Are you sitting comfortably?

What can chairwork offer CBT? - Page 16
Welcome to the latest issue of CBT Today. We have another wide range of topical features in this issue, which I hope continues to reflect the diverse interests of our membership.

In this issue, you should have a nominations form for our Trustee elections this summer. If you want to be a part of shaping the organisation in the next few years, we want to hear from you.

As always, thank you to all our contributors. Please get in touch with ideas for future articles.

Enjoy the summer, however long it lasts this year!

Peter
Peter Elliott
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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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Disclaimer
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Well, this is my last article as President. It’s been a privilege doing this role for the last two and a quarter years – and also a very interesting contrast with the role when I was President in 2001-2. Then, the role was just for one year, and the focus at that stage was on helping prepare the organisation to become a company limited by guarantee. Howard Lomas was CEO, and we were in a small office in Accrington. I was advised by the then past-President, Jan Scott, to choose one main thing to implement that year and focus on that. If only that advice could still apply today.

Sixteen years later, the frequency and demands of the wider organisation have speeded up and expanded enormously. The membership, office and staff are many times greater in size. Yet many of the issues remain the same.

**Statutory regulation** – now very much back on the agenda as this is being introduced in the Republic of Ireland. We wish to support this in order to protect the public – but by doing so there will be potential challenges and risks to the organisation.

**Accreditation** – as always, we want to build the reputation of our accreditation. These last two years have seen a major focus on updating systems of re-accreditation. There has been a strengthening of this, with a move to annual online declarations and a robust audit process.

**Complaints** – The complaints team has worked with our lawyers to update and create a clearer process that enables us to get to the right ‘size’ and to balance this work with the resources needed to deliver it well. In addition, we have agreed recently to employ a Complaints Coordinator to help administer and support these processes.

**IT systems** – have been now put in place to support this work, and these systems are now, finally, starting to work as originally planned. Members should start to see the benefits of this over the coming months.

**The office** – we are looking at scoping a move/purchase or office build. If we did this we could potentially both save money, have a built for purpose base, and potentially rent out space and training areas to other organisations as an income generator.

**Staff** – BABCP is a large organisation with many valued employees. We have recently agreed to implement a staff assisted support scheme inclusive of a support helpline (counselling), and financial help for certain work-related health needs. We have taken on new staff – notably in Finance with an additional Finance Officer and strengthened the finance team with a promotion for Isabelle Scrimms with the advertisement for a new Accounts Assistant to be advertised shortly. We have employed a dedicated full-time Membership and Branch Liaison Manager for the first time (Michelle Livesey), and a part-time Senior Clinical Advisor (Lucy Maddox). As a result, we are more able to influence policy and have joined with wider organisations to better represent CBT and psychotherapy.

**A delivery/communications plan** – BABCP is an organisation which aims to further the practice of CBT. It does this, and can only do this, through the office and staff, the Board and various committees and sub-committees led by excellent chairs, the branches and the members. It can only function effectively when all these different aspects communicate and work well together. A key next step is reviewing and implementing changes to strengthen the governance and delivery arrangements in BABCP with a recently-created draft Aims and Objectives document to help inform our wider delivery and consultation processes – currently itself out for consultation. This aims to summarise how the Board, responsible for the strategic direction of the organisation, will triangulate this with the office, committees and others, to improve communications and deliver of our key goals as a charity, to further CBT.

It’s been a very interesting, and at times challenging last couple of years. I wish our next President, Professor Paul Salkovskis, every good wish. BABCP is both at times demanding, but also an incredibly important and rewarding organisation to be part of. I’d also like to thank Ross White, an incredibly able lead for the organisation, and the staff in Bury and further afield. BABCP couldn’t exist without you. We all believe CBT can change lives. Thank you all for your contributions in helping achieve that.

Chris Williams, BABCP President

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

We made a mistake in the publication of Rob Griffiths’ article *Spot the Difference: Comparing three approaches to CBT* in the February issue of *CBT Today*. The link to Rob’s work should have read [https://soundcloud.com/user-70781254](https://soundcloud.com/user-70781254).

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**GDPR**

With the introduction of tighter data protection regulation from 25 May in the form of the General Data Protection Regulations (GDPR), we have had several requests for information from members about changes that they need to make to their current practice in relation to data protection.

Among these have been requests for clarification on how long records need to be kept.

There is nothing in the *BABCP Standards of Performance Conduct and Ethics* which states specifically the length of time you must keep clinical records. Having said that, for accreditation purposes, members would need to keep records long enough to allow for proper submission of accreditation/reaccreditation applications. You are responsible for agreeing with your clients the length of time it is necessary to keep them.

Any business which keeps personal data is a Data Controller, and it is a requirement for each controller to have in place a data retention policy, as well as a privacy policy which is made available to clients and members of the public, stating what data is collected by you, how, and what is done with that data. Clients have the right to ask for their data to be released to them, or alternatively, deleted completely.

The Information Commissioner Elizabeth Denham said recently: “We want you to feel prepared, equipped and excited about the GDPR. I know many of you do. For those that still feel there is work to be done – and there are many of those too – I want to reassure you that there is no deadline. ‘25 May is not the end. It is the beginning.”

The Information Commissioner’s Office has a wealth of information available free of charge on its website at [www.ico.org.uk](http://www.ico.org.uk) and will gladly help enquirers deal with their GDPR compliance.

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**Course Accreditation**

The Course Accreditation Committee is seeking up to three new committee members to contribute to its work of developing processes and delivering course accreditation on behalf of BABCP.

With over 50 CBT courses in the UK now accredited, including training in CBT, specific IAPT trainings, Doctorate of Clinical Psychology trainings, parenting and children’s work, postgraduate trainings and many courses expressing an interest in becoming accredited; the work of the Committee is increasing.

The Committee meets approximately monthly via teleconference, with at least one face-to-face meeting each year. They also host a CBT Course Directors’ meeting twice per year; and members take part in other meetings as needed, for example with other stakeholders such as IAPT National Teams or the British Psychological Society for example.

In order to join the Course Accreditation Committee, it is expected that you will be a BABCP Accredited Practitioner. You will have interests and experience relevant to course accreditation development processes, and you will be able to take part in accreditation panel visits. Previous experience of taking part in panel visits is an advantage but not essential. Please note that this is a voluntary position, though all reasonable travel, accommodation and subsistence expenses will be covered by BABCP.

Please provide an expression of interest by way of a brief CV and a covering statement of up to 200 words as to why you believe that you are a suitable candidate to join the Course Accreditation Committee. This should be sent via email to Rachel Osborne, Course Accreditation Support Officer, rachel.osborne@babcp.com before 16 July 2018. Please contact Helen Macdonald helen.macdonald@babcp.com if you have any questions or need any further information.

Arrangements will be made for a telephone interview to take place with Sarah Corrie (Chair) and Helen Macdonald (Course Accreditation Registrar) once expressions of interest have been received.
46th BABCP Annual Conference and Workshops

University of Strathclyde, Glasgow
17-20 July 2018

Workshop Leaders and Keynote Addresses confirmed:

Frederike Bannink, Private Practice, Amsterdam
Linda Clare, University of Exeter
Michelle Craske, University of California, Los Angeles
Ray di Giuseppe, St John’s University, New York
Barney Dunn, University of Exeter
Chris Ecclestone, University of Bath
Anke Ehlers, University of Oxford
Alice Gregory, Goldsmiths, University of London
Andrew Gumley, University of Glasgow
Ian James, Northumberland, Tyne and Wear NHS Foundation Trust

Freda McManus, University of Stirling
Richard Meiser-Stedman, University of East Anglia
Rory O’Connor, University of Glasgow
JD Smith, Northwestern University Feinberg School of Medicine, USA
Gail Steketee, Boston University, USA
Michaela Swales, Bangor University
John Taylor, Northumbria University
Hannah Turner, Southern Health NHS Foundation Trust
Glenn Waller, University of Sheffield
Steve Holton, Vanderbilt University, USA

To register and see the full conference programme go to www.babcpconference.com
Around 300,000 people in the UK have Tourette Syndrome (TS), an inherited, neurological condition which is characterised by tics, involuntary and uncontrollable sounds and movements. Dr Seonaid Anderson, Research Manager for Tourettes Action (TA) and Dr Tara Murphy, Consultant Clinical Psychologist, discuss behavioural therapy for tics.

Tics usually start in childhood with a significant reduction in tics or full remission for most (80%) individuals by early adulthood. TS is a complex condition and is often accompanied by co-occurring conditions such as OCD and Attention Deficit Hyperactivity Disorder.

There is no cure, but there are treatments available including behavioural therapy (BT) and medication. Tourettes Action is the national charity in the UK for people with Tourette Syndrome and it offers subsidised training in BT for therapists across the UK as access to BT is frequently sought by patients.

Providing this training is an expensive exercise and disappointingly the uptake for places on the courses has been limited. It would be helpful to open a discussion as to why more clinicians and therapists are not coming forward to take part in the training or with an interest in treating people with TS.

Currently there are no NICE guidelines for treating tics, perhaps down to a lack of research and funding and general awareness of the condition. There was a Health Technology Assessment panel funded by the NIHR which created a systematic review.

This extensive review hopefully has the potential to act as a precursor to the synthesis of NICE guidelines for TS. There are European, Canadian and US guidelines but clear indicators for clinical care is currently limited to expert consensus.

Treatment offered is typically medication for tics but patients often seek behavioural intervention.

The most scientifically validated behavioural treatment is called Habit Reversal Therapy (HRT), which has been shown to be moderately effective when delivered as a package alongside other elements of therapy (CBIT: Comprehensive Behavioural Intervention for Tics). Another BT which has emerging evidence is called Exposure and Response Prevention.

The European clinical guidelines for Tourette Syndrome and other tic disorders suggest that behavioural therapies are ‘first line [behavioural] treatments for tics for both children and adults’. Research in the past 10 years has focused on delivery of effective treatment and has demonstrated successful treatment with BT delivered by telemedicine, group interventions and there are currently exciting projects for children and adults with tics using remote access, online treatments both with and without therapist support.

At Tourettes Action we often hear from clinicians and patients that they would like access to BT for tics but find it a struggle to offer it or find it. Therefore, we wonder why more clinicians and therapists are not coming forward to take part in the training. In order to open a discussion on this subject we suggest that this may be due to several issues.

Treatment of tics may be given a low priority in regards to training. This may be caused by a lack of awareness of the efficacy of treatment for tics, small numbers of referrals, funding difficulties, or that other conditions are given more of a priority for training.
We have spoken to clinicians who are knowledgeable about tics and TS but the impression is that they almost want to keep it under the radar and not bring too much attention to it from NHS managers. From some professionals there seems to be a reticence to step forward and advertise their service perhaps related to a fear of being inundated with referrals. The reasons for this remain opaque.

There also seems to be confusion in CAMHS provision across the UK with families telling TA that some CAMHS have refused to treat tics with families being told that this does not come under their remit and there is no provision of BT available.

The patients then may end up being re-referred to CAMHS with depression and/or anxiety and they are then treated for these secondary disorders.

Another possibility is that individuals with tic disorders often fall between psychology, psychiatry and neurology services which results in less specialist treatment and possibly a lack of referral to a therapist. Other issues include that once trained there may be a lack of access to supervision expertise. These are all hypotheses that can be explored but remain unanswered.

We hope that an interest in BT for tics will continue to grow. Tourettes Action established a program of BT training across the UK in 2016/2017 with previous workshops being offered annually since 2011. TA also offers ongoing support for clinicians with clinical consultation sessions three times a year. The sessions are held in London for clinicians from around the UK accessing the session in person or through teleconference. It gives clinicians supervision and peer support to discuss complex clinical work and share professional support, giving them the confidence to offer BT to people with tics.

More information on the research referred to in this article can be found at www.tourettes-action.org.uk and Seonaid Anderson can be contacted at seonaid@tourettes-action.org.uk
A mental health model for schools

Schools can play a key role in tackling poor mental health. Too often, however, they don’t have the capacity, lacking funding and resources to support students, says Charlotte Lowe.

Over the course of my career working as a cognitive-behavioural therapist at Lostock Hall Academy (LHA) in Lancashire, I have developed a mental health model to meet the emotional and mental health needs of students; existing as a wellbeing framework transferable to all schools.

The prevalence of mental health problems in children throughout the UK is deeply concerning, with one in 10 young people experiencing a mental health problem at any one time; equating to roughly three children in every classroom. The recent publication of the Transforming children and young people’s mental health provision Green Paper in 2017 highlights the vital role that schools can play in supporting children and young people’s (CYP) mental health. However, these plans are set to be rolled out over the next few years and in the meantime many schools are struggling to cope.

The mental health model developed takes a proactive approach to combatting poor mental health, encouraging a whole-school approach to mental health and suggesting targeted...
interventions to support students. The model follows guidance published by the Department for Education, combining a range of elements which aim to meet the emotional wellbeing and mental health needs of CYP. Most schools now recognise the need to support a student’s emotional health along with their learning. However, the use of clear terminology needs to exist across the whole school to ensure there is a shared language whereby we distinguish between mental health, mental health problems and mental illness.

The following is a summary of the areas highlighted as being essential to creating and implementing a whole-school approach to mental health and wellbeing.

**Whole school approach:** This is about taking responsibility. All staff need to be responsible for identifying students who may be experiencing challenging times emotionally, being clear on the protocol to follow where there is cause for concern.

**Mental health policy:** Every school needs a mental health and wellbeing policy. This should exist alongside other school policies and needs to be available to all key stakeholders (school staff, governors, parents/carers).

**Training all staff:** The government has recently stipulated that at least one member of staff in every secondary school will receive Mental Health First Aid (MHFA) training in the next few years. Full staff training around mental health is provided at LHA; ensuring school staff feel confident in identifying early signs and symptoms of mental health difficulties in young people and know what support is available for them. Early intervention is vital, therefore mental health awareness training is essential in all schools.

**Promoting positive emotional wellbeing:** The promotion of positive emotional wellbeing around school helps to tackle the stigma surrounding mental health issues. At LHA we aim for a culture whereby talking about how we feel, and seeking help when needed, is the norm. Positive emotional wellbeing is embedded in the school’s ethos and its engagement with students; promoted in assemblies, tutor time and covered in the PHSE curriculum.

**Single point of contact/mental health champion:** Having a single point of contact, or a mental health champion, is something deemed to be significant; it opens a single channel of communication with external agencies, such as Children and Young People’s Mental Health Services (CYPMHS) or Children’s Social Care (CSC). This person will also ensure that relevant staff are made aware of a student’s circumstances as necessary.

**Parental support:** Parental support is invaluable as they are often first to highlight concerns about their children. Schools need to make clear to parents who they need to contact if they are worried about their child, with regular contact and signposting of parents to available support being important.

**Targeted interventions:** While a whole-school approach to mental health and wellbeing is paramount, it is important to meet the needs of any student experiencing mental health difficulties; and this is where assessments are a useful tool, and a clear referral pathway is essential.

**Assessments:** At LHA the mental health needs of CYP are assessed in school by making use of Routine Clinical Outcome Measures recommended
A mental health model for schools

by Children and Young People’s Improving Access to Psychotherapies (CYP-IAPT) programme. Conducting such assessments means referrals to CYPMH5 are limited to those who actually need them, avoiding backlogs and ensuring that the students who need attention receive it.

**Specialist support in school:** Employing a mental health specialist is not a realistic aim for most schools, I believe it is essential for students to have access to some specialist mental health support in school. I think a part-time school counsellor or CBT therapist should be employed or alternatively a small cluster of schools could employ a shared mental health specialist.

**Up-skilling the pastoral team:** Your pastoral team are in an ideal position to support CYP experiencing difficulties, such as anger or mild anxiety issues, and should therefore undergo continuous development to ensure that they are equipped to help students.

**Peer mentoring:** LHA developed a peer mentoring programme which involved training KS4 students to become peer mentors or ‘buddies’ to younger students. Training focused on promoting positive emotional wellbeing and supporting students experiencing students with less serious issues such as low self-esteem and confidence.

**External agencies:** Your school’s mental health champion is responsible for keeping up-to-date with the external services available to support CYP and must understand the referral routes as well as the support that they can offer so that referrals can be made efficiently when required.

**Staff wellbeing:** Staff wellbeing must not be overlooked – they too are susceptible to mental health issues, with a recent report suggesting a high number of school staff experience mental health difficulties related to their job role. Ensuring staff are in an emotionally positive place means that they are better-equipped to support CYP experiencing mental distress.

I believe early intervention and prevention is key to tackling poor mental health in CYP. To achieve this, schools need to prioritise the promotion of positive emotional wellbeing and mental support.

This mental health model developed is one example of how schools can manage mental health and provide effective support to students.

“The prevalence of mental health problems in children throughout the UK is deeply concerning, with one in 10 young people experiencing a mental health problem at any one time.”
Sofia so good

The European Conference lands in Sofia, Bulgaria in September 2018

Katy Grazebrook EABCT Secretary

The 48th Congress of the European Association for Behavioural and Cognitive Therapies (EABCT) will be held in Sofia, Bulgaria from 5 to 8 September. The theme is ‘Improving cognitive behavioural therapy and access to it across the lifespan’ and the joint scientific chairs are Pavlina Petrova and Paul Salkovskis (pictured).

The conference organisers are reflecting inclusion and diversity in their invited speakers (with an equal number of male and female keynote speakers) and also in the submissions process.

The Bulgarian Association for Cognitive Behaviour Psychotherapy was founded in 1998 and has joined forces with BABCP’s Paul Salkovskis and many of the key conference organisers/scientific committee members in Europe, to bring a multi-stream congress covering topics such as General mental health; Children and young people; Psychosis; General psychological processes and neuroscience; and Behavioural medicine and health, with some cross-cutting themes of trauma, substance misuse and inclusion & diversity.

The conference language is English, which is always an advantage to us BABCP members, as you will be eligible for the membership registration rates.

Getting there

I attended an EABCT meeting in Sofia in March this year and visited the conference centre, so I was able to find out for myself what it would be like travelling to Bulgaria. The first thing to say is that the currency is the Bulgarian Lev, which you will have to order in advance from a currency exchange if you don’t want to get it at the inflated rates at the airport.

Continued overleaf
Ryanair, Easyjet, Wizz Air and British Airways fly directly to Sofia. Flights are about £150 return if you buy now. Travelling into Sofia is easy on the metro, or about 10 Lev by taxi for a 20 minute drive (£1 is 1.6 Lev if you are lazy and buy at the airport – and exchange rates will vary of course!).

The Conference Hotel is the 4-star Hotel Marinela, which doubles as the Conference venue and it is two stops on the metro from Serdica station in the centre of Sofia (or about a 30 minute walk). There is lots of good accommodation to suit any budget.

Expect it to be lovely and warm in September (daytime temperatures of around 20ºC). All the hotel rooms had umbrellas in for people to borrow, and we were told that towards the end of September it starts to get quite wet, but early September should be okay. It was fantastic weather in March!

Sofia is a lovely city and the people are friendly and seem to have quite a quirky style – check out some of the restaurants such as Made in Blue (a blue house with no indication whatsoever that it is a restaurant – you have to be ‘in the know’). You can even book a free eco-tour of the city on foot or by bike with Sofia Green Tour.

Check out the conference details at www.eabct2018.org, where you can view the full programme, see the accommodation and other details about travel to Bulgaria.

The conference organisers are reflecting inclusion and diversity in their invited speakers (with an equal number of male and female keynote speakers) and also in the submissions process.
48th Annual Congress of the European Association for Behavioural and Cognitive Therapies/EABCT 2018
September 5-8, 2018, Sofia, Bulgaria

FROM APPLIED RESEARCH TO QUALITY TREATMENT:
IMPROVING COGNITIVE BEHAVIOURAL THERAPY AND ACCESS TO IT ACROSS THE LIFESPAN

Amongst the innovations which we plan to introduce to the EABCT is an emphasis on Diversity and Inclusion, something the Scientific Committee will be strongly encouraging.

The overall scientific theme is “Improving cognitive behavioural therapy and access to it across the lifespan”. Within the programme, we are also seeking to set up subject streams, so that participants with particular interests can maximize their ability to attend sessions focusing on these. The streams will be:

- GENERAL MENTAL HEALTH
- CHILDREN AND YOUNG PEOPLE
- PSYCHOSIS
- GENERAL PSYCHOLOGICAL PROCESSES AND NEUROSCIENCE
- BEHAVIOURAL MEDICINE AND HEALTH

We have tried to bring the best of applied science in CBT in all of these areas and we hope that you will find the programme as exciting and stimulating as we do. In troubled times, we have also developed a cross-cutting theme in the conference regarding the importance of trauma-focused and trauma-informed approaches.

EABCT 2018 welcomes the submission of abstracts. For more information, please view the submission guidelines on the EABCT 2018 website. By April 20, 2018 you also have the chance to register for the Congress with an early bird registration fee.

Come and join us in Sofia!
Since completing my training as a Psychological Wellbeing Practitioner (PWP) two years ago, I have come to understand how a level of frustration can arise within the role due to the perceived lack of variety and a desire to develop clinically with more challenging cases, writes Sue Flower, a Psychological Wellbeing Practitioner at Hertfordshire Partnership University NHS Foundation Trust.

The Health in Mind IAPT (Mid Essex) phobia clinic has brought together a variety of clinicians in the service at low and high intensity to offer a pathway for individuals with ‘simple’ and ‘complex’ phobias.

However, this desire to develop is often in direct opposition with the instructions provided on the PWP training course where ensuring fidelity to the NICE guidelines is paramount, as is the discouraging of therapist drift and not working outside of one’s own competence as a PWP. This is sensible of course and should be followed in routine practice. However, within my current service I have been fortunate enough to be offered the opportunity to develop my skills and practice as a PWP by working within our phobia clinic, which has allowed for a certain flexible and creative approach to treatment, including additional and longer sessions as well as in-vivo work.

The Health in Mind IAPT (Mid Essex) phobia clinic has brought together a variety of clinicians in the service at low and high intensity to offer a pathway for individuals with ‘simple’ and ‘complex’ phobias. More importantly, being involved in the phobia clinic has demonstrated how the PWP role can evolve and take on more variety and has allowed the opportunity for some joint working between services.

There is no NICE guidance for specific phobias, but it is expected that these cases are treated by a High Intensity Therapist (HIT) and not by a PWP. This is understandable as specific phobias can often be chronic and complex in nature so might require an intervention which goes beyond the remit of PWP routine practice, and as an area of treatment is not regularly covered on PWP training courses. In my case, I was asked to contribute to the phobia clinic with support from the service.
where I expressed particular interest in working with blood-injection-injury phobias.

Following some valuable training received from the Centre for Anxiety Disorders and Trauma on specific phobias – as well as an agreement to receive ongoing specialist supervision – I proceeded to nervously take on my first phobia cases at low intensity. These cases were screened for complexity, co-morbidity and risk followed by a further assessment to determine their suitability for low intensity work before offering treatment.

A few cases on, what I have learnt is that in addition to mastering the correct relaxation technique (applied muscle tension), the main focus of treatment is exposure with the added bonus of being a little more inventive within the hierarchy. Examples include the use of images and videos, introducing tourniquets using props such as needles, syringes, alcohol wipes and plasters all the way to mock blood tests including the palpating of veins. I have also been extending sessions in order to continue working through the hierarchy to the point of having blood taken.

A valuable joint working alliance has been forged with Allen Mitchell, an intensive support healthcare assistant and trained phlebotomist from the North Essex Community Learning Disability (LD) team, who was instrumental in helping me prepare by supplying much needed props for preparatory exposure work.

Allen has since become a therapeutic collaborator and been introduced to my clients in order to provide education on the processes involved in having a blood test and what to expect, and often completing mock blood tests and even demonstrating a live blood test with me as the subject. Usually this would be the last step before the client feels ready to face their fear and have a blood test of their own. Eventually I hope to be able to assist Allen in the community with some of his LD clients who have their own fear of giving blood.

Working this way has given me a valuable and interesting insight into the differences in treatment methods for similar conditions but with different types of service user. For instance, Allen routinely offers home visits due to high levels of avoidance with his clients and uses the desensitisation process and focuses on the benefits to the person of having their blood taken and tested. He has seen success with this way of working although is more than prepared to be flexible with his approach.

Whilst I primarily use the graded exposure technique, more time is usually offered in creating the hierarchy and completing and repeating each step to ensure that habituation occurs prior to moving on to the next more anxiety-provoking stage. Allen continues to help other clinicians in the IAPT service with similar work.

It is well known that IAPT services struggle with PWP recruitment and retention, and that opportunities available for their professional development vary between services. PWPs can usually advance in their careers by taking on extra training and responsibility as a senior PWP, and many may also wish to consider the High Intensity role or training as practitioner psychologists as natural progressions.

I wonder if another way to maintain the interests of PWPs is to explore how their clinical delivery can be diversified. Experiencing this opportunity to develop and provide a form of ‘specialism’ at low intensity has provided me with a break from the usual high volume, often back-to-back way of working and allowed for greater variety and development which I believe has also led to overall increased satisfaction within the role.

In doing so it has also allowed a working relationship and collaboration to form between two different teams who share an environment but rarely collaborate clinically, and encourages utilising resources and experiences from other departments.

It is my hope that going forward other PWPs may have the same opportunities afforded them, and that my learning and experiences of what has worked well and not so well can be shared with my colleagues. Furthermore I feel proud to have been part of building a working partnership to benefit clients, which will hopefully continue to develop.
What can chairwork offer CBT?

A chair can be many things, writes Matt Pugh, a cognitive behaviour psychotherapist at the Vincent Square Eating Disorders Service in London

It can be a seat, a step, or even a bed. We use them to rest, observe, and eat. And, of course, we occupy them daily in our clinical practice. Chairs hold our bodies in innumerable ways, but they are capable of holding much, much more. For example, we might use an empty chair to represent a negative thought or dysfunctional assumption. It may hold someone we love or someone we despise. It may contain a specific emotion such as sadness or anger. It could symbolise our ‘rational’ mind or our ‘compassionate’ mind. With a little imagination, an empty chair can be anything we like, and with that comes tremendous therapeutic opportunities.

Chair-based techniques have been used in psychotherapy for over a century and have formed a collection of interventions termed “chairwork.” Often affiliated with Gestalt and emotion-focused therapy, chairwork techniques are also long-established in CBT and have experienced renewed interest in allied approaches including schema, compassion-focused, and Acceptance and Commitment Therapy.

How chairwork is used depends upon the type of therapeutic dialogue we want to construct. For example, a client can be invited to speak from chairs representing conflicting viewpoints (e.g. the costs and benefits of a decision) (two-chair techniques) or to speak with an ‘other’ who is placed, imaginatively, in an empty chair (empty-chair techniques).

Chairwork can also aid perspective taking: switching seats enables clients to explore problems through different self-perspectives (e.g. from a self-

“With so many techniques available, CBT therapists may ask: is there any benefit in using chairwork?”
Broadly speaking, chairwork (including cognitive-behavioural chairwork) is guided by three principles. To begin with, and in line with theories of ‘self-multiplicity’, therapists must first decide which perspectives or ‘parts’ of the client they would like to work with. These self-parts are then placed in separate chairs.

When working with Negative Automatic Thoughts (NATs), for example, we might ask the client to imagine their ‘irrational side’ is contained in chair one, whilst their ‘rational side’ is contained in chair two. Secondly, each self-part must be endowed with a capacity to convey and receive information to enable cognitive and emotional modification. This can be facilitated through either embodiment (e.g. asking the client to switch seats and ‘become’ their irrational side) or personification (e.g. asking the client to imagine how their rational side might look in the chair, if it were human-like).

Finally, these self-parts are invited to speak to one another, or to the client, or to therapist. Returning to the example of NATs, this might involve asking the client to passionately outline evidence supporting their NAT from chair one, followed by the evidence disconfirming their NAT from chair two. Once both sides have spoken, a more balanced thought can be elaborated in a third ‘metacognitive’ chair.

Continued overleaf
Cognitive behavioural chairwork offers more than just bringing cognitive restructuring to life. Within the cognitive domain, chairwork can be used to construct positive self-beliefs, explore the advantages and disadvantages of cognitive processes such as worry, or (like imagery rescripting) confront individuals who have led to the formation of negative beliefs. Regarding affect, different chairs can be used to disentangle, express, and soothe distressing emotions. Applied to behaviour, chairwork provides a realistic medium for observing, practicing and evaluating new behavioural skills. Therapists are limited only by their imagination (and the number of chairs available!) when using chairwork.

With so many techniques available, CBT therapists may ask: is there any benefit in using chairwork? Theories of cognitive change suggest there could be. Chairwork tends to generate more intense affect than disputational techniques such as automatic thought records (ATRs) and may, therefore, enable more effective cognitive restructuring and emotional processing. Additionally, chairwork uses multiple sensory mediums simultaneously (including visual, auditory and bodily feedback), thus impacting upon all schematic domains and encouraging deeper information. This can be particularly helpful when working with cognitions which do not shift at an emotional level.

Finally, the novelty of chairwork may help construct positive cognitive representations which are particularly memorable. Initial studies lend some support to these proposals. For example, CBT augmented by emotion-focused forms of chairwork has yielded promising outcomes, whilst preliminary research suggests that chairwork could be more effective than some pen-and-paper interventions including problem-solving and ATRs. Further studies are needed to confirm these findings.

So the next time you work with a client and reach for a pen, ask yourself: how might this intervention look using chairwork? You never know – it could be that you are sitting on something pretty important.

You can read more on Matt’s research at https://tinyurl.com/ycjx828z
Self-esteemers or self-accepters?
Teaching Children Confidence

Albert Ellis, creator of Rational Emotive Behaviour Therapy, once famously said: “Self-esteem is the greatest sickness known to personkind because it’s conditional.” Even the most competent and composed amongst us will say how we have battled or continue to battle our inner demons of self-doubt and low self-worth, says Giulio Bortolozzo.

Some would measure their self-worth against goals achieved and how popular they are with others. This kind of ‘confidence glow’ can be temporary if one is inclined to put all of their psychological wellbeing eggs in the same ‘self-esteem’ basket.

We condition ourselves when we rehearse and re-rehearse certain ingrained thought constructions that are unhelpful to us. Ellis claims, and I agree, that if a person’s self-worth is contingent on how others regard them or how well they do at tasks it can be very harmful. They will feel okay or not okay depending on which way the self-esteem winds blow! This is what Ellis called conditional self-worth, how one considers oneself when they are approved of and when they do well.

What then is the psychological antidote to the self-esteem scourge? How do we start to help those students whose confidence waxes and wanes in response to the approval of others? Perhaps it would be useful to note some of the consequences of coming down with a bout of the dreaded self-esteem bug – approvalitis!

People who conditionally accept themselves are much more likely to experience mental ill-health than not. Why? They tend to put all their faith in how others value them and if this is not forthcoming they feel down, undervalued, and disapproved. They might say to themselves: “I’m worthless. No one likes me. I’m a failure” and so on.

If a person’s significant other withdraws her friendship and approval this can have an adverse impact on her. The fact that she has been unfriended is a fact, there is evidence to support this conclusion. However the belief that this then means she is worthless is a position that can be challenged. It is here that the teachers and counsellor’s work begins because the goal is to help her understand that her worth was never given to her in the first place so it can’t be taken away. She has constructed these ‘thinking rules’ so she can deconstruct them if she works hard at it.

The question is how? As Eleanor Roosevelt said: “No one can make you feel inferior without your consent.”

Another question is if she gives another person consent to make her inferior how does she know she is doing this? The job is to help her understand that whilst others may reject her in fact, it is a myth to then believe she is worthless because she has been rejected. It is the goal of the educator to help her replace her fragile self-esteem belief with the more robust and evidence-based unconditional self-acceptance habit of thinking. This will not change how life unfolds but it will lessen the impact of unwelcomed events because she is tougher psychologically.

Dr Jonas Salk who developed the polio vaccine talked about the idea of psychological immunisation: “If I were a young scientist today, I would still do immunisation. But instead of immunising kids physically, I’d do it your way. I’d immunise them psychologically. I’d see if these psychologically immunised kids could then fight off mental illness better. Physical illness too.”

This article originally appeared on Giulio’s blog site www.rebtoz.blogspot.com.au where he has authored several blogposts which suggest ways in which we can assist students develop unconditional self-acceptance. Giulio can be followed on Twitter @getzested and on his facebook page at https://www.facebook.com/TheCentre4RationalEmotiveBehaviourEducation/

He is currently studying for his Ed. D. at the University of South Australia.
The December 2017 issue of *CBT Today* carried John Minto’s call to action for the improvement of access to mental health care in low and middle income countries. Here, John addresses key questions around ‘capacity building’ in meeting this challenge.

The conclusion of the EMERALD project has afforded an opportunity for stakeholders and interested parties to reflect on the most appropriate ways in which to strengthen systems which will result in an improvement in patient-centric mental health care in low and middle income countries (LMICs).

These reflections are starting to focus on practical ways in which to develop and implement appropriate approaches to the key challenges which are, in turn, opening up opportunities for influential bodies such as BABCP.

In overall terms, most recent initiatives at addressing the ‘treatment gap’ (essentially the difference between the number of people needing
mental health support and the number of trained people available to provide it) have focused on the capacity building of three target groups.

First, mental health service users and caregivers. Although many health systems have, in the past, been designed and implemented in an exceptionally 'top down' fashion, there is growing recognition that the engagement of service users and caregivers can play a significant part in the development and implementation of mental health systems. This also helps to address issues surrounding the – often extreme – vulnerability which those suffering from mental health challenges in LMICs face.

Frameworks are now being developed which ensure that this engagement goes beyond mere tokenism and capture important elements of effective screening and treatment regimes. Organisational and political challenges remain significant, however, with many LMIC health systems having been designed and implemented by central government which is often reluctant to cede control (as they see it) from the 'centre to the periphery'.

Second, service planners and policy makers. Creating the 'political space' with service planners and policy makers is increasingly seen as one of the key challenges facing the global mental health community. While many LMICs have adopted the World Health Organisation’s Mental Health Gap Action Programme (mhGAP) initiative and have even invested in a ‘mental health desk’ often located within the Ministry of Health, these are often underfunded and understaffed.

This tends to reflect the fact that many Health Ministries are set up along silo lines, with major efforts being focused, perhaps understandably, on addressing the causes and impact of mainly communicable diseases such as HIV and TB. Working with service planners and policy makers will be an increasingly important initiative if mental health is to gain further traction within LMICs and the impact of ageing populations will be an important element within this.

Many LMICs are characterised by large ‘young populations’ but as has been seen in Nigeria (Africa’s largest country by population) as a range of health initiatives take hold and people start to live longer, addressing the cognitive challenges of old age will become increasingly important. This represents a potential opening for mental health activists both globally and within LMICs.

Third, mental health researchers. EMERALD has been on the cutting edge of raising awareness about the importance of developing mental health research capacity within LMICs and has suggested a set of guiding principles related to this which include ‘local training’, reciprocity between north-south partners, the definition of clear outputs to monitor success or otherwise, the focus on ‘junior and senior’ research and the development of in-country expertise through the training of trainers.

Continued overleaf
Improving access to patient-centric mental health care in low and middle income countries

Continued

One major challenge over time will be to address the understandable ‘brain drain’ from LMICs to high income countries vis-à-vis mental health researchers. Without the generation of in-situ mental health research, however, political engagement with key LMIC decision makers will prove problematic – and perhaps understandably so.

The overall approach of the EMERALD project has been based on the principles of sustainability, reciprocity and appropriateness and although it is at pains not to promote a ‘one size fits all’ model, its conclusions suggest that many LMICs will have a number of mental health challenges in common.

For all the recent positive developments in terms of promoting patient-centric approaches to mental health care in LMICs, significant challenges remain, perhaps none greater than the need to address the treatment gap ‘directly’.

Although impressive approaches to culturally-appropriate screening and treatment initiatives are being piloted in a number of LMICs (including in Zimbabwe where the Friendship Bench has gained national and international recognition), the uncomfortable fact remains that the training of lay health workers in mental health protocols will remain the norm for some time to come. In countries such as Zimbabwe where 13 psychiatrists cover a population of 13 million, questions are being raised in terms of the practicality of regular in-service training as well as key aspects of follow-up, monitoring and evaluation. It is difficult to see how any model of mental health care in any LMIC can – in the short and medium term – be effective without the engagement of bodies such as BABCP, the diaspora and information technology. Other health sectors, including (for example) the training of midwives in Somaliland, have engaged such an approach and time will tell whether or not momentum can grow for a ‘champion’ to emerge to propose similar approaches within mental health in LMICs.

The overall approach of the EMERALD project has been based on the principles of sustainability, reciprocity and appropriateness...
Digital first for MindMate

An NHS mental health and wellbeing campaign targeting previously hard-to-reach young men has chalked up a digital first, by placing geotargeted ads in PC game Football Manager.

Adverts promoting the Leeds-based MindMate service will be displayed via clickable on-pitch ads during game simulations.

The campaign is being geotargeted so that only players in Leeds will see the promotion, marking the first time that the NHS has used such tactics. When clicked on, the eight-second ads take players to a relevant part of the MindMate website.

The placement will allow the campaign, which aims to promote MindMate throughout the city at roadshows and events, as well as with digital and social media, to speak to a typically hard-to-reach audience. The campaign will last six months.

Dr Jane Mischenko, commissioning lead for children and maternity services at NHS Leeds Clinical Commissioning Group (CCG), which runs MindMate, said: “Mental health and wellbeing is an important subject for children and young people, so our aim is to signpost MindMate as a resource that they can turn to for support and advice when the time suits them.

“In the coming months we will be hoping to reach as many young people in the city as possible to make them aware of the help available via MindMate.”

Children at ‘crisis point’ before accessing mental health services

The Care Quality Commission (CQC) reported recently that health care, education and other public services are not working together as effectively as they could to protect and support the best interests of children and young people.

Government proposals – such as establishing dedicated mental health support teams in schools – are welcome, and the commitment of funding in the NHS’s The Five Year Forward View for Mental Health has been a significant intervention and an important signal that this is a priority for the whole system to address. However, unless the pace of delivery is accelerated, these commitments will not be enough to achieve the scale of change that is required to protect children and young people from unnecessary distress and avoidable deterioration in their mental health.

Among its recommendations, CQC is calling for the Secretary of State for Health and Social Care to use the inter-ministerial group on mental health to guarantee greater collaboration across Government departments in how their policies prioritise the mental health needs and wellbeing of children and young people in England.

The CQC is calling for changes to how local bodies work together to support and care for children and young people with mental health needs and for national bodies to champion and enable this change by ensuring their work does not reinforce the boundaries between services, which can lead to people’s care and access to services feeling fragmented.

Speaking about the report, Dr Paul Lelliott, Deputy Chief Inspector of Hospitals (lead for mental health) at the CQC said: “Children and young people deserve to have their mental health needs and wellbeing put at the heart of every decision, be that planning, commissioning or resourcing. Currently, this is not the reality everywhere and we heard from too many young people who felt they could only access care at a crisis point because local services are not working together, or are not able to work together effectively to support their mental health and wellbeing.

“Our report provides clear recommendations based on listening to children and young people, as well as looking at all the organisations with a role to play in this area. We all need to act now and to act together. If we do not, we risk letting down children and young people across the country and undermining their potential in adult life.”
To find out more about these workshops, or to register, please visit www.babcp.com/events or email workshops@babcp.com.
branches and special interest groups

Chester, Wirral & North East Wales Branch
presents

Understanding and treating hoarding: A question of value
with Professor Paul Salkovskis
8 June 2018
Ellesmere Port

Devon and Cornwall Branch
presents

Personal Reflections on the Development of CBT
with Amanda Cole
6 June 2018
Chudleigh

Chester, Wirral & North East Wales Branch
presents

Working with Dissociation: A Practical Clinical Workshop
with Dr Fiona Kennedy
5 & 6 July 2018
Bristol

Devon and Cornwall Branch
presents

CBT for Rumination
with Morten Hvenegaard
6 July 2018

West Branch
presents

Psychosis and Trauma
with Dr Amy Hardy
14 September 2018

Both events are held in Sevenoaks

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branches and special interest groups

Manchester Branch
in conjunction with Greater Manchester Mental Health CBT Training Centre
presents

CBT for Personality Disorders
with Professor Kate Davidson
7 June 2018
Manchester

North West Wales Branch
presents

A brief introduction to
Compassion Focused Therapy for Long Term Health Conditions
with Dr Mary Welford
18 May 2018

CBT for Social Anxiety
with Professor David M Clark
5 October 2018

Both events are held in Bangor

Eastern Counties Branch
presents

Adapting Brief Behavioural Activation for Young People with Depression
with Professor Shirley Reynolds
5 October 2018
Norwich

Compassion Special Interest Group
presents

Compassion Focussed Staff Support
with Kate Lucre
7 June 2018
Birmingham

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Self Esteem Made Simple:  
Getting Unstuck with Acceptance, Mindfulness and Self-Compassion  
Dr Joe Oliver & Dr Richard Bennett  
Thursday 28th & Friday 29th June, 2018

Central London
Are you a therapist who works with issues relating to self-esteem? Do you work with people who struggle with their self-image? People who don’t know who they are? People who constantly judge themselves negatively? People who lack direction and drift through life? If so, this workshop will be of great relevance to your practice.

This workshop will present cutting edge developments in contemporary theory and practice, drawing on Acceptance and Commitment Therapy (ACT) and Relational Frame Theory (RFT) to help therapists simplify their interventions as related to notions of the self.

Workshop Aims
• To promote the latest developments in ACT and RFT in making sense of the self in therapy
• To help therapists understand the important difference between self-esteem and self-acceptance
• To equip therapists with practical skills for moving towards self-acceptance through the elegant use of the therapeutic relationship

The workshop will be presented from an Acceptance and Commitment Therapy (ACT) framework, and involve case formulation, group role-play, and presenters’ audio/video material of therapy sessions.

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• Student rate - £90 (£108 inc VAT) - limited places

For more information on how to register, go to: www.contextualconsulting.co.uk

UPCOMING WORKSHOPS

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Looking for a more interactive experience? CBT made simple with Russ Harris, June 2018.

LONDON
ISC International  
June 30th and July 1st 2018

Dr. Daniel Siegel  
www.international-isc.com
Supercharging Your CBT Practice: Integrating the best of DBT, ACT and CFT for maximum effect
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Thursday, 1st of November & Friday 2nd November, London

If you want to:
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• Increased confidence in applying these skills into your own therapy context
• A free copy of Get Your Life Back, The Most Effective Therapies For A Better You

For more detail, go to www.contextualconsulting.co.uk

www.greenwoodmentors.com
An Introduction to Compassion Focused Therapy
12th, 13th & 14th November, 2018, London Prof Paul Gilbert
Join via Live Interactive Webcast

Compassion focused therapy is one of the most exciting and fastest growing modern therapeutic approaches. Its application is wide and far reaching as a method to promote deep healing for clients struggling with a variety of issues.

Join the originator of Compassion Focused Therapy, Professor Paul Gilbert, as he takes you through an extensive introduction to the approach. Learn the cutting edge innovations in CFT that you will be able to implement in your practice immediately. If you're looking to widen and strengthen your ability to help clients and make real and substantial differences in their lives, then this workshop is for you.

Paul is a master trainer whose international reputation is well deserved. Don't miss out on this chance to see him in action!

For more information:
www.contextualconsulting.co.uk
Up-and-Coming OCTC guest events

1 June, Tim Williams
CBT for Children & Young People with OCD
Tim Williams has extensive experience of working with young people with OCD, both clinically and in research, with a particular interest in contamination fears. In this workshop, participants will learn how to apply CBT skills to enable young people to overcome their OCD, through changing appraisals of their intrusive thoughts and helping them reduce the occurrence of their repetitive behaviours. There will be practical tasks and examples taken from therapy sessions.

2 June, Cathy Grossell
Working with Parents of Anxious Children: Effective & Efficient Treatment Approaches
In this workshop, Prof Grossell will provide an overview of therapist-guided, parent-led CBT – a brief, effective intervention for pre-adolescent children with anxiety disorders, based on her recently published guide for clinicians. She will review the theoretical background and evidence base for working with parents, provide an overview of the clinical approach and illustrate the core therapeutic techniques.

13 June, Deborah Lee
The Compassionate Mind Approach to Recovering from Complex PTSD
This workshop explores the use of compassion focused therapy to treat those with Complex PTSD. The explicit goal of compassion focused therapy is to develop, access and stimulate positive affect associated with self-nurturing in the mind and body of the patient in order to promote an inner sense of psychological well-being (Gilbert, 2005). Dr Lee is author of the Compassionate-Mind Guide to Recovering from Trauma and PTSD: Using Compassion-Focused Therapy to Overcome Flashbacks, Shame, Guilt, and Fear (2013). She has extensive clinical experience of working with a range of complex trauma populations and has pioneered the use of developing compassion as part of a phased based treatment approach to complex PTSD.

Commencing 18 June, Fiona Kennedy
Dialectical Behaviour Therapy (DBT) Programme
DBT is especially good for building commitment and therapeutic alliance, for working with difficult to treat presentations and for behaviour change focused work.

Introduction to DBT – This one day training will familiarise you with DBT as a therapy and give you take away techniques to use in your every day contact, whatever your therapeutic orientation. Induction 3 days: This five day training will allow you to explore the theory and practice of DBT in more depth. You will be able to understand personhood disorder and other challenging presentations from a behavioral point of view, structure the treatment and use mindfulness, metacognition, and behavioral change strategies to bring about positive change. Whatever your field, you will find insights and practical skills to take away and integrate into your practice. Practitioner Certificate: Building on the five day training, participants who wish to obtain the DBT Practitioner Certificate from OTC will take six months to work with clients and non-DBT skills groups, with supervision. You will present your case studies and reflections as well as undergoing other assessments of competence, compassion and confidence in delivering DBT.

26 June, Kludaf Roft & Kevin Jones
Helping those who Suffer with Suicidal Ideas
This workshop will look at theory –practice links around suicide prevention, ensuring participants learn about the most up to date research evidence on CBT for suicide prevention. Participants will also have the opportunity to build confidence in assessing suicide risk, formulating the suicidal cycle with clients, building safety plans and applying CBT interventions to help people reduce their risk. There will be opportunity to reflect on working in this difficult area and participants will be able to observe and practice key skills, under the guidance of two seasoned CBT therapists working on the front line.

5 September, OCTC Congress
The Best of Both Worlds Integrating CBT and Technology
Integrating new technology into your CBT practice may add value to your service, introduce patients to the latest research evidence and improve adherence to treatment. This Congress will discuss the research evidence and practical issues involved in implementing technology in CBT. The Congress will take place over one day on the lovely setting of New College, Oxford.
Well over 100,000 professionals have attended APT live courses, many more online. We are leaders in:

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