely the need to keep this strand of work going. The sorts of issues that we are working on this year aren't going to go away. We are going to need that voice.

"It's vitally important that we work together across the psychological professions. The only way we can be taken account of and heard is when we join up, and to do that involves us recognising the different individual contributions of the psychological professions but also being prepared to see what we have in common and to work together."

> "It's vitally important that we work together across the psychological professions"

The Psychological Professions Network launched #PPSIntoAction in January 2020, an online space for the psychological professions, related health and care workers, as well as service users, carers and families to shape the future of the Psychological Professions in England.

We would encourage all members to get involved. To do so, find out more at ppsintoaction.clevertogether.com

We also recommend that members respond to the current consultation on the NHS Vision for the Psychological Professions in England here: https://www.engage.england.nhs.uk/consultation/psychological-professions-strategy-2019-24/consult_view/

A Patient's **Death**

I went to the funeral recently of someone I knew very well, says **Victoria Whitley**.

I got to know Louise* a couple of years ago and we saw each other every week. I was very fond of her, with her warm and generous personality. She was a similar age to me, married, with a boy and a girl like me, loved horses and the countryside, like me. She was recovering from breast cancer when we met and was full of hope for her future. She'd got her exercise regime back on track, was eating well, making plans and feeling better about herself. We talked about her remaining worries and self esteem and she visibly blossomed during the time we spent together.

I was hit hard when I heard the cancer had returned with a vengeance. We arranged to meet on one of her good days, but she deteriorated quickly and the good day never came.

Hundreds of people were at her funeral. Stories were shared about her childhood, her adventures, parties, trips, naughty behaviour on nights out. But this was not the Louise I knew. I was her psychotherapist. I saw glimpses of her 'public' life but I also knew things most people there would never know. I heard things she would never have dreamed of sharing, even with those closest to her. Thoughts about her family, actions she was ashamed of, well-hidden anxieties, fears and frustrations.

She was very open about seeing me to help with her emotional needs after her cancer treatment. Her family and friends knew she was seeing 'Victoria', and I heard much about them during our sessions. She even recommended my services to several of her close friends. One of these friends emailed to let me know about the funeral arrangements and I faced an emotional and ethical conflict. I reflected on my own need to attend and pay my respects, with ensuring confidentiality was maintained if anyone asked how I knew her. I weighed up this conflict, and I went; listened, mourned and slipped away unnoticed and unquestioned.

I found an article online which reflected this issue perfectly. One section resonated:

My patient's privacy must be protected, dead or alive; the secrets I hold must go with me to my grave. At the same time, I cherish the wonderful relationships I have had with many of my patients. Just as I have become a compelling voice in their lives, they have also become part of me. Out of respect for this valued alliance, we need to grieve. We need to find ethically informed ways to participate in the rites of death and the process of mourning.

(Richard P Halgin, 2008)

Our work allows a unique relationship, the therapeutic alliance. We may have different personal responses to each patient but there is an undeniable bond forged through therapy which, I believe, should be as real and genuine for both patient and therapist. We part ways with hope for change. I was bereaved by Louise's untimely death. It is a tragedy that she died too young and has left so many people grieving. I shared my sadness with my supervisor Dr Ken McFadyen, who acknowledged and validated my experience, and offered warm support. Even my grief required bounds of confidentiality that couldn't be shared.

Many colleagues will have had similar experiences, whether their patient dies unexpectedly during treatment or, as in Louise's case, whilst forging ahead after successful therapy. In most cases we will never know what happened to our patients once they have left the therapeutic relationship. Some linger in our thoughts, and we catch ourselves wondering how it turned out for them. This is the first time, to my knowledge, I have lost a patient, and it is a unique kind of grief.

*Names and some details have been changed for confidentiality.

Reference

Professor Richard P Halgin, 2008, *When a Patient Dies…Should I got to the funeral?* https://www.psychotherapy.net/article/when-patient-dies

*The Oxford Cognitive Therapy Centre (OCTC) was founded in the mid-1990s, when Dr Joan Kirk gathered together a small group of Oxford cognitive therapists to consider how we might best survive yet another round of NHS budget cuts. Twenty-five years later, three of that original group - **Helen Kennerley, Gillian Butler** and **Melanie Fennell** - met with OCTC's new lead, **Dr Sarah Rakovshik,** to reflect on the past quarter of a century.*

Twenty-five years of CBT: an OCTC perspective

There was a clear consensus that CBT is a psychotherapy success story, but in good cognitive therapist tradition, we were curious as to why.

One of our team (Melanie Fennell), suggested that three core characteristics/principles might have a substantial role to play in the longevity and popularity of CBT.

1. It is theory driven

Not just in terms of highly specific models of particular disorders, but as a reflection of human functioning that can explain in a readily understandable way how people become, remain and recover from distress. Hands up anyone who can't see themselves in it? The original depression model provided a clear and flexible template to work with. This flexibility is clear when we consider the extraordinary range of different problem areas for which highly specific models and demonstrably effective treatment protocols have been successfully developed. The theory includes both learning and maintenance processes (e.g. avoidance of one kind or another, getting tangled up in one's own thinking), and it applies across diagnostic boundaries. Indeed, the processes identified are not exclusively related to serious psychopathology. Rather, the emphasis on normal human processes is clear throughout.

2. It is relationship based

CBT works through a warm, empathic, respectful, and – above all – collaborative therapeutic relationship. Collaboration is central. Through a process of inquiry and experimentation CBT encourages people to get curious about their own thinking, feelings and behaviour, and to be willing to explore new ways of operating through direct action (behavioural experiments). So it encourages direct experiential learning, the most effective means of encouraging deep processing, accurate recall, and the capacity to use knowledge and skills independently in the real world, both between sessions and after therapy has finished.

3. It is empirical

Not just in the sense of emphasising the importance of action/experience, but also science based. We have Aaron T Beck to thank for this. His habit of scientific thinking has remained integral to the approach. This has led to a substantial and growing evidence base, which, in turn, has encouraged bodies such as universities as well as the NHS to see CBT as something worth pursuing and developing. MBCT provides a particularly good example: it's hard to imagine something so apparently foreign to western psychology being recommended as a treatment of choice for depression without the scientific validation research gave it.

There is probably a good deal of support for the view that the interplay of these principles creates something that is more than the sum of its parts. This is because good CBT goes beyond sound technical skills and an ability to appreciate the therapeutic alliance. A good CBT practitioner delivers therapy with rigour **and** flexibility; draws on general **and** specific skills; reflects the application of art as well as science (an observation made by Gillian Butler).

We have all benefited from, and indeed been actively involved in, teaching and training over the past 25 years and our discussion reminded us just how vital it is that contemporary training continues to embrace these characteristics. It is crucial that CBT is taught as something more than a collection of technical skills, despite its emphasis on using specific, theory-based skills. CBT has been a success because it is a living, breathing therapy. That's why it has been so adaptable, growing and developing in numerous exciting directions.

In the early 1980s, three of us were working in the Oxford University Department of Psychiatry where we witnessed this blossoming of CBT first-hand. In the space of a few years from the publication of Beck's *Cognitive Therapy of Depression* in 1979, CBT's robust psychological framework was being applied to several anxiety disorders, eating disorders, somatic problems – and always with a healthy respect for the empiricism that has become its hallmark. Protocols began to be refined for a range of specific problems and practitioners from a variety of backgrounds could, relatively quickly, be trained to apply them. CBT was becoming more and more accessible from primary care through to highly specialist services.

Over the last 25 years, CBT has been applied to a seemingly ever-increasing set of psychological problems: medically unexplained symptoms, complex trauma, personality disorders, chronic depression, bipolar disorders – the list goes on.

> "CBT has been a success because it is a living, breathing therapy. That's why it has been so adaptable, growing and developing in numerous exciting directions."

There was a myth that suggested CBT was a relatively superficial method, and not appropriate for people with longstanding and complex problems. This was refuted early on in its history. CBT is versatile, and its more sophisticated applications, which combine principle-based work with a highly individualised approach, now help many people who suffer from chronic and complex problems.

This is not a case of the same old format being rolled out with different disorders. Yes, key principles have been maintained, but the emphasis on particular elements of the CBT approach has evolved to reflect the distinctive qualities of particular disorders and the idiosyncratic needs of the patient or patient group. More recently, research has shown us what is key to the successful application of CBT in different specific problem areas. We have seen, for example, an emphasis on modelling and role play with social anxiety, the importance of understanding meta-cognition in GAD, and chronic depression; the value of imagery work in PTSD or in bipolar disorder.

The flexibility of the approach, the importance of not automatically rolling out the same old format, came to the forefront again when the need to increase the accessibility of CBT became a pressing issue. Twenty-five years ago, much CBT was offered in conventional mental health settings, but we now know that it can flourish in other health settings, in non-health settings, and via virtual and online delivery. Importantly, the ongoing evaluation of CBT's effectiveness in routine clinical practice continues to expand.

The most striking example of adapting CBT delivery to the times must be the IAPT initiative, the brainchild of Professor David Clark and Lord Richard Layard. Launched in 2008 with direct

Continued overleaf

Twenty-five years of CBT:
an OCTC perspective

(continued)

government funding, IAPT combatted the most common of psychological problems: anxiety and depression. Although IAPT does not exclusively offer CBT, it is the predominant therapy used, which meant that a contemporary means of training 1,000 additional CBT therapists per year had to be devised. Accountable to the government, the impact of the training and clinical interventions was carefully evaluated. Year by year more therapists have been trained, more IAPT services opened and because the outcome data has been compelling, the subsequent government-supported IAPT service has expanded to the treatment of children, those with co-morbid conditions and those with severe-mental illness and long-term physical conditions.

In the past quarter of a century, there has also been an enormous increase in developing the means of CBT dissemination: training, supervision and research. Even before OCTC had been established, Drs Melanie Fennell and Joan Kirk set up a CBT training course in Oxford. In response to the comments from graduates of the course, Melanie developed a Diploma/MSc in Advanced CBT studies, designed specifically to help experienced CBT therapists to move to the next level – honing the skills of dissemination. We have continually been guided by those principles of theory, relationship and empiricism. Our training was based on the best contemporary theory available to us, but we also turned to our student body to understand their needs and feelings, and we have never stopped evaluating. Along with other sites in the UK we offered the sort of training that would soon be recognised by the BABCP as essential when it laid out criteria for accreditation as a CBT Supervisor and Trainer.

The Oxford course in Advanced CBT studies no longer exists, but that's not a bad thing because it has evolved in response to the needs of students, and the financial and political climate. It is now delivered in a way that is more appropriate for clinicians working in a time of co-existing health service cuts and health service advances; that is, it is modular and allows specialisation for particular clinical populations. This responsiveness echoes what we have already noted about successful CBT clinical practice and service delivery.

If asked to predict what will happen to CBT over the next quarter century, we would have no hesitation in saying that it will be a survivor, as we continue as we started – with curiosity, humanity and empirical integrity. It has the adaptability, robust theoretical base and empirical foundations to survive. Not without changes, of course, but still recognisable, useful and effective. ■

Recommended reading

Beck, A.T., Rush, A.J., Shaw, B.F. & Emery, G. (1979). *Cognitive Therapy of Depression.* Guilford Press, New York.

Beck, A T, & Haigh, E A. (2014). *Advances in cognitive theory and therapy: The generic cognitive model. Annual review of clinical psychology, 10,* 1-24.

Salkovskis, P M. (Ed.). (1997). *Frontiers of Cognitive Therapy.* Guilford Press.

> "Twenty-five years ago, much CBT was offered in conventional mental health settings, but we now know that it can flourish in other health settings, in non-health settings, and via virtual and online delivery."

TEAM CBT has been developed over recent years by Dr David Burns (of "Feeling Good" fame). It represents a structure which contains a distillation of what has been shown to be bring about consistently very good results, writes **Dr Peter Spurrier.**

My experience of 'TEAM' CBT

It is backed up by solid evidence of proven effectiveness for mood disorders, relationship problems and habits/addictions. TEAM therapy can achieve complete and sustained recovery often in just a few sessions of treatment.

I first came across TEAM therapy in 2015 when I was developing my generic CBT skills, post-BABCP accreditation. I was lucky enough to attend a two-day workshop on the treatment of anxiety, called "Scared Stiff". I learned the basic concepts of TEAM from Dr Burns himself. I realised at that stage that there was much to be gained by adopting many of the processes, however it became lost in my general CBT personal development until it re-merged for me over a year ago. I started using some of the tools, concepts and methods. I developed my understanding and skills by visiting Dr Burn's website which has a host of useful resources including easy-to-listen to podcasts on many subjects.

In August 2019 I visited San Francisco for a four-day intensive workshop. I found the content and teaching methods excellent and enjoyed meeting other attendees, who also appreciate the quality and power of this new approach. I am now keen to further develop my skills to fully embrace the structure and methods and am gradually integrating the TEAM structure with with my previous practice. I would love to see it take off in the UK and I hope this article helps.

What is TEAM CBT?

This stands for an ordered structure for each session:

Testing – Dr Burns has worked hard to develop a very quick and reliable "Brief Mood Survey" to test for levels of depression, suicidal thoughts and urges, anxiety and anger which takes a minute or two to fill in. This, together with a "Positive Feelings" survey and a "Relationship Survey", is done before and after each session. At first, I needed to work on my aversion to forms to embrace this step, now, I would not be without them in any CBT session. For me, it saves time and adds greatly to my understanding of the client's problems. I can see just how off-track I can be in imagining that I can intuitively know how the patient is feeling. After the session I can see just how effective (or not) the session has been, as well as how effective I'm being in the course of therapy overall.

After each session, the patient also fills in an evaluation of the session. Again an indispensable tool to keep me on track, guide my learning and development needs and pave the way for some powerful interventions.

Empathy – I really thought (like most other therapists that I've spoken to) that I was really good at empathy. The evaluation of session questionnaire told me otherwise. Dr Burns has also provided a simple to understand (not so simple to master) road map to improve', and now my scores are consistently excellent. It is essential to get this step right to gain the necessary trust and rapport to move on to the next steps.

Agenda setting – To understand the huge importance of this element is perhaps the biggest change from CBT as usual. It's all to do with motivation and resistance. The steps require some radical shifts in approach, but once mastered, appear to improve the effectiveness and satisfaction with therapy immensely.

Methods – Dr Burns has worked for many years on distilling out what really works. He recommends working through a number of different CBT approaches incorporating elements from different schools of CBT and psychotherapy, rather than repeatedly grinding through one or two approaches which may not be working for the client. He has developed many methods and works hard to teach the skills to other therapists as well as non-therapists.

I would love to hear from any other UK therapists who are interested in this approach. I would also appreciate any ideas on how this approach could be promoted in the UK. ■

Dr Spurrier is a BABCP-accredited therapist and can be contacted at docspurr@gmail.com

Did you know...

In 2019 our network of branches and Special Interest Groups provided CPD opportunities across the UK and Ireland to more than 2,800 CBT practitioners. Here are the standout figures from the workshops delivered last year. You can always see our latest workshops online at www.babcp.com/events

East Midlands Branch
presents

Introduction to Evidence-Based CBT Supervision

with Hannah Whitney

24 April
Nottingham

Liverpool Branch
presents

Cognitive Behavioural Analysis System of Psychotherapy (CBASP): One Day Primer Workshop

with Jonathan Linstead & Erin Graham

22 April
Liverpool

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

South East Branch
presents

Behavioural Experiments in OCD

with Dr Joel Oliver

2 April
Sevenoaks

London Branch
presents

Brief Parent-led CBT for Child Anxiety Disorders

with Professor Cathy Creswell

27 March
London

North East & Cumbria Branch
presents

Cognitive Therapy for Social Anxiety Disorder in Adults and Adolescents

with Professor David M Clark

16 & 17 April
Grasmere

North West Wales Branch
presents

Brief Parent-led CBT for Child Anxiety Disorders

with Professor Cathy Creswell

29 May
Bangor

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

CBT Medics Special Interest Group
presents

Fifth Annual Conference

with Patrick Harper, Norman Macaskill & Mark McCartney

13 March
Leeds

ACT Special Interest Group
presents

Experiential Introduction to Acceptance & Commitment Therapy

with Martin Wilks

20 & 21 April
Ipswich

Group CBT Special Interest Group
presents

Understanding Group Dynamics

with Isabel Clarke

15 May
York

South East Branch
presents

Motivational Chairwork

with Matthew Pugh

15 May
Sevenoaks

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

Eastern Counties Branch
presents

Flexible ACT Practice: A skills building workshop

with Jim Lucas

1 May
Colchester

Integrating CBT and Third Wave Therapies: CBT+

with Dr Fiona Kennedy

1 & 2 July
London

10th International Congress of Cognitive Psychotherapy

Rome, 18th - 21st June 2020

ANGELICUM, the Pontifical University of Saint Thomas Aquinas

INVITED SPEAKERS

Arnoud Arntz (Netherland)
Schema Therapy for Cluster-C Personality Disorders

Judith S. Beck (USA)
A Cognitive Behavioral Approach to Weight Loss and Maintenance

Janina Fisher (USA)
Working with the Neurobiological Legacy: Developing Resources for a Life After Trauma

Paul Gilbert (UK)
Evolution, Attachment and Compassion Focused Therapy

Steven C. Hayes (UK)
Stefan G. Hofmann (USA)
Process-Based Cognitive Behavioral Therapy

Robert L. Leahy (USA)
Emotional Schema Therapy for Difficult Emotions

Lynn McFarr (USA)
Cognitive Behavioral Therapy for Chronic Depression

Mehmet Sungur (Turkey)
Cognitive Behavioral Systems Approach to Couple Problems

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The Therapy Relationship in ACT

with Dr Kelly Wilson

Monday 12th & Tuesday 13th October, 2020

Focusing on the Meaning and Development of the Therapeutic Relationship.

One of the great causes of suffering is a sense of isolation, of not being fully heard, understood, truly known. Persistent exposure to social isolation and/or social hostility is a risk factor for virtually every source of disease burden in the modern world—including both mental health and physical disease burden.

When done skilfully, the therapy relationship offers a powerful and healing antidote to this.

The workshop will offer a personal and impactful guide to the therapeutic relationship in from an ACT perspective. What can happen when you slow down, let go of your usual patterns? When you shift your attention from fixing to listening and appreciating? What happens when we offer mindful attention? Clients can be truly heard and, will sometimes, hear themselves for the first time.

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- Impact of Trauma and Post Traumatic Stress Disorder
- Social Anxiety Disorder
- Working with Selective Mutism
- Treating Tics and Tourette's Syndrome
- Working Across Cultures

CERTIFICATE FEEDBACK:

I would like to say that the ***Certificate Course*** has been excellent especially all the days on Anxiety and Panic. The school refusal too was immediately effective and I am working with a school team and parents using Lisa Anderson's Module. Dr Linnell's days were exceptional. Dr Beck was exceptional also. The Diploma Course was excellent the modules that stood out for me were the introduction, substance misuse , anger management, Working with suicide , anorexia and all the modules on Anxiety. The Post Traumatic Stress course too was immediately useful. Finally, thank you to SDS staff, nothing was too much trouble for any of you!

Kate M., CBT for Children and Adolescents Certificate Participant, feedback via Webcast Private Message

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