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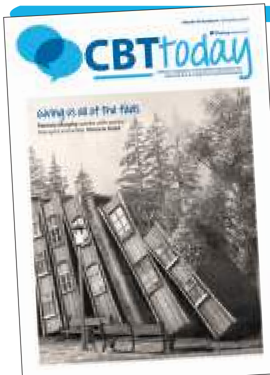
Giving us all of the feels

Patricia Murphy speaks with poetry therapist and writer **Victoria Field**



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Volume 47 Number 4

December 2019

Welcome to the final issue of CBT Today for 2019. I'm delighted that we have been able to include Patricia Murphy's interview with poet Victoria Field for this issue, as well as continuing Sarah Rees and Heather Howard-Thompson's series on working in private practice.

As always, our members continue to show their willingness to help others around the world, so it is my pleasure to have had Kirstie Fleetwood and Tara Murphy write about working in Uganda.

As always, thank you to everyone who has contributed during the year.

All the very best to you for the festive season and the new year.

Peter

Peter Elliott

Managing Editor

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Disclaimer

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contents

3 News

4 Mental Health & Diabetes
Charlotte Ready writes about integrating services in North East Essex

6 Our year in Uganda
Kirstie Fleetwood and Tara Murphy on volunteering in Kampala

10 Insight into an IAPT Service/Higher Education Institute Partnership
Could partnerships between these bodies provide important CPD opportunities, ask Lucy Hart and Tamara Weihe

12 CBT in Private Practice
Our series on working in private practice - Sarah Rees and Heather Howard-Thompson look at referral sources

14 Giving us all of the feels
Following on from the benefits of poetry therapy in the last issue, Patricia Murphy talks to poet Victoria Field

18 Turning research ideas into reality
How can we better support 'on the ground' clinicians to become research active?

21 Workshops

Expressions of interest are requested to be support a proposed Special Interest Group - Migrant, Asylum Seeker and Refugee SIG

Refugees and asylum seekers often arrive in the UK having experienced trauma in their own country and sometimes on the way to the UK, loss of possessions and family, loss of cultural identity, loss of role and stability and often physical health problems.

This presents a challenging profile for therapists by itself, but many also experience difficulty accessing support and may reject support initially due to the shame involved in seeking help for emotional problems, externalising and somatising expressions of mental ill health, language barriers, service attitudes towards ability to treat, or psychological models, concepts and frameworks having a western bias which may not fit with the client's formulation of the problem.

This presents significant difficulties for many therapists trying to work with this client group. This SIG proposes to address and manage many of these issues:

Provisional aims of the group -

- To provide support and guidance to BABCP members in the area of migrants and refugees
- To provide clinical guidance to BABCP in the area of best practice on issues relating to migrants and refugees
- To educate members on a range of issues related to migrants and refugees through CPD, conference presentations, pamphlets, etc.
- To co-develop research and an evidence base in the areas of CBT with migrants and refugees
- To disseminate research findings to members

If you are interested in being involved in this group, please contact Matt Wilcockson at mattwilcockson@hotmail.com

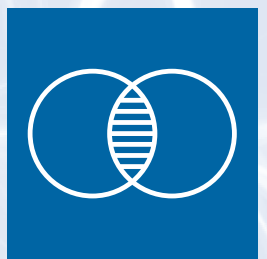
Let's talk about CBT

Our latest podcast episode was released recently. Dr Lucy Maddox spoke with Ben Adams about his experience of CBT for chronic fatigue syndrome, and to Professor Trudie Chalder about how CBT for CFS works. You can find the podcast at **letstalkaboutcbt.libsyn.com**

If you have ideas for future topics or would like to contribute, you can email Lucy at **lucy.maddox@babcp.com**

Adam May

We were saddened to hear of the death of Adam May just as this issue was going to press. Adam was one of the original signatories to the formation of the Independent Practitioners Special Interest Group, had been chair of the SIG since 2016 and was very well respected by those who knew him. Our thoughts are with his family and friends. A tribute to Adam will feature in the February 2020 issue of *CBT Today*.



Mental Health & Diabetes
Service Integration in North East Essex

*The association between diabetes and mental health is well recognised and this co-morbidity leads to worse outcomes for both conditions writes **Charlotte Ready,** an Assistant Psychologist working for Health in Mind (North East Essex IAPT Service).*

Diabetes can have a profound impact on emotional and psychological wellbeing. Depression and anxiety are the most common mental health illnesses amongst diabetes patients. These psychological conditions can affect people's ability to self-manage their diabetes. For example, it is common for diabetes patients to worry about keeping their diabetes under control. Effective management may require personal motivation and lifestyle changes such as diet and exercise.

The National Institute for Health Care Excellence (NICE) recommends the use of psychological interventions for people with long-term conditions such as diabetes. Access to psychological interventions has been demonstrated to improve patient outcomes, reduce health care costs and enhance patients' quality of life.

The North East Essex IAPT service offers various NICE-approved interventions, including CBT and adapted psychological interventions for diabetes patients. The service works in collaboration with North East Essex Diabetes Service (NEEDS) who are the local diabetes provider that offers support for adults living with diabetes in the area. NEEDS have identified psychological barriers for diabetic patients accessing treatment with their service for various reasons, including depression, anxiety, needle phobia, eating disorders, fear of complications, fear of hypoglycaemia and PTSD after a hypoglycaemic episode.

North East Essex IAPT Service offer a specialised diabetes pathway, which runs in collaboration with NEEDS, for diabetic patients in the service if their main difficulty is related to their diabetes. The diabetes pathway offers psychological interventions at step 2 or step 3, which are either face-to-face therapy or group therapy.

The project reviewed scores for measures of anxiety, depression and diabetes specific measures, for diabetic patients in the North East Essex IAPT Service.

A strong correlation exists between diabetes and mental health diagnoses.

North East Essex IAPT service receives on average 300 diabetes referrals a year.

By integrating support from NEEDS, with the psychological care from the IAPT service, this can breakdown psychological barriers for diabetes patients accessing medical care, resulting in improved glycaemic control and a reduction in psychological stress, ultimately resulting in a reduction in health service costs.

Collaborative working with local diabetes provider's NEEDS reduces psychological distress, improved self-management of diabetes and ultimately reduces NHS costs.

Findings

The North East Essex IAPT Service reviewed the sources of referrals and recovery rates for diabetes patients between 1 April 2018 and 31 March 2019. The main source of referrals were self-referrals, followed by referrals from GP's, Colchester General Hospital and NEEDS. Out of the range of psychological interventions offered by the IAPT service, most patients received treatment from the specialist diabetes pathway within the IAPT service.

North East Essex IAPT service found that:

- 64% of diabetes patients had a primary diagnosis of depression
- 26% of diabetes patients in the service had a primary diagnosis of generalised anxiety disorder (GAD)
- A reduction was seen in pre and post anxiety and depression scores following psychological intervention with recovery rates of 65.96% for depression and 68.09% for GAD

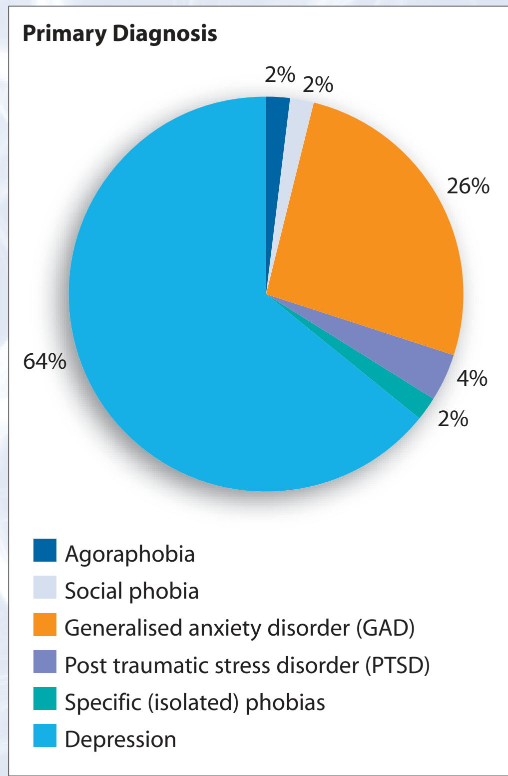


Figure 1. Primary diagnosis for diabetes patients within the IAPT service over time period of 1 April 2018 to 31 March 2019

- For patients who attended a diabetes co-location clinic at step 3 over the time period of 7 February 2018 to 17 May 2019, the average reduction for the depression measure was 8.29 and 8.86 for the anxiety measure.

- A reduction was seen in diabetes specific measures (Diabetes Distress Scale and/or Problem Areas in Diabetes Scale) for patients who attended the diabetes co-location clinic, highlighting the effectiveness of psychological talking therapies for reducing emotional burden, regimen distress, interpersonal distress, physician distress and diabetes-related emotional distress.

The benefits of an IAPT service working with a diabetes provider are a reduction in psychological distress which results in improvements in self-management of diabetes, in turn reducing health care costs and improving patients' quality of life.

> "Psychological interventions are effective in reducing diabetes related emotional distress."

Case reviews from the co-location clinic:

'Kathy' didn't always remember to take her insulin and would sometimes take it hours later. She worried about keeping diabetes under control. She worried about taking diabetes medication in public as she thought that people would mistake her for a drug-user. 'Kathy' engaged very well with exposure therapy. When her anxiety started to come down, she tried behavioural experiments to take her injection in a coffee shop – looking around from her seat (she didn't normally look) to see if anyone was noticing. She realised that no-one was paying attention to what she was doing and became a lot more comfortable with injecting in public. 'Kathy's' anxiety and depression scores were in recovery following treatment.

'Pete' was avoiding checking his blood sugar levels frequently enough. He was less active and low in motivation for things in general. Through using behavioural activation techniques 'Pete' became a lot more accepting of the fact that he couldn't cram lots and lots of activities into each day and focussed on what he could do instead. He also started taking more of a longer term view of diabetes and kept diabetes related paperwork in a folder. Pete's scores for anxiety and depression were in recovery following treatment.

Future work

- To continue co-location between the North East Essex IAPT Service and the local diabetes service, to further enhance work towards better integration of mental and physical health treatment.

- To increase diabetes and long term physical health condition referrals to North East Essex IAPT Service.

Charlotte Ready works as part of an innovative long-term physical health conditions team that is led by Dr Rebecca Clodfelter (LTC Lead Psychologist). This article was written with thanks to Pat Raven and Kate Goodge (Psychological Therapists leading diabetes co-location clinics) and North East Essex Diabetes Service (NEEDS).

Advertisement

*Counselling Psychologist **Dr Kirstie Fleetwood** and Consultant Clinical Psychologist **Dr Tara Murphy** spent 2018 volunteering in Kampala, Uganda. Along with Trainee Psychologist **Pauline Akello Bachayaya**, they report on their experiences at Butabika National Psychiatric Referral Hospital, Uganda's only dedicated mental health hospital.*

Our year in UGANDA

> "One of the most enjoyable and encouraging parts of the role was to provide supervision for psychological treatments..."

With almost a third of the population of Uganda estimated to be living in poverty and with reduced life expectancy, the prevalence rate of mental health conditions is high (estimated to be 35%), so addressing the mental health of children and adolescents is essential.

In conjunction with Makerere University, Butabika National Psychiatric Referral Hospital provides training for the psychiatrists, psychiatric nurses and other mental health professionals employed in mental health units in regional hospitals and community services throughout Uganda. Our volunteership was organised through the Butabika - East London link, a multi-disciplinary collaboration with East London NHS Foundation Trust. There were several planned roles and responsibilities for the funded child and adolescent mental health (CAMH) project and others that we identified during our time there.

We were involved in weekly outpatient clinics in the children's ward, which mostly involved assessment of commonly presenting conditions such as anxiety, depression, autism, somatisation disorders, learning disabilities and epilepsy. In addition, a significant part of our role was to assist with the facilitation and teaching on an Advanced Diploma in Child and Adolescent Mental Health, provided by Mbarara University of Science and Technology at Butabika. The program was established in 2013 by the East London NHS Foundation Trust, with funding from DFED. The diploma enables qualified mental health professionals (mental health nurses, psychologists, psychiatric clinical officers, social workers, psychiatrists) and more recently professionals working in child health to specialise in child and adolescent mental health.

We travelled to locations across Uganda to join peer support meetings enabling staff to share their own successes and challenges, and to feel less isolated – as many workers might be the only child specialist in their hospital. Educational events for staff and the local community were well attended

and a great opportunity to spread the message about the importance of psychological treatments in CAMH. The meetings enabled us to get a good overview of the health and mental health systems throughout Uganda, and were also a fantastic chance to see the country!

Our fundraising efforts enabled us to facilitate many practical projects, including repainting the interior of the children's ward, as well as establishing a new speech and language clinic, where Joseph Isimbwa, our SLT, is only one of about 60 speech therapists in the whole of East Africa. We also received donations from Miss Pride of Africa (UK), which facilitated a social worker to resettle 18 children back to their families. Inappropriate admissions and the extended overstay of children on the ward once treatment was completed creates overcrowding, one of the biggest problems faced by ward staff. Many of the children had neurodevelopmental or intellectual disabilities, rather than mental health problems. However, as a number of the children were brought by police or members of the community, and some were unable to speak, the whereabouts of the children's families were often unknown. Donations enabled a social worker to travel to different locations and go door to door to try to find the child's family.

One of the most enjoyable and encouraging parts of the role was to provide supervision for psychological treatments and research for mental health workers, nursing and medical students, as well as undergraduate and trainee psychologists, which left us feeling positive about the future of psychology in Uganda. One of the trainees we worked closely with is Pauline Akello Bachayaya, who co-wrote this article. The CAMH diploma has a significant focus on promoting evidence-based talking therapy in Ugandan services. We were keen to briefly discuss one particular treatment case which focused on an intervention for tics, which has not been well recognised or understood in Uganda to date.

The case details the treatment journey of a 15-year-old female in Kampala. The girl was seen by several members of the multi-disciplinary team and previously misdiagnosed with other conditions (depression, conversion disorder and epilepsy) before being correctly diagnosed with Tourette syndrome (TS). She did not appear to have any additional co-occurring conditions but the tics had bothered her and her family throughout her later childhood and into adolescence. As a result, she was the first person that we know of at Butabika Hospital to be treated with behavioural therapy for tics, with other patients subsequently identified and also treated.

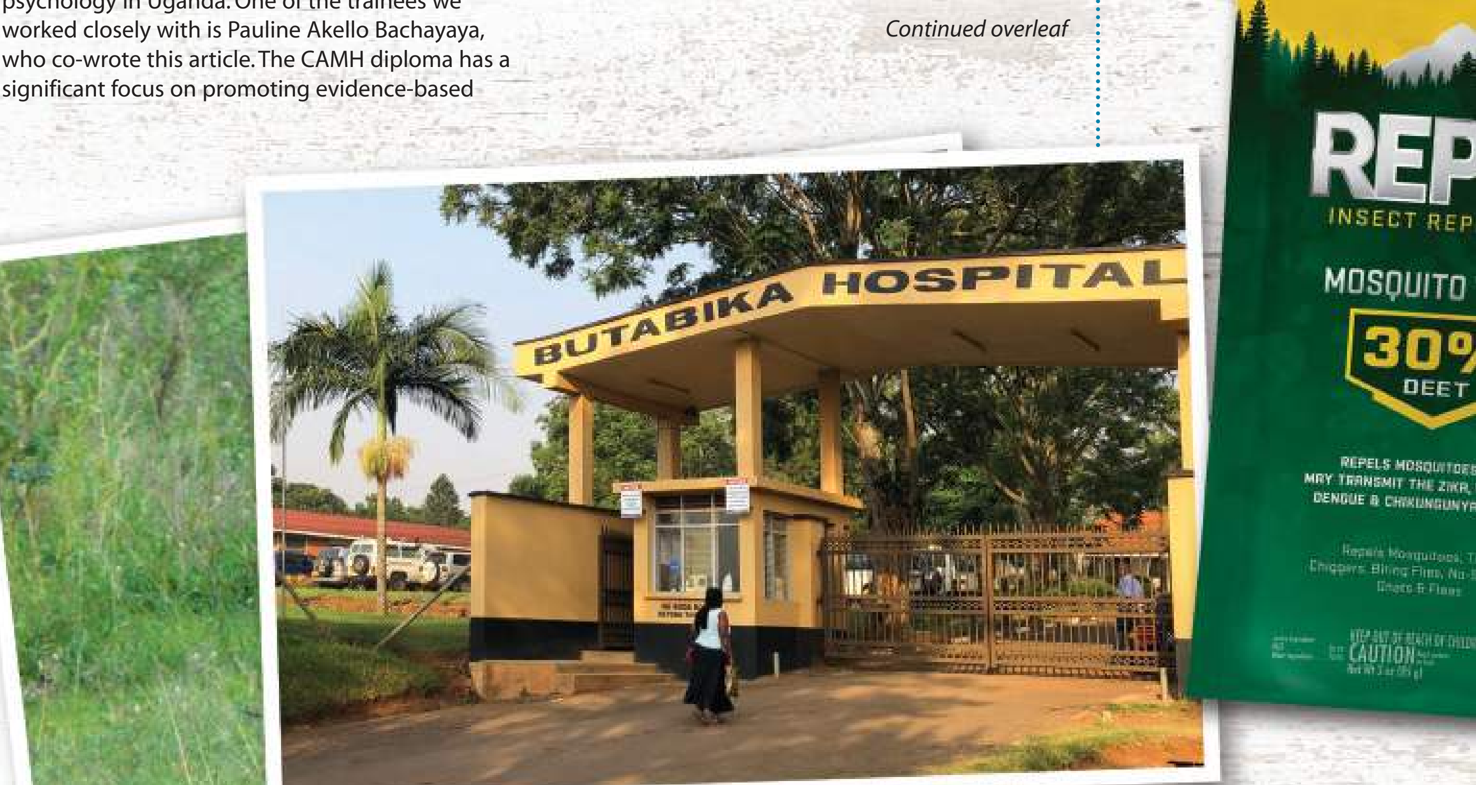
A key lesson from our time in Uganda is to be able to improvise creatively in assessments and therapeutic work. We learnt how to understand that our emphasis in treatment was sometimes different to our supervisees and patients. At times, we were limited in relation to toys and resources available in assessments, often finding the printer not working, or having no paper to copy materials. Power cuts and water outages were relatively regular. This presented us with an opportunity to draw on well-honed therapeutic skills for communicating, understanding and interpreting. This was quite a steep learning curve with difference in language, communication, belief systems, values and many other factors.

Continued overleaf

Photographs:

Opposite top
Children's Ward and staff
Photo credit:
Dr Kirstie Fleetwood

Below left
Entrance to Butabika
National Psychiatric
Referral Hospital
Photo credit:
Dr Kirstie Fleetwood.



Our year in UGANDA *continued*

Our capacity to manage these differences grew over the course of the volunteership and often discussion between the two of us from a similar culture and training facilitated this and our capacity to cope. We were consistently viewed as being from another culture. This led to different assumptions sometimes that we must know certain information (e.g. models, theory, professional skills) and have specific competencies and at other times that we could not possibly know certain information (e.g. understanding about Ugandan life and culture).

Psychology is still in its infancy in Uganda, and some families were disappointed when referred for talking therapies rather than receiving medication, or medical investigations such as scans. But this enabled us to develop our skills in succinctly explaining and selling psychology! It was both a learning curve and a privilege to work therapeutically with Ugandan families and children during the year. Through adapting our clinical skills and therapeutic approaches to the varied cultural and religious beliefs, we were able to witness positive change.

We would like to thank the staff at Butabika Hospital and our colleagues on the Diploma in Children's Mental Health, Dr Alyson Hall, Consultant Child Psychiatrist and Mr Edmund Koboah from Butabika and East London Link for their enthusiasm, support and collaboration.

For more information about the Butabika – East London Link see https://www.butabikaeastlondon.com or email Edmund Koboah e.koboah@nhs.net

Key reading

Bennett, S. M., Beaumont, R., Catarozoli, C., & Kushman, A. M. (2018). Problem-solving strategies to overcome common challenges associated with Tourette syndrome. In J. F. McGuire, T. K. Murphy, J. Piacentini, & E. A. Storch (Eds.), *The clinician's guide to treatment and management of youth with Tourette syndrome and tic disorder* (pp. 201-223). San Diego, CA, US: Elsevier Academic Press.

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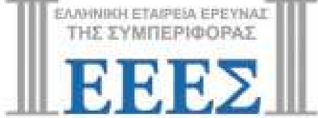

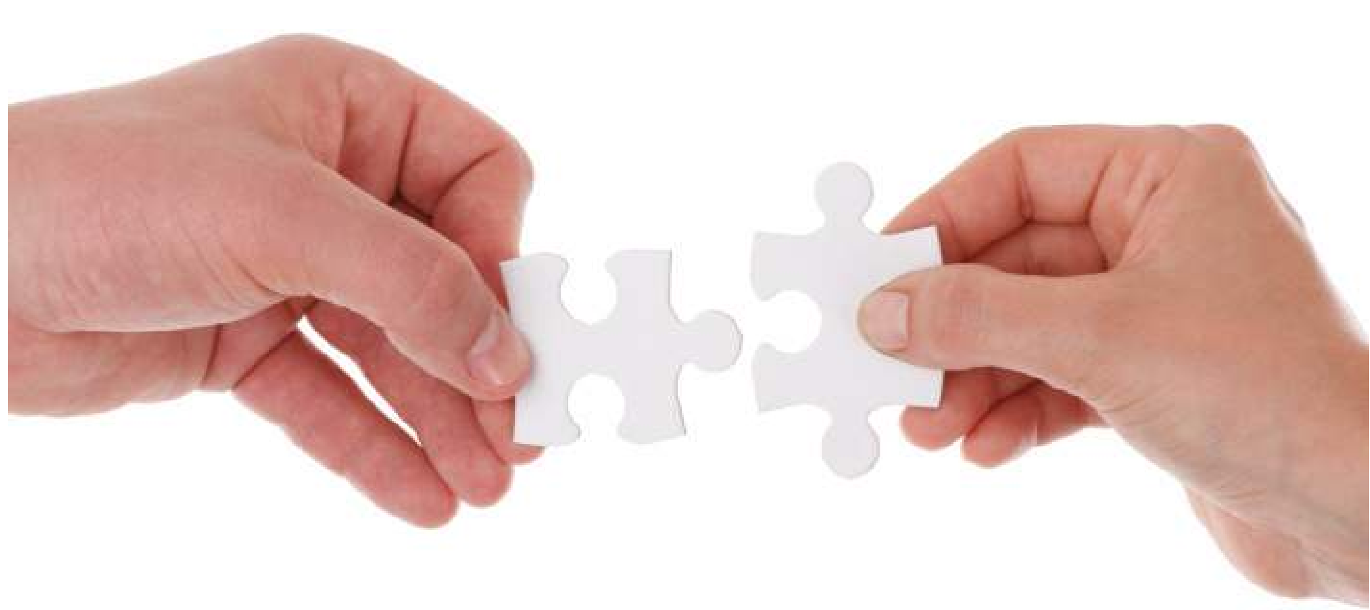

Insight into an **IAPT Service/ Higher Education Institute** Partnership

*Could partnerships between IAPT services and Higher Education Institutions provide important Continual Professional Development (CPD) opportunities and serve as part of a preventative strategy to burnout and attrition in the PWP workforce? PWP **Lucy Hart** and PWP Clinical Educator **Tamara Wiehe** share their experiences.*

Due to increasing pressures across mental health care, IAPT services are facing the problem of retaining Psychological Wellbeing Practitioners (PWPs). This could in part be related to limited career development opportunities and poor workplace wellbeing which can have adverse implications for patient care.

The evidence-base for Low-Intensity CBT (LICBT) tells us that collaborative care – a multifaceted model where healthcare professionals work with the patient, around the patient – is essential in IAPT for optimising patient care and treatment outcomes. Mirroring this approach for local IAPT services and Higher Education Institutions, we partnered trainee PWPs with PWP Clinical Educators to together re-design an assessment used on a PWP training programme. Students and staff had previously highlighted issues with the existing assessment, sparking our re-design process.

We theorised that enabling PWPs to engage in CPD projects such as this could act as a preventative strategy to their burnout and attrition through increased engagement in the workplace. A more engaged, empathic and sustainable workforce will contribute towards higher quality patient care, and towards achieving IAPT's targets in line with national key performance indicators.

Making connections

Due to the nature of the programme, trainee PWPs have limited contact time with the Higher Education Institution and are more likely to live closer to their service. This provided several barriers meaning that more traditional methods of partnership working were not suitable.

We applied our PWP skills to collaboratively troubleshoot the barriers to engagement and came to a shared decision to use technology and remote working to form a meaningful partnership. As the PWP training programme is grounded in evidence, it was appropriate to utilise this approach throughout the project, especially self-reflective and collaborative practice.

An overview of the three key steps used to re-design the assessment can be seen in the Partnership model.

Outcomes and reflections

A new assessment was created as a result of this meaningful partnership that better reflected the views and needs of trainee PWPs. This should, in theory, lead to better engagement with the assessment as it would with our patients and their inter-session tasks in clinical practice.

"Working alongside our trainee PWPs felt natural due to my training in collaborative care. It was essential to not only hear about their experiences but to take it a step further by involving them in a more meaningful way. Projects like this one benefit not only those directly involved but also the key stakeholder, our patients! We will continue to work in partnership with local IAPT services to offer this CPD option to PWPs as a way to increase engagement in the workplace with the hope that this helps to promote wellbeing and retention."
Tamara Wiehe
PWP Clinical Educator

Both sides of the partnership were able to develop a range of transferable skills and reported that being a part of a meaningful partnership gave them a sense of belonging to the IAPT service and Higher Education Institution. The latter finding in particular helped to address an issue both trainee PWPs and PWP Clinical Educators face around having a dual identity as a student or member of staff within a Higher Education Institution and as a healthcare professional.

Diversity and inclusivity were key considerations throughout as we implemented methods that engaged as many trainee PWPs as possible who represented PWPs from a range of backgrounds. Surveys enabled high levels of engagement during the consultation stage, but participation decreased significantly during the review stage. Despite this, members of the focus group were able to apply their skills from their PWP training to consider the impact of the new assessment on students with one or more protected characteristic (Equality Act, 2010). On reflection, we could time future partnership opportunities better to increase engagement as this one coincided with the end of the PWP training year and also include qualified PWPs who are interested in this type of CPD.

Impacts of partnership

Consultation
Design
Review

Course reps used electronic surveys to gather ideas.

Sample assessment materials were created based on students' ideas.

Students participated in a virtual focus group to review the proposal.

Partnership model

Enhancing the connection between IAPT services and High Education Institutions can have a wide range of benefits for all stakeholders.

The Higher Education Institution benefits by improving the student experience – the PWP training year can feel disjointed for trainees at times, but there is scope for a more fulfilling experience for all involved if IAPT services and Higher Education Institutions better complement each other and involve trainees in their journey in a more meaningful way.

Offering more career development opportunities to PWPs – such as contributing to the PWP curriculum – can lead to an increased sense of belonging and purpose greater than 'trainee' status, which promotes wellbeing and retention. Partnerships could improve the transition from trainee to qualified PWP as it is not uncommon for trainees to relocate after their training year to alternative services or entirely different roles. Retaining PWPs in IAPT services reduces financial burden spent on recruitment – funds that could be better utilised to upskill and invest in employees. In turn, ensuring that PWPs are able to contribute towards meeting the service's key performance indicators set by commissioners and securing additional funding for more complex, co-morbid presentations such as patients with long term conditions.

A more academically, emotionally and psychologically sound workforce is better able to meet its purpose of improving access to psychological therapies. Even higher standards of patient care can be achieved if our PWPs can offer a more compassionate and consistent service with less cancelled appointments or the need to re-allocate cases due to burnout-related sickness and attrition.

In summary, partnerships between IAPT services and Higher Education Institutions offer important benefits to PWP wellbeing, retention and patient care. Let's bring our PWPs to the forefront so that they can continue to deliver the essential work of supporting thousands of people with common mental health problems.

Both sides of the partnership were able to develop a range of transferrable skills and reported that being a part of a meaningful partnership gave them a sense of belonging to the IAPT service and Higher Education Institution.

"In training we learn that the patient is the expert of their experience and the PWP is the expert of the LICBT techniques. Through the collaborative partnership, we can reverse this relationship and be considered as the 'expert' in our learning and clinical practice. As a result, our needs as trainees are appropriately met from both academic and clinical perspectives. A balanced and collaborative approach means we do not feel out of our depth when conducting assessments and treatment sessions with patients. Our confidence in our capabilities and delivery of interventions means the patient has a smoother journey and is better able to utilise the techniques both now and for the future."
Lucy Hart
Trainee, now Qualified PWP

CBT in Private Practice

The number one question we hear in our CBT in Private Practice Facebook group is

"Where do therapists get their referrals from?"

In the previous article, we talked about investing time in creating a business plan. This work will provide a solid foundation for your referral stream, helping you to learn the type of clients you would like to attract and where you hope they will come from. This will help you direct your energy in terms of marketing your business.

When we are starting in private practice we often become focussed on gaining referrals and don't really mind where they come from. We can happily shape our business later on down the road through finding out what works and what doesn't. Be prepared to make mistakes if this is the path you take but we have to start somewhere.

Good starting questions to ask yourself are: How will potential clients be able to find me? How will my business be visible? If I was looking for a therapist what are the steps I would take?

Overview of referral sources

Your website Having your own website really establishes you as a business in your own right. When you are just setting out you don't need a website with all the bells and whistles. You can get away with a basic site if the images are professional and logos have been well designed. Spend time on your website content, considering whether it reflects your values and personality. This ensures that you will attract clients that are in line with the service you offer.

You can build a website for free or pay thousands. How much you spend is a personal decision and depends on how much you would like to earn from your website – if your referrals will be generated from other avenues there is not much point in investing too much. If you plan to earn the majority of your wage from your website, more investment will ensure a better return. An important point to remember is that it's not just how a website looks, it's how it's maintained going forward and the SEO quality. SEO stands for 'Search Engine Optimisation', which is how easily your website can be found on Google. There is no point having an amazing site if no-one can find it.

There are cheap options for building your own website yourself like Wix, Wordpress or Squarespace. Alternatively, there are dedicated services for therapists like pocketsite.co.uk and webhealer.co.uk or you can go to an independent web designer. It's a lot to think about but your website is your own platform to sell yourself, and if nurtured well it will serve you well.

Social media platforms We have mixed views about social media. Heather has a solid following on Facebook and generates a good amount of referrals, but Facebook decided a few years ago not to prioritise business pages anymore, so lots of businesses who depended on Facebook for referrals really began to struggle. Therefore, it can be very hard to build an audience with Facebook pages. If you are considering building a business on a social media platform, always bear in mind somebody else owns the platform and can change the rules at any time. It's a great way to be visible and people do expect you to have a social media presence. Heather's top tip around social media is to think of it as a chance to build your tribe…let people know a little bit about you, your practice, share photos of your room, even your dog!

Referral agencies These are companies that you can sign up with as a treatment provider and they will contact you when they have a referral in your area. The pros of this is that you don't have to put any effort into finding the referrals and there is no cost for you. The cons are that rates of pay can be low and invoices can take a while to be paid, paperwork demands can be high and it can generally be more complex dealing with emails and other demands that insurers bring. If they go into administration you could also lose out or if another therapist in the local area is offering better rates you could see your referrals suddenly drop. They can be a good way to get started while you build own your online profile.

Insurance companies Similar pros and cons to referral agencies, the logos on your website can improve your authority and they can serve as another regular income stream. Having a few income streams can be helpful so you don't have all your referral source eggs in one basket as the market is always changing.

Local community Getting to know your local community has been very valuable for referrals for myself and Heather, popping into shops and using the services of other therapists and health and wellbeing practitioners allows them to get to know you and when they do they are more likely to refer you to their clients. There's no harm in having lots of reflexology, acupuncture or massages either!

Heather has consistently written to local service providers and while this has taken time to show a return she has now established some good relationships with general practitioners, local businesses, schools and solicitors. The key here is to be consistent. A one-off letter might just hit the bin but if you plan a mail drop every

Sarah Rees and **Heather Howard-Thompson** continue their look at setting up in private practice. After looking at your business plan in the last issue, this time they focus on getting those all-important referrals.

> It takes time for word of mouth referrals to come through because we are still fighting the stigma of mental health.

six months, services will become more familiar with who you are. We get so few letters these days that people seem to be taking more notice when they do get them.

Research indicates that people need to see your service seven times before they make a referral or a purchase.

Directories There are a number of directories where you can pay to be listed such as the Counselling Directory. The most popular one at the moment is Psychology Today. They have some good introductory offers so you can try it out for a while. Alongside paid directories, do a search for local business directories in your area - the more places you can be the better. There are also professional directories to consider for different professional bodies, check out BABCP's CBT Register for accredited members and IPSIG.

Paid advertising Google adverts or Facebook adverts can be a great way of generating traffic to your website to improve it's SEO and to get yourself known. However, people can spend a lot of money and if you don't know what you are doing you may not get the returns you hope for. It's often worth paying someone who knows their stuff to get the campaigns going for you. We'd advise to tread with caution.

Google My Business is your new best friend. If we are relying on our websites for even part of our referral source then we want to be found on Google. So give Google some love, use Google's maps on your websites and create a Google My Business account. Update it regularly and pop photos and blogs on your account. Google reviews will attract more people to your profile and website and push you up the Google search engine. Google will reward your efforts with more visibility.

The gold standard of referrals is word of mouth, when people have heard about you what you do and how amazing you are! It's also high pressure when people come with high expectations but very rewarding. It takes time for word of mouth referrals to come through because we are still fighting the stigma of mental health and we don't often talk about the therapy we have. One way to encourage some word of mouth is to ask for anonymous feedback following therapy or send the link to your Google business account, make it easy for people to give feedback and often they will. This can then be shared on your website.

This has been an overview and I'm sure there are many other avenues. It's important to remember that what works well for one person might not for another, there is no right way so do what feels right for you. If you hate social media, don't do it - you won't enjoy it and won't give it your best energy, so create a business that's unique to you and a business you love.

If you would like to keep up-to-date you can join our little community on Facebook CBT in Private Practice, where you can discuss referral sources and learn from fellow CBT Therapists!

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

Giving us all of the feels

In the last issue of *CBT Today* (October 2019) **Patricia Murphy** introduced readers to the benefit that poetry brings to us all. In this issue, she speaks with poetry therapist and writer **Victoria Field**

Patricia Murphy: Can you tell us a bit about the thinking behind setting up a community poetry group?

Victoria Field: The answers to that question are multi-layered – much like a poem! I have always been an advocate for libraries ever since I was a young child. My mum dropped me off in Ashford Library every Saturday while she did the shopping and I would always come home with the maximum number of books. I think libraries are key to a civilised society and offer genuine public space welcoming everyone and can help build society. When I lived in Cornwall, I worked on many projects in the library service and moving to Kent I was surprised there was no provision and so applied for a small grant to set the ball rolling – the group has run on and off now for six years.

More generally, I have worked with poetry therapy and expressive writing in many settings and am interested in the theoretical justification for it. Is it a 'treatment'? A set of techniques like CBT? A form of group psychotherapy? I think there are elements of all these but for this particular community group, I see it as a 'maintenance model' – like exercise – which can help us maintain good psychological, spiritual and social health. The pattern of attendance seems to confirm this.

PM: I am regularly amazed by what we create as a group but also by the ways in which these activities foster a connection with the self at a very profound level. What do you think it is about poetry that appears to speak so directly about and to people?

VF: Yes, one of the great pleasures of this work is seeing and sensing these connections. There are many things happening when we connect with poems - some identifiable, some mysterious.

Writing in groups, trusting the process and having some gentle time pressure enables us to bypass the various personae we adopt and often get to the heart of the matter very quickly.

A poem is typically concise, often with striking metaphors and satisfying artistically so we get a sense of completion and meaning. Here I think poems are analogous to dreams, where an image can offer deep insights. A metaphor can often reveal more than a straightforward description and provides a bridge between our conscious and unconscious thought processes. Even a simple exercise like describing your anger as an animal can tell us a lot about how we see ourselves.

Giving something form, like the container of a poem in fourteen lines or a piece of writing that takes six or ten minutes is also a way of making the

Vicky Field
(Ranald Mackechnie)

> "I think poetry, story and song are examples of the creative and expressive impulse that makes us human. We have lost something profound in our culture that these things are no longer part of everyday life. We need to make meaning and create beauty out of our experiences."

unmanageable manageable. The material of our lives is infinitely rich and can be overwhelming so being able to look at it in bite-sized pieces can help establish a sense of mastery and control.

There's also a sense of community when we read a poem or listen to one where someone has articulated an emotion or experience on our behalf. We realise that we are not alone. An example of this 'isoprinciple' is the way sad poems or music can be comforting when we also feel sad. Knowing that our own trials and tribulations are part of the wider enterprise of being human can help us manage them better.

Finally, I think poetry, story and song are examples of the creative and expressive impulse that makes us human. We have lost something profound in our culture that these things are no longer part of everyday life. We need to make meaning and create beauty out of our experiences.

PM: One of my favourite things about the group is when we take it in turns to read our own or a selected piece of poetry. I imagine that many of us have probably not had an opportunity to read aloud to others since we were either in school or reading to children. Many of my patients have had aversive school experiences and lack confidence in speaking out in front of others so the opportunity to lay down fresh memories of communal speaking in a safe place can be really healing. What do you see as the value of reading aloud as a group?

> "Reading aloud is a simple and powerful way of regaining that confidence and I am pleased to see that shared reading groups are proliferating."

VF: I think 'unsilencing' and giving voice to the voiceless is an important aspect of healing, both of individuals and society. As you say, many people have lost confidence in their voices.

Reading aloud is a simple and powerful way of regaining that confidence and I am pleased to see that shared reading groups are proliferating. One of my Cornwall Library groups simply consisted of reading aloud novels week-in-week-out and gradually people gained confidence and would read longer passages and start talking about things that mattered in the intervals and many reported reductions in depression and anxiety.

Reading aloud also slows the world right down. It's an immersive process and very mindful in that you have to concentrate not to miss your turn. This can be very helpful for people who may have a tendency to ruminate.

The converse of reading is listening which is restorative for many people who may not have been listened to in their lives. There are many ways of setting up poetry therapy sessions but increasingly I think simply having words listened to attentively and kindly by others is a powerful experience.

Finally, we are reading carefully chosen words which has an impact on us the reader. A poem has been described as a machine for remembering itself and 'remember' has an interesting etymology – as if we are putting ourselves back together. As these words come through us, I think we are subtly changed. I had a recent profound experience when a friend asked me to read the words of diarist Etty Hillesum at a lecture he gave and it was as if I felt them for the first time. We've prioritised silent reading in our culture but reading aloud means both taking in – like breathe and inspiration – and then expressing and even tasting the words on our tongues. In other words, it's embodied and again modern life has created a

Continued overleaf

Giving us all of the feels *continued*

disconnect between our intellects and bodies which reading aloud re-establishes.

PM: You have had extensive experience of working in health and social care settings with many different client groups. What benefits from poetry therapy do patients report and what impact do you think it has on physical and psychological well-being?

VF: I'm going to quote here from the report of a previous iteration of the Wise Words for Wellbeing group. There is a strong social component to these answers which I think is central to poetry therapy – although poetry and writing can be useful in one-to-one psychotherapy, I think the benefits are multiplied in a group setting.

- The group allows an opportunity for members to express their individual spirituality in an environment of acceptance and openness.
- I have enjoyed sharing my work and hearing others' work. It is a kind of intimacy that I don't normally have with my friends. I have been more open in sharing my creative side with my friends since doing the wise words sessions, and it has been rewarding. I could also say that my mental health has improved a lot, as I have a lot more calm and clarity, and actually a lot more self-confidence. I am more aware of, and appreciative, of my own unique voice. Having this writing practise is a great outlet for stress and pent-up emotions.
- Throughout the various workshops I have attended, I've been fortunate to be able to interact with a variety of different people from a variety of different cultural and social backgrounds, across a wide age range. Our enjoyment of writing has enabled me to begin forming new relationships which I may not have made outside of the workshops
- I have a 25 minute walk each way so that's good exercise. I meet up with an old friend who also comes.
- I have unexpectedly gained new friends and felt stimulated to look after my physical health
- Have reconnected with people I've not seen for years and met new people. I have a chronic anxiety problem, this is giving me the confidence to help combat this.
- I did not really expect a writing group to have such an influence on my emotional and social wellbeing, and not at all on my physical wellbeing, but as these are connected it unavoidably influenced all of them.
- Reawakens a writing habit.

PM: I am greatly admiring of your ability to contain the space inhabited by the group. You have a very light touch and are able to set clear boundaries whist also being acutely aware of and managing the individual sensitivities of each member. How the devil do you do that?

VF: It feels like a bit of high-wire act at times as with an open group you never know who might be in the room and what experiences and expectations they are bringing. I try to be a facilitator rather than a tutor or therapist in that I want to allow individuals to shape and express their own material and simply witness it, rather than get into processing or analysing what's emerged.

Groups in a hospital or dementia setting which tend to be closed might have a different dynamic but will also entail the balancing of the needs of individuals and the group as a whole. People need to feel both safe and free to take risks and this tension is paramount – both in groups and in daily life. A colleague and I teach an online course called Running Writing Workshops. We've drawn on the experience of other facilitators in a series of interviews as well as our own and related that to the literature on group process – it's fascinating stuff!

On a personal level, I've discovered over the years that I have a bodily sense of people's moods and emotions. A lot of what happens, even in a poetry group where our business is words, is non-verbal. We are giving subtle messages all the time through posture, gesture, eye contact and so on. I've found that to be especially apparent when I've worked one-to-one with someone with dementia and felt how they might open up or close down in response to different poems – hard to explain but once you tune in, it's very clear.

PM: It is fascinating to see the range of responses to the material you share with the group but also how shared themes can emerge. For example, this Spring you brought in a daffodil for everyone and we had to write a poem for it and then write a poem from the daffodil's perspective. How interesting that it brought to mind for many of us themes of being undervalued and transience. Can you say something about how poetry can create a common bond, decrease a sense of isolation and increase affiliation with our fellow humans?

VF: In our secular society (although some argue that we're now post-secular), questions such as what happens after death, how to find meaning and what values we should live by are all up for grabs and as individuals we can feel isolated as we grapple with these questions. This can be especially apparent at times of loss and change when life is challenging or simply when we have to confront - as all of us will - mortality and aging. Whatever the surface stimulation is – in this case a daffodil – it's likely eventually to bring us back to those important questions about our transient human existence.

In poetry therapy, we often draw on poems and images from the natural world as this provides a background that hints at eternity and puts our own concerns into some kind of perspective. The cycle of the seasons, the way flowers and trees die back and then return to full bloom can be comforting and make us feel part of something larger. Many people who are disenchanted with organised religion may say that for them, nature gives a sense of transcendence and wonder. These responses can be cultivated by close observation – as we did with the daffodil and subsequent reflection. In many ways the practice of poetry therapy relates to the current enthusiasm for mindfulness. Paying attention and staying with the present moment can be transforming.

Time is a perennial theme in people's expressive writing. Such writing is a way of engaging with the question of what we should do with (in Mary Oliver's words) 'this wild and precious life'. Exploring these questions collectively and without any agenda in a kind and supportive group can help counteract the atomistic, disconnected sense nature of modern life.

PM: The poet, novelist and teacher Kate Clanchy recently gave an interview regarding her recent book based on her work in a small comprehensive school where the children speak 30 languages. A

comment was made about the degree of reverence shown toward poetry by the children and she acknowledged that it was part of being a multi-cultural community.

VF: I love Kate Clanchy's work and have heard her speak about 'the very quiet foreign girls' she works with at her Oxford comprehensive.

I think inclusivity and diversity are an issue in many areas of the arts and of course society more generally, whether we are talking about race, gender, sexuality, being differently-abled or class. As KC says in your quotation above, if we can see ourselves reflected in the poems, then we are more likely to engage.

Your question is one that I have grappled with for a long time – both as a practitioner and when I was on the Board of Lapidus and various Arts for Health organisations where it often felt as if we were looking in the mirror, and I've yet to find an answer.

On a more positive note, in the wider world of poetry publishing and performance, there's definitely been an increase in the diversity of those winning prestigious prizes or appearing at festivals. And there are also movements like Survivors' Poetry and The Deaf Poets Society which are user-led and provide platforms outside of the mainstream.

PM: Last year I went to hear Lemn Sissay, Canterbury's Poet Laureate perform his 'A poem for Canterbury' in the Cathedral. It was utterly magical. Sissay's traumatic experiences of being in care led him to become involved in 'Warrior Poets', a collaboration between artists from across Kent and the South East working with young people in care and young refugees to explore and celebrate the resilience that develops through facing adversity at such a young age.

What do you think can be done to change the perception of poetry as not just entertainment but as a powerful agent of change in health care?

VF: I think people have always known that poetry is important. Many people I've learned are secret poets, possibly only writing at times of heightened emotion such as a bereavement or falling in love and many people carry a poem that's given them hope, inspiration or solace. It's free, requires no special equipment and I think we instinctively know that shaping our thoughts is therapeutic – many teenagers start writing diaries and listening to music that reflects their current feelings.

The above though is part of the problem in that poetry is as varied, diffuse and accessible as music so getting it recognised as a powerful agent of change in healthcare is difficult. The challenge is both to define what's happening and also to demonstrate its efficacy in promoting health. I was an adviser on a systematic review of the literature on therapeutic writing for long-term conditions published in 2016 which, not surprisingly, was inconclusive. For me, poetry therapy and therapeutic writing, especially in groups, is a holistic intervention not susceptible to randomised controlled trials and wellbeing measures like the Warwick Scale. One of the challenges is that benefits are likely to be long-term and cumulative and we may feel 'worse' but paradoxically more authentically ourselves initially (not dissimilar to exercise).

The best way to change perceptions is for people to experience the power of the process directly. It's difficult for busy, senior people to have that opportunity so I am always delighted if I can present a session at a conference or on a training course as even with a short demonstration exercise, I get a sense of the penny dropping as people see how their own written responses can give them powerful insights into an issue.

But to answer your question, there are optimistic signs now that the NHS has embraced social prescribing as one aspect of more personalised care, especially for people with long term conditions and complex needs. Community writing and poetry groups fit well into that model.

You can follow Patricia on Twitter @Mspmurphy

In poetry therapy, we often draw on poems and images from the natural world as this provides a background that hints at eternity and puts our own concerns into some kind of perspective.

Turning **research ideas** into **reality:**

How can we better support 'on the ground' clinicians to become research active?

CBT has a strong scientific tradition, with on the ground practice being informed by basic science and trial findings (evidence-based practice) and research theory and models being informed by on the ground practice (practice-based evidence). Our greatest advances as a field have come from an interaction between the laboratory and the clinic (Clark, 2004; Salkovskis, 2003). For this tradition to continue requires symbiotic working between clinically informed researchers and research informed clinicians in the NHS (and other applied) settings.

This article considers what can be done to help support 'on the ground' clinicians to become research active, recognising that this can be a challenge because of the ever-increasing pressures of the 'clinical coalface'. The idea for this article emerged during a skills workshop run by Barney Dunn and Shirley Reynolds at the BABCP Annual Conference in Bath about how to help clinicians turn their research ideas into reality. The session identified a range of opportunities and challenges for clinicians wishing to be research active and brainstormed a number of ideas about how the BABCP might be able to intervene, which were elaborated on in a follow-up survey sent to all attendees. The attendees at the workshop (and others who contributed to the debate) agreed to co-author this article to share these discussions.

The themes identified can be usefully organised around the COM-B framework of behaviour change (Michie, van Stralen & West, 2011). This argues that key to successful behaviour change (in this case, getting research active in clinical practice) is individuals having the necessary

motivation, capability (knowledge), and opportunity (time, money and support) to carry out the target behaviour.

In terms of motivation, there was no shortage of intrinsic interest in research of those attending the workshop, with people feeling research is clinically important, theoretically interesting and would help them remain fresh and engaged with their clinical roles. However, people did describe sometimes lacking confidence about whether they were the right person to carry out research and that 'middle management' in the NHS did not always see the value of research so were reluctant to support it. In terms of capability, people described lacking sufficient research knowledge (how to choose a question; how to write an application, grant, or publication; which specific methodologies to use; how to analyse data); that research felt like an 'alien language' to those who were not already immersed in it; and that it was hard to navigate the research funding landscape.

There was a recognition that those from different professional backgrounds have had different degrees of research training (and in particular it is important for the BABCP to ensure its research support endeavours do not become 'psychologist centric' given that currently a majority of active CBT researchers have a clinical psychology background). In terms of opportunity, the critical rate limiting step was a lack of time, with very few people having any research time in their roles. People also felt isolated in their research endeavours and did not know who to turn to for research support and mentoring. There was little or no funding available to support early stage projects to get off the ground and for some it was hard to gain access to journal articles in NHS Trusts.

This analysis of barriers to becoming research active has the seeds of change within it. In terms of building capability, it would be helpful for the BABCP to support systematic research training (for example, establish online resources, adding a research skills stream to the Annual Conference, running research skills events in regional branches). In terms of building motivation, it would help for clinicians, researchers, and research participants to write position papers that clearly articulate the value of research to all levels of the NHS and to help promote and showcase role models (ideally beyond clinical psychologists) that illustrate how it is possible to get research active in routine clinical practice.
In terms of resources, it would be helpful to establish a register of potential mentors or academics willing to support clinicians to get research active (or who would value collaborations around specific projects); to provide seed-corn funding for early stage research or research methods training; and to establish a forum for research-interested clinicians to share ideas with each other.

Moreover, clinicians should be encouraged to reach out to academic departments who often are very keen to establish NHS links (and may have students looking for a research project to complete as part of their training). It would also be useful to raise awareness in the BABCP membership of research funding schemes they could potentially apply for. For example, the National Institute of Health Research (NIHR) has established the Integrated Clinical Academic (ICA) scheme that offers fellowships from pre-doctoral to senior lecturer level for allied health professionals (including psychologists, nurses, social workers and occupational therapists).

The NIHR has appointed training advocates to support allied health professionals become research active (see the NIHR training advocates website for details). 'Clinical Psychology Research Opportunities' is a useful twitter feed source of information (@Clin_Psy_Res), providing regular updates about research jobs, sources of funding, case studies of active researchers, and tips about how to get research active. Clinicians can also contact NIHR Research Design Services (RDS) to seek advice about developing research ideas and applying for funding.

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Turning research ideas into reality:

How can we better support 'on the ground' clinicians to become research active?

Continued

research active is to focus on an aspect of your routine clinical work that you think other people will be interested in and explore this area with a greater degree of methodological rigour. For example, this could include characterising the clients presenting to services, reporting a case study of an unusual clinical presentation, running a case series of a novel therapeutic approach, or analysing routine clinical outcomes to see how these benchmark against randomised controlled trial data. Such studies can be conducted without extensive time and funding and tend to have clear operational value to NHS management.

It is important for the CBT research community to reflect the diversity of the BABCP membership (and the clients it serves). A cursory review of recent BABCP conference keynote speakers and funded CBT researchers suggest progress has been made with gender diversity but that the majority of speakers are of White ethnic origin. Given the additional, and intersectional, structural barriers applicants from ethnic minority backgrounds face, what could we do to better support them to become research active and develop clinical-academic careers? Increasing ethnic diversity has been identified as a priority area by a number of research funders and it will be important for the CBT community to consider how to take this agenda forwards.

Our hope is that this piece will 'whet the appetite' of interested clinical researchers, inspire debate in clinical services about how to support 'grass roots' research, and encourage already research active members of the BABCP to consider what they can do to further support the creation of a research capable (and diverse) CBT workforce for now and the future.

Contributors

Barnaby Dunn (Mood Disorders Centre, University of Exeter), Shirley Reynolds (Department of Psychology, University of Reading), James Blacklock (Mental Health Matters, Sunderland), Abigail Bradbury (CBT therapist in private practice), Eleanor Chatburn (Department of Psychology, University of Bath), Cathy Creswell (Department of Experimental Psychology, University of Oxford), Lauren Cox (North West Boroughs NHS Foundation Trust), Zaid Hosanye (University of West London and Berkshire HealthCare NHS Foundation Trust), Pamela Jacobsen (Department of Psychology, University of Bath), Taf Kunorubwe (TalkPlus North East Hants & Farnham), Tom Kent (School of Psychology, University of Surrey), Jessica Kingston (Department of Psychology, Royal Holloway), Maria Loades (Department of Psychology, University of Bath) & Rosie Stevens (Mood Disorders Centre, University of Exeter).

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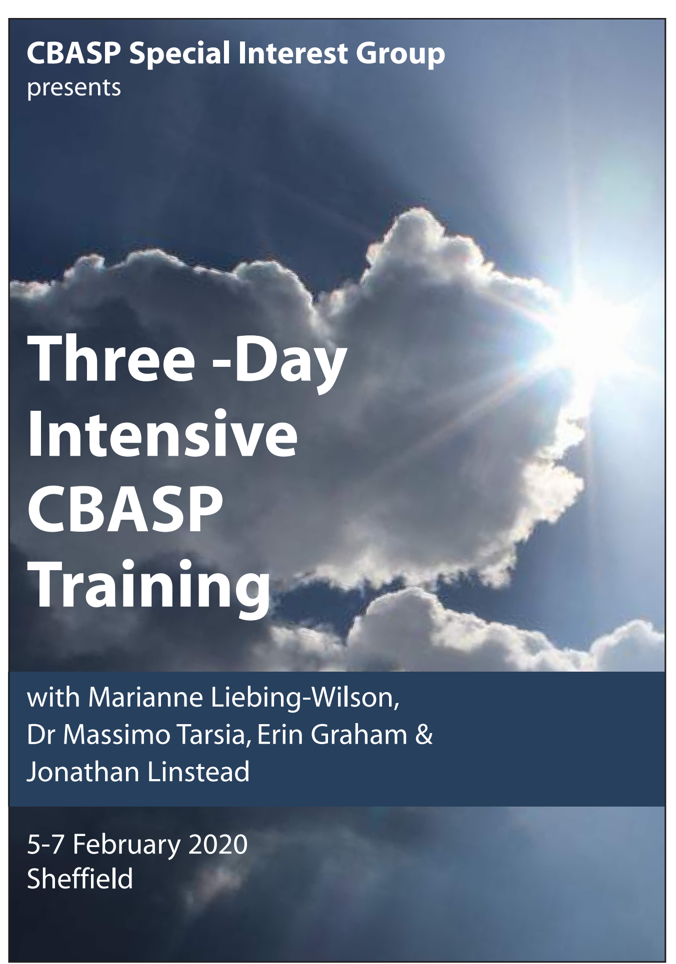

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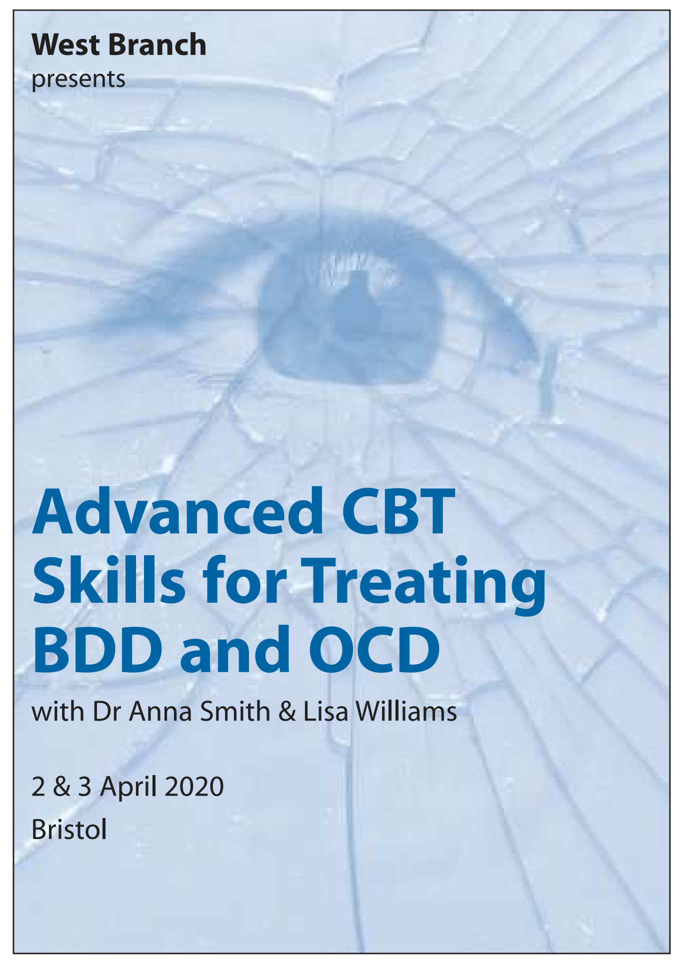

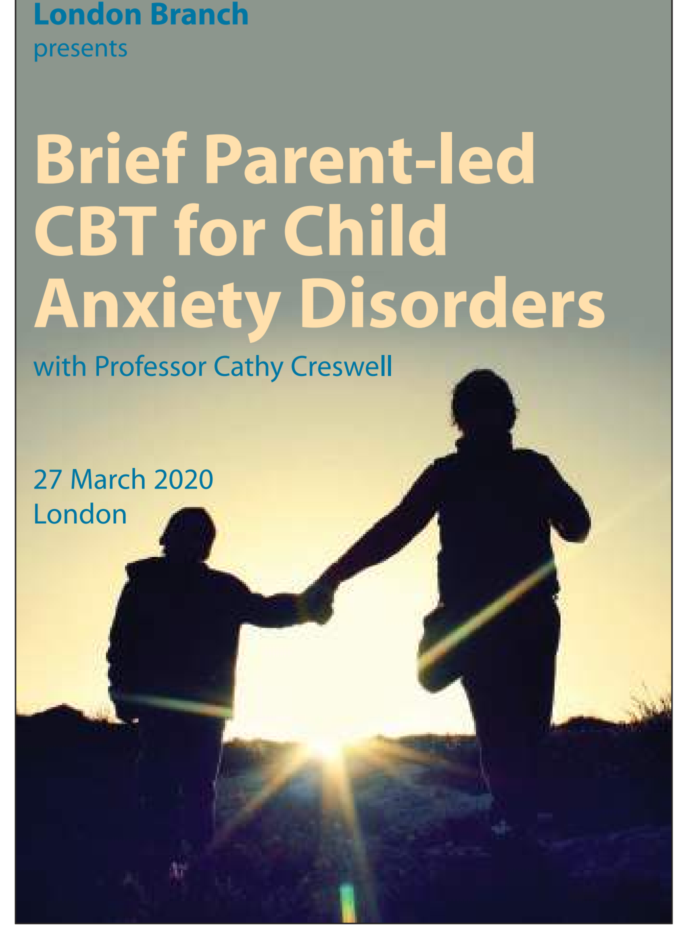

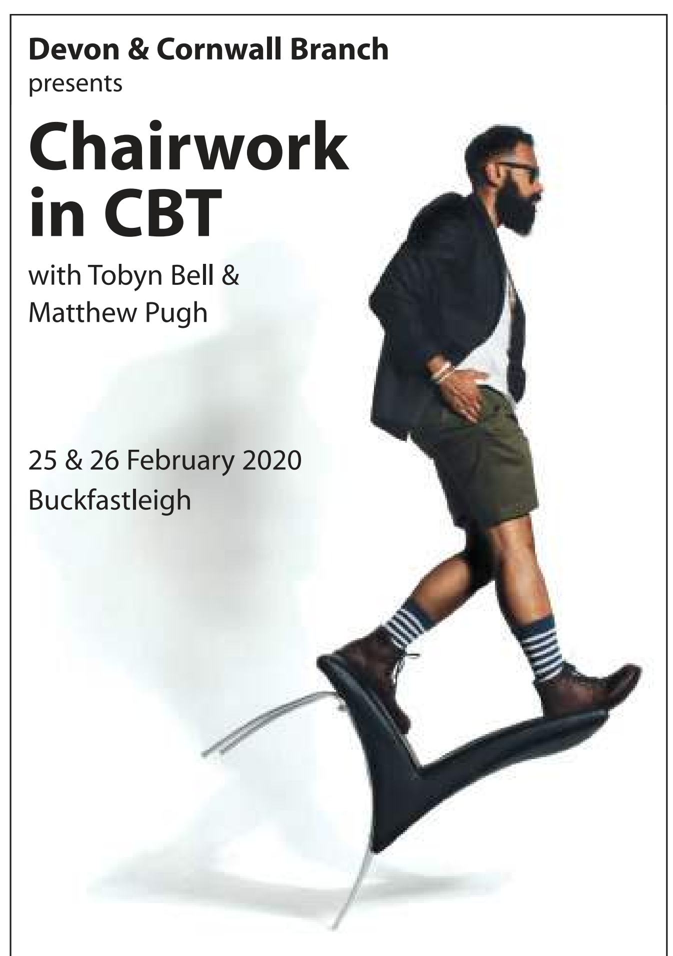

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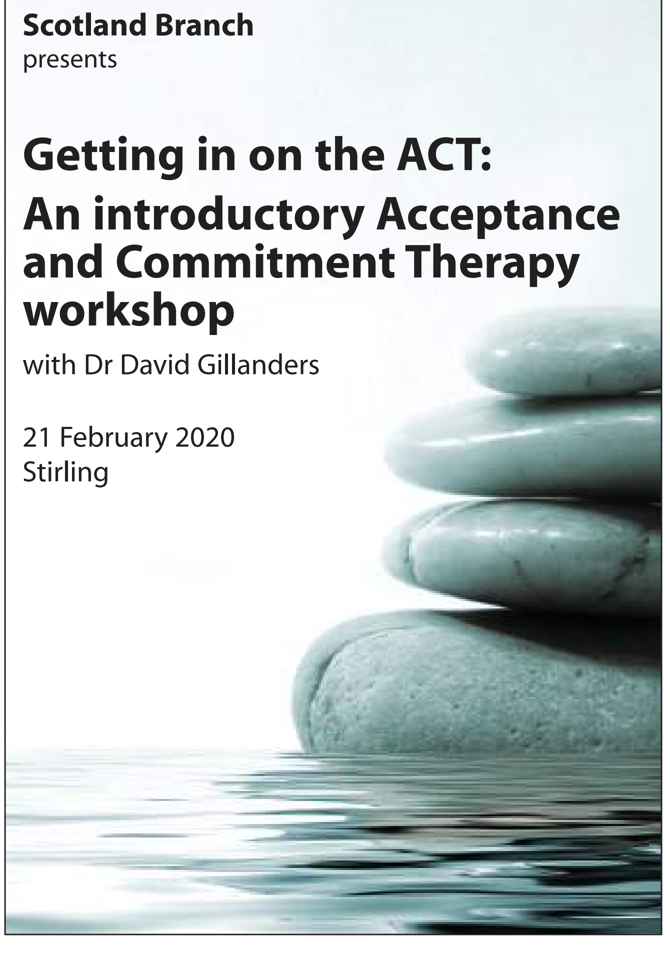

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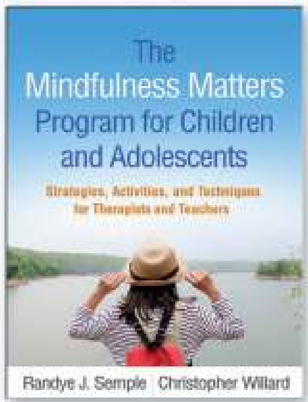

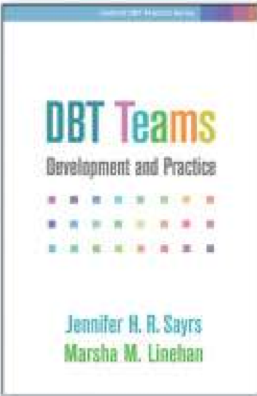

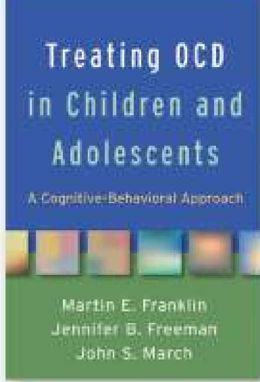

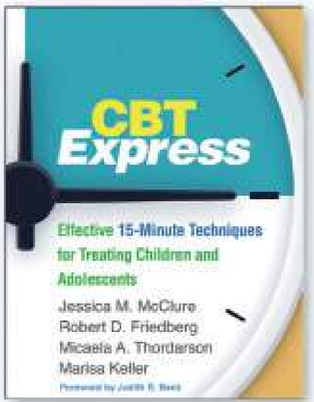

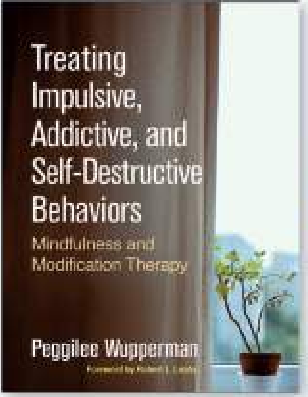

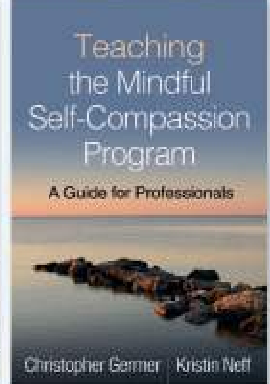

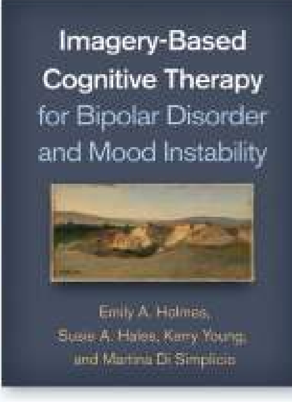

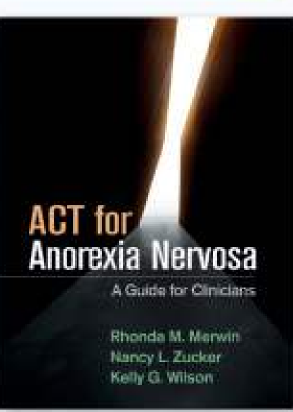

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Judith S. Beck (USA)
A Cognitive Behavioral Approach to Weight Loss and Maintenance

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

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

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Stefan G. Hofmann (USA)
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Robert L. Leahy (USA)
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Lynn McFarr (USA)
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SINGLE SESSION THERAPY

with Professor Windy Dryden

The assumption that therapy and counselling should always be long-term has been challenged repeatedly over the last 30 years. Data from public and non-profit therapy agencies indicate that the most frequent number of sessions that clients have is '1' and that 70-80% of clients having a single session are satisfied with the session given their current circumstances.

Single-Session Therapy (SST) has been developed to reflect these findings. It is best seen as a therapeutic mind-set and way of delivering services to provide help at the point of need rather than at the point of availability. What is particularly appealing about SST is that it can be practised by therapists from different approaches, making it of general appeal.

Professor Windy Dryden leads this one day SDS workshop on Single Session Therapy, a way of working that takes the best of your therapeutic toolkit and enables you to apply it effectively in a single meeting with your clients to achieve realistic positive results. The course is packed with extremely skilful live demonstrations, led by Prof Dryden who is famous for them, and with many opportunities for the participants to practise these new skills.

"So why did I become interested in SST? Whenever I give a training course, I do a demonstration session of therapy and have done so for many years. I came to realise that these sessions were examples of SST [...]. Looking for a new challenge when I retired from my university post, I re-read Talmon's 1990 book and got enthused by the possibilities. Based on his and others' writings, I developed a single session-based approach to CBT which I called 'Single-Session Integrated CBT' (Dryden, 2017) which can be used in the NHS as well as in private practice." ***Windy Dryden, from The Psychologist, November 2019, Vol.32 (pp.40-46)***

28 January 2020, BPS Office, London or via Interactive WEBCAST

www.skillsdevelopment.co.uk/single-session-therapy.shtml
Call: 01825 763710

Russ Harris

2020 ACT Workshops

Dr Russ Harris returns to the UK in 2020 to deliver two highly acclaimed workshops

For the first time ever in the UK, an Introduction to ACT, and his very popular ACT for Depression and Anxiety.

Russ Harris presents ACT in a truly accessible style, seamlessly weaving together theoretical knowledge and practical application. His workshops are entertaining and inspiring, brimming with thoughtful experiential exercises presented with clarity and authenticity.

Introduction to ACT workshop

Central London 23rd & 24th March

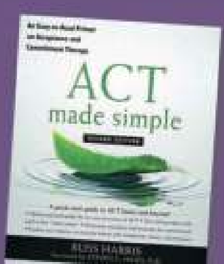
ACT for Beginners Workshop

A very practical, experiential workshop where you'll come out with a solid grounding in ACT. It will be useful for therapists, coaches and practitioners.

The workshop is a 'jargon-free zone' guided by three core values: simplicity, clarity, and accessibility and it covers so much material in such a short space of time. (There's also a big emphasis on having fun).

You will experience a wide variety of ACT exercises, and you will be encouraged to work with your own personal issues. You will be led through these exercises in the same way as you would instruct them to your clients.

You will also receive extensive support materials (more so than in any other ACT training around the world) including an album of professionally-recorded mp3s of key mindfulness skills, and a 3-months-long follow up e-course.



ACT for Depression and Anxiety

Central London 25th & 26th March

EVERY DAY, AROUND THE GLOBE, DEPRESSION AND ANXIETY SHATTER THE LIVES OF MILLIONS.

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Do you want to help your clients find rapid relief from suffering? And go on to build richer, fuller lives? If so, this 2-day advanced level workshop on is for you. You'll go deeper into the ACT model, take your skills to the next level, and learn specific methods for depression and anxiety disorders. You'll learn about common stumbling blocks and sticking points, and how to quickly get around them.

And you'll discover a wealth of practical tools and strategies to effectively target depression (major depressive disorder and dysthymia) and the full range of anxiety disorders (from OCD & phobias to social anxiety & panic disorder). The workshop will include live demonstrations, videos of therapy sessions, and a wide range of experiential exercises.

Check out our other 2020 workshops!

Intro to ACT Matrix - webinar
with Richard Bennett - Feb

ACT for Physical Health
with Ray Owen - April

Using Metaphors in ACT webinar
with Niklas Torneke - May

The Therapy Relationship in ACT
with Kelly Wilson - October

ACT for Chronic Pain
with Lance McCracken - November

For more workshop information, rates and **special discounts for booking both workshops,** venue locations and how to register please see:

www.contextualconsulting.co.uk

Oxford Cognitive Therapy Centre

www.octc.co.uk

Oxford Cognitive Therapy Centre

OCTC 2020

Forthcoming Events

20 January, Andrew Beck
Staff Burnout in Mental Health Service: Bringing about Change at an Organisational Level and Through CBT Supervision

It is well established that Burnout affects the wellbeing and performance of therapists. This workshop enables participants to identify individual, inter-personal and systemic factors that may increase risk of therapist burnout, and to address these through CBT supervision. There will be practical opportunities to look at putting possible preventative and restorative ideas into practice. This workshop will be of interest to therapists, clinical supervisors and service leads.

22-23 January, Dan Freeman, Louise Isham, Bryony Sheaves & Felicity Waite
A New Translational Treatment for Persecutory Delusions: The Feeling Safe Programme

Delusions are one of the most frequent and distressing psychotic experiences. In the last ten years they have become the focus of considerable psychological research. This research is being used by Professor Daniel Freeman and colleagues to develop a new targeted, personalised, modular therapy for patients with persecutory delusions, called The Feeling Safe Programme. The aim is for a much higher recovery rate in delusions. This 2-day workshop will provide an overview of key elements with the new approach to delusions, including the assessment process, reducing sleep disturbance, tackling worry, enhancing self-confidence and building a renewed sense of safety.

19 February, David Clark
Cognitive Therapy for Social Anxiety in Adults and Adolescents

Social anxiety disorder is common and remarkably persistent in the absence of treatment. Clark and Wells (1995) developed an effective cognitive therapy that targets the maintenance processes in social anxiety. This workshop presents the Clark & Wells model and key treatment procedures, illustrated with case material and videos clips from therapy sessions. As social anxiety disorder usually starts in adolescence, the workshop covers how to use the treatment in adolescents as well as adults.

9 March, Khadj Rouf & Kevin Jones
Helping Those who suffer with Suicidal Ideas

This workshop looks at theory & practice links around suicide prevention, ensuring participants learn about the most up to date research evidence on CBT for suicide prevention. This practical workshop presents an opportunity to build confidence in: assessing suicide risk; formulating the suicidal cycle; building safety plans; applying CBT interventions to help reduce risk. There will also be opportunity to reflect on working in this difficult area and for participants to observe and practice key skills.

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For more information or bookings, & for more events, see the OCTC website.

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