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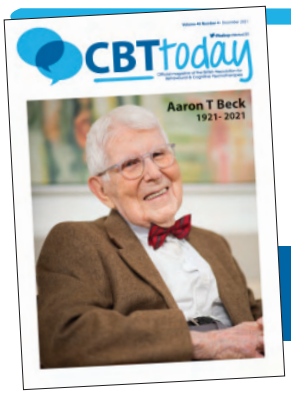
CBT today

Official magazine of the British Association for Behavioural & Cognitive Psychotherapies

Aaron T Beck
1921- 2021



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Welcome to the final issue of 2021. All of us at BABCP were saddened by the passing of the 'Father of CBT' Dr Aaron T Beck. Rod Holland provides some recollections of his interactions with BABCP in this issue.

As always, we include contributions about issues that matter to us in the here and now. Drs Kerry Young and Nick Grey have kindly shared their work on providing assistance to IAPT services working with refugees and asylum seekers, while we have first-time contributors with a range of perspectives on what matters to those who work in the field of CBT.

The effects of the pandemic will be with us for years to come, so sharing information about the effects of Long-Covid, for example, have been very welcome.

As always, we would like to wish readers a happy festive season, with lots to look forward to in the new year.

Peter

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

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Advertising

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In this issue

President's message

This Autumn we have lost two of the key figures in the development of Cognitive and Behavioural therapies, Jack Rachman and Aaron T Beck. Both were good friends of the BABCP and many members had the opportunity to be trained and supervised by them directly over the years, and those of us who didn't have that direct opportunity to work with and be trained by them will have still benefited from their insights into treating mental health problems and their clarity of vision and generosity in disseminating their ideas.

When you think about the therapists and supervisors they trained, and the therapists and supervisors they went on to train and the people who were successfully treated as a result you can see how so much suffering and impairment was reduced and what a great legacy they both left through that. We have published obituaries and reflections in this issue to describe their profound impact on mental health care and their contributions to the BABCP and our members.

We also have an important article on work with refugees and asylum seekers in this issue that I want to especially recommend to you. We are lucky in having something from genuine experts in this area who have specialised in working with some of the most marginalised groups in the mental health care system. Again this team has worked hard over many years to disseminate their insights and good practice and underpinned this work with a solid evidence base. Their work is a great example of how the insights and models of people whose work provides the foundation of what we do can be adapted to contexts and cultures that are very different to the ones that they were developed for. It is a testimony to the robustness of cognitive and behavioural therapies that they lend themselves so well to this adaptation.

As this will be with you in the run up to the Christmas season I want to wish you all the best at a time when demands for mental health care are likely higher than we have seen as a result of the pandemic and economic pressures and I hope that you all have time to rest and take some time for yourselves and your loved ones.

Dr Andrew Beck

New BABCP Special Interest Group: TEAM-CBT

A new BABCP Special Interest Group was recently established to develop knowledge and practice of TEAM-CBT in the UK. The SIG will be organised by BABCP members who provide TEAM-CBT training and support in the UK. There will be an introductory event in early 2022 for those interested to find out more about TEAM-CBT and then a full day workshop later in the year.

What is TEAM-CBT?

TEAM-CBT was developed by Dr David Burns, who is an Emeritus Adjunct Professor of Clinical Medicine at Stanford University School of Medicine. In the early days of his career, David Burns worked very closely with the late Aaron Beck, the founder of CBT, and also wrote the highly popular and influential self-help book, Feeling Good.

Burns's decades-long research into the best clinical tools to treat depression and anxiety resulted in the development of TEAM-CBT, an evidence-based structure to support therapists in providing rapidly effective treatments for mood problems, relationship issues, habits and addictions.

The framework is very inclusive, as it incorporates methods from many therapeutic schools. It is an approach which therefore emphasises "tools, not schools" of therapy. In brief, the structure of TEAM-CBT revolves around the following areas:

T – Testing. TEAM-CBT involves regular mood surveys and feedback questionnaires to obtain the most accurate data possible to help clients.

E – Empathy. Empathy has been shown to be a key factor in therapeutic outcomes. TEAM-CBT offers therapists strategies to enhance and communicate empathy.

A – Agenda setting. A crucial element of TEAM-CBT is its focus on client resistance to therapy, which is often a challenge to therapeutic success. TEAM-CBT examines the causes of resistance and provides a clear path to try to overcome it.

M – Methods. TEAM-CBT uses an extensive inventory of effective and rapid therapeutic interventions drawn from a variety of approaches, which can be incorporated into therapists' existing practice.

TEAM-CBT is a natural extension of traditional CBT training and is a great way to learn about new, effective skills within a clear framework.

More information about the SIG's launch event will be emailed to members in early 2022.

Aaron T Beck,

BABCP Honorary Fellow

Rod Holland *pays tribute to the 'father of CBT'*

By the time you read this article you will have heard about the death of Aaron T Beck who passed away on 1 November peacefully at his home in Philadelphia. You may have also read the many tributes that have been paid to him in the press and in many other publications and messages that have been sent. It is a sad loss and one that has come just over three months since we sent him our best wishes on his 100th birthday which took place in July this year.

Tim (as he was known) Beck was a remarkable man, and he has had a very special place in BABCP for nearly four decades. Many BABCP members have had the privilege of meeting Tim on one of his trips to the UK or in Philadelphia. The UK was a place he loved to visit and where he forged strong collaborations with many clinicians and researchers across the country. He would always receive a warm welcome and would never fail to engage with those he met. He was enthusiastic about the ground-breaking work that UK and Irish CBT clinicians were developing and frequently credited them with having played a key role in developing new directions in CBT.

Early interest in the work of Aaron Temkin Beck by BABCP members began in the late 1970's when Ivy Blackburn in Edinburgh and John Teasdale in Oxford were developing their interest in cognitive therapy for depression. They both presented in a symposium on cognitive therapy and depression at the World Congress Behaviour Therapy in Jerusalem in 1980 where He was a discussant. Interest in his cognitive therapy for depression developed at our annual

conferences with John Teasdale and Melanie Fennel running a Cognitive Therapy for Depression workshop at the 1980 Conference in Sheffield and a follow up workshop in Spring 1981. Melanie was then joined by Amanda Cole to run an Introductory Workshops on Cognitive Therapy for Depression at the 1981 Conference in Bristol.

In 1982 Tim attended the EABCT Congress in Rome where he was presenting in a Roundtable chaired by Victor Meyer. David Clark and John Teasdale were also attending that meeting and David took the opportunity to have dinner with him, which was the start of a close relationship and collaboration between them both which lasted a lifetime.

In 1993 he travelled to the UK to attend the annual meeting of the Society for Psychotherapy Research hosted by David Shapiro at the University of Sheffield. Here he ran a workshop "Cognitive Research in Depressive Illness: Where to?" moderated by Ivy Blackburn. It was at this meeting that David Clark suggested that he might like to travel to the University of Hull where BABP (as it was then) was holding its 11th Annual Conference to meet some of the people developing cognitive therapy in the UK. He readily accepted and although it was too late to include him in the programme it established a link with BABCP. The warm welcome he received helped persuade him to return to future BABCP meetings. This was in spite of being greeted on his arrival in Hull by Howard Lomas, the BABP Membership Secretary, dressed in Archbishop robes accompanied by Sally, his partner dressed as a nun! That is another story in the history of BABCP.

He became a member of BABP in 1984 and ran his first workshop for us at our Spring meeting in Winchester. It was an advanced workshop for people who had already attended one of the introductory workshops and gave those signing up to attend a teaching experience they would always remember.

Tim took a sabbatical leave from the Centre for Cognitive Therapy in Philadelphia in 1987 and spent much of his time in the UK working with David Clark and his colleagues in Oxford. By now he was probably receiving more recognition in the UK than he was in the USA, and he was enthusiastic about the contacts that he developed. It was during his time in the that he was elected as a fellow of the Royal College of Psychiatry.

BABP hosted the Behaviour Therapy World Congress in Edinburgh in 1988 and he accepted an invitation to deliver a workshop and a keynote address. Unfortunately, illness prevented him from running the workshop, but his co-presenter and collaborator Christine Padesky stepped in and saved the day. Fortunately, he was able to

make a quick recovery and deliver his keynote address entitled "New Developments in Cognitive Therapy: a dialogue with Aaron Beck".

he returned to the UK many times over the next few years. In 1989 he was back in Oxford to attend the World Congress of Cognitive Therapy. In 1993 it was to attend the BABCP/EABCT Annual Congress in London where he was honoured with a Festschrift for Aaron T Beck. The four sessions lasting 20 hours on "Frontiers of Cognitive Therapy" involved 21 presentations by the most distinguished speakers from the UK, Europe and the USA.

Our 25th anniversary was in1997 and he was with us once again at our Annual Conference in Canterbury. Another workshop and another keynote, and some of you will remember another side to Tim when he appeared without his signature red bow tie on the dance floor. It is sad that we will be unable to hear directly from him about his life as a BABCP member when we celebrate our 50th Anniversary next year but his kindness to everybody and the warmth he generated will live on together with the impact of his contribution to CBT for ever.

The last time we were able to see Tim at a BABCP/EABCT conference was in Manchester in 2004. He was a late addition to the programme and ran a half-day masterclass and the opening keynote address on the "Origin, Evolution, and Current State of Cognitive Therapy: The inside story". He was particularly keen to be in Manchester where CBT for psychosis was developing. He formed a strong relationship with this group and others in the UK working with psychosis. Although his ability to travel was lost in his later years his inquiring mind and capacity to develop new areas continued with his most recent work on the development of Recovery-Oriented Cognitive Therapy (CT-R). There was never a chance that he would stop expanding the reach of CBT. In 1998 Tim was made an Honorary Fellow of BABCP.

Rod Holland

BABCP at 50

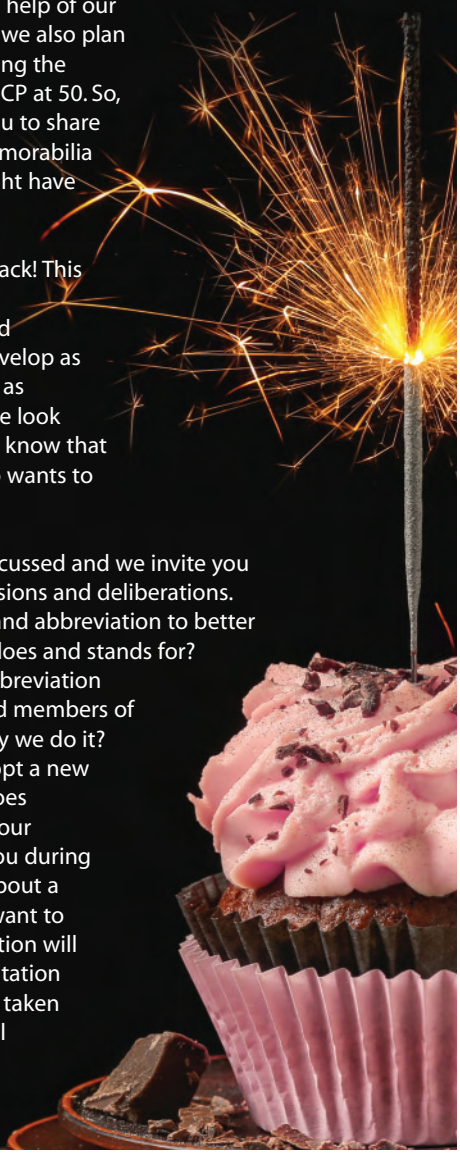
We will celebrate our 50th birthday on 10 November 2022 and will mark this milestone by having a 50th Anniversary Year, which will launch at our 2022 Annual Conference in London from 20 to 23 July. After the Anniversary year launch we will enjoy a year of activities, culminating in our 2023 Annual Conference in Cardiff, with plans for regional conferences in Scotland and Ireland as well as other special events.

A small working group, co-chaired by Andrew Beck and Rod Holland, has come up with some ideas about how to mark the Anniversary and we invite you to consider how we might celebrate this special Anniversary.

Since forming in 1972, much has changed, and this Anniversary Year will be a good time to look back at how CBT and our Association has developed. We have an extensive archive of material from our journals, conference programmes and magazines, beginning with Issue 1 of our newsletter, which has developed into the full-colour glossy magazine you're reading now. We will be collating some of this material into a new BABCP archive, which will also include an oral history archive, which will consist of interviews with key people who have been involved in BABCP since its early years. We aim to identify and hear from a wide range of individuals who represent multiple aspects of BABCP and its history. With the help of our journals and magazine editors we also plan to publish special editions during the Anniversary Year to reflect BABCP at 50. So, look out for an email asking you to share your reflections, memories, memorabilia and photographs that you might have lurking in your bottom drawer.

But we won't just be looking back! This is a great opportunity for us to consider the future of CBT - and BABCP. How do we want to develop as an organisation? What do you as members want from us? As we look towards the future, we want to know that we are reaching everyone who wants to connect with us.

One major change is being discussed and we invite you to get involved in these discussions and deliberations. Do we need a different name and abbreviation to better reflect what our organisation does and stands for? Does our current name and abbreviation convey to our stakeholders and members of the public what we do and why we do it? If you think not, should we adopt a new name and abbreviation that does these tasks better? Whatever your thoughts, we will be inviting you during 2022 to share your thoughts about a possible change in name. We want to consult widely, so the consultation will follow our Membership Consultation Policy and any decision will be taken together at our Annual General Meeting.



Chris Atha

Chris Atha passed away on 3 February 2021 and is sorely missed by so many people. As a teenager he was a champion of justice, protest and change; these turned out to be lifelong values and Mental Health and CBT have been the beneficiaries. Chris qualified as a mental health nurse in 1973 and as a general nurse in 1975. He trained at Highroyds Hospital in Menston and he fought consistently to improve standards of nursing practice and patient care. He was the first male charge nurse at the General Infirmary at Leeds when he opened the Liaison Psychiatry ward. In the early days this ward and Chris were a thorn in the side of the traditional general nursing hierarchy at the LGI. When the unit was threatened with closure, he led his team in a five day sit-in with the patients, alongside informing the Yorkshire Post. These actions led to the decision being reversed.

At a time when hospital treatment was the main focus in mental health, Chris, alongside three colleagues, became the first Community Psychiatric Nurses in Leeds and the first team outside London. With other CPNs in the country he was a founding member of the Community Psychiatric Nurses'Association (CPNA). This is a national organisation, still in existence today that led and shaped the emerging role of the CPN as psychiatric hospitals were closed and care in the community began to take shape. With his CPN colleague and friend Graham Watt, Chris founded, edited and published the Community Psychiatric Nursing Association Journal, one of the earliest mental health nursing journals in the UK. This still exists today as the *Journal of Mental Health Nursing*.

He became a Research Nurse in the early 1980s, working in liaison psychiatry. He moulded research on mental health issues in Accident and Emergency, and was the therapist in a key study developing CBT for people who repeatedly attempted suicide. His ability as a therapist for some of the most depressed and suicidal patients stemmed from his clear ability to both empathise with and empower people who had reached the end of their tether. This revolutionised his clinical practice and led to publications and speaking at national and international conferences.

From this Chris went on to train as a cognitive behavioural psychotherapist and he worked as a psychotherapist in liaison psychiatry at the LGI and in general adult psychotherapy in Bradford, Wakefield and York. He was the first Cognitive Behavioural Therapist recruited to work in the new Adult Psychological Therapies Service in Wakefield in the late 90s, being key in a multi-disciplinary service which integrated therapists from a range of therapeutic orientations. In this, as in other roles, he was immensely supportive of that which would improve the lot of service users. In that role he drew on his research experience in a move to routine outcome monitoring across the piece, and developing CBT based self-help interventions and resources for clients who were waiting for therapy.

Before retiring he returned to research, working at the university of Nottingham as a research therapist in two trials related to frequent attenders in primary care and a brief, telephone intervention for self-harm.

Chris was a loyal, steadfast and inspiring colleague who supervised and mentored many who continued in his example. He did not, however, suffer fools gladly, and was particularly scathing to a person's face if he believed the care and treatment they delivered did not cut the mustard.

More personally, Chris was very proud of his Yorkshire heritage and never moved away from his beloved county of origin. His dry humour and wit went hand in hand with committed, honest and unshakeable friendship. As one close friend commented at his memorial, he was always completely and authentically himself. He was a life-long fan of cricket and Leeds United fan, and a decent football player when younger.

He loved to travel, with memorable trips to Mauritius, New Zealand and favourite New York. In recent years he had taken up pottery. He adored his wife, Anne; his children and grandchildren, loving to spend time with them when he could.

Chris Atha was ahead of his time, and made a huge impression on CBT in the UK.

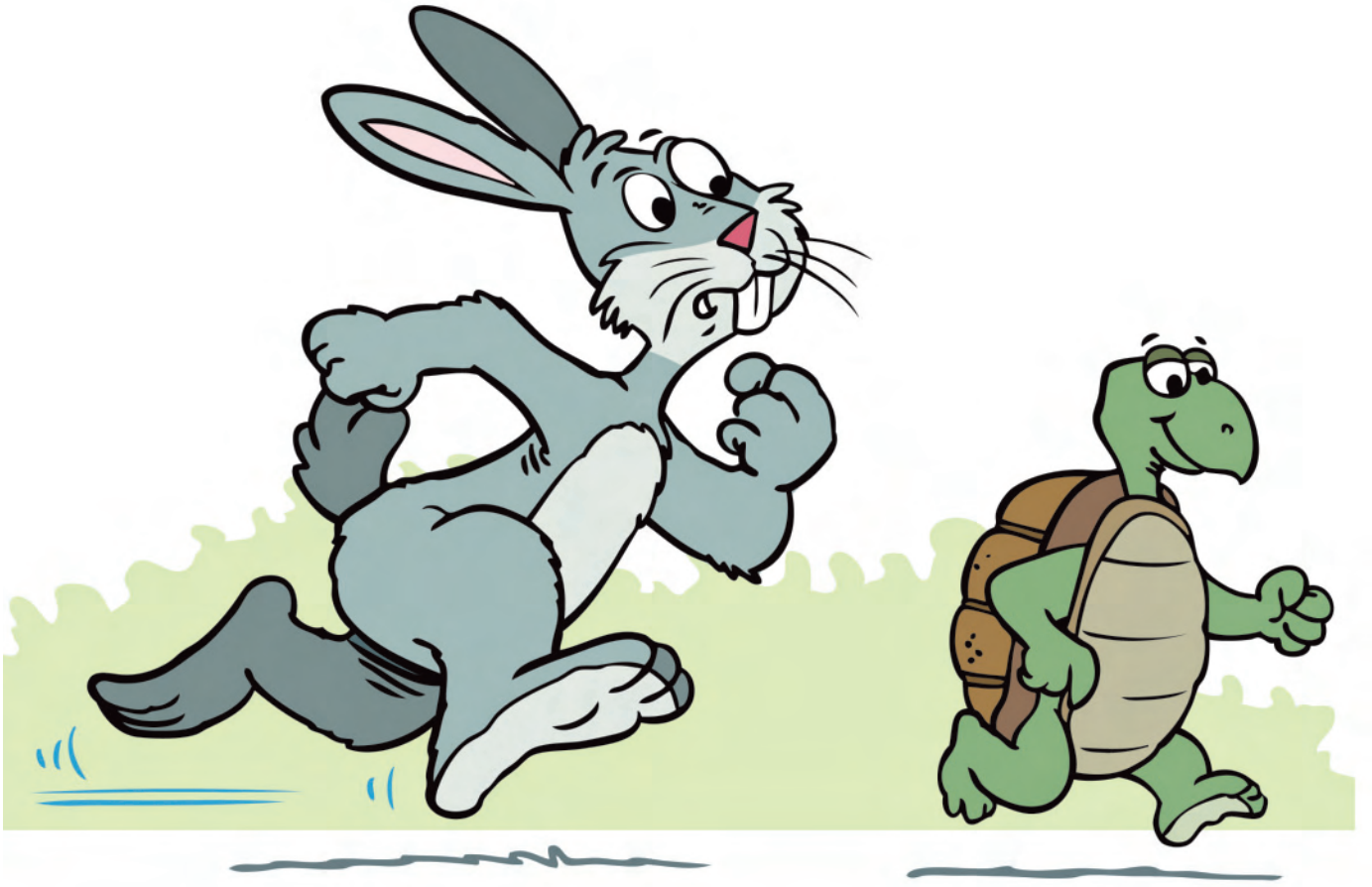
Paul Salkovskis, Anne Garland and **Helen Macdonald**

Jack Rachman 1934-2021

It is with great sadness that we learned of the passing of Jack Rachman, who died in Vancouver on 2 September 2021. As a field we owe a tremendous debt to Jack. For decades his ideas stimulated research worldwide and launched many careers. The journal he started along with Hans Eysenck, Behaviour Research and Therapy, allowed many to publish their work, and which he edited for 39 years. He was a true innovator and was one of the original architects of the field we all know and love.

An online memory board for people to share their memories with friends, family and colleagues is at https://www.kudoboard.com/boards/ZqRMx4Vg

Your worth is not your recovery rate



As a clinical supervisor I often hear myself saying "The slower you go, the faster you go". What I mean by this is that treatment failures in my experience can often arise when the therapist has rushed straight into 'change methods' after a less than thorough assessment or formulation, writes **Jason Roscoe.**

> There is an urgency to get the client into 'recovery' before they reach an arbitrary service session limit and this pushes the therapist into threat mode (see Gilbert, 2009) where they lose composure and stop seeing the bigger picture.

Taking the time to explore willingness to do what is necessary for change is priceless, but I am often met with a response along the lines of "Yes but we've only got six sessions left".

There is an urgency to get the client into 'recovery' before they reach an arbitrary service session limit and this pushes the therapist into threat mode (see Gilbert, 2009) where they lose composure and stop seeing the bigger picture. There may be an underemphasis on perceived soft skills such as empathic attunement to the client's moment to moment needs and consequently, interventions are deployed without fully understanding why or establishing if the client is truly on board.

(Continued overleaf)

Your worth is not your recovery rate

Continued

Before the routine use of outcome measurement through psychometrics, clients benefited from therapy and therapists no doubt, felt like they had helped the client to make the changes that they were able to in the timeframe available. So, when a therapist anxiously says to me that the clock is ticking on how much longer they have left with the client, I encourage them to think about the broader outcomes of engaging in therapy.

I have noticed from my own work as a therapist that time and again one of the biggest changes that clients report is a newfound awareness. We might translate this as an increased ability to develop some distance from their automatic thoughts, to disobey longstanding 'rules for living' or to recognise what a 'safety behaviour' is and how it inadvertently makes their problems worse. In addition to this, clients may develop new skills in how they relate to their problems by using applied problem solving rather than cognitive avoidance, worry or rumination. However, these useful insights and skill acquisitions do not always translate into a notable reduction on a PHQ-9 or GAD-7.

A therapist can feel deflated and be highly self-critical if a client reaches the end of a course of therapy and has not fallen below 'caseness' (National Collaborating Centre for Mental Health, 2021). It is very easy to blame oneself for lack of skill and to believe that another therapist would have achieved a better outcome. In these instances, it is always worth remembering that only fifty percent of your clients are expected to 'recover' (Layard, 2006). Furthermore, it is highly reductionistic to say that all improvements or deteriorations in a client's symptoms are wholly the result of therapeutic skill or incompetence.

Whether we like it or not our worth as therapists is to some degree judged externally by employers or referrers on our recovery rates, yet that does not have to influence our internal judgment of our worth. Developing an ability to see beyond outcome measurement and having self-compassion are, I believe, vital skills that all therapists need in their locker if they are to survive the real risk of burnout and compassion fatigue (see Kaeding et al., 2017).

What can we do to counter the tendency to blame ourselves for treatment 'failures'?
Self-reflection / Self-practice (SP/SR) as developed by Bennett-Levy et al (2001) suggests that using CBT formulation and techniques on ourselves can bring a whole range of benefits including meta-cognitive awareness and de-centering from our thoughts and emotions. In recent years, SP/SR books have also been written from the perspective of third wave therapies such as Compassion-Focused Therapy (e.g. Kolts et al., 2018). Below, I have provided a selection of methods that CBT therapists can use on themselves to manage how they respond to times where they feel criticised externally or internally by a part of ourselves that places too much value on outcomes as a measurement of worth.

"So, when a therapist anxiously says to me that the clock is ticking on how much longer they have left with the client, I encourage them to think about the broader outcomes of engaging in therapy."

Responsibility Pie chart
When a client does not meet recovery or perhaps deteriorates in therapy we may have the tendency to apportion one hundred percent of the blame to ourselves for not having the knowledge or skills to 'fix' them. As in therapy, it can be useful to write down a list of all the possible reasons why therapy did not 'work' for the client (e.g. co-morbid drug or alcohol problem, personality difficulties, social stressors such as insecure housing or relationship, service limitations). Having done so we would then consider how big a slice each of these factors would warrant and finally consider how much is left for our role.

Noticing our own thinking errors
All or nothing thinking might be very common in how therapists appraise treatment outcome e.g. "I'm either a great therapist or a rubbish therapist" or mental filter where we only recall the clients that did not improve and overlook the many that did e.g. "None of my clients get better". Stepping outside of service targets, how do we personally define 'better'? Is the client better at communicating with others, better at recognising and differentiating emotions, better at learning to tolerate discomfort in the service of their values? These changes could be much more significant to the enrichment of the client's life in the here and now and going forward than a ten-point reduction on a questionnaire.

Developing a compassionate internal supervisor
Bell et al., (2017) wrote about therapists developing an internal supervisor that possessed qualities of compassion and who they could turn to for unconditional support in times of need. Taking some time to construct an image and persona of this internal supervisor could help us to counter our tendency to speak to ourselves in a harsh and unforgiving way. What would you ideally want to hear when you are feeling sad or angry with yourself or the client for how treatment has ended? Perhaps you might take your thinking errors and responsibility pie to this internal supervisor as a self-supervision exercise.

Conclusion
Working as a therapist can be highly rewarding when clients make expected improvements and we may feel proud of our recovery rates. We need to be careful however not to base our global self-worth on our performance within a system that only captures one way of framing therapeutic success. As CBT therapists we have tools at our disposal that can help us to notice our tendency to discount our successes and magnify our failings and to ultimately recognise that our worth is far more than our recovery rate.

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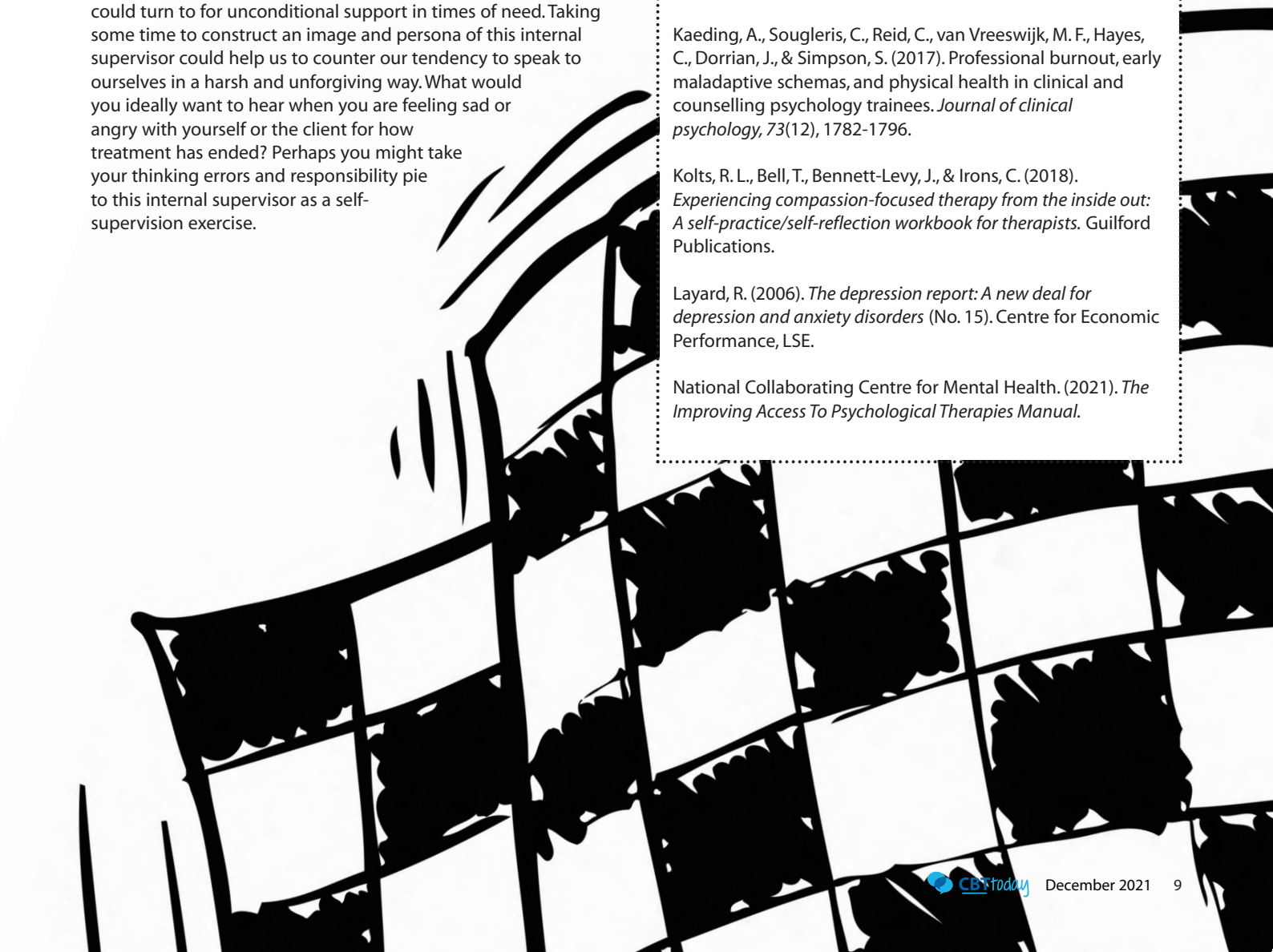
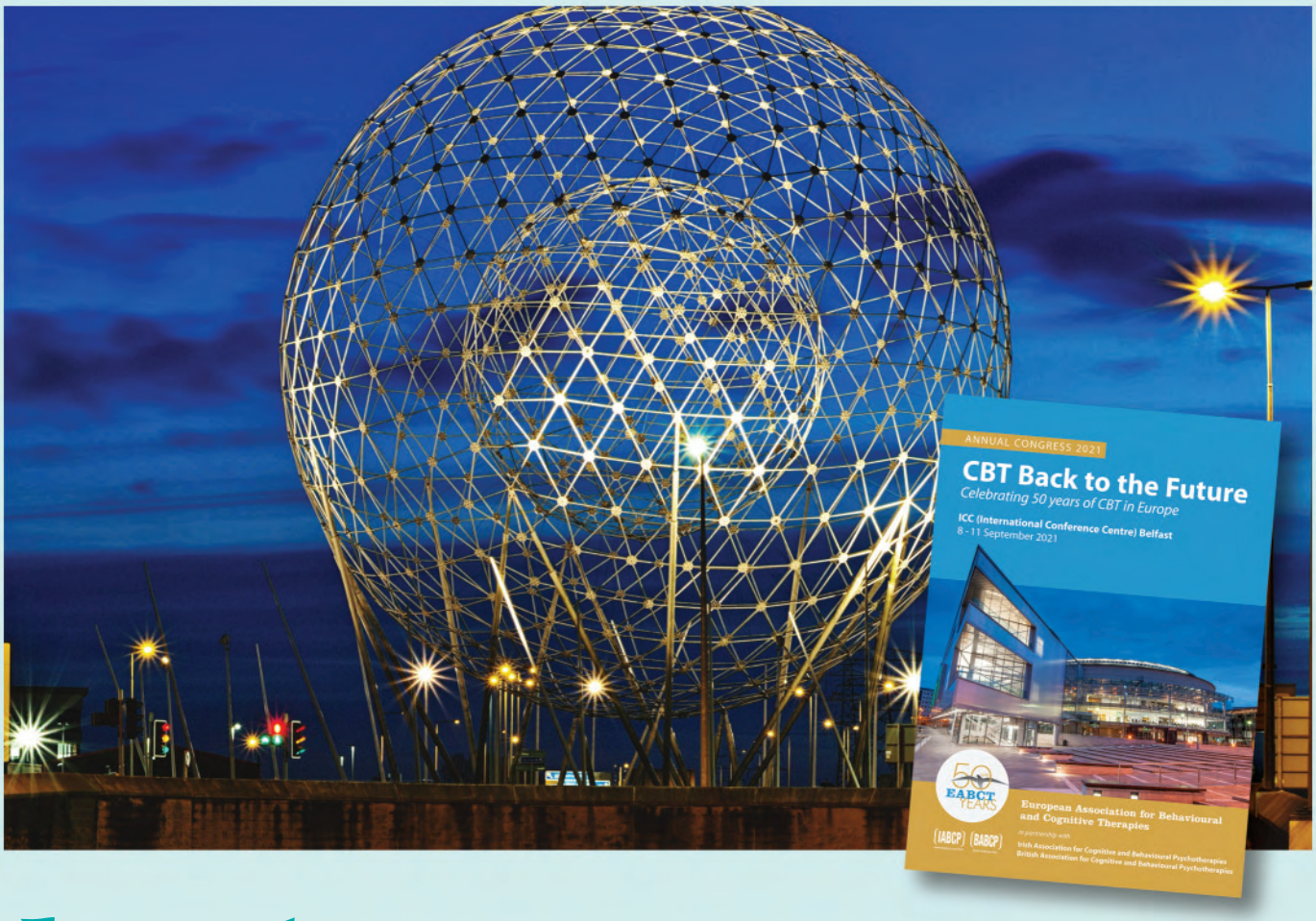




belfast

Conference review

Long before we even imagined that a pandemic would change our lives, the Irish Branch of the BABCP won their bid to host the 2021 EABCT Congress. They chose the International Convention Centre (ICC) in Belfast as the venue – where we successfully held our Annual Conference in 2016. This was the third time that the EABCT Congress was held in Ireland following Wexford in 1972 and Cork in 1998.

Choosing Belfast as the host city for the 2021 EABCT Congress was very appropriate because 2021 marked the 50th anniversary of the founding of EABCT and the 50th Anniversary of the Belfast 'Behavioural Engineering' Group, the precursor of the Irish Branch of BABCP. The 'Behavioural Engineering' Group, based mainly in Queens University and Belfast City Hospital, played a key role in setting up the European Association in 1971.

By the time the pandemic took hold early in 2020, planning for the Belfast 2021 EABCT congress was well underway. Although we had to postpone the 2020 BABCP Annual Conference and the 2020 EABCT Congress moved to a virtual platform the Organising Committee of the Belfast 2021 EABCT Congress decided to run a hybrid conference and to give delegates the opportunity to

participate in person or online. This decision was made with the hope that the course of Covid-19 and the vaccine programme would make it possible for many of us to meet face-to-face.

The progress of the pandemic during the spring and summer of 2020 and into 2021 was not easy for anyone as we moved in and out of lockdowns. Uncertainty became something that we all had to manage. In this context planning a major event like a hybrid international conference became a massive task for everyone involved in the organisation. Individual delegates also had to balance ongoing uncertainty about the course of the pandemic, personal concerns about travel and health, local and regional guidelines and travel restrictions, with their own wish to return to some normality.

However, the response to the call for papers was amazing and it was clear that we were could assemble a first-class programme with people presenting from across Europe, and with the majority wishing to attend in person. Opening registrations also showed us that many people wanted to attend and with many more than we expected indicating that they would prefer to attend in person.

As a result 1,571 delegates registered to join the scientific conference and workshop between 8 – 11 September 2021. Delegates registered from 55 different countries. Not only did they join from all the European countries that are members of EABCT but also from as far away as Japan, Australia, Thailand, India, Pakistan, the USA and South America.

The quality of the programme was exceptional, with 22 keynote speakers, 57 symposia, 18 open paper sessions, five panel debates, three roundtables and 12 skills classes. The programme involved over 400 presentations delivered from across the globe. Having a mixture of in-person, live remote, and pre-recorded presentation delivered to a mix of in-person and online delegates was a huge technical challenge.

EABCT 2021 in Belfast was the first conference that the ICC had been allowed to run for 18 months and was also the first fully

(continued overleaf)

> “Over 400 delegates travelled to Belfast, met colleagues and rediscovered the rewards of a live congress. We were even able to have a social programme with a celebration party to mark EABCT’s 50th Anniversary and a gala dinner in the wonderful Titanic Museum.”

belfast

Conference review

Continued

hybrid event to take place in the UK. Travel restrictions and the prohibition on large in-person meetings were lifted in Northern Ireland in August but unfortunately Covid-19 cases in the UK increased over the summer and a number of countries in Europe re-introduced travel restrictions. Therefore many European delegates - including keynotes and workshop leaders - who had planned to attend in person had to attend remotely,

As a result, the conference organisers and the ICC had to try to connect significantly more remote presentations than had been anticipated, often with very little notice or at the last minute. It was disappointing and frustrating that presentations that had been prepared by delegates could not be broadcast as planned. However, we were able to successfully run 95% of the programme as scheduled and delegates were able to watch over 120 hours of recordings of the programme for nearly two months after the congress.

Over 400 delegates travelled to Belfast, met colleagues and rediscovered the rewards of a live congress. We were even able to have a social programme with a celebration party to mark EABCT's 50th Anniversary and a gala dinner in the wonderful Titanic Museum. As a special bonus the Northern Ireland Assembly lifted their restrictions on dancing just a few hours before the gala dinner...and how we danced that night!

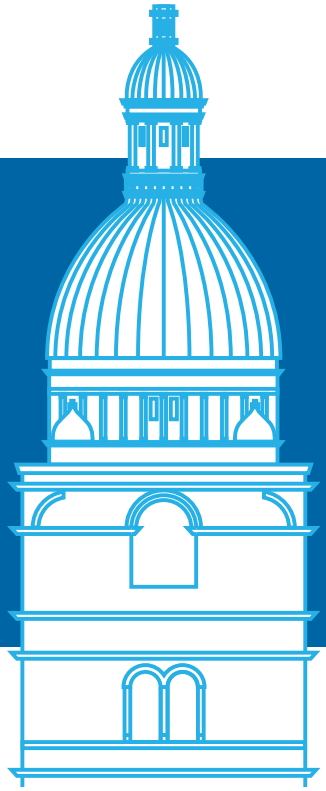
Running a fully hybrid conference with 10 parallel streams is not something we expect to have to do again. But the experience taught us a lot and will use this experience to improve the accessibility of our future annual conferences.

Looking forwards beyond our own BABCP conference, in Belfast we also heard that EABCT had decided to hold their 2025 Congress in Glasgow. This will be hosted at the same venue as the recent COP26 meeting. Planning has already started and we look forward to welcoming all BABCP members to a Covid-free international conference experience – it is not to be missed.

IABCP/BABCP Congress and scientific organisers

BABCP's Annual Conference Returns

Join us for the start of our 50th Anniversary celebrations



BABCP
50th Annual Conference
IMPERIAL COLLEGE LONDON

20-23 July 2022

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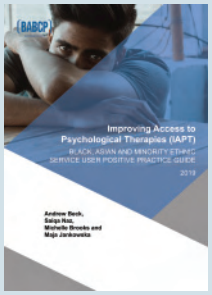
Sharing platforms and experiences at the EABCT Congress

The September 2021 ***EABCT Congress/BABCP Annual Conference*** *presented opportunities for many new presenters, with three writing about their experiences in Belfast.*

Leila Lawton, Cognitive Behavioural Psychotherapist

Flying for the first time since the pandemic made this event feel extra special for me. The opportunities for in person meeting, both professional and personal, a range of symposiums and master classes at our fingertips. This seemed significant in a multitude of ways. Although this doesn't mean that there was no stress involved in the process, balancing needs of home, work and children before setting flight. The relief came when the plane took off and to another degree once our symposium was completed. Excited to cross virtual platforms and real seas, to connect with a number of dear friends and colleagues.



My first time attending the EABCT I had the privilege of presenting a symposium alongside esteemed colleagues Michelle Brooks-Ucheaga (University of Derby and co-author of the 2019 *BAME Positive Practice Guide*) and Dr Romana Farooq (Cumbria, Northumberland, Tyne and Wear NHS Trust and Newcastle University) with our chair former BABCP Equality & Culture Chair - now President-elect, Saiqa Naz.

Our symposium *"Is CBT only for White People?"* - a controversial and important piece, shared our learning from research in clinical practice, where we unpacked the anti-racist foundations needed for CBT therapists to meet the needs of their patient populations. We explored what it means to be anti-racist, how this evolves through teaching and training, and centring the importance of critical reflection and interrogation of our relationships with race, power and privilege. We demonstrated the importance of developing the knowledge, skills, beliefs and confidence to both adapt therapy and have conversations (that might feel difficult or anxiety-provoking) regarding the everyday experiences of racism that our patients are likely to experience. We then provided a frame to the canvas and a rationale for CBT therapists to include local, national, and international context into individual formulations and therapeutic conversations and interventions, concluding with highlighting the integral role of supervision. We benefited from the wisdom, expertise and sacrificial time provided by Richard Thwaites and Andrew Beck.

With the impact of inequity within our systems highlighted during the pandemic, this has created a healthy thirst quenched by anti-racist practice. Having opportunities to present these topics on such platforms can help mitigate the implications of racial battle fatigue.

As members of the BABCP Equality and Culture SIG, we were excited to network share ideas and promote the *BABCP Positive*

Practice Guide for racially minoritised communities. The depth and richness in the different workshops and symposiums reinforcing the multiple layers of CBT.

Networking between attending rich, engaging and informative workshops, roundtable discussions and symposiums was invaluable. Although new and old connections were also reinforced through explorations of Belfast's streets, pubs and dance floors. Performing with an Irish band and singing in the streets was priceless. Moving moments much needed in the wake of deeply disturbing atrocities locally, nationally and globally. Moved to tears at times, a rainbow of emotions, sharing life challenges, hopes and aspirations.

There is a cost in attending which for some is met by university affiliations and others met by personal pockets. I wanted to consider accessibility, what does it mean to be present? To have the access to such wide-ranging high quality continued professional development. The networking and therapeutic interactions do not solely take place on teaching platforms and within conference rooms. Sincere thanks to Saiqa, @NotaPWPguru, Shah, Afsana, Daniella, Peter, Helen, Monnica and many more.

Dr Shah Alam, Clinical Psychologist & CBT Therapist

This was my first time in Ireland and also presenting a piece of my own research, which is really meaningful to me, as it was part of my doctoral thesis. I researched into exploring mental health within my own community, with British Bangladeshi Muslim men. I was glad to have been introduced to two other trainee Clinical Psychologists (Hasan Waheed, University of Manchester; Bianca Vekaria, University of Southampton) and a lecturer (Afsana Faheem, University of Bath) through Saiqa Naz and Andrew Beck. With online working and video chats, we all got to know each other and work on creating a research symposium focused on reducing health inequalities for minoritised people. I was inspired by the work of my colleagues and the shared values we have, research to help better service minoritised people within healthcare.

The conference was a brilliant opportunity to meet some of the people who supported me and shared my research over social media and helped to open up other avenues and opportunities. It gave a space to network in person with people from different parts of Europe and meet colleagues who I had trained with in the past. I enjoyed exploring Belfast and exploring the city, catching up with friends and colleagues who I had not seen in years! The hybrid platform also meant that people could join in person or online. There were a fantastic range of speakers and

(Continued overleaf)

Sharing platforms and experiences at the EABCT Congress

Continued

talks, which I had the privilege to join and contribute to.
As much as I am grateful to have been able to attend the conference and have the opportunity to present my research, as soon as I walked into the main conference room where everyone was seated around round tables there was a clear disparity and difference. Amongst all the people, the majority were white and there were fewer racially minoritised people. This was clear to me, as a Bangladeshi Muslim man. I could understand when I thought about this to myself, tickets to the conference were priced at a point which would exclude people. Not only this conference but others that are widely held. I was only able to attend due to my university funding me and I remember thinking at the end of the conference, I would really love to attend next year but can I really afford this? As much as conferences are needed, I urge people to question who are they for? Who is able to attend? What barriers exist? Who are the research symposium, skills classes and workshops reaching and who is excluded? In order to address wider inequalities, these conferences need to become more accessible.

I acknowledge that now I have completed my doctoral training, I hold a position of power and hope to use my professional privilege, being a 'minority' in the field to better serve minoritized populations.

Afsana Faheem, Lecturer in Applied Clinical Psychology at University of Bath

If I had to sum up the conference in one word, it would be 'inspirational'. I was fortunate to present findings from my PhD research for the first time at an international conference. My study explored whether evidence-based psychological therapies are suitable to the needs Black, Asian, and Minority Ethnic (BAME) service users accessing Improving Access to Psychological Therapies (IAPT) services. Our symposium, titled "Tackling mental health care inequalities: Inclusion of diverse communities within culturally responsive clinical practice" was co-presented with clinical psychologists Shah Alam, Hasan Waheed, and Bianca Vekaria. It was a pleasure to have worked alongside such capable and committed clinical practitioners who are actively seeking ways to diversify clinical psychology and make it more inclusive. The alignment of our research, experiences, and pathways to clinical psychology brought us together as a team and made this opportunity incredibly meaningful.

Not only this, but the conference offered a platform for me to meet others that exuberate talent and passion for the field. This includes Leila Lawton, Saiqa Naz, Daniela Zigova, and Dr Andrew Beck. The instantaneous connections I developed at this conference led to many days (and nights!) of sharing personal experiences, planning collaborations, and not to mention… lots of laughter! Ireland was truly a magical place. I loved meeting the locals, hearing their stories, and venturing out to take in Ireland in all of its glory! But what I took away the most, was life-long friendships that would not have existed if it wasn't for the conference bringing us together in a shared space. Diversity matters. Feeling that I am represented in research and within such events matters. I hope that this is the start to many more wonderful experiences, with opportunities for others to shine their light within the sector.

There is a lot of space on these platforms that needs to be filled, increased diversity in these spaces equates to balanced shared learning widely decimated. Access, experience and outcomes need to be considered for both patients, trainees and qualified therapists.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What should we be offering people who are refugees or seeking asylum?

News reports of the evacuation of Afghan nationals fleeing Kabul earlier this year forced us to confront the reality of what it means to be displaced due to persecution and war.

Thousands of these families were evacuated to the UK. Some are British Citizens who were working in Afghanistan and many others have sought asylum. Reports suggest that there are a large number of family groups, as well as lone individuals.

Adult asylum seekers and refugees present with depression and post-traumatic stress disorder (PTSD) at fourteen and fifteen times the rate of the general population respectively. Child asylum seekers and refugees show rates of PTSD five times greater, and depression two times greater than in the general population.

Nevertheless, many asylum seekers and refugees do not experience mental health problems, and not all emotional difficulties experienced are well captured by existing diagnostic categories.

Risk Factors for mental health problems in people seeking asylum or are refugees

The greatest risk factor for mental health problems in asylum seekers and refugees is the number of traumatic events the person has experienced and how closely involved they were in these events. While the traumas generally occur in the country of origin, they can also take place during the refugee's flight to the UK.

Pre-and peri-migration factors associated with mental health problems in asylum seekers and refugees	Post-migration factors associated with increased mental health problems in asylum seekers and refugees	
	Adults and children	Children only
• Number of traumatic events experienced • Proximity to traumatic events	• Detention during asylum process • Longer asylum process • Dispersal • Financial hardship • Physical health problems • Discrimination from host population • Unemployment (adults only) • Lack of proficiency in host language • Lack of social support	• Parental mental health problems • Lack of social network • Schools with lack of preparation for refugee children • A greater number of moves during asylum process

Post-migration factors are also very important and are the areas in which we can intervene once people are asylum seekers and refugees in a safe country.

In 2019, Dr Kerry Young and Dr Nick Grey co-produced a briefing paper for the Home Office about what mental health services should be offered to refugees. In this, they reviewed available evidence and interviewed UK experts . To date, statutory support across the UK has not been co-ordinated, with many refugees and asylum seekers receiving help from a range of charities local to where they are living.

The recommendations which follow are based up on the findings in that briefing paper.

Recommendations for Adults:
For adult asylum seekers and refugees, it is important that we help them if necessary to:

1. Access primary care – we might need to educate providers about legal entitlements to care, the need to provide interpreters to help them register with and talk to GPs, the need to extend appointment times to account for interpreting

2. Ensure that their physical health needs are properly investigated alongside any mental health problems

3. Ensure adults seen in secondary mental health services are given a comprehensive needs assessment

4. Access safe and suitable housing

5. Access English language classes and opportunities to enter employment, education or training

6. Access early evidence-based treatment of identified mental health problems – particularly PTSD, but also depression, anxiety, traumatic bereavement, anger, self-harm, suicidality.

Recommendations for children:
For child asylum seekers and refugees, it is important that we help them if necessary to:

1. Access comprehensive assessment in the context of their family, school and community environment. These assessments should also include physical and neurodevelopmental factors.

2. Receive a stepped care model of intervention, with low intensity interventions offered in schools by Education Mental Health Practitioners (EMHPs) and high intensity therapies out of schools. These interventions must follow NICE guidance.

3. Ensure that the mental health needs of their parent(s)/carers are met

(Continued overleaf)

> "The greatest risk factor for mental health problems in asylum seekers and refugees is the number of traumatic events the person has experienced..."

What should we be offering people who are refugees or seeking asylum? *Continued*

What are the evidence-based treatments for mental health problems in people seeking asylum or are refugees?

PTSD

There is clear evidence for the effectiveness of treatments for PTSD and comorbid conditions, in both adult and child asylum seekers and refugees. Various meta-analyses [1-3] and systematic reviews [4-8] have reached similar conclusions. First line treatments are psychological therapies with a trauma focus – that is, where the traumatic events are discussed in detail.

The trauma-focused therapies that are recommended for adults with PTSD in NICE guidelines[9], are trauma-focused cognitive behavioural therapy (TF-CBT)[10] and Eye Movement Desensitisation and Reprocessing (EMDR)[11] . NICE guidance describes Narrative Exposure Therapy (NET) as a form of TF-CBT. NET should be considered separately from other TF-CBTs for the treatment of PTSD in asylum seekers and refugees, as it was developed for this population. It was developed originally as a treatment to be used in refugee camps in low income countries. In recent years, it has been evaluated in middle- and high-income countries. Of recommended treatments for PTSD in asylum seekers and asylum seekers and refugees, NET is considered to be the most culturally appropriate.[12. 13] Currently, NET is accepted as the treatment with the most evidence for effectiveness in treating PTSD in adult asylum seekers and asylum seekers and refugees who have experienced multiple traumatic events.

In cases where the psychological treatments have not been helpful or where the adult refugee is also suffering from depression alongside PTSD, NICE recommend a particular category of anti-depressant medication known as SSRIs (Selective Serotonin Reuptake Inhibitors).

For treating PTSD in children and young people, NICE recommends that TF-CBT should be offered first. This is similar to the treatment for adults but also encompasses greater involvement of the wider system, including caregivers/parents, other family, schools etc. There is a form of NET that has been developed specifically for use with children called KidNET.[14]

There are not yet studies examining its use in high income countries but it has been successfully trialled in low income countries. KidNET can be considered to be part of the broader family of TF-CBTs and as such may be of benefit to refugee children with PTSD.

Experts agree that timely treatment of PTSD in refugee adults and children allows wider social benefits. Once their PTSD has been treated, asylum seekers and refugees will be better able to concentrate to learn English, to engage in meaningful activity and to be well enough to consider work if appropriate.

Depression

The systematic reviews and meta-analyses find that when asylum seekers and refugees are suffering from both PTSD and depression (which is commonly the case), treating the PTSD with a trauma-focused therapy also improves levels of depression. Otherwise, there is no available evidence for the treatment of depression alone in adult or child asylum seekers and refugees. Experts agree that, in such cases, clinicians should follow NICE guidance for the treatment of depression and culturally modify on a case-by-case basis.[15]

What about low intensity interventions?

Experts agree that existing psycho-educational materials for anxiety and depression will work well with refugee populations, although they may need to be culturally adapted on a case-by-case basis. These materials may need to focus more on the effects of multiple traumatic events (if appropriate.) In addition, if they have been through many traumatic events, asylum seekers and refugees are also more likely to experience dissociation. Please see Chessell et al. (2019)[16] for a practical guide to working with dissociation in this population.

Training

In line with expert recommendations, training has begun for IAPT services to enable them to provide evidence-based help to refugees and asylum seekers. Funded by Health Education England

Evidence-based treatments for PTSD in adult asylum seekers and refugees	Evidence-based treatments for PTSD in child asylum seekers and refugees
First line treatments are psychological therapies where traumatic events are discussed in detail: • **Trauma-focused CBT - which includes Narrative Exposure Therapy** • **EMDR** **Second line treatment is SSRI anti-depressant medication.**	**Only recommended treatments are psychological therapies where traumatic events are discussed in detail:** • **Trauma-focused CBT (which could include KidNET)** **Second line treatment is to consider EMDR.** **No medication recommended.**

Evidence-based treatments for PTSD in adult and child asylum seekers and refugees

and run from the London CBT Training Centre, the programme began in June 2021. It is being delivered to services where refugees are settling around the country. High Intensity Therapists are invited to apply for the training package, which involves three days training to deliver evidence-based therapy, directed self-study and six, monthly supervision sessions from refugee experts.

Dr Kerry Young and Dr Nick Grey

Resources

Woodfield Trauma Service has produced a number of films for patients – in English, Arabic and Farsi - that can form part of low intensity interventions. They have also produced protocols for psycho-education, dissociation and Behavioural Activation in this population. Links to these resources will be hosted on the BABCP website in the Featured Article section.

The Centre for Anxiety Stress and Trauma has also gathered translated materials for use with refugees and asylum seekers (castcentre.org)

We also recommend that all psychological therapy services read and act on the IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide (Beck et al, 2019).[17]

For those working with Unaccompanied Asylum Seeking Minors, please read recent helpful guidance, 'Practice guidelines for clinical psychologists for supporting appropriate care and treatment for Unaccompanied Asylum-Seeking Minors in the United Kingdom' (Said and King, 2020) available at https://acpuk.org.uk/guidelines_for_working_with_uam/

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LONG-COVID:

a multi-professional approach to treatment

An IAPT Long Term Conditions team at Rotherham, Doncaster and South Humber NHS Foundation Trust present findings on group efficacy, outcome measures and patient feedback of Long-Covid treatment approaches.

What is Long Covid?

The NICE Guidance (2020) provides 3 sub-categories of Covid-19:-

- Acute Covid-19 infection = >4 weeks
- On-going symptomatic Covid-19 = 4-12 weeks
- Long-Covid or Post-Covid-19 syndrome – symptoms 12+ weeks

Long-Covid is a multi-system disorder, symptoms may include (NIHR,2021):

- Respiratory symptoms – shortness of breath, persistent cough
- Musculoskeletal symptoms – joint pain, muscle pain, fatigue
- Cardiovascular symptoms – chest pain/tightness, palpitations, arrhythmias
- Neurological symptoms – headaches, dizziness, reduced concentration, forgetfulness
- Gastrointestinal symptoms – nausea, abdominal pain, anorexia
- ENT symptoms – loss of taste/smell, swallowing difficulties, earache, sore throat
- Psychological symptoms – anxiety, depression, PTSD, sleep disturbance and cognitive damage due to hypoxia
- General symptoms-persistent fever and rashes.

Long-Covid is a phenomenon that has been increasingly recognised over the past 18-months (Greenhalgh, 2020; RCGP, 2020). Within this short article information will be provided regarding Long-Covid and descriptive information concerning a local CBT based group pathway, delivered by IAPT Clinicians and Cardiac and Pulmonary Allied Health Professionals.

The treatment for Long-Covid is emerging and developing and advocated to be approached from a collective physical and psychological perspective (NHSE/I,2021).

Effects

The effects of Long-Covid can be varied and in some cases very debilitating. Many people describe the experience as having a significant impact on family life and caring responsibilities. People's ability to work is affected significantly in the first 3 months, and over one-fifth of people also report an inability to work 6 months after their initial Covid-19 symptoms. The difficulty in working may then have financial effects. These factors can then result in a worsening of mental and physical health.

Prevalence

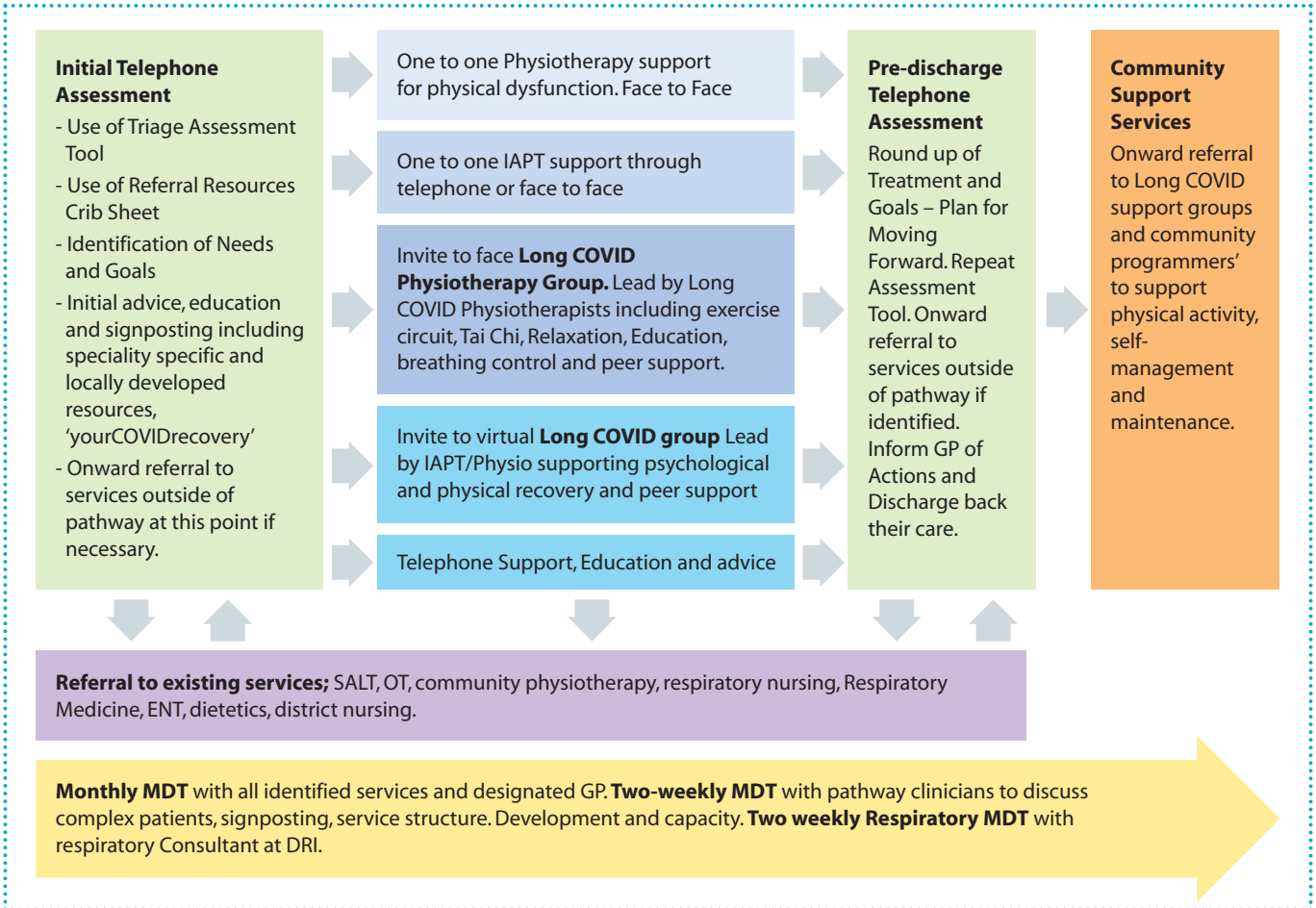
The ONS (2021) estimated 1.1million people in the UK experienced Long-Covid symptoms in March 2021.

Treatment

A treatment pathway has been developed locally for Long-Covid which focuses on a holistic, individualised and de-medicalised model of care, place emphasis on self-management and patient empowerment.

A local training programme has been developed to upskill psychological therapists. A monthly MDT forum has also been established led by a cardiorespiratory physiotherapist and GP which includes input from SALT, Dietetics, OT and Community Nursing. The service pathway is detailed in Figure 1.

Figure 1



Within this pathway a 4-step treatment approach is available:

- **Step 1 – Education and self-management via telephone**
  Information resources used include the NHS 'YourCOVIDrecovery' website, British Thoracic Society and locally developed material.

- **Step 2 – Long COVID Psychological and Physical Therapy Group (virtual)**
  This is a bespoke virtual group conducted by IAPT CBT practitioners and Physiotherapy team, and is a 12-week programme.

The group includes understanding Long-Covid, fatigue management, pacing, energy conservation, return to physical activity and exercise, vocational support and return to work, management of breathlessness and breathing control and relaxation.

There is also a focus on longer term self-management and coping strategies. The aims and objectives of the group are detailed in Figure 2 below.

(continued overleaf)

Figure 2

The aims of the group are:

- To educate and teach evidence based, Cognitive Behavioural Psychotherapy (CBT) interventions, to promote recovery from symptoms associated with Long Covid
- To give people the opportunity to share experiences and recommendations with others who are also recovering from COVID19
- To increase activity and social contact, in a helpful way, to aid symptom reduction

Six sessions are held fortnightly to allow for learning to occur, the group helps people:

- Understand the cycle of wellbeing and the role of behaviours whilst considering values and emotional influences of values not being evident in one's life
- Identify the impact of activity on emotional and physical health, whilst looking at what might behaviourally need to change
- Highlight behaviour patterns and consider room for improvement to have positive impact on individual body conditioning physically and emotionally
- Wholly bring together and implement learning thus far, whilst sharing importance of maintaining for physical and emotional recovery
- Recognise impact of learning and practice, whilst identifying possible obstacles to progress before considering how such obstacles might be better managed to engender positive change both physically and emotionally
- Consolidate learning and overall impact on physical and mental health whilst considering how to prevent setbacks

LONG-COVID: a multi-professional approach to treatment

continued

> The effects of Long-covid can be varied and in some cased very debilitating.

> People's ability to work is affected significantly in the first 3 months, and over one-fifth of people also report an inability to work 6 months after their initial covid-19 symptoms.

- **Step 3 – Long-Covid Physiotherapy Group (face-to-face)**
  The group also has a holistic physical and psychological approach to care (therapists are CBT trained) and includes and exercise component, Tai Chi, education, relaxation and breathing control. There is also the peer support element. The group also runs over 12-weeks, outcome measures used are:-MRC breathlessness scale, Fatigue Severity Scale, DASI (physical activity index), Grip strength, GAD7 and PHQ9.

  Groups are delivered in a leisure centre setting which fits with the de-medicalised model of care. This integrates patients into a functional community setting and aims at enabling people to have the confidence to engage in these settings, where appropriate, on discharge.

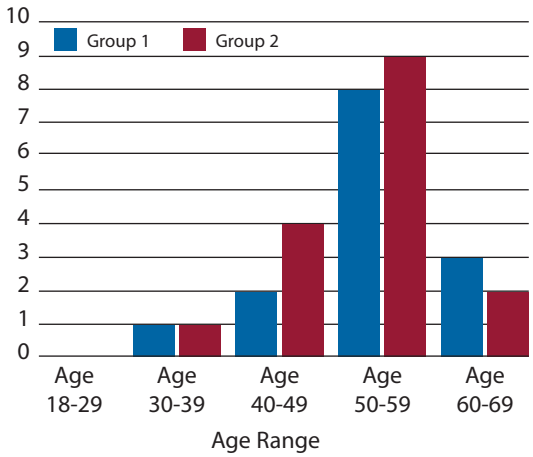
- **Step 4a – 1:1 Psychological Therapy**
  Patients with more complex psychological needs or who decline or are unable to attend the group are offered 1:1 support from IAPT practitioners.

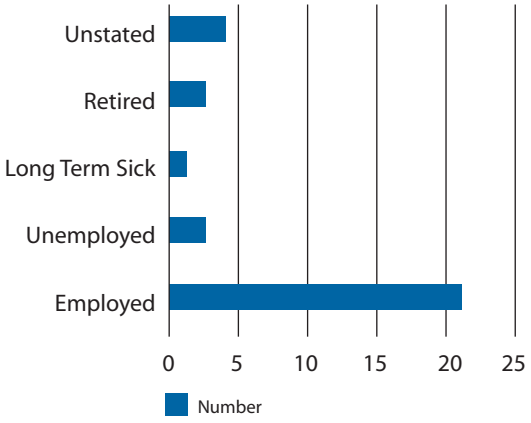
- **Step 4b – 1:1 Physiotherapy**
  This may take place in a clinic, outdoor, home or leisure centre setting depending on patient need and preference. Appointments are offered out of normal working hours and on a more ad hoc basis to accommodate patients with work, childcare, and other commitments with sometimes negates participation in the groups.

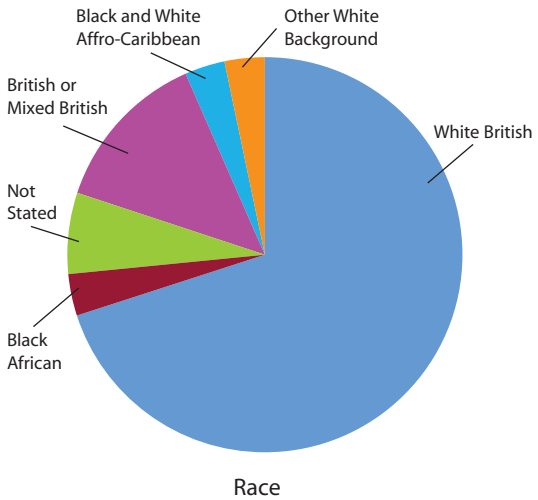
Pilot CBT Group Results

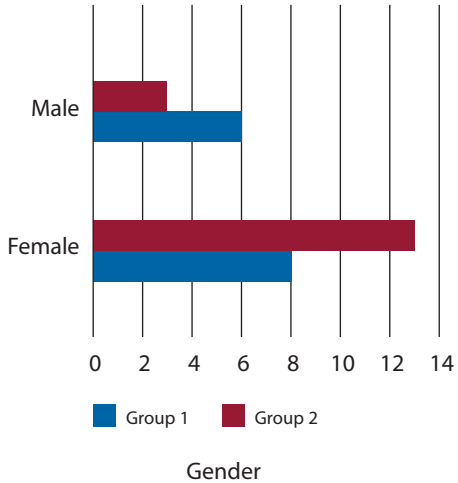
Two Step 2 group programmes have now been completed, with a third under evaluation. Below are initial outcomes for the two groups.

Figure 3
Demographic Information









30 people accessed the service separated into two group cohorts. The demographics of the cohort accessing the services is aligned with the national reported experience for Long-Covid; the largest number of people in the cohort being white, employed females between the ages of 40 and 60.

Outcome measures used in the groups were PHQ9, GAD7, WSAS, Phobia scales which are consistent with and IAPT LTC bundle. Recovery rates varied; seven members of the group were unable to be included in the recovery rates as they did not attend all of the sessions. Of those who participated an average recovery rate of 49% was achieved over the two groups.

Qualitative feedback was also received which indicated that people felt the method and content of delivery was helpful, that the group setting and ability to share was helpful, and even those who did not achieve statistical recovery in terms of the outcome measures described a positive benefit to their health and wellbeing through group engagement,

Challenges

1. As Long-Covid is an emerging phenomenon we are 'learning as we go'. Our learning is derived from research and from experience from our patients and clinicians.
2. Non-recurrent funding for Long-Covid treatments makes recruitment and forward planning more difficult.
3. Engaging underserved communities is a national problem, however we are working locally with community links to tackle barriers and increase inclusivity.

Positives

1. Our service has been well received and people are discharged who have either recovered or are on a recovery journey. All patients report having developed better skills to self-manage.
2. Although there are no clear treatment comparators, when we compare our Long-Covid group attendance with other IAPT LTC groups we have experienced a lower DNA rate.
3. Funding has enabled equipment, patient resources, specialist training and adequate staffing to deliver treatment.

Conclusion and Next Steps

Within this short article we have attempted to provide details about Long-Covid and also detail a case example concerning coproduced treatment. The results from the initial CBT group programmes demonstrate positive improvement for patients and have comparable results in terms of other LTC group programmes.

We are hopeful that the evidence presented will be helpful for others developing services for Long-Covid and our results are also being considered in terms of extending funding for treatment beyond the current allocation.

We are proud of our achievements, but are also progressing our next steps, some of which are summarised below:

- Analyse and share data from Long-Covid Physiotherapy group programme, following the completion of three cohorts.

- Build upon the patient information, resources videos, web pages and adjuncts to treatment.

- A research project has been commenced with a partner University and a Culture and Leisure Trust regarding the use of 'Power Assisted Exercise' which will expand treatment options.

- We are progressing an enhanced communication programme to increase the reach of the service and enhance accessibility inclusivity to help reduce health inequality and target underserved populations.

- We are working with an app design group who concerning digital applications which allow patients to complete questionnaires that align with our outcome measures and dataset and feeds directly into the clinical records system. This app has been used in different NHS trusts and is developing rehabilitation content in conjunction with the World Health Organisation.

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The Memorandum of Understanding against Conversion Therapy

As an organisation, we are proud to be among the coalition of signatories to the UK Memorandum of Understanding against Conversion Therapy in the UK (MOU2), who have updated their commitment in November 2021 to "…work with Government in achieving its promise of bringing forward legislation that will be paramount in ensuring LGBTA people are protected from the abhorrent practice of Conversion Therapy".

Conversion therapy refers to therapeutic models, approaches or viewpoints that attempt to change or suppress someone's sexual orientation or gender identity or expression. These approaches are based on assumptions that some sexual orientations or gender identities may be inherently preferable to any other. Such practices are sometimes referred to using terms such as 'cure' or 'repair' of someone's sexual orientation or gender identity. In May 2021, the UK government committed to ensuring that such approaches will be banned.

We agree with the other signatory organisations of the MOU2 that these practices are unethical and may be harmful. Being stigmatised, excluded or suppressed and subjected to additional stress due to gender expression, identity or sexuality can lead to emotional distress, making substance use or suicidal behaviours more likely. The diversity itself is not pathological, it is repression and marginalisation which is harmful.

The British Psychological Society guidelines on gender, sexuality and relationship diversity outlines best practice in relation to working with people, whether or not these specific diverse characteristics are the focus of therapeutic work.

At a recent event, we heard people with lived experience speak about what happened to them. Survivors of conversion therapy shared experiences of physical abuse at the hands of therapists using electric shocks to attempt to change their sexual orientation. Another example was being given 'therapy' in a religious context to change their sexuality. Someone else had 'counselling' to help them to choose to completely suppress their authentic self-expression, in order to avoid being excluded by their family, community and faith group.

It is deeply uncomfortable to hear about these coercive practices and abuses of power which were promoted as 'therapeutic' by those delivering them.

The MOU is not aimed at discouraging or disallowing people who seek help for feeling uncertain, in distress or needing professional support around their sexuality or gender identity. This is not the same as therapists behaving as if gender and sexuality variations are disorders or require 'treatment'. The MOU2 document states: "For people who are unhappy about their sexual orientation or their gender identity, there may be grounds for exploring therapeutic options to help them live more comfortably with it, reduce their distress and reach a greater degree of self-acceptance. Some people may benefit from the support of psychotherapy and counselling to help them manage unhappiness and to clarify their sense of themselves. Clients make healthy choices when they understand themselves better."

We want to support and promote ethical practice, and recognise that, as clinicians, we may need to seek additional training to have enough knowledge and understanding of the spectrum of gender and sexuality diversities. This can be part of initial training, or continuing professional development. The BPS document includes the expectation that psychologists will promote acceptance and challenge misconceptions.

Using self-reflection is also key to promoting respectful and inclusive working. We recognise that we will not be bias-free in our work. This means that we will benefit from reflecting on our own sexuality and gender diversity; our own history, beliefs and context. Making use of clinical supervision and seeking CPD opportunities will help us to provide more inclusive services, it will also help us to be aware of our limitations and act appropriately in the best interests of our clients.

Helen Macdonald,
BABCP Chief Accreditation Officer and Registrar

"It is deeply uncomfortable to hear about these coercive practices and abuses of power which were promoted as 'therapeutic' by those delivering them."

Further reading

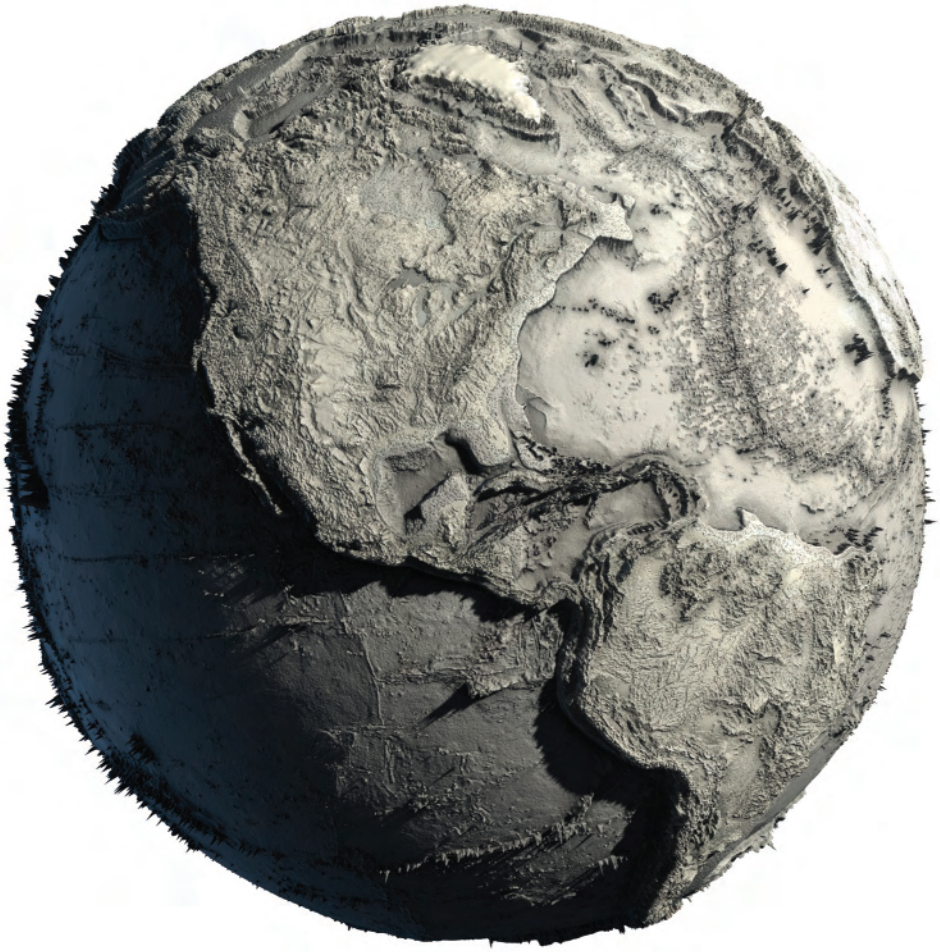
Memorandum of Understanding (Version 2)
https://bit.ly/MOU2babcp
https://www.babcp.com/Portals/0/Files/About/Press/Memorandum-of-Understanding-Conversion-Therapy-UK-compressed.pdf?ver=2020-07-07-112248-533

British Psychological Society: Guidelines for psychologists working with sexuality and relationship diversity
https://bit.ly/bpsgsrd
https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Guidelines%20for%20psychologists%20working%20with%20gender%2C%20sexuality%20and%20relationship%20diversity.pdf

UK Government: Plans to introduce legislation to ban conversion therapy
https://bit.ly/govctban
https://www.gov.uk/government/news/government-sets-out-plan-to-ban-conversion-therapy

UKCP statement: Conversion Therapy
https://bit.ly/ukcpct
UKCP statement: Conversion therapy (psychotherapy.org.uk)

Stonewall: Queen's Speech statement
https://bit.ly/stoneqs
Stonewall statement on the Queen's Speech | Stonewall



CBT in a time of climate emergency

With COP26 just behind us, we are more aware than ever of climate change, says **Dasal Abayaratne.** *Yet the mental health effects of climate change are little discussed. I am no expert in this area; however, in this piece I will try and scratch the surface of how we as CBT therapists might contribute to tackling this wicked problem, based on a recent case.*

The Problem

Anthropogenic climate change is real (IPCC, 2013). It can impact mental health via numerous pathways. This includes the direct impact of trauma associated with extreme weather events, as well as the indirect impacts of vicarious trauma and chronic stress associated with witnessing a changing planet and imagining a future in line with predictions (Lawrence et al., 2021). Turning on the television, we are all too aware of the impacts of climate change.

At times, I feel saddened, and even overwhelmed when I think about this. So called climate emotions, e.g. anxiety, sadness and anger, are now common (Clayton, Manning, Speiser & Hill, 2021). The future of the environment has made 43% of British adults feel anxious at least monthly (Office National Statistics, 2021) and 45% of young people are affected by sad feelings about climate change daily (Hickman et al., 2021).

Where does CBT fit in? My experience

Affected people are increasingly presenting to mental health services. More than 50 percent of child psychiatrists reported seeing young people with climate anxiety in clinic (Royal College of Psychiatrists, 2020). Last year, I had the experience of working with a 43-year-old woman who was referred with anxiety and depression, of which climate anxiety was a large component. I was unsure how to approach this, and how relevant CBT might be. I was not alone in this. Most surveyed therapists feel their training didn't prepare them for such presentations (Seaman, 2016).

My first thought was to target misappraisals of threat likelihood and severity as we might in other forms of anxiety (Salkovskis, 1996). Using this model faulters. Instead of being pathological misappraisals, climate anxiety instead might be viewed as a proportionate and even protective response to a planet-sized existential threat that we are already facing. It is threatening and it is likely. Other approaches however might have a role, such as increasing resilience and adaptive behaviours in response to this normal anxiety.

On further assessment, my patient presented with beliefs of high personal responsibility for climate change, that they were not doing 'enough' in response, as well as behavioural responses of self-criticism, avoidance, and behavioural disengagement to the point they'd "given up trying". These are all areas CBT therapists are familiar with. Together, a collaborative case formulation was built, and maintenance processes targeted. Pie charts (Greenberger & Padesky, 1995) were used to examine personal responsibility for climate change and action, and continua (Padesky, 1994) used to challenge dichotomous perceptions of doing "enough" and "caring". Alongside, a sense of acceptance was built. New compassionate beliefs and behaviours were constructed, acknowledging its okay to rest and not be constantly "fighting" climate change.

Finally, new adaptive behaviours were built, linked to the patient's key values of climate justice and her updated balanced beliefs. They were encouraged to choose behaviours that would move them "that bit closer" to these goals, for example, writing to their MP and joining a community litter pick. These were in part derived from perspective taking exercises focussed on active hope in the face of climate change (Macy & Johnstone, 2012). A combined approach of acceptance and action was adopted, as advocated for matters of social injustice (Padesky & Greenberger, 2020). The patient adopted a position of "yes, climate change is happening. It is awful, but I am doing my bit, in my own way. I don't have to be a superhero. That's impossible". Their depression, anxiety and sense of fulfilment improved and continued to do so at six-month follow-up.

A greener future

We all have thoughts, feelings and behaviours when confronted with the stark realities of climate change. Some of these will be more helpful than others. At a certain level, climate emotions may be beneficial and drive action. Some people however may be more vulnerable to these than others. As CBT therapists, we can have an important role in helping people work through these difficulties and shape adaptive response. This brief case study is just one example of this on an individual level. There are likely more areas to explore, such as working with larger groups, as well as exploring negative response to, and even denial of, climate change. Whilst we may feel unprepared, we have important experience and tools at hand. Other mental health professionals have risen to this challenge. Maybe it is time for us to join them.

To end, I ask anyone reading this to explore their own responses to climate change, ask themselves what it is they stand for in this area, and find just one thing they can do in the next week in line with it.

> "The future of the environment has made 43% of British adults feel anxious at least monthly (Office National Statistics, 2021) and 45% of young people are affected by sad feelings about climate change daily (Hickman et al., 2021)."

Reflection in CBT supervision

Supervision is an important part of therapy practice – it supports accreditation but also ensures we are providing best practice for our clients. But, **Holly Stokes** *asks, where do we as therapists fit into this?*

> Self-reflection is a key skill in ensuring we bring relevant questions to supervision, are open to the process of supervision and can express our own thoughts and feelings to our supervisors.

In a recent conversation with colleagues the question was raised about how much we reflect on ourselves, our beliefs or therapeutic relationships in supervision, particularly within an IAPT framework; for example, within group supervision which equates to around half an hour per therapist to discuss assessments and clients? Our discussion highlighted that in supervision we often focus on problem-solving approaches, such as appropriate treatment options or diagnosis, risk issues or what skill to implement for a specific problem. This led me to think about how supervision is used and if I use it in the most beneficial way.

Self-reflection, within a therapeutic context, is the continuous process of recognising our own emotions, thoughts and behaviours. By reflecting on and recognising these, it allows therapists to hold an awareness of their own inner emotions, process these emotions and consider responses during supervision and therapy sessions. It also allows therapists to identify triggers of stress (e.g. client induced, work-related, home-life etc.). Self-reflection can be done at any point, either within or outside of supervision.

As a newly qualified CBT therapist, I was encouraged in my training to engage in Self-Practice and Self-Reflection (SP/SR) (Bennett-Levy, et al., 2015). This is a strategy to reflect on personal or professional difficulties, practice therapeutic techniques on oneself and then reflect on that process. However, in my experience supervision has tended to focus specifically on professional difficulties or issues a therapist may be having with complexity, skill, or risk. We therefore focus on work we are doing with clients, to ensure we were applying appropriate skills and providing best practice - which is important - but may overlook personal difficulties or beliefs that are having an impact on building a rapport with a client or fully understanding their experiences.

Prasko et al., (2012) discuss that self-reflection can be done in two ways. The first is similar to SP/SR and suggests completing self-reflection in our own time through using traditional CBT techniques. Alternatively, they suggest that reflection can be facilitated through supervision, whereby the supervisor encourages reflection of the therapist's thoughts, feelings, attitudes and beliefs to increase

learning. This method relies on a level of self-disclosure from the supervisee, whereby the supervisee reveals personal information, beliefs, emotions and experiences. For example, I once wanted to discuss the question "am I authoritative enough with clients?". This led to a discussion around my belief that clients will become angry or dislike me if I interrupt them to hold time boundaries. Self-reflection is a key skill in ensuring we bring relevant questions to supervision, are open to the process of supervision and can express our own thoughts and feelings to our supervisors.

Research suggests that there are many benefits to self-reflection and disclosure in supervision. For example, it can help us to manage stress and increase empathy for clients, reduce burnout, increase staff morale, and improve service delivery (Gale & Schröder, 2014). Prasko et al., (2012) discuss that those who are able to self-reflect are better able to understand their own and their clients' emotions, make better decisions and are able to distinguish their own needs from the clients. This in turn helps to recognise when transference may be occurring and to consider appropriate responses during a therapy session, which keep the client's best interests in mind. Milne (2020) confirms this by highlighting how staff burnout or personal distress can lead to harm to the client as increased stress will understandably impact our work if it is not addressed in a skilful and helpful way.

Prasko et al., (2012) go on to discuss that if therapists cannot recognise their own thoughts, emotions and attitudes, they may begin to feel overwhelmed by them, meaning that their emotions or those of the clients may take over or control reactions, at a detriment to both parties.

Haarhoff, Thwaites and Bennet-Levy (2015) highlight that there are barriers to therapists engaging in self-reflection, self-disclosure or SP/SR, such as a perceived lack of time. Other barriers include concerns about being perceived negatively, having differing theoretical orientations, supervisors not encouraging reflection and group settings providing less of an opportunity to focus on individual beliefs. From a personal perspective, I am aware that a barrier for me was being in a group. It took time to work out what is appropriate to share and when. I also felt uncomfortable to share personal information with people I did not know well.

One study suggested that the better the relationship with a supervisor the more likely the supervisee will feel comfortable to self-disclose. Haarhoff, et al. (2015) discuss that it can help for management to acknowledge these barriers by discussing them and promoting the benefits of self-reflection – as mentioned previously on reducing burn-out, encouraging self-care, increasing staff morale and client outcomes. In doing this, therapists may feel safer to self-disclose and reflect on relationships and beliefs.

It raises many questions for me, such as is there enough encouragement of self-reflection within CBT supervision? Are we reflective enough? Can we be more reflective in an IAPT framework - is there enough time for this?

Self-disclosure and self-reflection, as part of the supervision process, are clearly important and can have many positive impacts on all of us – but do we feel able to disclose our beliefs within supervision?

The research suggests that both the supervisee and the supervisor have a role to play in encouraging, completing and being open to self-reflection. Do we encourage each other to speak freely within supervision? If not, how might we create a safer, more supportive environment?

It also seems even more important considering the current pandemic, which has led to lots of change and uncertainty – such as working from home, increased isolation, and lone working alongside completing appointments and supervision virtually. Maybe now, more than ever, self-reflection is imperative to our roles?

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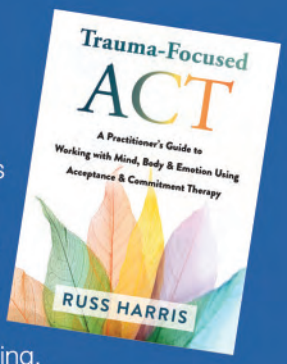

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