Eating disorders: new online hope

Anorexia nervosa (AN) affects approximately one per cent of young women and men, not to mention their families. Parents and others often present their concerns about the person with AN near the beginning of the clinical presentation, and seek help from the health service. Some are referred to specialist eating disorder units early on (especially if there is a crisis or low weight); some who are less clearly unwell or who are ambivalent about specialist referral will be cared for by GPs and carers in the first instance. Meanwhile, up to 40 per cent of those with AN do not seek NHS help for a variety of reasons (e.g. uncertainty, stigma, lack of information and access), leaving carers in a difficult position. Overall, there is a significant burden falling upon relatives, friends and others who often have limited knowledge and skills as to how best to help the person.

Previous research has confirmed the high prevalence of anxiety and depression amongst carers, who identify that they lack information, feel ill-equipped to cope, and can respond in ways which backfire. In particular high expressed emotion (HEE), where carers express hostility or are overly protective of the person they are supporting, is known to worsen the outcomes of those they care for. Interventions giving information about the disorder, building skills of support and self-care, and specifically targeting HEE are known to be effective. Family systemic interventions have been shown to be of benefit in the treatment of AN, especially in younger adolescents. Ideally information and supported change in how carers provide support should be delivered early enough in the clinical course to allow changes to be made before unhelpful support patterns become established and the AN becomes severe and enduring. Early access to carer support is extremely limited, however, even though carers often express a desire to receive information and carer support early on, they rarely do. Ulrike Schmidt, Janet Treasure, Chris Williams and colleagues have successfully developed and evaluated a new online resource in an RCT. The package - developed in collaboration with B-eat (previously the Eating Disorders Association), a recovered person with anorexia, a carer, and

Continued overleaf
Eating disorders: new online hope (continued)

Experts in CBT, family therapy and self-help CBT - aims to allow rapid, early access to carer interventions. To date, two published studies have been completed, which both found reduced carer anxiety, increased carer skills and confidence, and reduced HEE.

A recent qualitative study of carers, who had had access to the package, found that carers strongly identified a wish that they had received access to the package at an early stage in their support journey, with carers suggesting that they felt both themselves and the individual they cared for would have benefited from access to the package at the point of diagnosis. We aim now is to evaluate the provision of rapid, local and early access to the carer support package within the first three years after initial help-seeking. The potential benefit is a reduction in chronicity and the costs of AN and carer co-morbidity.

The online package referred to in this article can be found at www.overcominganorexiaonline.com

References

For more information about B-eat, visit: www.b-eat.co.uk

BABCP members win prestigious university award

The University of Sheffield Senate Awards annually recognise individuals and collaborations for excellence in learning and teaching.

Amongst this year’s winners are the IAPT Team in the Clinical Psychology Unit of the Department of Psychology: Professor Gillian Hardy, Dr Steve Kellett, Gill Donohoe, Ann Swift, Helen Macdonald, Fiona Bellhouse, Ingrid King and Angela Rollinson.

Readers will no doubt be familiar with fellow BABCP members who form part of this award winning team. CBT Today sends congratulations to all!

 Winning team: (left to right) Helen Macdonald, Steve Kellett, Ann Swift, Ingrid King, Angie Rollinson, Gill Donohoe, Fiona Bellhouse and Gillian Hardy
The distinction of BABCP Honorary Fellow is to recognise those members who have made an outstanding contribution to the advancement of Behavioural and Cognitive Psychotherapies.

At the AGM held on 21 July, President Professor Shirley Reynolds announced that this year’s recipients of the BABCP Honorary Fellowship are Amanda Cole and Francis Lillie, in recognition of their distinguished service to the Association and the CBT community as a whole.

Amanda (Mandy) is the first woman in the history of BABCP to be made an Honorary Fellow. A member of BABCP since 1975, she has contributed to the work of the Association in various roles since 1978. Her contribution alone on Accreditation over the past 19 years is clear evidence of the remarkable contribution she has made, not only to BABCP, but also the reputation and credibility of CBT practitioners and educators across the UK.

It is in large part due to Mandy’s leadership that the Association continues to set high, world class standards, raising the quality threshold for CBT through the excellent support provided through Practitioner, PWP, Supervisor, Trainer and Course Accreditation.

She is a practising NHS therapist, and CBT supervisor and trainer across the South West region. Remarkably, she has also found time to remain involved with BABCP at local level, where she is currently Chair of the newly re-formed Devon and Cornwall Branch.

Francis is a highly experienced and well respected expert CBT therapist, with a special interest in developing in vivo applications of CBT. He has held senior leadership roles both within the psychology and general management in the NHS, which played a significant role in him obtaining considerable funds for the development of CBT services for patients.

BABCP has benefited from his management experience and style in loyally and effectively representing the organisation within many arenas. Through the 1980s and 1990s, he was instrumental in teaching and training a range of professionals in CBT, which enhanced the status and effectiveness of CBT in the eyes of senior management and decision makers across the health service and beyond.

Overall, his significant contribution to the development of CBT in the UK – not forgetting the Association of which he was a founder member cannot be underestimated.

For the first time, BABCP is also this year bestowing Fellowship status on two members. This follows a piloting of the process for nomination and successful application. The process will be available to all members from September 2011.

The distinction of BABCP Fellow is to recognise members who have made a significant contribution to the advancement of Behavioural and Cognitive Psychotherapies. The first recipients of the Fellowship are Charlie McConnochie and Nick Grey.

Charlie has been involved in CBT for over 15 years, and a BABCP member since 1997. His significant contribution has been demonstrated by his involvement setting up of services providing CBT training to counsellors in Scotland.

He has been instrumental in generating activity within Scotland, which had hitherto been stagnant.

He has also made a significant contribution to the development of BABCP Accreditation services, as well as demonstrating long term commitment to the continued development of the Association as a whole.

Nick has been involved in CBT for over 15 years, and a BABCP member since 1998. His significant contribution has been demonstrated by conducting what is considered to be cutting edge research.

He is recognised as an expert trainer, clinician and researcher, particularly in the field of PTSD. He is also Associate Editor of the BABCP printed journal and has contributed hugely to BABCP conferences and workshops.
Introducing BABCP’s new conference assistant

Amy Hamilton recently joined BABCP as the new conference assistant working with the Scientific Committee. CBT Today invited Amy to introduce herself

Exactly 12 months after graduating with a first class honours degree in Psychology I started my role as the BABCP conference assistant this July. After working in various roles during this period, I was thrilled to be putting my degree to good use in working for the lead organisation for CBT in the UK.

Supporting the Scientific Committee in putting together the programme for the BABCP Annual Conference is a major part of my role. This includes helping to identify prominent figures in the field to invite to deliver keynote and workshops, as well as looking at the most relevant themes to base the conference around each year.

I hope the role will allow me to gain a detailed knowledge of the range of psychotherapeutic approaches used to treat those suffering with mental health issues. I also look forward to learning about the most recent and cutting edge research in the area.

Within days of starting in this role, I found myself at the BABCP Annual Conference in Guildford, which was my first ever conference experience. I was at once daunted at the prospect of having to organise the event the following year, and excited by the idea of how much I will learn from doing so. The conference I will be involved in arranging will take place at the University of Leeds from 26 to 29 June 2011. This will be the BABCP Annual Conference’s 40th anniversary and so promises to be a very special occasion.
BABCP Spring Workshops and Conference

Trauma across the Lifespan

Thursday 12 - Friday 13 April 2012
King’s College London

For further information and details of how to register, please visit www.babcpconference.com
Health Minister attends BABCP open meeting

The fourth BABCP open meeting was held in Guildford on 20 July.

The open meeting, held during the Annual Conference week, is a yearly event run by BABCP that aims to raise awareness of CBT and its effectiveness in enabling people to reclaim and sustain their quality of life.

In previous years, the open meeting has taken place on the conference site. This year, in response to feedback, it was held in one of Guildford’s schools. The setting was particularly poignant, given that the open meeting focused on how CBT has been effective in supporting vulnerable children, adolescents and families. As such, it was pleasing to welcome parents and teachers, as well as professionals working in local health and social care settings.

The open meeting consisted of presentations on how CBT works from Paul Farrand, CAMHS service user perspectives from Faramarz Hashempour, and CBT with families from Cathy Creswell and Sam Cartwright-Hatton. There was also an opportunity for the audience to ask questions.

Making a special appearance at the open meeting was Anne Milton MP, Parliamentary Under Secretary of State for Public Health, whose portfolio includes children’s health. The Minister praised the efforts of BABCP in reaching out to the public in this way, as well as acknowledging the important role that CBT therapists play in improving the emotional wellbeing of children and supporting families.

BABCP President Professor Shirley Reynolds says: ‘The success of our open meetings reflects a growing public interest in CBT and how it works. This year we responded to popular demand by focusing on CBT for vulnerable children, adolescents and families. Having the Minister not only attend but speak at the event is a real vote of confidence in BABCP’s efforts to engage in a dialogue about CBT with the public.’

Obituary - Hugh McFadden

We were all deeply saddened when we heard of the sudden and untimely death of our co-professional and friend Hugh McFadden recently. His colleagues would have described him as a man ahead of his time, certainly in terms of his adaptation of information technology. But his feet as a Behavioural Therapist were firmly grounded in the here and now.

Hugh started his working career as a young man in the Irish Government Department of Posts and Telegraphs in Letterkenny, County Donegal. He made his way into Psychiatric Nursing as a student at the local nursing school in St Conal’s Hospital. During the 1980s, he embarked on a training programme at the School of Nursing and Midwifery in Dundee in Behavioural Therapy. He was part of the second group of nurse therapists to qualify in Ireland, in a project pioneered by his local area health authority, the North Western Health Board. Howard Lomas paid tribute to this intrepid band of Irish therapists in his retirement speech in Exeter in 2009. Having qualified as Behavioural Therapists, Hugh and his colleagues in Letterkenny had then to come home and persuade their Directors of Nursing and Hospital Managers to set up appropriate units and structures in which to practice. Hugh was at the vanguard in this ultimately successful effort. The North Western Health Board became a leader in the training of therapists. Taking this mission to the Nursing Schools at the Letterkenny Institute of Technology and the University of Ulster at Magee College, Derry, Hugh persuaded the relevant authorities to incorporate a CBT module into the undergraduate syllabus. He was awarded a Master’s Degree by the University of Ulster in 1999.

Among the first group of members to receive BABCP Accreditation, he fostered this process by acting as a Clinical Supervisor and Mentor for many trainee therapists. His cordiality to his peers is worthy of mention, in his welcoming comments, sound advice and sense of humour, when case peer review was needed. Hugh retired from the public health service but continued to work on a private basis in CBT and EMDR, while retaining his contact with educational institutions and professional organisations such as the Irish Council for Psychotherapy and BABCP.

We used to joke that both his art and his golf would improve in retirement. While his art flourished, the jury is still out on his golf game. He served as Captain, President and on committees with distinction in Letterkenny Golf Club; the number of green blazers at his funeral paid witness to his contribution as an active member.

His colleagues and friends in BABCP throughout Ireland and the UK fondly remember Hugh and offer their sincere sympathy to his wife Vera, his four sons and two daughters and his extended family.

Maureen McGroary-Meehan
IABCP Committee
National Wales Forum gets to work

The BABCP Annual Conference was the venue for the inaugural meeting of the National Wales Forum. Although very much in England, Guildford provided the ideal opportunity for those of us who live and work in Wales - where connections north to south and east to west are made so difficult by the terrain itself - to meet and discuss the future of CBT within the Welsh context. What quickly emerged from the meeting was that we all are facing similar challenges in terms of service development, and career and training opportunities. It was also apparent that, while good practice exists throughout Wales, we have not benefitted from the investment in services that England has enjoyed through IAPT. There was clearly enthusiasm amongst those attending to work together to try and influence a similar path for CBT in Wales.

We were pleased to be joined by BABCP President Shirley Reynolds, Rod Holland from the Scientific Committee and Professor Paul Salkovskis, which afforded the opportunity for a very useful discussion on what had provided the momentum behind the development of the IAPT programme in England.

The timing of the meeting was fortuitous, as the following week ITV Wales broadcast a documentary on the lack of CBT provision for clients with OCD in Wales. The documentary, which had prominently involved Professor Salkovskis, revealed that many OCD sufferers are offered non-CBT interventions such as psychosurgery as a first line of treatment. What we identified in our meeting is that similar inequalities of access appeared to manifest across disorders.

Building on the publicity provided by the ITV Wales documentary for our objectives, we agreed an action plan which proposed to:

• Hold a one-day conference in Wales featuring a half-day training programme open to clinicians and relevant service user groups, and a meeting to discuss how we as a group can raise the profile of CBT in Wales and influence improving access to evidence-based therapies.
• Build a coalition with service user groups.
• Lobby for a structure that works for Wales rather than simply creating a carbon copy of IAPT scheme, and refer to this as CBT Wales.

Our first step will be to organise the conference so watch this space for further details. We hope to see as many as possible attending and getting involved in the event. In the meantime, we will attempt to find that ‘holy grail’: a venue that is convenient for delegates from all parts of Wales.

Maggie Fookes
North West Wales Branch

Self-help CBT possible treatment for unexplained symptoms

In a recent randomised study, guided self-help CBT was tested as a way to treat medically unexplained functional neurological symptoms. Diagnosing a functional neurological condition can often prove difficult. Symptoms such as pain, weakness, dizziness or fatigue lack an underlying disease in around 30 per cent of cases in neurology clinics.

In this study, researchers in the Universities of Edinburgh and Glasgow developed a workbook that people could use at home following a short series of training sessions. 62 people using the workbook with up to four 30 minute support sessions were compared with 63 who did not. All participants continued to receive their existing medical care.

After three months, significantly more patients in the self-help group rated their overall health as ‘better’ or ‘much better’. At six months symptoms and physical function had also improved significantly although self-rated symptoms were now equivalent in both groups. Overall, 47 per cent said the specific symptoms that had sent them to the doctor in the first place were better or much better, contrasted with 30 per cent of the comparison group.

Professor Michael Sharpe, who led the study, said: ‘This approach needs further evaluation but can be a potentially effective and cost-effective first step toward providing more help for these often neglected patients.’

References
The study paper - ‘Guided self-help for functional (psychogenic) symptoms: A randomized controlled efficacy trial’ - is published online at: http://is.gd/sLd0B2

The treatment manual tested is Overcoming Functional Neurological Symptoms: A Five Areas Approach by Chris Williams, Alan Carson, Sharon Smith, Michael Sharpe, Catriona Kent and Jonathan Cavanagh, published by Hodder Education (London, 2011)
Diversity matters

Adam May (AM): What client population do you work with?
Phil Tyson (PT): I work in independent practice with men aged 16 and over.
AM: What are the key defining features and ways in which people in this group present?
PT: Men face many unique challenges. As fathers, men are increasingly experiencing the pain of separation from their children. With heightened cultural pressure to achieve the body beautiful, men are increasingly being diagnosed with eating disorders and the peculiarly male variant of ‘bigorexia’. All men are vulnerable to psychosexual problems and the rise of internet porn is creating an army of men who are struggling with sexual self-control. Men are victims of domestic and sexual abuse with little help available to them. Gay men continue to experience appalling levels of discrimination. It is little wonder, therefore, that men are now four times more likely to commit suicide than women.

Men often believe that talking about an emotional problem is a sign of weakness, and presenting as a client represents ultimate failure. As a consequence, when men do present, they have often struggled with their issue for a considerable period of time. Their problem is usually chronic. Furthermore, the perception of many men is that mental health and GP services are not male friendly, presenting a further barrier to receiving the help they need. In my experience men are prone to ‘act out’ their unhappiness in ways which are self-defeating; for example, with anger, with drugs or alcohol, by withdrawing socially or by having affairs or other sexually unhelpful behaviour.

Men can suffer from what I call ‘status distress’. All men are sensitive to their dominance position with respect to other men. If they perceive a loss of status, this can be particularly upsetting for men. Similarly, bullying at school or at work can be deeply damaging. Bullying shows men that they are at the bottom of the dominance hierarchy, and this often remains as a ‘core belief’ even when there is evidence to the contrary.

Finally, because of the surge in testosterone and its impact on the emotional brain, boys tend to withdraw emotionally at puberty. If boys develop mental health problems at this time, it is often devastating as they endure the pain alone and in silence. Much of my work involves men in their twenties making sense of just such withdrawal and isolation.

AM: How do you adapt the way you deliver CBT?
PT: Men will only present for treatment if they feel welcome. Advertising a service as a ‘safe place to share your feelings’ is likely to put many men off. Whereas suggesting that therapy could lead to ‘new skills’ and ‘more effective strategies for living’ is more likely to appeal to men. CBT is ideally placed to appeal to this group.

The negative thoughts and beliefs men have about themselves as emotional creatures and being in therapy are often a great place to start CBT work. Thoughts such as ‘it won’t work’ and ‘therapists know nothing’ are common in men seeking help. Many men also hold a ‘core belief’ that to express emotion is a weakness. By dealing with such thinking and beliefs early in therapy, the client not only gains a ‘quick win’ but it also builds trust and socialises the client to the CBT model.

In my experience men do not want to express too much emotion in therapy. For them it is a matter of protecting their dignity. Although it is important to create emotion in therapy in order...
to elicit negative thinking, I always take great care that just enough emotion is elicited to serve the purposes of therapy without creating so much that the client feels too vulnerable.

With respect to ‘status distress’, I try to help men with psycho-education around childhood dominance hierarchies. I also attempt to normalise the negative beliefs they often form about the social world from their bruised encounters with those hierarchies. Challenging such beliefs can be good fun as men seem to respond well to behavioural experiments involving changing their status display behaviour.

Given that boys often withdraw emotionally at puberty, and see other boys as competitors rather than as sources of social support, I encourage all men to understand the protective factors of relationships. I encourage men to make more friendships, and make more effective use of the ones they already have. In activity scheduling for depression, for example, I tend to focus on activities that help men connect with other people.

Credibility is extremely important to men. Given the range of therapies available, men need to feel safe that the therapy they have chosen is ‘rational’. At every point in therapy, I try to relate what we are doing to the evidence base, something many men find reassuring.

AM: How would you respond to the argument that ‘people are people’ and the assertion that protocol-driven, evidence-based CBT should be as effective for this group as any other?

PT: CBT’s strength is its evidence base. But we should not ignore the evidence of the presenting client. CBT should be applied to any individual in a bespoke, empathic and culturally sensitive way. This is particularly important for men whose unique difficulties and ways of presenting have often not been expressly formulated in CBT terms, much less empirically tested. Collaborative empiricism demands that we take seriously the experiences, beliefs and thinking of the person in front of us. It means adapting the protocol in the service of the client. Proceeding with CBT on the basis of ‘people are people’ is in danger of missing the significance of ‘men as men’. I would suggest that to miss the client’s cultural identity is to fail to see them at all.

You can read Dr Tyson’s blog at menstherapy.co.uk.

Have you got good practice advice on working with diverse populations? If you deliver CBT to a specific population and would be willing to answer similar questions for a CBT Today article, email Adam May at adammay07@btinternet.com.
Dear BABCP

When I saw the ad for the ICCP congress in Istanbul, I knew I had to be there. With some of the biggest names in cognitive and behavioural psychotherapy, why wouldn’t you? My journey started on the plane, wondering if I was the only one going. I then looked around and saw Paul Gilbert, Adrian Wells and some lesser known but equally brilliant CBT colleagues. My thought was, if the plane went down, at least we could rely on the number of doctors on board to help us to detach from our catastrophic thoughts and be compassionate to ourselves – I guess it beats regular first aid! I then detached from that thought in the midst of the shock of a 15 euro entry visa! Once we got to Istanbul, we settled into our rooms and made the customary first night exposure to the local customs. To be truthful we just ate kebab and chips!

The first day of the congress involved pre-conference workshops. I attended Robert Leahy’s on working with resistance when treating anxiety. This was fantastic and he provided anecdotes and evidence for a very different approach to working with anxiety. He mentioned a client he had worked with who had seen a quote from Eleanor Roosevelt – ‘Do one thing every day that scares you’ - and had applied this quote literally (skydiving, climbing mountains, interviewing her ex-boyfriends) in order to reduce her avoidance. She had even written a book about the experience called My Year with Eleanor. Although it was an enlightening story, I did notice he said his clinic was in Manhattan and I was left wondering whether this was a transferrable intervention in Manchester!

The congress was awash with other fantastic workshops and seminars. Costas Papageorgiou provided a brilliant workshop on social anxiety and was highly engaging, emphasising the importance of context in cognitions. This was followed by Judith Beck, who I found to be very down to earth. I finished off the congress with a workshop by Steven Hayes on Acceptance and Commitment Therapy (‘ACT’ for the uninitiated – not A.C.T. I haven’t got a clue why but there you go). His presence and style were entertaining, better still hypnotic. I even felt I had received some subliminal messaging, as I don’t know why I felt so good about it and don’t know why I am so interested in it now. But something grabbed me. I don’t know if it was because Professor Hayes reminded me of Doc out of Back to the Future, or whether it was saying ‘milk’ over and over – there was something different about this and I am keen to learn more.

The congress wasn’t complete without the amazing hospitality of the Turkish Association for Cognitive & Behavioural Psychotherapy, and particularly its President, Mehmet Sungur. We had a boat cruise on the Bosphorus, saw Robert Leahy sing the Beatles, Professor Sungur sing a duet with Sara Tai and, well, as the saying goes, what goes on in Istanbul, stays in Istanbul!

Caroline Williams
Dear BABCP

‘Let’s stop translating and start adapting.’ These were the words of Paul Salkovskis opening a panel debate on the future of CBT on the first day of the ICCP congress in Istanbul. Poignantly, perhaps, given that the Turkish city straddles continental Europe and Asia. In fact, I carried the Professor’s sentiment in my head most of the week, and certainly on the evening I took a bus across the Bosphorus bridge into the less touristic Asian side for a splendid fish dinner.

In a literal sense, this bridge unites the West with the East. Within a geopolitical context, the symbolism of the bridge is more nuanced and inscribed with competing discourses. If Turkey moves closer to a political union with Europe and becomes a strategic outpost for the US military, Turkish authenticity will be compromised on a scale yet to be calibrated. Istanbul itself reflects many of the contradictions symbolically embedded in the bridge. Rather like CBT, I would argue.

Historically, the formative period for psychological therapies was found in places like Mesopotamia and Morocco, long before they reached the House of Bedlam. In a postmodern sense, CBT is often regarded as a Western treatment. As it moves out of its Western locale and into a global(ised) context, CBT now has to consider the extent to which it will collaborate with non-Western traditions.

Speaking at the same discussion panel as Professor Salkovskis was ACT co-developer Steven Hayes, who argued that a route needed to be found for putting cultural knowledge inside CBT processes. Two ‘cartographers’ are already on the case: BABCP’s own Faramarz Hashempour and Adam May, who presented a skills workshop on developing cultural competence when working with people from diverse backgrounds. Joining the workshop were delegates from Kosovo, Iran and Germany, which guaranteed a fascinating exchange of insights into how CBT is already adapting to non-traditional settings.

Professor Salkovskis might be onto something.

Stephen Gregson
Why develop psychological services for military veterans?

The UK military has been extremely busy since 2000 with military personnel being deployed in large numbers to Afghanistan and Iraq. There is currently approximately 10,000 UK personnel deployed to Afghanistan alone, with many more deployed around the world providing peacekeeping and humanitarian support. Against this current high tempo of deployment in often demanding environments has been a steady flow of injured personnel who require a range of physical and psychological healthcare.

Much of this healthcare is provided by the military medical services at the frontline in forward operating bases, field hospitals such as Camps Bastion and Kandahar and, for those requiring further treatment, Selly Oak NHS Hospital in Birmingham. There are also 16 out-patient defence community mental health teams around the UK, Germany and Cyprus, staffed by a military multi-disciplinary team including community mental health nurses with training in CBT and EMDR, who also deploy and provide mental health support and early psychological treatments.

**Increased support for veterans**

With 24-hour news coverage of current conflicts, there has also been a change in awareness and support for the armed forces from the Government and wider public. In 2007 the Ministry of Defence (MoD) and the devolved administrations funded six NHS community mental health pilots in Edinburgh, the North East, Staffordshire, London, Cornwall and Cardiff. These pilots were tasked to set up community veteran services to see what the uptake would be from veterans, the range of mental health presentations and which type of treatments was required and what worked. The pilots were staffed by either nurse therapists with a clinical training in CBT or clinical psychologists usually with 0.5 funding with administrative support. The pilots have all completed their work and have been subjected to a review by the University of Sheffield. They are currently all receiving funding while other areas are starting to develop and plan veteran services within existing IAPT teams. In Wales, where IAPT has not been implemented, this has resulted in a hub and spoke model with a total of nine CBT therapists providing an out-patient service to their local health board covering the whole of Wales.

**Why should veterans be targeted?**

As those of us who work in the traumatic stress field know, military personnel are considered one of the highest risk occupational groups for exposure to traumatic and adverse events. Such events and the demands of being deployed away from family and social support increase vulnerability to a range of mental health problems, in particular anxiety disorders, depression and substance dependency. Over the past 30 years, the development of evidence-based treatment approaches for mental health problems has greatly increased the range of options available to mental health clinicians.

Engaging veterans into mental health treatment programmes remains particularly challenging due to a variety of factors including stigma, perceived weakness at acknowledging emotional difficulties and the military’s macho culture. Recent studies have shown more than 60 per cent of US Iraq veterans, who screened positive for a mental health problem, did not seek treatment. Similar findings were reported in a UK study, in which only 23 per cent of serving personnel with common mental health problems were receiving any form of medical professional help. Chaplains were much more likely to be supporting these individuals. Those who were receiving medical help were mainly in primary care (79 per cent) and being treated with medication, counselling or psychotherapy. Trials are ongoing in the US and UK with group programmes such as Battlemind, and Trauma Risk Management (TRiM) respectively, with some evidence that they may improve attitudes to mental health seeking behaviours. In 2009 IAPT published the Veterans Positive Practice Guide with helpful information for the NHS and, in particular, primary care to aid commissioners when setting up veteran informed services.

**What treatments work with veterans?**

There are a range of evidence-based treatments for mental health problems that have been shown to be effective in civilian populations. But it is unclear whether or not they have similar efficacy in serving military and veteran populations, or how well these populations engage with them. Currently the information is just not there to address the specific interventions, settings and lengths of treatment that are applicable in the veteran population. Based on our experience in Cardiff,
the typical veteran is male, aged between 35 and 50, and served in the army with multiple deployments. Since leaving service he has found it difficult to stay employed, has many and varied social problems, may have had contact with the criminal justice system and been classed as vulnerably housed or homeless. These often complex presentations require a varied management plan with referrals and signposting to organisations and veteran charities that can assist with many of the social problems including debt and benefit advice. They often require pharmacological therapy for anxiety and depressive disorders in tandem with out-patient psychological therapies.

Veterans will attend NHS facilities but prefer a veteran specific service as they view their problems as being unique to the civilian population. Treatment gains are possible with the correct management plan but often modest. Targeting their social problems in the first instance appears to produce better attendance in out-patient psychological therapy and leads to improved positive outcomes.

Forming a veteran steering group, with a wide membership from the main veteran charities, MoD Service Personnel and Veterans Agency, Citizen’s Advice Bureau, prison healthcare, homelessness teams, Combat Stress and local military medical services, will help new veteran services develop positive veteran practices.

In the last 10 years, there has been a proliferation of charities that have emerged claiming to be able to treat and ‘cure’ veterans’ mental health problems, particularly PTSD. They are often staffed by well-meaning veterans with some medical training. The treatment programmes, though, are often residential focused and use unproven psychological treatments including neuro-linguistic programming.

Veteran mental health services need to collect routine outcome data and work together to share best practices. Continued research should also focus on which civilian treatments are transferable to this deserving and challenging occupational group and how they can be helped to reintegrate with the wider community.

Neil J Kitchiner

Neil is a Principal Clinician, Veterans Health & Wellbeing Service, Cardiff & Vale University Health Board, Cardiff. He is also a Captain in 203 Army Field Hospital, Cardiff. To contact him, email neil.kitchiner@wales.nhs.uk.

Critical thinking

*PWP Chris Morgan experiences a philosophical crisis*

This Spring I experienced a small philosophical crisis. Actually, crisis is too strong a word, but I have yet to find an alternative. It arose following a supervision session where we had quickly moved on from talking about relaxation, to issues of copyright, the use of approved self-help materials, and how these factors affected the PWP role. It was during the session that I began to experience an increasing sense of frustration regarding the constraints and requirements of my role.

This sense of frustration grew in my mind until eventually, some time after the session, it was ready to bear fruit. I asked myself two questions: What is the point of caring about what I do when I am so constrained? And, ultimately, what is the point of anything anyway since eventually we are all going to die. Now I have often been told by friends and family that I think too much, and certainly my final culminative experience was a very cognitive one. But, essentially, these two questions are really one and the same.

What amazes me about my experience is that, in the end, it was a very liberating one. I could see the possibility of two options presenting themselves side by side, both arising from the same experience. One in which I concluded that, since everything I do ultimately ends in death, all my actions are pointless, the other in which I concluded that constrained as I am, I am in possession of some kind of radical freedom, because being alive here and now I am able to alter the world through my actions.

I already had in my mind the idea that my experience was an ‘existential’ one. To make sure, I did some reading: Mel Thompson’s *Understand Philosophy* (from the *Teach Yourself* range) described existentialism as the ‘branch of philosophy concerned with the experience of meaning or purpose (or lack of it) in human existence’. This sounded about right, but how does this relate to the PWP role?

When I originally applied for the role, a friend of mine asked me if I was scared about getting the job. ‘What if something goes wrong?’ she said. I replied that I wasn’t scared because I strongly believed that, even if everything else fell apart, I could still care. Care about the people I was working with and the job I was doing. This then is the point. Constraints are a reality, there are certain givens we cannot escape. In the end, we can choose either to deaden our experience with apathy and ambivalence, or choose to enliven our role by caring. I am choosing to care. I hope and believe others will do so too.

Chris is the religion and spirituality correspondent for CBT Today.
Positive deviancy and CBT
Time for confessions

In the March issue of CBT Today I wrote about a small research project that had just started in the Department of Applied Psychology, Canterbury Christ Church University, on positive deviancy and CBT.

My personal interest in positive deviancy was triggered by my friend Mr Percy. For more than 14 years he was the co-therapist in many of my CBT sessions. His ‘natural’ interventions at times produced dramatic results, yet none of these interventions can be found in books on CBT. His most successful intervention was to slowly approach a client who was having difficulty processing strong negative feelings and then put his big head in their lap and look up at them. Whether it was imaginal exposure with PTSD clients or the reviewing of a very upsetting event, this was always the moment when clients suddenly had more strength to deal with their demons.

The project aims to identify ‘deviancy’ in CBT that has a positive impact on clinical results, and to what extent CBT practitioners engage in deviations of recommended protocols in order to produce good results. Ultimately the project hopes to find methods to capture these instances of positive deviancy and identify the therapist behaviours and/or organisational issues that lead to positive outcomes despite being deviant.

Our hypothesis is that there are CBT therapists out there using deviant strategies, which are perhaps more effective than, non-deviant strategies. How can we identify them and how can we then identify the therapist behaviours that are responsible for their exceptional success? This survey is a first step towards discovering effective, or positive, deviancy. Moreover, with many elements in CBT now highly prescriptive, the survey is an attempt to provide us with an initial idea of how CBT-ers deviate from recommended protocols and guidelines.

Many forms of CBT now have a rightful claim to being empirically supported. But what happens in everyday clinical practice, when clinicians in the field modify protocols to meet the special needs of their clients? It is in this regard that many clinicians revert back to an ‘experimental design’ on the foundation of an empirically supported treatment. That is, the idiosyncratic presentation of the client motivates the clinician to adopt a treatment approach that deviates significantly from the empirically supported protocol. These modifications are put in place by practitioners when clients present with problems that do not exactly fit with the diagnoses for which the empirically supported treatment was originally developed.

Despite this, many CBT practitioners consider their approaches to be empirically informed. In our opinion, these clinicians are correct in their assumption. The need for modifications to existing empirically supported interventions, however, also highlights some inherent challenges for CBT practice.

How much deviation is ‘allowed’ from an empirically supported model before it becomes an empirically unsupported intervention? We have designed a survey that aims to find out:

• What is the extent to which CBT therapists deviate from empirically supported protocols?
• What motivates clinicians exactly to deviate from a protocol/guideline?
• What are some examples of these deviations?
• How do clinicians monitor the impact of deviations?

We would like as many CBT-ers as possible to participate in this survey. If you leave your email address, you will be entered in a lottery with a chance to win a Zee Beatty and the Socks of Doom book and poster.

Henck van Bilsen

To participate in this online survey, please visit:
https://survey.canterbury.ac.uk/pdcbt

‘My positive deviance inspiration: my co-therapist for 14 years, Mr Percy, who went to dog heaven in June this year, but the legend lives on…’
Making IAPT more accessible to older people

By Paul Green

I was shocked but sadly not surprised to learn that only three per cent of referrals to the Kirklees Primary Care Psychological Therapies Service (IAPT) were for older people. If equality of access is to be achieved, the rate of referrals for those over 65 ought to be in the region of 12 to 15 per cent, a shortfall replicated in other areas of the country. However, good practice is gradually being established in some flagship IAPT services, most notably those in Southwark and the East Riding of Yorkshire. In Kirklees, we are exploring ways in which the barriers to older people’s participation in what is, theoretically, a service with no upper age limit, can be removed.

Older people are less likely to be offered psychological therapies than their younger counterparts due to ageist assumptions that anxiety and depression are ‘normal’ for this client group on the part of a minority of professionals and therapeutic pessimism about the outcome. Older people themselves may also have cohort beliefs that negatively affect their own attitudes towards therapy, while time constraints and lack of awareness may prevent GPs from making referrals where appropriate. Moreover, the models, self-help materials and assessments used within IAPT have not been validated for use with older adults. In fact, the main focus of IAPT services is on the needs of working age adults and relatively few staff members have previous experience of working with older people. Consequently, knowledge of how interventions might need to be adapted to meet the needs of this client group is often lacking.

Education and training are therefore crucial if we are to plug the knowledge and skills gap so that older people can receive a service more appropriate to their needs. With this consideration in mind, we have been collaborating with Steve Lyon at the University of Huddersfield to develop a new 24-week part-time course, HMH 2007 Cognitive Behavioural Therapy with Older People. Attendance will be for five days of teaching sessions and masterclasses over the academic year 2011-12. Students will also use electronic resources and independent study to produce a 5,000-word case report and 3,000-word transcript of a therapy session. The course can be completed as part of the MSc in Health Studies, if desired, and 30 Master’s level credits will be awarded upon successful completion. Equipping staff with the knowledge to understand how CBT can be

Continued overleaf

Older people are less likely to be offered psychological therapies than their younger counterparts due to ageist assumptions that anxiety and depression are ‘normal’ for this client group on the part of a minority of professionals and therapeutic pessimism about the outcome
Successfully applied to meet the needs of older people by setting interventions in the context of later lifespan development is an important step along the road to providing a more equitable service.

In order to remove barriers at the point of referral, we are currently liaising with the organisations providing existing services for older people in the NHS, Social Services and the voluntary sector. By raising awareness of what we can offer among those who have most contact with this client group, we hope to increase the referral rate. To this end, we recently held an event to promote this aspect of the IAPT service and provide information about how we can support older people with anxiety and depression. There are a number of adaptations which can be made, where appropriate, to how models are applied and therapy sessions delivered. It is important to communicate this effectively to potential referrers.

Formulations can be simplified to suit the needs of those who may be mildly cognitively impaired or have sensory impairments. They can also be developed in ways which encompass generational rules/norms, worth-enhancing beliefs that have kept people well in the past and the social, cultural and interpersonal aspects of ageing. Sessions can be made shorter, more frequent and taped for review if the client has memory problems. A transcript summarising each session in large print is often a useful handout to provide while notebooks, index and cue cards can help clients to review material and keep track of homework. A carer may be involved as a co-therapist if this is appropriate. Additional assessments, which have been validated for use with older people such as the Geriatric Depression Scale and the Geriatric Anxiety Inventory, can help to capture aspects of an older person's problems that might be missed by over reliance on the IAPT minimum data set.

Practitioners need to be aware that older people, particularly if they have impaired hearing, may not find telephone-based work helpful, while physical disabilities may affect their ability to travel to appointments. In response, we are exploring ways of making the service more accessible by offering some home visits and face-to-face appointments rather than telephone sessions. We will also try to identify venues in services used regularly by older people which might provide appointments which are more accessible. Age is a protected characteristic under the 2010 Equalities Act, which requires public bodies to demonstrate that their services are genuinely accessible to minority groups rather than simply declaring themselves open to all. Consequently, IAPT services cannot afford to follow a ‘one size fits all’ approach to the delivery of therapeutic interventions.

Paul contributed the chapter ‘New Directions in Cognitive Behavioural Therapy for Older People with Dementia and Depression’ to the 2011 book *Spirituality and Personhood in Dementia*, edited by Albert Jewell and published by Jessica Kingsley. He has published a number of articles on mental health issues in professional journals and is an occasional contributor to the arts pages of *The Friend*. His first novel, *The Devil’s Payroll*, will be published by Robert Hale in December 2011.

---

### BABCP CHES T E R , W IRR AL A ND NORT H E A ST WA LES BRANCH

#### Forthcoming events Autumn 2011

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
</table>
| Wednesday 28 September 2011 6.30-8.30pm | Day 1: Understanding and Treating Excessive Worry and Generalised Anxiety Disorder | Chester Rugby Union Football Club, Hare Lane, Littleton, Chester CH3 7DB  
***Please note change of venue***  
**Working with Fear of Medical and Dental Procedures**  
By Lynn Keenan  
Free for BABCP members  
Non-Members £10  
No need to book  
Please refer to www.babcp.com/cpd and www.chester-rufc.com for details  

**Two-day event (each day can be attended separately)**  
Thursday 10 & Friday 11 November 2011  
Cheshire County Sports Club, Plas Newton Ln, Upton, Chester, CH2 1PR  

**Day 1: Understanding and Treating Excessive Worry and Generalised Anxiety Disorder**  
**Day 2: Beyond the Textbook Case: Keeping on Track in the Treatment of GAD & Worry in the Face of Comorbidity, Complexity and Stuck Points**  
Both by Professor Mark Freeston  
Cost for the per event from £120 for both days and £65 for each day  
for members (early bird rate booking before 30/09) prices for non-members on enquiry - lunch included  
Please refer to www.babcp.com/cpd for further details. Booking is via the BABCP office (telephone 0161 705 4304)  

---

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
</table>
| Wednesday 26 October 2011 6.30-8.30pm | Anxiety and the Autistic Spectrum Disorders – What Should We Do Differently? | Chester Rugby Union Football Club, Hare Lane, Littleton, Chester CH3 7DB  
***Please note change of venue***  
**By John Barber**  
Free for BABCP members  
Non-Members £10  
No need to book  
Please refer to www.babcp.com/cpd and www.chester-rufc.com for details  

---
Feedback
The BABCP Annual Conference is one of the great opportunities provided by the Association for practitioners and researchers to come together to discuss the most recent developments and biggest issues related to CBT. This year’s conference was held at the University of Surrey in Guildford, and having now processed the delegate feedback it seems it was a great success.

Quality and diversity of scientific programme
One of the things that came across most strongly in feedback was how delegates felt about the standard of the scientific programme: ‘the academic quality was superb, better than Boston last year’, said one delegate, while another stated, ‘as always, the best conference of the year’. Delegates particularly appreciated the chance to explore the new developments within the field, allowing them to feel they had been ‘brought right up to date with what is happening in CBT’.

Delegates not only noted the quality of the scientific programme, but also the variety of the topics included, thereby offering ‘a comprehensive coverage of the field’. Also appreciated were the various formats in which to gain this information, including keynotes, pre-conference workshops, symposia, panel discussions and clinical roundtables: ‘I felt like a child in a sweet shop – spoilt for choice’!

Skills classes
As seen in previous years’ feedback, skills classes are the most popular choice for delegates wishing to learn practical skills; once again this year we have received a very positive response. Delegates found that skills classes ‘helped consolidate and support learning’ and gave them ‘something new to take away from the conference’. Many delegates commended the accessibility and relevance of the information given in skills classes, as well as the way in which this knowledge can readily ‘translate into practice’.

Balance of research and clinical
BABCP always endeavours to ensure that both research and practical clinical applications are available throughout the conference in order to cater for delegates’ varied needs. Feedback from Guildford suggests delegates felt this was achieved, with one delegate stating the ‘balance between clinical skills and scientific presentations is just right’. Delegates were also pleased with the usefulness of conference materials and handouts, which they described as ‘extremely useful for work’.

Socials and networking opportunities
Alongside a high quality scientific programme, those who attended Guildford also enjoyed the ‘fantastic organised social events’. The party at Denbies, one of South England’s finest vineyards, was extremely well-received by delegates who enjoyed wine tasting, a buffet supper and a disco. Delegates also stated they enjoyed the ‘more informal opportunities to socialise at the curry and beer night’, where they enjoyed an Indian banquet, Indian beer and superb Bollywood dancers. Delegates also frequently mentioned the great networking opportunities provided by the conference, particularly the chance to meet ‘fellow practitioners from other areas, sharing experiences and ideas’ as well as the chance to ‘exchange different working approaches’.

Suggestions for future conferences
Feedback is vitally important in identifying what worked well for delegates, and what didn’t, with any suggestions helping to shape future conferences. The Scientific Committee would, therefore, like to thank every delegate who took the time to complete the feedback form. There were concerns about the venue layout and access around the campus. This is an issue that we need to consider each year as the conference moves around the country. For next year’s Annual Conference in Leeds from 26 to 29 June 2012, we are lucky to have a single building to hold the majority of the parallel sessions. Several requests were made to increase the relevance of the presentations to clinical...
practice and will continue to request this of our presenters, whilst of course maintaining the scientific focus of the event. The Scientific Committee will, of course, consider these suggestions as they begin planning for the 2012 programme.

Amy Hamilton, Warren Mansell, Roz Shafran and Rod Holland
BABCP Scientific Committee

For a richly scientific perspective on key themes raised during the Guildford conference, visit James Hawkins’ Good Medicine blog: http://goo.gl/px5Ey

My BABCP conference
A-level student Libby Rackham reflects on her week as a steward in Guildford

When given the opportunity to steward at this year’s BABCP Spring Conference at the University of Westminster, I jumped at the chance. When asked if I would steward again in Guildford, I couldn’t have been more excited. As an A-level psychology student, going to conferences and workshops, attending symposiums and meeting internationally renowned psychologists isn’t something I normally get the chance to do. This became especially obvious when first meeting my fellow stewards, as they talked about which university they were at, their clinical work, their latest research projects. All I had to offer was that I’m still learning Freud’s theories!

One of the conference highlights for me was Renee Harvey’s pre-conference workshop, An Introduction to the STEPPS Programme for Emotional Intensity’. Not only was Renee great to talk to, but she also made the treatment very accessible and easy to understand. When I got home I was repeating statistics, giving clinical examples and recreating graphs on emotional intensity. My passion for telling others about the subject grew to the extent that, when a work colleague asked me how many times I’d drawn the graph before, I was forced to rather sheepishly admit, ‘…six’.

I found the symposia and keynotes very interesting. Having never studied in this much detail before, I did find that at times I struggled to fully understand some of the content aimed at a much high level than I am used to. Again, the presenters managed to evoke my enthusiasm for the subject. I thought that Bob Woods was an especially charismatic speaker on his topic of age-related illness, as he managed to get a laugh out of everyone despite describing everything we have to look forward to as we age!

I had a wonderful time. The other stewards were extremely friendly and altogether we enjoyed not only the presentations, but also exploring the exhibitions and the poster sessions. The University of Surrey was also fantastic, and my time spent there during the conference has made me seriously consider Guildford as a potential choice. Most importantly, the conference made me certain that I will continue to learn more about CBT, as I have seen the ways in which theories are put into practice and help people to live happier lives. For me, to say the conference was a very rewarding experience would be a bit of an understatement!


BABCP West Branch presents a one-day workshop

Collaborative Case Conceptualization

Three Principles and Steps for Individualizing Evidence-Based Treatments

by Professor Willem Kuyken with Dr Robert Kidney

Friday, 30 September 2011

Bristol Zoo, Clifton Pavilion, College Road, Bristol BS8 3HH

Registration from 9.00 am - Workshop begins 9.30 am

Workshop fee includes: two course buffet lunch, refreshments and entrance to the zoo

Registration fee

£75 BABCP Members  £95 Non-members

For further information including how to register, please visit www.babcp.com/cpd
Our newest presenters at the 2011 BABCP conference were considered for three Excellence Awards: two for new researchers presenting the best open paper and poster, and one for the best case report poster.

Dave Pasalich received the open paper award for his presentation, ‘Do callous-unemotional traits moderate relationships between coercive and affective-based dimensions of parenting and child conduct problems?’ Judges were impressed by the rigorous approach taken to tackling this question. The results of Dr Pasalich’s research speak to the issue of why parenting programmes are currently ineffectual for some children with conduct disorder.

The poster award went to Elizabeth Mason for her poster, ‘Insomnia pre- and post-treatment for anxiety and/or depression.’ This research mixed empirical research and case studies to explore the interplay between sleep and affective disorder. The research findings were interesting and novel, and presented in a clear and attractive poster.

In the case report category, Sinead O’Connell won the award for her poster, ‘Delivering CBT in a complex case presentation of OCD and co-morbid depression with a diagnosis of Asperger’s disorder.’ This case report clearly depicted the challenges associated with delivering CBT in the context of difficulties in accessing and articulating cognitive and affective states, and approaches to overcoming these problems.

We are very grateful to Professor Steve Hollon for judging the poster awards. Professor Hollon particularly asked that we highlighted the high standard of posters overall. We noted the rising numbers of delegates providing case report posters, which is very encouraging. The Scientific Committee also commented on the large audiences attracted by open paper sessions this year, reflecting the quality and relevance of the work submitted. The three award winners will receive free registration and an invitation to present at next year’s BABCP Annual Conference in Leeds. We will be running the same awards in Leeds, so check the conference website for details: www.babcpconference.com.

Sarah Halligan and Cathy Creswell
Judges, Excellence Awards 2011
BABCP 40th Annual Workshops and Conference

UNIVERSITY OF LEEDS

THE EVENT COMES EARLY NEXT YEAR!
26 – 29 June 2012

40th Anniversary Theme

Does Life Begin at 40 for the BABCP? Past, Present and Future Developments for CBT

In addition to the main theme, the conference will include the following topics:

- How does CBT work?
- Increasing the Efficiency and Impact of CBT
- Military Veterans
- Sport, Exercise and Motivation
- CBT and Healthy Living

CALL FOR PAPERS

The scientific committee invite submissions of Pre-Conference Workshops, Symposia, Clinical Roundtables, Panel Discussions, Skills Classes, Open Papers and Posters.

We especially welcome submissions relating to the key themes of the conference.

Deadline for Workshops, Symposia and Skills Classes: 19 December 2011

Deadline for Open Papers and Posters: 6 March 2012

For more information please visit www.babcpconference.com
Earlier this year, Oneworld published the latest in its Coping with series. Written by two psychologists and a psychiatrist, Coping with Depression: a guide to what works for patients, carers, and professionals aims to provide the most essential facts about depression and helping readers learn how to effectively overcome it. When the market is clearly overcrowded by a number of excellent books on depression, why do we need another such book? CBT Today asked Costas Papageorgiou (pictured below), who wrote the book with Hannah Goring and Justin Haslam, to explain why.

Rather than just writing about what we, as depression clinicians and researchers, believe should be written about this problem and its evidence-based treatments, we wanted to be closely guided by individuals who were, or had been, suffering from depression as well as those involved in their care. To this end, we facilitated several depression focus groups, where individuals had the opportunity to participate in discussions and express what they believed was most helpful for them. We also closely consulted with their carers/families and numerous clinicians and therapists. Essentially, individuals who took part in this exercise asked for a depression book that could instil hope right from the start and was clear, jargon-free, user-friendly, factual but not speculative or experimental, and more multi-professional. Importantly, the participants from the focus groups asked for a book covering the main currently recommended effective treatments for depression (ie fully NICE-compliant), rather than focusing on single treatments. We believe that this is crucial because currently there is not one treatment that is effective for all individuals or all types of depression. If one particular treatment does not appear to work for an individual after a period of time, it is important for them to know that there are other effective treatments available. So, until new and exciting treatments for depression (such as metacognitive therapy) are fully validated and incorporated into clinical guidelines, individuals need to know what all the effective treatments are and what they should expect from them.

In Coping with Depression, we have attempted to write a book about what individuals told us was most helpful for them and what NICE currently recommends as best practice for depression. After a brief introduction, the book proceeds with an unedited chapter written by an individual who experienced recurrent episodes of depression over the years and was able to benefit from both psychological and pharmacological treatments. We believe that this is a particularly helpful, motivating, and inspiring chapter detailing a person’s unique experiences of depression and its treatment. Chapters 2 and 3 focus on the nature, characteristics, and key facts and figures about depression. In particular, we present a section on the perceived myths and actual facts about suicide following specific requests from various healthcare professionals. Chapters 4 to 8 describe in detail how to effectively overcome depression through behavioural activation, cognitive therapy, interpersonal psychotherapy, and pharmacotherapy. The chapters focusing on the psychological treatments encourage individuals to actively try out the strategies and techniques described, and how to overcome some common problems in implementing these. The book ends with chapter 9, which provides specific advice on preventing relapse and recurrence of depression. On completion of this book, we asked for comments from individuals who have participated in focus groups and consultations, and this feedback helped us further revise and improve the contents so that, collectively, it served the purpose of assisting in Coping with Depression.

If you are an author and would like to talk about your book in CBT Today, email stephen@babcp.com
Much of my work in Tanzania involved training staff in the basics of talking therapy and orienting them to CBT in particular. I hoped they would join me in a collaborative search for a meaningful model of CBT adapted for Tanzania, or Mirembe at least. Many would say this was optimistic at best, even naïve: CBT can be seen as a Western therapy that may lack relevance in Africa where there are bigger health and social problems to tackle. I have heard such views both in the UK and Tanzania.

It is, nevertheless, my belief that taking CBT to Mirembe had a positive effect. Of course, CBT is not being used at Mirembe in any ‘pure’ form that UK clinicians might understand. I evaluated the training I carried out, not only using various questionnaires, but also through interviews with clinicians and patients. CBT was particularly appreciated for its collaborative nature, its focus on the client as a source of their own solutions, and the freedom that both clinicians and patients felt from identifying alternative ways of thinking and acting.

Clinicians in the UK I have spoken with about my Tanzanian experiences often seem nervous about the idea of developing CBT in such a different culture. Some of their reservations may have validity. But, I believe that the bigger issue is to adapt CBT so that the techniques and strategies used find their substrate in spite of any differences: not just cultural ones, but across all equalities groups. Since returning to the UK, I have been working within a CAMHS service in an area of London with a diverse population, focusing on providing a psychology service to looked-after children. Again I have found the need to change my approach in engaging the young people the service works with, to stimulate their thinking and change behavioural patterns while trying to apply CBT throughout.

Most clinicians come up against challenges when working with people from diverse backgrounds, but they should find the courage to face this with honesty and in collaboration with our clients. The more we work with diverse groups, the more we can understand what, how and why different elements of CBT are effective for different difficulties and symptoms.

In 2009 Lydia Stone wrote an article for CBT Today whilst working in Mirembe Psychiatric Hospital in Tanzania. Almost a year after returning to England, she reflects on what this experience taught her as a psychologist and particularly working with people from diverse backgrounds.

Lydia Stone

In 2009 Lydia Stone wrote an article for CBT Today whilst working in Mirembe Psychiatric Hospital in Tanzania. Almost a year after returning to England, she reflects on what this experience taught her as a psychologist and particularly working with people from diverse backgrounds.
Religious Trauma Syndrome...

The kind of religion that causes damage is that which requires rigid conformity in order to survive in the group or have hope for the afterlife. Such a fundamentalist religion has a closed system of logic and a strong social structure to support an authoritarian worldview. It can be a comfortable environment as long as a member does not question. Children learn very early to repress independent thinking and not to trust their own feelings. For truth, believers rely on external authority – Scripture and religious leaders. With the consequences of disbelief so severe, leaders are able to demand acceptance of far-fetched claims at the expense of personal observation or scientific evidence. The culture rewards individuals who contribute in religious ways. Proselytising is generally expected, even for children. Obedience is the highest value and personal development truncated. Clearly, psychological problems can develop long before the additional trauma of leaving the fold. I will use the example of Bible-based fundamentalisms.

Foundation of fear

The first key doctrine is eternal damnation or annihilation for all unbelievers. This is the terrifying backdrop for the salvation message presented to all newcomers and all children born into the faith. The Bible is quoted to paint a horrifying picture of hell as a lake of fire, a fire of eternal torture impossible to quench despite any pleading. Mormons describe a hell of ‘outer darkness’ that is cold and just as terrifying. Jehovah’s Witnesses threaten the horror of dying forever at Armageddon.

Small children can obviously visualise these things while not having the brain capacity to evaluate the message. Moreover, the powerful social context makes rejecting these teachings impossible. Children are completely at the mercy of religious adults. The salvation formula is offered as a solution of course, but for many, it is not enough to ward off anxiety. How does one really know? And what about losing one’s salvation? Many adults remember trying to get ‘saved’ multiple times, even hundreds of times, because of unrelenting fear.

‘I feel little hope, because I don’t know how it is remotely possible for me to ever let go of my fear of hell. If I give up my belief system, I’ll go to hell. Even though my whole life has been so unhappy in the church, it has brought me nothing but turmoil and heartbreak and disappointment and unanswered questions and dissatisfaction.’

A variation on this is fear about missing the ‘rapture’ when Jesus returns. I have heard many people recount memories of searching for parents and going into sheer panic about being left alone in an evil world. Given that abandonment is a primary human fear, this experience can be unforgettably terrifying. Some report this as a recurring trauma every time they couldn’t find a parent right away.

‘During my freshman year in college, I started having nightmares. In my dreams, the rapture would happen and I would be left behind, or worse, sent to hell. Several times I woke up just before I was tossed into the flames, my mouth open, ready to scream.’

‘After 27 years of trying to live a perfect life, I failed… I was ashamed of myself all day long. My mind battling with itself with no relief… I always believed everything that I was taught but I thought that I was not approved by God. I thought that basically I, too, would die at Armageddon.’

Finally, believers simply cannot feel safe in the world. In the fundamentalist worldview, ‘the World’ is a fallen place, dangerously ruled by Satan and his minions until Jesus comes back and God puts everything right. Meanwhile it is a battleground for spiritual warfare and children are taught to be very afraid of anything that is not Christian. Much of ‘the World’ is condemned at church, and...
Understanding Religious Trauma Syndrome (continued)

parents try to control secular influences through private and home-schooling. Children grow up terrified of everything outside the religious subculture, most of which is simply unfamiliar.

'I was raised on fire and brimstone, speaking in tongues, believing the world was a dangerous and evil place, full of temptation and sinners seeking to destroy me/drag me down.'

Self as bad

Second to the doctrine of hell, the other most toxic teaching in fundamentalist churches is that of ‘original sin’. Human depravity is a constant theme of fundamentalist theology and, no matter what is said about the saving grace of Jesus, children (and adults) internalise feelings of being evil and inadequate. Most of these churches also believe in demons quite literally, some to the point of using exorcism on children who misbehave. One former believer called it ‘bait-and-switch theology -- telling me I was saved only to insist on my bad behaviour, so I misbehaved to please Him and follow His perfect will. But what if it doesn’t work? Fundamentalist Christianity promises to solve all kinds of personal problems and when it does not, it is the individual that bears the paralysing guilt of not measuring up.

'I have tried to use this brand of Christianity to free myself from the depression and addictions that I have struggled with from childhood... I have fasted, prayed, abstained from secular things, tithed, received the spirit, baptised in the spirit, read the Bible, memorised Scripture etc. None of it has worked or given me any lasting solution... I have become so desperate at times, that I have wanted to take my own life.'

Cycle of abuse

A believer can never be good enough and goes through a cycle of sin, guilt, and salvation similar to the cycle of abuse in domestic violence. When they say they have a ‘personal relationship’ with God, they are referring to one of total dominance and submission, and they are convinced that they should be grateful for this kind of ‘love’. Like an authoritarian husband, this deity is an all-powerful, ruling male whose word is law. The sincere follower ‘repents’ and ‘rededicates’, which produces a temporary reprieve of anxiety and perhaps a period of positive affect. This intermittent reinforcement is enough to keep the cycle of abuse in place. Like a devoted wife, the most sincere believers get damaged the most.

'I spent most of my life trying to please an angry God and feeling like a complete failure. I didn’t pray enough, read enough, love enough, etc.’

To think you are good or wise or strong or loving or capable on your own is considered pride and the worst sin of all in this religious worldview. You are expected to derive those qualities from God, who is perfect. Anything good you do is credited to God and anything bad is your fault. You are expected to be like Him and follow His perfect will. But what if it doesn’t work? Fundamentalist Christianity promises to solve all kinds of personal problems and when it does not, it is the individual that bears the paralysing guilt of not measuring up.

'I have tried to use this brand of Christianity to free myself from the depression and addictions that I have struggled with from childhood... I have fasted, prayed, abstained from secular things, tithed, received the spirit, baptised in the spirit, read the Bible, memorised Scripture etc. None of it has worked or given me any lasting solution... I have become so desperate at times, that I have wanted to take my own life.’

Don’t think, don’t feel

Fundamentalist theology is also damaging to intellectual development in that it explicitly warns against trusting one’s own mind while requiring belief in far-fetched claims. Believers are not allowed to question dogma without endangering themselves. Critical thinking skills are undervalued. Emotions and intuitions are also considered suspect so children learn not to trust their own feelings. With external authority the only permissible guide, they grow up losing touch with inner instincts so necessary for decision-making and moral development.

‘Fundamentalism makes people crazy. It is a mixture of beliefs that do not make sense, causing the brain to keep trying to understand what cannot be logical.’

‘I really don’t have much experience of decision-making at all. I never made any plans for my adult life since I was brought up to believe that the end of the world would come.’

Abuses of power

Added to these toxic aspects of theology are practices in the church and religious families that are damaging. It is known that physical, sexual, and emotional harm is inflicted in families and churches because authoritarianism goes unchecked. Too many secrets are kept. Sexual repression in the religion also contributes to child abuse. The sanctioned patriarchal power structure allows abusive practices towards women and children. Severe condemnation of homosexuality takes an enormous toll as well, including suicide.
I had so many pent up emotions and thoughts that were never acknowledged… Instead of protecting me from a horrible man, they forced me to deny my feelings and obey him, no matter what. It’s no wonder I developed an eating disorder.’

While the religious community can appear to offer a safe environment, the pressures to conform, adhere to impossible requirements, and submit to abuses of power can cause great suffering, which is often hidden and thus more miserable. More sensitive personalities are more vulnerable as well as those who sincerely believe the dogma. Individual churches, pastors, and parents make a big difference too, in the way they mediate the messages of the religion.

Letter to the editor

Dear Editor

We read with interest the article by Dr Marlene Winell on Religious Trauma Syndrome (RTS) in the May 2011 issue of this magazine. Whilst it was clear that Dr Winell has a lot of experience in this area and has a valid contribution to make in respect to many who have left abusive spiritual and religious situations, we felt it was unbalanced. This may be because the language she uses reflects cultural differences between UK and USA which in turn may also affect the accuracy of the piece. We thought that your readers would benefit from the points below:

1. The article describes RTS arising from ‘fundamentalist’ backgrounds but does not expand on what this means. In the UK, the word is more often associated with terrorism or extreme authoritarian groups (be they religious or otherwise). Other emotive words are commonplace. Phrases such as “mind control and emotional abuse is actually the norm for many large, authoritarian, mainline religious groups”. Whilst true of some religious groups (and cults), these statements do not acknowledge the continuum of abuse and may be offensive to many UK Christians.

2. Similar specialist work is underway in the UK for people who have been spiritually abused and abused in cults – www.hopevalleycounselling.com.

A charity has been set up - Encourage Survivors of Cults and Abuse, no.1104694. www.encourage-cult-survivors.org - in order to raise funds to subsidise specialist psycho-education and therapy with Approved Service Providers who are trained to work with spiritual (including religious) and cultic abuse.

3. The article does not make any reference to the well-known benefits to mental health of religious activity, recently summarised in a comprehensive book from the Royal College of Psychiatrists Spirituality Special Interest Group (Cook, Powell and Sims, 2009), which incidentally contains a comprehensive chapter on pathological spirituality. CBT as a profession has begun to engage with this, which is also not mentioned (Elders, 2008; Waller, 2010).

4. The church in the UK also offers a huge amount of therapy. There are 2000 Christian Counsellors who are part of the Association of Christian Counsellors (ACC) in the UK, and others who do not belong to ACC but who are in other organisations BACP and BABCP for example. Many Christians are trained in CBT to various levels. ACC is a professional body who support Christians in both core counselling training and Continuous Professional Development (CPD). There is also an accreditation system with criteria very similar to other professional bodies. They encourage high standards and professionalism and are active within many UK churches. Whilst there are some religions in UK that are anti-psychology, many in the UK are nowhere near as anti-psychology as the article portrays.

5. The one reference used to support these claims is from an American Epidemiological study. Traditional denominations in the UK are actually stable, with some parts of the church growing (Christian Research, 2011).

References


Yours

Dr Rob Waller
Consultant Psychiatrist

Greta Randle
Chief Executive of the Association of Christian Counsellors

Gillie Jenkinson, MA
UKCP Accredited Psychotherapist, Coordinator of Encourage Survivors of Cults and Abuse and Director of Hope Valley Counselling Limited

Greta Randle and Gillie Jenkinson are not BABCP members
The Branch Liaison Committee represents all the geographical Branches and Special Interest Groups (SIGs) within the Association. Over the past few months, this Committee has been exploring ways to evolve in line with the BABCP Development Plan’s objectives. Committee member Fiona Kennedy reports along with other elements within BABCP, one of the challenges for the Branch Liaison Committee has been to respond creatively to the Development Plan.

Chair Gill Donohue, BABCP Communications Development Consultant Stephen Gregson and myself got together to plan a morning workshop to look at the Committee’s role and function in terms of how we can further BABCP’s strategic progress.

We began by looking at our own perceptions of the Committee in relation to BABCP as a whole, and in relation to the wider public and political context.

Some great metaphors emerged from the exercise, with the Committee comparing itself to the watering can for the growing membership (or the manure). BABCP as a person was seen as an uncle, or even a politician. ‘BABCP as an object’ invoked a Zeppelin, at once floating skyward to be aspired to and admired, and anchored firmly to the ground.

After this bout of energetic thinking we discovered a few themes. BABCP as an organisation is seen as precious, valuable and giving appreciated nurturing and support to members and committees. On the other hand, it is perhaps somewhat distant, hard to grasp and mysterious. Remembering our core function being to support local committees at the heart of BABCP in the delivery of fabulous CPD opportunities, this is what we came up with:

---

**Mission Statement**

To be the central cohesive source of support and integration for BABCP members, and Branch and SIG committees, promoting CBT and professional development

**We value:**

- Continuous personal and professional development
- Being a voice for CBT
- Upholding standards
- Fairness and parity for members and public
- Accessibility
- Nurturing professionalism
- Fostering creativity and diversity within a CBT framework

**Our vision**

- Uphold and support the strategic intent of the organisation ‘To be the lead organisation for CBT in the UK and Ireland
- Facilitate local provision of high quality affordable CPD for BABCP members

**Growing BABCP**

- Increase the membership of BABCP by raising awareness of CBT and recruiting new members

**Communication**

- Communicate with, inform and respond to the BABCP Board, its members, political stakeholders and the public
- Represent the interests of BABCP members to the Board

**Diversity**

- Welcome and encourage diversity within the membership.
- Include diverse psychotherapeutic approaches that have CBT at their centre
- Include people from diverse professional backgrounds who practice CBT
- Promote equality of opportunity amongst these diverse professions
- Support diversity awareness as an essential competence for CBT therapists

**Accessibility**

- Enable access to training and CPD for all BABCP members whatever their location or specialism
- Work to enable access to all elements of the organisation by all members and by the public

**Creativity**

- Provide access to support and information for CBT practitioners
- Provide opportunities for networking for Branches and SIGs to share resources, information and ideas
CAFSIG named Branch of the Year
Highly Commended nod for Irish Association

Every year BABCP recognises the geographical Branch or Special Interest Group that has demonstrated particular excellence and imagination in providing high quality CPD and promoting the Association to a wider audience.

For the second year running, choosing the winner was an almost impossible task. In response, a Highly Commended Award was considered to be in order. This Award went to the Irish Association for Behavioural & Cognitive Psychotherapies (IABCP), whose members have impressed with their energy, enthusiasm and imagination in the first few months since relaunching at the end of last year.

This year’s winner is the Children, Adolescents and Families Special Interest Group (CAFSIG), whose enthusiastic committee has been passionately focused on addressing the lack of CBT provision and training for those working with children, adolescents and families across the UK. They are also very much committed to making training in this increasingly important area accessible through a nationwide CPD programme, not to mention their efforts in working towards a dedicated conference in 2013 on CBT for children, adolescents and families.

Congratulations from CBT Today!

CAFSIG member Maria Barquin discusses their winning ways...

CAFSIG is made up of a small group of individuals who defy even the worst snowfalls to attend scheduled meetings nationwide. Thanks to the commitment of committee members who come from as far afield as Cornwall and Scotland, CAFSIG has successfully achieved an increasingly prominent role for CBT within CAMHS services.

We successfully ran an International conference on CBT within CAMHS (in conjunction with the Association for Child and Adolescent Mental Health) in December 2009. We are planning a further (even more ambitious) conference, which will be held at the University of Birmingham from 10 to 12 April 2013, this time on our own.

The first call for papers for this conference can be found on page 29.

CAFSIG has grown considerably over the last year. Every three months, we host a business meeting and a CPD event. We partly funded a well-attended two-day workshop on CBT Supervision in CAMHS in October 2010 and were oversubscribed for a half-day workshop in June 2011 on CBT for children and young people with ASD. Our next CPD event will be in Cardiff in November 2011 on the topic of Mindfulness and ACT with young people.

CAFSIG provides support and facilitates information sharing group for its members who often struggle with lack of clarity over roles, such as in relation to Accreditation as a CAMHS practitioner. It is a great opportunity to network and gain understanding of a wider perspective of CBT within CAMHS. CAFSIG also contributes at a National level to wider policy issues such as the development of IAPT within CAMHS.

For more information about CAFSIG, please visit www.babcp.com/cafsig

Highly Commended: IABCP committee members (back, from left to right) Damian Price, Lea Connell, Brendan Armstrong, Gerry McAleer, Maureen McGroary-Meehan, Gerry McElraine, Maria Kee, Fionnula McLiam, Marjorie McMurray, Paul Quinn and Jacqueline McKenna; (front, from left to right) Debbie Mairs-Houghton, Michael Duffy, Roy Cheetham, Paddy Love and Mairead Ryan
The Queen wasn’t the only visitor to Ireland this Spring

As even the most fleeting visitor to the excellent BABCP Jiscmail knew, Cognitive Therapy (CT) is a generic term that refers to diverse cognitive approaches broadly designed to help modify human interpretation of their experiences and activities. This approach focuses on altering or changing negative appraisal and is based on the theories developed by Beck and Ellis.

The traditional cognitive approach assumes that it is irrational or negative beliefs, rather than negative activating experiences, that lead to or cause negative emotional states (eg depression or anxiety) and dysfunctional behaviour. The traditional aim of CT is to restructure the client’s irrational, negative and distorted beliefs into more rational, accurate and realistic ones. Although CT has been shown to be superior to medication in the treatment of depression and anxiety, the precise mode of action remains unclear.

Classic CT is a theoretical model that, until recently, seemed strangely divorced from modern cognitive science. Even committed cognitive theorists are forced to conclude that, following almost 40 years of research, there remains limited evidence for supporting the notion that cognitive change alone brings symptomatic improvement in patients suffering from anxiety and depression. It appears that behavioural interventions and the use of experiential accommodation of negative affect and thoughts are emerging as the most probable mechanism of change.

Within the context of this debate, the newly constituted Irish Association for Behavioural & Cognitive Psychotherapies (a member of the BABCP family) invited Joe Curran, CBT Consultant from Sheffield University, to deliver a one-day workshop in Dublin on Acceptance and Commitment Therapy for CBT therapists on 13 May.

The workshop was positively evaluated by all and the interactive, thought provoking and engaging presentation sparked off some very interesting debates about the actual components of change in a traditional CBT approach. The Ashling Hotel in Dublin proved to be an excellent venue and the hotel tolerated some very lively and animated experiential exercises. One can only imagine what other hotel guests and staff thought as they passed the conference room to hear over 40 people shout aloud a number of negative, disparaging beliefs at each other during the cognitive defusion exercise.

The IABCP Committee would like to sincerely thank Joe for a very memorable and enlightening day and hopes to continue to maintain a link with this new friend – and honorary Irishman!
South East & London Branch
On 13 June the Branch welcomed Carol Vivyan and Michelle Ayres to Maidstone to present a half-day workshop on the BPD Tool and The Decider. Many members will be familiar with their website which provides free CBT self-help resources and therapy worksheets for clients and clinicians.

Carol and Michelle have also developed a 12-week skills based training package ideally administered in a group setting for clients who have difficulties with impulsivity, a trait that is often seen in patients with borderline personality. The aim of the course is to demonstrate and teach clients how to live a more skilful life. As the duo hail from Guernsey, it seemed fitting that nautical metaphors and imagery were shamelessly utilised, with the central image of a deflated life jacket depicting a client’s skill deficit that required inflating!

Thirty-two skills were divided into four subsets - distress tolerance; mindfulness; emotion regulation; and interpersonal effectiveness - and Carol and Michelle chose three skills formulated from DBT literature to showcase.

Emphasis was placed on the need for therapists to completely commit to using a combination of creativity and competency when delivering the programme, together with a willingness to take responsibility for ensuring that clients are able to understand the material. This might typically involve repetition, Albert Ellis-style humour or contemporary references to reinforce the message.

Pictorial imagery was presented as a manageable tool that rationalises complexity and aids comprehension, whilst efficiently reaching a mutual understanding of client distress. It is hoped that these learning materials will be incorporated into a skills training manual due out in January 2012.

We are very grateful to Carol and Michelle for sharing their work with us and hope to invite them back next year to present the full two-day workshop.

Members are encouraged to keep an eye on the Branch webpages for details of forthcoming events. The AGM is scheduled for Thursday, 22 September 2011 at Gatland House, Maidstone, which will directly follow a morning workshop on Cognitive Analytic Therapy by Bev Brookes. Please contact Keith Furey at Keith.Furey@kmpt.nhs.uk to book a place.

Patricia Murphy
Branch Secretary
Carol and Michelle’s website can be found at www.getselfhelp.co.uk
BD-SIG was formed in 2009 at the BABCP Annual Conference in Exeter. It aims to:

• Facilitate dissemination and awareness of developments in the psychological understanding of the experiences of individuals diagnosed with bipolar disorder, and of those with related mood experiences in the wider community

• Support co-operation of clinicians, researchers, and service users in research designed to develop and evaluate improved psychological approaches for individuals with experience of bipolar disorder

• Support dissemination of evidence-based psychological approaches for individuals with experience of bipolar disorder, including enhancing training opportunities for clinicians

A core principle of the BD-SIG is that the work we do should be directed towards improving service user valued outcomes and developing therapies in collaboration with service users. Central to our endeavours is that we will liaise and collaborate with service users in all of our future discussions and projects.

Held at Lancaster University on 20 May 2011, the second BD-SIG Annual Conference included talks from applied, service user, and theoretical/academic perspectives. The morning session offered insights from clinicians working with individuals who have a diagnosis of bipolar disorder, service user researchers, and service user facilitators of psychosocial interventions.

Kirsten Bond (Manchester Mental Health & Social Care Trust) discussed her research on psychoeducation for bipolar disorder, while Paul Hammersley, Glenn Judge and Jane Fisher (all from the NIHR-funded PARADES programme at the Spectrum Centre, Lancaster University) discussed personal reflections and experiences of delivering and facilitating group psychotherapy. Debbie Mayes and Kirsty Stevenson-Turner (both from the Spectrum Centre) presented a lived experience story of recovery, and John Mulligan (NIHR Recovery programme) gave a talk on promoting recovery in bipolar disorder from the perspective of a newly qualified psychotherapist.

In the afternoon session, Erin Michalak (CREST.BD, Mood Disorders Centre, University of British Columbia), Steven Jones and Fiona Lobban (both Spectrum Centre), and Kim Wright (Mood Disorders Centre, University of Exeter) presented their innovative research focused on improving our understanding of, and developing novel interventions for, bipolar disorder. Topics included quality of life, the treatment of co-morbid conditions, enhanced relapse prevention and experiences of exercise in bipolar disorder.

Delegates came from a range of backgrounds that exemplifies the BD-SIG membership, which includes those involved in academic, service user, voluntary sector, NHS mental health and trainee clinical psychology settings. Plans are already underway to host a third BD-SIG Annual Conference in Spring 2012. If you would like any further information about joining the BD-SIG or attending its events, email Alyson Dodd at a.dodd@lancaster.ac.uk.

Branch news...

Bipolar Disorder Special Interest Group (BD-SIG)
Annual Conference 2011

Why Music?
Is Music Different from the Other Arts?

In a day of talks, discussions and performance, leaders in the fields of science and the humanities examine the value of music to the human being, in comparison with the other arts

Conference Leader: Professor Michael Trimble
Artistic Director: Ian Ritchie
Speakers: Professor Roger Scruton, Professor John Onians, Professor John Sloboda, Professor Nigel Osborne, Professor Ray Tallis, Stephen Johnson
Musicians: Ian Brown piano, The Sacconi Quartet

Friday 7th October 2011
Institute of Neurology, Queen Square, London WC1N 3BG

Further information, including how to register, can be found at www.themusicalbrain.org
Certificates of attendance for CPD can be provided on request
South London and Maudsley NHS Trust

Psychological Interventions Clinic for Outpatients with Psychosis (PICuP) - Autumn 2011 Workshop At the Institute of Psychiatry, London

Monday 7th and Tuesday 8th November 2011

New Approaches to Working with Voices: CBT Techniques for Command Hallucinations, Distressing Beliefs and Images

Dr. Nadine Keen and Dr. Louise Johns

Venue: The workshop will take place in the Seminar Room of the Henry Wellcome Building for Psychology at the Institute of Psychiatry, De Crespigny Park, London. Please go to the “Information about the Institute” section on the Institute of Psychiatry website for maps and directions: www.iop.kcl.ac.uk

Time: Registration will begin at 8.45am. The workshop starts at 9.30am and will finish by 5.00pm.

Cost and Payment: The cost of the workshop is £290. Cheques should be made payable to “South London and Maudsley NHS Foundation Trust”. If you wish us to invoice your organisation please complete billing details on registration form.

Abstracts: To read an abstract of the workshop and for registration forms please log on to either the Institute of Psychiatry website: www.iop.kcl.ac.uk/events/ or the SLAM website: www.slam.nhs.uk If you do not have Internet access and/or require a hard copy of the abstracts or registration form please call Dorothy Abrahams on 020 3228 3524 or e-mail picup@slam.nhs.uk

Booking a place: Please send completed registration forms to: Dorothy Abrahams PICuP, PO79, Maudsley Psychology Centre, Denmark Hill, London, SE5 8AZ

e-mail: picup@slam.nhs.uk   Fax: 020 3228 5278   Phone: 020 3228 3524

Are you delivering psychological wellbeing courses? Or training to be a psychological wellbeing practitioner?

Available now – Course books for students (and supervisors) training to be Psychological Wellbeing Practitioners – from the charity Rethink Mental Illness. £9.99 plus P&P.

Learn practical and skills based information gathering and giving, shared decision making, and low intensity treatment interventions. Includes a free DVD.

www.rethink.org/PWP or call 0300 5000 927 and quote ‘Reach Out’.

Challenging attitudes, changing lives.
Acceptance and Commitment Therapy
Introductory Two-Day Experiential Workshop
Facilitated by David Gillanders CPsychol
12-13 November 2011 from 9.30am to 5.30pm (both days)
Barcelo Carlton Hotel, North Bridge, Edinburgh

A two-day experiential workshop aimed at any professional who uses structured psychological interventions to help people change. The workshop will contain significant elements of experiential exercises, combined with teaching, discussion, listening to audio of real sessions and role-play. Participants will gain a deep understanding of ACT both conceptually and ‘from the inside’. This workshop will focus on the classic hexaflex ACT model and will walk participants through the various metaphors and exercises typically used in ACT. David is an ACBS peer-reviewed ACT Trainer and member of the ACT Training Community.

<table>
<thead>
<tr>
<th>Early bird discounts before 1 October</th>
<th>Standard Pricing</th>
</tr>
</thead>
<tbody>
<tr>
<td>BACP Members: £140</td>
<td></td>
</tr>
<tr>
<td>Non Members: £160</td>
<td></td>
</tr>
<tr>
<td>BACP Members: £160</td>
<td></td>
</tr>
<tr>
<td>Non Members: £180</td>
<td></td>
</tr>
</tbody>
</table>

For further information including how to register, please visit: www.babcp.com/CPD

Acceptance & Commitment Therapy for Psychosis:
A Mindful Approach to Recovery
Eric Morris & Joe Oliver

Date: Thursday, 1 December 2011
Time: 9.30am-4.30pm
Venue: Institute of Psychiatry
King’s College London

Acceptance and Commitment Therapy is a contextual cognitive behavioural therapy, which incorporates mindfulness and values-based behavioural activation.

This workshop will give an overview of ACT and how this approach can help people with psychosis. It will be practically focussed, using case material, transcripts, and recordings of sessions. The presenters will describe the approaches they take in using ACT in community, inpatient, and early intervention settings. Case conceptualisation will be covered alongside the use of key metaphors and treatment exercises.

Presenters: Eric and Joe are clinical psychologists, working for the South London & Maudsley NHS Foundation Trust in early intervention for psychosis. They have been developing and researching ACT/ mindfulness individual and group interventions for psychosis at the Institute of Psychiatry, King’s College London. Both regularly deliver ACT teaching and training, in the UK and internationally.

Workshop rates: BACP Member: £90
Non-member: £110

Email to register: actpsychosis@gmail.com
Identifying and Using Values in Psychotherapy

With JoAnne Dahl

A Two-Day Workshop with JoAnne Dahl
organised by the
BABCP ACT Special Interest Group
Thursday, 3 November 9.30am - 4.30pm
Friday, 4 November 9.00am - 4.00pm

JoAnne is an internationally respected ACT trainer and has presented workshops in many parts of the world. She is associate professor and senior lecturer of psychology at Uppsala University in Sweden. She is a prolific researcher and author and has written numerous papers about ACT. JoAnne’s areas of expertise include chronic pain and identifying and working with values.

JoAnne’s books include:
The Art and Science of Valuing in Psychotherapy

This experiential workshop is suitable for both novice and expert therapists. The aim of this workshop is to provide participants with experiential exercises aimed at identifying values both personally and professionally. These exercises can be transferred into the therapeutic arena to assist clients to overcome obstacles (including both external and internal psychological blocks) that have been identified as barriers to valued living. By transferring the events that previously had to be avoided into events with which clients have behavioural flexibility, new options open up for them.

Warning: Finding values may change your life!

Venue
Solent University, Conference Centre, 157-187 above Bar,
Southampton, Hampshire, SO14 7NN

Rates
BABCP Members: £180
Application forms at babcp.com
Limited Student places: £120
Cheques made payable to BABCP
Non-members: £200

For more information email: sue@act-thelifeuwant.co.uk
**International Conference:**

**A Pluralistic Approach to Practice?**

Implications for the psychological therapies

Saturday, 12th November 2011 - 10.30am to 4.30pm
Registration 10.00am

Roehampton University, Whitelands College, London

Speakers: Mick Cooper, John McLeod, Del Loewenthal & Earl Hopper

UPCA members £75.00; non-UPCA participants £90.00; UPCA student members £45.00; non-UPCA student participants £55.00 (Bookings received before October 14th get a £5 discount)

Booking forms from:
The Administrator, UPCA, P.O. Box 142, St. Leonards-on-Sea, TN38 1DN (upca@hotmail.co.uk)

(NB: Attendance counts as 6hrs C.P.D. requirement met)
CPD workshop programme

In addition to the training workshops listed below, CWI run year-long Certificate and Diploma courses in Evidence-Based Psychological Treatment, as well as shorter flexible CPD modules. All the training is aimed at a mixed ability audience and held local to Reading unless otherwise indicated. More information about our workshops, postgraduate courses and CPD modules can be found at www.reading.ac.uk/charliewaller

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Speaker/Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 October 2011</td>
<td>Treatment of anxiety disorders in youth</td>
<td>Professor Philip Kendall Temple University, Philadelphia</td>
</tr>
<tr>
<td>14 November 2011</td>
<td>Treating serious mental illness and substance misuse</td>
<td>Professor Kim Mueser Dartmouth Medical School, NH</td>
</tr>
<tr>
<td>29 November 2011</td>
<td>Substance misuse: how to use psychological treatments effectively</td>
<td>Dr John Marsden Institute of Psychiatry</td>
</tr>
<tr>
<td>6 December 2011</td>
<td>Augmenting self-help: how to use self-help approaches to reduce client distress</td>
<td>Dr Rachel Varley South West Yorkshire NHS Trust</td>
</tr>
<tr>
<td>11 January 2012</td>
<td>Single session treatment of specific phobia in the real world</td>
<td>Professor Lars-Göran Öst Stockholm University, Sweden</td>
</tr>
<tr>
<td>24 January 2012</td>
<td>CBT for health anxiety</td>
<td>Professor Paul Salkovskis University of Bath</td>
</tr>
<tr>
<td>1 February 2012</td>
<td>Evidence-based psychological therapy for Chronic Fatigue Syndrome (CFS)</td>
<td>Professor Trudie Chalder SLAM NHS Foundation Trust</td>
</tr>
<tr>
<td>21 &amp; 22 February 2012</td>
<td>Group and individual treatment for social phobia</td>
<td>Professor Richard Heimberg Temple University, Philadelphia</td>
</tr>
<tr>
<td>5 &amp; 6 March 2012</td>
<td>State-of-the-art CBT for depression</td>
<td>Professor Steven Hollon Vanderbilt University, Nashville</td>
</tr>
<tr>
<td>13 March 2012</td>
<td>Understanding and treating OCD effectively</td>
<td>Professor Sabine Wilhelm Harvard Medical School</td>
</tr>
<tr>
<td>14 March 2012</td>
<td>Beauty and the beast: the nature and treatment of BDD</td>
<td>Professor Sabine Wilhelm Harvard Medical School</td>
</tr>
<tr>
<td>20 March 2012</td>
<td>The psychological management of pain</td>
<td>Professor Christopher Eccleston University of Bath</td>
</tr>
<tr>
<td>26 March 2012</td>
<td>CBT for older people</td>
<td>Dr Ken Laidlaw University of Edinburgh</td>
</tr>
<tr>
<td>16 April 2012</td>
<td>CONFERENCE Self-esteem and self-compassion</td>
<td>Professor Paul Gilbert, Dr Debee Lee see website for updated speaker list</td>
</tr>
<tr>
<td>23 &amp; 24 April 2012</td>
<td>Using CBT to address insomnia across mental health problems</td>
<td>Professor Jack Edinger Duke University, North Carolina</td>
</tr>
<tr>
<td>1 &amp; 2 May 2012</td>
<td>Transdiagnostic CBT for eating disorders</td>
<td>Professor Christopher Fairburn University of Oxford</td>
</tr>
<tr>
<td>18 May 2012</td>
<td>Anger treatment: case formulation and the stress inoculation approach</td>
<td>Professor Ray Novaco University of California</td>
</tr>
<tr>
<td>11 June 2012</td>
<td>Cognitive behavioural treatment of GAD</td>
<td>Professor Tom Borkovec Pennsylvania State University</td>
</tr>
<tr>
<td>12 June 2012</td>
<td>Interpersonal and Emotional Processing therapies (IET) for GAD</td>
<td>Professor Tom Borkovec Pennsylvania State University</td>
</tr>
</tbody>
</table>

1-day workshop £130; 2-day workshop £250

For more information please contact cwi@reading.ac.uk or call 0118 378 6668 www.reading.ac.uk/charliewaller
## Psychological Therapies @ UEA
### Advanced CBT Workshops 2011 – 2012

<table>
<thead>
<tr>
<th>Date</th>
<th>Speaker</th>
<th>Topic</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>7th October 2011</td>
<td>Dr Stirling Moorey</td>
<td>Cognitive therapy for medical conditions</td>
<td>Institute of Psychiatry Kings College University of London</td>
</tr>
<tr>
<td>11th November 2011</td>
<td>Dr Nick Grey</td>
<td>Contemporary advances in CBT for anxiety disorders</td>
<td>Institute of Psychiatry Kings College University of London</td>
</tr>
<tr>
<td>8th &amp; 9th December 2011</td>
<td>Professor Mark Freeston</td>
<td>Cognitive therapy for GAD and obsessions</td>
<td>Newcastle University</td>
</tr>
<tr>
<td>9th &amp; 10th February 2012</td>
<td>Dr Deborah Lee</td>
<td>Compass focused cognitive therapy for shame based flashbacks in PTSD</td>
<td>University College University of London</td>
</tr>
<tr>
<td>16th March 2012</td>
<td>Ms Anne Garland</td>
<td>Advances in CBT for acute depression</td>
<td>Regional Psychotherapy Unit, Nottingham</td>
</tr>
<tr>
<td>20th April 2012</td>
<td>Professor Trudy Chalder</td>
<td>Cognitive therapy for chronic fatigue syndrome</td>
<td>Kings College University of London</td>
</tr>
<tr>
<td>17th &amp; 18th May 2012</td>
<td>Professor Willem Kuyken</td>
<td>Advanced cognitive case conceptualisation</td>
<td>Mood Disorders Centre, Exeter University</td>
</tr>
</tbody>
</table>

### Cost
- 1-day workshop: £100.00
- 2 day workshop: £200.00
- Discounted price: £400.00 for 5 days of workshops; £750.00 for full programme (10 days)

### How to apply
For further information and application forms contact Natasha McGowan:
Email: n.mcgowan@uea.ac.uk

---

If undelivered, please return to:
BABCP, Imperial House, Hornby Street, BURY BL9 5BN