SPECIAL EDITION

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CBT Today

BABCP
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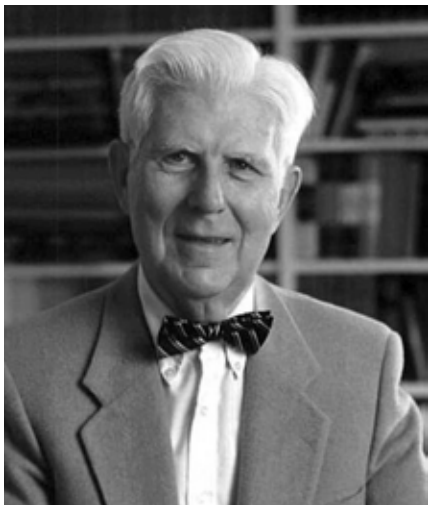
The official magazine of the British Association for Behavioural & Cognitive Psychotherapies



BABCP 'my home from home'

As BABCP celebrates a landmark anniversary, Dr Aaron Beck reflects on his involvement with the lead organisation for CBT in the UK

In 1983 I was attending a meeting of the Society for Psychotherapy Research in Sheffield. I was in a state of high frustration, since a symposium that I had exhaustively prepared to discuss ran out of time before I had a chance to go to the podium. Luckily for me, David M Clark, whom I had met the previous year, informed me that he was planning to go to a meeting of BABP in Hull and suggested that I might want to go along. Since I was already fed up with the Society for Psychotherapy Research programme, I jumped at the opportunity to attend the meeting of BABP in Hull. I had heard only vaguely about BABCP and I realised that the organisation had basic roots in behaviour therapy, but I figured that I would learn something if I attended the meeting. When I arrived at Hull, Andrew Mathews, the programme chairman, suggested that I might say a few words over lunch. I was indeed gratified at the suggestion, and managed to draw a few laughs. I also had occasion to meet David A Clark, who was at the Institute of Psychiatry at the time, as well as Paul Salkovskis. David M as well as Paul spent time with my group in Philadelphia and David A came a bit later. BABP turned out to be a very rich source of outstanding individuals who later became leading cognitive therapists in Britain.

Following my warm introduction to BABP, I tried to attend the meetings of BABP, later BABCP, as frequently as I could. When I started going to Britain, Rod Holland would generally meet me at the airport and guide me to the BABP meetings. While there, I made many interesting contacts, had the opportunity to present workshops, and also learned a great deal.

As a background to all of this, I should mention that, back in the United States in the 1970s and early 1980s, there were very few people that I could talk to and share ideas and research findings with. By creating my own Center for Cognitive Therapy, I was able to draw talented younger people into my orbit.

Now, as I reflect back over the years, I realise that I had been looking for a home, and this Association and the other institutions turned out to be my home away from home!

Dr Beck is an Emeritus Professor in the Department of Psychiatry at the University of Pennsylvania and the Director of the Aaron T Beck Psychopathology Research Center. He is also the co-founder, with his daughter Dr Judith Beck, of the Beck Institute for Cognitive Behavior Therapy in Bala Cynwyd, in suburban Philadelphia. Dr Judith Beck writes about the work of the Beck Institute on pages 8-9.

Inside this special edition:

Project 40
see centre pages

BABCP 40

From strength to strength

New BABCP President Professor Trudie Chalder welcomes readers to this special 40th anniversary edition of CBT Today

I feel truly honoured to be BABCP President, particularly during this landmark year. As this is my first contribution to the magazine in this role, I would like to take this opportunity to thank my predecessor Professor Shirley Reynolds for her commitment and energy during her term of office.

Continued overleaf

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CBT Today is the official magazine of the British Association for Behavioural & Cognitive Psychotherapies, the lead organisation for CBT in the UK. The magazine is published quarterly, is posted free to all members and can be downloaded from our website. All copy proposals or contributions should be emailed to the relevant person below.

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From strength to strength *continued*

the Development Plan into life and responding to external factors such as the Coalition's spending cuts and lack of progress towards regulation. While she has been President, membership levels have been steadily progressing towards the 10,000 mark, while the reputation and relevance of the lead organisation for CBT remains as strong as ever.

I have been associated with BABCP for over 25 years now. I have always felt privileged being a member and it has always felt a natural allegiance. Of all the psychotherapies, CBT stands out because of the extent to which it has embraced the scientific method. In the period since this Association was established in 1972, CBT has gone from strength to strength because the evidence suggests it works. Treatments have been evaluated in the context of randomised controlled trials and then rolled out if they were found to be effective.

It is appealing to both health professionals and users because of the transparency in its method, while its relatively short-term nature means that benefits can be realised quite quickly. It not only focuses on problem-solving, but does this collaboratively and in a non-judgemental and supportive way. Therapists connect with users in order to alleviate their suffering.

In the next issue I will be writing in more detail about what I would like to focus on during my time as President in the two years ahead. However, I can already state that the overarching challenge for BABCP will be to maintain a welcoming and collaborative membership community, while it continues to change dramatically in terms of size, accountability and the roles that it undertakes.

Thank you for reading -
and happy anniversary!

BABCP 40 1972 - 2012

LEEDS 2012

Full coverage of this year's highly successful BABCP Annual Conference, which took place in Leeds from 26 to 29 June, will appear in the October issue of *CBT Today*, including the announcement of BABCP Fellows and Branch of the Year.

For the latest information on the 2013 Conference programme, please check www.babcpconference.com.

Olympic Torchbearer Chris Ferry poses with Scientific Committee Co-Chairs Warren Mansell and Roz Shafran

From the editor's desk

My core profession is journalism and editing. Therefore, it is a personal privilege to be writing to you as the Managing Editor of *CBT Today* in this very special year for the Association. Supported by a wonderful team of volunteers, it has been important to me that you all get the best possible membership magazine. Many of you have been kind enough to tell me how much more you, as well as your colleagues, clients and friends, enjoy *CBT Today*. So thank you - it is very much appreciated.

The editorial team and I wanted to do something highly distinctive for this commemorative edition. Rather than produce 'just another' *CBT Today*, we have tried to offer you something original and enduring.

It is an absolute honour to have Dr Aaron Beck leading this issue. Dr Beck, who recently turned 91, has been typically generous with his time in reflecting on his involvement with the Association over the years. Belated happy birthday from everyone at *CBT Today*!

For his daughter and current President of the Beck Institute, Dr Judith Beck, to write for this issue as well further validates the affection and respect that BABCP has garnered amongst CBT's most eminent pioneers.

Included with this issue is a 'timeline' poster, which chronicles some of scientific, clinical and historical points of significance in the last 40 years. I am particularly grateful to Howard Lomas and Warren Mansell for their incredible energy, imagination and commitment in bringing this timeline to fruition.

B.A.B.P. newsletter

BRITISH ASSOCIATION FOR BEHAVIOURAL PSYCHOTHERAPY

Vol. 1, No. 1 Quarterly December 1972

Editorial

I would also like to pay a great deal of thanks to those who participated in Project 40, the results of which can be found in the centre pages.

Lastly, I would like to acknowledge the inspiration of Iain Burnside and Francis Lillie, and their editorial for the Association's first newsletter published in December 1972. I came across this editorial when I began to build an editorial team for *CBT Today*. While I am not from a psychology background, I have tried to live up to the aspiration embodied in this editorial: namely, to 'reflect the inter-disciplinary nature of this Association'. I hope that I have gone some way to help produce a magazine which has resonance with BABCP's ever-diversifying membership.

Stephen Gregson
Stephen is also BABCP Communications Manager

Open for business

BABCP's new moderated online discussion forum CBT Café went live on 12 June.

This forum has been created primarily for BABCP members. Stakeholders are also welcome to register and participate in discussions, but they will be subject to the exact same moderation policy as BABCP members.

If you have not done so already, you will need to register at www.babcp.com/cafe before you can start and participate in discussions. CBT Café is a standalone facility which is not linked to the membership database.

In response to BABCP members' suggestions, the moderation will combine automated and reactive systems.

It is hoped that CBT Café users will appreciate the need to allow the facility to 'bed down', and every effort is being made to reduce, and eliminate as far as possible, spamming.

There are currently nine broad areas for discussion, which will be reviewed on a regular basis, as will the format of the forum itself. It will also be an online sister companion to *CBT Today*, with all book reviews now moving to the Critics' Corner discussion area on CBT Café.

Professor Shirley Reynolds, who was BABCP President at the time of the launch, said: 'You may remember that a year ago we were advised that our subscription to Jiscmail was ended. This was not something we wanted to do because it provided an informal place for BABCP members to debate and discuss. We have been working hard to develop an alternative forum. I am pleased that we can now offer members this forum, which has been designed in response to their suggestions. I hope that you will find it welcoming and useful.'

If you have any suggestions about CBT Café, or if you are interested in becoming a book reviewer, please email cafe@babcp.com

Ruby anniversary on the Emerald Isle

Paddy Love chairs the Irish Association for Behavioural & Cognitive Psychotherapies (IABCP), this year's BABCP Branch of the Year winner. He also chairs the Carryduff Gaelic Athletic Association (GAC), which is celebrating its 40th anniversary this year too. CBT Today *invited Paddy to reflect on his involvement with these two organisations*

My first meaningful BABCP experience was attending the 1997 Annual Conference in Canterbury during its 25th anniversary. It was a particularly stressful time for me and my colleagues, in the middle of CBT training and grappling with applying theory to practice. We sought solace in sharing clinical dilemmas with fellow practitioners, and augmented debates with attendance at the workshops and symposia. We immediately felt at home and were introduced to BABCP stalwarts Howard Lomas and Francis Lillie. A game of soccer spontaneously developed in the evening sunshine. I seem to recall it was Ireland against the UK. The competition was fierce despite the result being immaterial. We felt part of the BABCP family and vowed to become accredited members.

The friendships forged in BABCP remind me of my first ever experience of joining an organisation in my youth. I became a member of Killyclogher GAC in County Tyrone in 1976, after moving from my birthplace of Belfast at the height of the Troubles. After initial suspicions of the 'Belfast Kid', I was made to feel part of the team and local community. I played both Gaelic Football and Hurling for Killyclogher at Juvenile Level and then Senior Hurling Level. Friendships developed in adolescence were retained into adulthood, created through shared experiences of success and failure on and off the pitch. Thankfully, I was part of a very talented football and hurling squad at the time, which won the Tyrone County Championship back to back at Juvenile Level. I missed out on success at Senior Hurling Level, as they won the Senior County Championship the year after I stopped playing.

I trained as a Registered Mental Health Nurse at Tyrone & Fermanagh Hospital in 1984, returning to Belfast in 1987 to take up my first post at Purdysburn Hospital. That year I married my wife Teresa (25 years ago – another anniversary!), who was working as a Registered General Nurse in Belfast City Hospital, and we set up home in Carryduff. The focus turned to developing careers and bringing up family, including working as a Community Psychiatric Nurse before training in CBT at the University of Ulster in 1996-98. I had found my niche in life and returned to the University of Ulster in 2003-04 to teach CBT. I eventually re-established my links with the Gaelic Athletic fraternity by joining Carryduff GAC in 2002 and, within 10 years, have retired from playing sport to managing teams and, in the last three years, have been the chair of Carryduff GAC. It was the experience of chairing a successful club with approximately 32 teams and 1,200 people that led to my CBT colleagues nominating me to stand for IABCP chair in 2010.

IABCP is a vibrant, hardworking branch of the BABCP family which has gone from strength to strength since its relaunch and resulted in being named Branch of the Year 2012. After a series of successful workshops in Belfast and Dublin, the IABCP committee has firmly set its sights on encouraging BABCP to host an Annual Conference in Belfast in the near future. As a springboard to this goal, it has just been agreed to host next year's BABCP Spring Workshops and Conference in Belfast on 4-5 April at Queens University Belfast.

Further information

Carryduff GAC:
www.carryduffgac.com

IABCP website:
www.babcp.com/irish

(Above) Paddy Love with the award-winning IABCP Committee

Background image Wikimedia Commons/Gaelic Sports Club Luxembourg

BABCP

www.babcpconference.com

Belfast 2013

BABCP Spring Workshops & Conference

Titanic Struggles for CBT

Queen's University Belfast

4 - 5 April

Confirmed Workshops Leaders:

Professor David A Clark
(University of New Brunswick)
Dr Michael Duffy
(Queen's University Belfast)

Confirmed Keynote Speaker:

Professor David A Clark
(University of New Brunswick)

Full programme to be confirmed soon - check www.babcpconference.com for updates

For information on visiting Belfast, please visit www.belfastconventionbureau.com or www.gotbelfast.com

Belfast welcome

Georgia on their minds

As BABCP celebrates a landmark anniversary as one of the longest-standing organisations of its kind in the world, CBT Today *invited one of the youngest to write about their work and aspirations*

The Association of Cognitive Behavioural Therapy of Georgia was founded in 2010 by a small initiative group of Georgian psychiatrists and psychologists.

The idea of establishing the Association came about in 2004-2005 when the Global Initiative in Psychiatry and the Georgian Mental Health Association invited Dr Louise Johns from the Institute of Psychiatry in London to Georgia. A number of mental health professionals were trained and supervised by Dr Johns in CBT specifically for psychoses, depression and anxiety disorders. One of the positive outcomes from the training was the 2006 publication of the book entitled *Cognitive-Behavioural Therapy* in the Georgian language, which contained the training materials.

At the same time, discussions started in earnest on how to deal with the difficulties hampering the implementation of CBT in various services within Georgia. These difficulties (which still exist) can be summarised as follows:

- There is a limited number of CBT therapists within Georgia.
- There is limited access on literature (especially in the Georgian language), as well as the non-existence of internationally recognised accredited courses and/or supervision which makes it very difficult to train therapists.

These difficulties have become a key concern for newly developed outpatient psychiatric services.

The situation was further aggravated after the military conflict between Georgia and Russia in August 2008. The need for evidence based psychotherapy was incredibly crucial for treating over 160,000 internally displaced people suffering from various trauma-related psychological difficulties.

In September 2008, Dr Jane Rawls from the New Zealand Psychological Society and her husband Dr Barry Parsonson from the University of Waikato, New Zealand, trained and supervised a small group of Georgian psychologists and psychiatrists in trauma-focused CBT. They assisted Georgian specialists to deal with conflict-related trauma difficulties in children, adolescents and adults.

Finally, the two waves of mental health specialists trained by international professionals came together and formed the Georgian Association, with the aim of disseminating and promoting CBT in different settings across the country.

Meanwhile, a training programme on CBT for mental health specialists was accredited in 2009 by the Georgian Ministry of Health.

The members of the Georgian Association are continuing psychotherapeutic activities in their private practice, while supporting each other through the sharing of experiences about dealing with problems faced in the process of delivering therapy. The data in regards to the effectiveness of CBT in treating disorders - such as schizophrenia and other psychotic disorders, anxiety disorders (especially for panic attacks and PTSD), OCD, and hypochondria - is being accumulated. The documentation and analysis of this data are useful in gaining a better understanding of the cultural influences (or characteristics) which play a role in the effectiveness of CBT.

Our goals also include identifying strategies for the training of qualified professionals, and raising awareness of and legitimating CBT within Georgia. We see the sharing of Western experiences as a crucial factor in our professional growth as well as our organisational development. Academic and supervisory support from Western colleagues is critical to the effective implementation of CBT in Georgia.

We look forward to collaborating with BABCP and its members and hope to become a 'Western CBT family member' in the future.

(Right) Training event organised by the Georgian Association for mental health professionals working in different regions in Georgia, using video demonstrations of CBT techniques in the Georgian language

Where is Georgia?

The republic of Georgia is located at the crossroads of Western Asia and Eastern Europe. The capital of Georgia is Tbilisi. The official language is Georgian - a language with its own unique alphabet. The majority of Georgians are Orthodox Christians.

The Board of the Georgian Association would welcome any advice or support from BABCP members

Natia Badrishvili, Clinical Psychologist (natia@gamh.org.ge)

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Ketevan Abdushelishvili, Psychiatrist (kateabdu.abdushelishvili@gmail.com)

Accreditation milestone

In this 40th anniversary year, BABCP Accreditations now exceed 3,000 out of a membership fast approaching 10,000. CBT Today *invited Senior Accreditation Liaison Charlie McConnochie to reflect on this remarkable achievement*

It seems appropriate that news of BABCP Accreditations topping 3,000 should cross my desk on 1 May of all days - as this has long been marked out as International Workers Day!

Such figures would not have been possible without the fantastic work that has been put in over the years by a large number of volunteers within BABCP – from those currently serving on the Board or on Committees – and from those who have fulfilled such roles in the past.

BABCP's development has been driven from the earliest days by engaged and engaging practitioners who have contributed an enormous amount of labour - to their own, and other members' benefit.

Since I came into the Accreditation Liaison role in April 2006, their efforts have been supported and extended by an ever-increasing number of hugely dedicated and facilitative employees. Whilst acknowledging the contributions of all members and staff, both past and currently serving, I would like particularly to congratulate the entire Accreditation team.

In the past six years, the Accreditation functions have been made considerably easier by administrative support from Anne Gorse and Julie McIntosh, who between them handle a workload which seems to increase exponentially the more work they carry out!

The Liaison role has expanded over the last few years and many members will have enjoyed both formal and informal contact with Tamera Bateman-Wright, Carolyn Quinn and Mark Addis (and, in the past, Christine Richardson). Individually, and as a team, they have contributed to an entire overhaul of Accreditation processes – and the establishment and management of the new teams of paid Accreditors who are now contracted to carry out the actual Accreditation processes. They have also been instrumental in making personal contributions to the swelling of those Accreditation figures through determined efforts to troubleshoot the less-routine applications. The Accreditors also deserve mention, not least for their contribution to efficiencies made over the last year or so in processing times. I am sure that there are many applicants who have been agreeably surprised at the speed of the processes in recent times!

(Above) International Workers Day parade in Madrid

Of course, in looking at figures for individual Practitioner Accreditation in particular, mention should also be made of the contribution of the entire Course Accreditation team, which has provided the feeder channels for such expanding numbers through their work in accrediting courses.

Well done to all who have played a part!

A BABCP Accreditation special supplement, including a feature article by Ken Lewis on Professionalism, will accompany the October issue of *CBT Today*

New BABCP Trustees

The results of this year's election of new Trustees to the BABCP Board were announced at the AGM, held on 28 June at the University of Leeds.

Gerry McErlane is the new Honorary Treasurer, while **Jennie Beattie** and **Victoria Williams** are the two new Elected Members.

Those elected will join the Board from September, which will be chaired by Professor Trudie Chalder who took over as President at the AGM.

Watch this space for profiles of the new Trustees.

Gerry McErlane

Jennie Beattie

Victoria Williams

CBT Training at the Beck Institute

Dr Judith Beck writes for CBT Today *on the training opportunities offered by the centre she founded with her father, Dr Aaron Beck*

Aaron T Beck, MD, and I established the Beck Institute, a non-profit organisation, in suburban Philadelphia, Pennsylvania, USA, in 1994. We have had an interesting evolution since then. Initially, our centre was primarily a clinical site. From the beginning, though, we had a vision of transforming the Institute into a national and international training centre. This vision was gradually realised, greatly aided by the explosion of research that demonstrated the efficacy of CBT and by the internet which allowed literally millions of professionals, students, researchers, educators, and consumers to discover and learn about evidence-based treatment. (We now have over 100,000 visits to our websites each year.)

As of 2012, we have trained more than 3,000 health and mental health professionals through our workshop and supervision programs. Our trainees, who have ranged from novice therapists to experts in CBT, have been from all 50 US states and 75 countries. They are professionals in every mental health discipline and many related fields (medicine, education and occupational therapy, to name a few). We have trained many thousands more via offsite (customised) workshops, conferences, and webinars, and we will soon be offering online training programmes.

Dr Aaron Beck first began to teach cognitive therapy to psychiatric residents and post-doctoral fellows in psychology at the University of Pennsylvania in the 1970s. He started a distance supervision programme in 1980. Mental health professionals travelled to Penn for workshops and received weekly phone supervision from master supervisors based on tape reviews of their therapy sessions.

We have trained more than 3,000 health professionals through our workshop and supervision programmes. Our trainees, who have ranged from novice therapists to experts in CBT, have been from all 50 US states and 75 countries

In 1994, we established the Beck Institute, whose mission is to encourage the growth and dissemination of CBT throughout the world through leadership in the field and the provision of professional training, outpatient clinical services, and research. We have maintained a strong connection to the University of Pennsylvania. To this day, Dr Aaron Beck continues his research with his team at Penn, and I continue to teach courses to psychiatric residents. But we moved our clinical and educational operations to our current site. Several Penn faculty members still supervise in what is now called our supervision programme and teach both at our onsite and offsite workshops.

We also offer opportunities for students and professionals from other institutions to learn more about CBT.

For many years, we have invited students and faculty from all the mental health disciplines to attend case conferences, in which Dr Beck interviews a patient live, via closed circuit television. Following the interview, I conduct a review of the therapy session and moderate questions and answers with Dr Beck. In 2010, we established a student and faculty scholarship competition. Each year, we receive hundreds of emails from students and faculty, describing their exposure to CBT, and how they use or plan to use CBT in the future. And each year, we award 10 or more full scholarships to our special three-day student and faculty workshop, which we offer every August.

In addition to training individuals, we work with hospitals, health systems, community mental health centres, and other organisations whose aim is to establish or improve the delivery of CBT treatment by their staffs. Training is individualised and often involves a hybrid of workshops, supervision, and supervision on supervision.

In terms of research, we are currently conducting a pilot study on the efficacy of a CBT programme for weight loss and maintenance. (A third generation in the Beck family, Deborah Beck Busis, LSW, is currently working on a therapist manual for weight loss and maintenance in anticipation of developing a training programme for health and mental health professionals to test the programme we developed more widely.) Other research activities include training, monitoring, supervising, and/or assessing the competence and fidelity of CBT research therapists.

We also seek to educate others in a variety of different ways. We interact with professionals and consumers and keep them up-to-date on cutting-edge research and practice through a variety of social media platforms, including Facebook, YouTube, Twitter, LinkedIn, and our blogs.

What does the future bring? We continuously update our basic and advanced workshops and expand our specialty workshops offerings (for example, CBT for children and adolescents, schizophrenia, substance abuse, PTSD, and groups, as well as a workshop in Spanish) and we will broaden our range in the future. While we have a large faculty of supervisors from North America, we have a few supervisors to whom trainees send therapy tapes in their native languages (chiefly Spanish, Chinese, and Thai); most of our international trainees currently find English-speaking clients or submit translated transcripts of their sessions. So another goal is to develop a larger group of international supervisors. We will also expand our supervision on supervision programme, in which therapists first reach significant proficiency in delivering CBT to clients and then learn how to supervise other therapists. And we are eager to reach many more students and mental health professionals with our forthcoming online training programmes.

Now that CBT is becoming (more of) a household name, and especially as social service and governmental agencies recognise the importance of evidence-based treatment, we foresee an ever-expanding role for training in the field. We welcome your ideas and collaboration of BABCP members in fulfilling our mission.

Dr Judith Beck is the President of the Beck Institute for Cognitive Behavior Therapy

Contact

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Email: jbeck@beckinstitute.org

Yorkshire Branch

BABCP
www.babcp.com

Regional Forums

The Branch invites members and non-members alike to attend our quarterly Friday morning forums. These are held at the Behavioural Psychotherapies Department, Michael Carlisle Centre, Sheffield S11 OBF between 9.30am and 12.00pm. They usually include two main presentations from CBT practitioners or researchers in the region. The presentations are free of charge (50p contributions for hot drinks and biscuits) and are followed by the Branch committee meeting.

Dates for future Forums are as follows:

- 28 September 2012 (Annual Workshop see below)
- 2 November 2012 (including AGM)
- 1 February 2013
- 3 May 2013
- 5 July 2013
- 1 November 2013

Speakers to be announced - any suggestions or offers welcomed

Please contact Forum Co-ordinator Julie Forrest at julie.forrest@shsc.nhs.uk or Branch Liaison Officer Gill Donohoe at gillian.donohoe@shsc.nhs.uk for further information

Portrait of the behaviourist as a young man

Any celebration of BABCP's achievements over the last four decades would be incomplete without Howard Lomas, one of the founder members present at the Association's inaugural meeting in 1972. CBT Today *invited Howard to 'go back in time' and write a letter to the membership of 2012 about that legendary meeting 40 years ago*

Accrington

Saturday, 11 November 1972

Dear members

A momentous day yesterday! I went to London to attend a meeting to discuss the inauguration of a new national organisation for Behaviour Therapy. Three of us travelled down on the train early in the morning from Manchester in the cold and mist (or was it smog in London?).

I was among hordes of Behaviour Changers/Modifiers/Engineers/Therapists (all soon to become Psychotherapists) making their way from the four corners of Britain to the Middlesex Hospital in London. When we arrived, we were refused entry unless we paid £3 annual membership fee to the very smartly dressed bouncer on the door who claimed to be the Treasurer of the not-yet-existent Association and turned out to be Robert Sharpe. 'But I thought the meeting was to decide if we are going to form an Association and, if so, to elect the officers!' My protests were in vain, as would have been our 460-mile day trip if we had not parted with our £3. I have never really mastered contingency management!

The Association was inaugurated, but only after a lengthy debate about what it should be called. The troublesome word was 'Psychotherapy'. In the end Isaac Marks won the vote and the British Association for Behavioural Psychotherapy was born. Bob Sharpe was elected Treasurer. Laurence Burns from Rochdale became Secretary, which means that I am to take over from him as Secretary of the North West Behaviour Modification Study Group.

The last 10 years since 1962 have been quite an eventful journey in the modification of my behaviour starting with my interest in programmed learning from my physics teacher at school. A couple of sixth form projects I undertook were to create a film, partly animated, to teach in programmed learning steps, how to use a chemical balance. Also, I constructed a mechanical teaching machine which drew on B F Skinner's programmed learning techniques of a few years earlier. After dabbling in Psychology as a subsidiary subject for one year at Keele in 1964, I switched my principal subject from Maths to Psychology for the next four years.

Psychology at Keele was very much learning theory oriented. I recall in the final year having a three-hour tutorial with B F Skinner himself. He had delivered a guest lecture the night before and offered an informal chat to any final year Psychology undergraduates on the Saturday morning. Another guest speaker I met at Keele in 1969 was Derek Jehu, Director of the School of Social Work at Leicester University. That meeting led a week later to me being accepted on the two-year post-grad Diploma in Social Work Course at Leicester – the only behavioural social work course in the country at the time. When I started at Leicester in 1969, Derek Jehu told me I was a behaviourist and introduced me to meetings of a group of behaviourists who met monthly at the Middlesex Hospital in London. On the first Monday of every month, Derek and I would get a late afternoon train from Leicester to London and the meeting would be from 8pm until 10pm when behaviourists would present their research or debate the latest theories and 'techniques'. The meetings were organised by Derek, Vic Meyer and Isaac Marks among others. We would go for a drink together afterwards to kill time before the midnight train back to Leicester usually arriving home about 2am.

When I moved to Lancashire, Derek Jehu introduced me to Laurence Burns who was Head of Clinical Psychology at Rochdale. Laurence was secretary of a group who met monthly in Manchester similar to the Middlesex Hospital group, and I started attending their meetings and was soon invited onto the organising committee.

It was key people in groups like these up and down the country who had got together to consider the creation of a national organisation which culminated in the meeting yesterday. I've come a long way since my teaching machine 10 years ago! I wonder what the next 10 years and beyond may hold?

I've not always felt comfortable with all aspects of behaviourism. The darker side was portrayed in last year's film *A Clockwork Orange*. Admittedly, this was greatly exaggerated though I have personally witnessed, in a clinical psychology department, the use of electrical aversive counterconditioning techniques for the 'treatment' of homosexuality based on Feldman and MacCulloch's work. The law has only recently changed to allow exemption from prosecution for consenting males over 21, but homosexual acts still remain criminal offences in Scotland and Northern Ireland as well as in the armed forces and merchant navy. It would be good to see further changes in the law and also to see behaviourists treating

Continued opposite

people to make them less anxious and more happy with their homosexuality – perhaps even confident enough to go public.

Talking of happiness, I have always been uncomfortable when criticised by Derek Jehu for referring to feelings and thoughts. 'If you can't see it, you can't measure it and if you can't measure it, you can't change it', we were always told in training. I would like to see a move towards consideration of cognitions and affect. There is some hope in this direction. I have just been reading a book by Arnold Lazarus published last year called *Behaviour Therapy and Beyond* which talks about 'cognitive therapy'. Similar ideas are emerging from Albert Ellis and also Aaron Beck. Maybe they will become big names of the future.

I wonder if my mechanical teaching machine may develop into an electronic form. Perhaps computers will continue to develop so that they become small enough and cheap enough for individuals to have one at home. They could become very powerful teaching machines and maybe psychologists might even develop self-help treatments that could be administered from home. I think I am now dreaming rather beyond 10 years!

I wonder, with the development of BABP, what the future will be of the independent behavioural groups like the Middlesex and Rochdale groups? Perhaps geographical branches of BABP may develop from these. I do hope that the informal, friendly nature of the local groups can be carried into the national organisation. I always fear that bureaucracy can set in with rules and restrictions being applied; lawyers and accountants could swallow up our subscriptions; Charity Commissioners demand our registration; Inland Revenue may want to tax us; BABP want an office and start employing staff; even become a limited company with all the accompanying expense and hence subscription increases.

Let's hope we keep it simple and BABP carries on the friendly, informal, multidisciplinary forum its formative groups have enjoyed. I certainly look forward to the first conference promised soon and also the newsletter. It is good to have a national organisation because if I ever move to the Outer Hebrides, which I love and have visited regularly for the past six years, I doubt there would be a local group existing there.

Best wishes,
Howard Lomas

Thanks for the memories

Some of BABCP's longest-serving members write about their memories of being involved with the Association

Singing in the key of CBT
I am sure that I didn't imagine 30 years ago that I would still be singing in the key of CBT (and I haven't quite finished yet). BABCP has always been an open-minded and friendly organisation and so I am not surprised it has grown to its present strength. Many happy memories collected along the way!

Richard Hallam

Stood me in good stead
Although in the last decade or so I have worked progressively more and more in the corporate and organisational psychology domains, the core tenets and values of the Association have stood me in good stead.

Rupert Barker

Encouraging work on accreditation
I am particularly pleased to see how active the Association has become in work with children and families. The extended work now undertaken on accreditation is also very encouraging and the wide range of research undertaken and reported.

David Lane

Giving people space
'Everything that I have learned I learned at my grandmother's knee.' Certainly I did learn something from both my grandmothers, but not half of what I learned in those days from BABP. I still draw on paper given and informal conversations in Edinburgh in 1988.

Christopher Macy

Breath of fresh air
I thought the Association was a great breath of fresh air when it launched, and have been stimulated and inspired by the conferences and journal throughout the years.

Elsa Schmidt

Radical and visionary
I was fortunate in that my first supervisor as a clinical psychology trainee (in Manchester in 1971) was the late Laurence Burns, one of those visionaries who laid the groundwork for the formation of the Association. I doubt that people know now how radical the idea of psychologists providing therapy was at the time, or how intense were the debates concerning insight therapies versus behavioural therapies. But Laurence and a number of our other supervisors were firm in their commitment and we learned our behavioural theory and practice, both through the clinical training course and professional meetings of those interested in behavioural approaches.

Bernard Kat

Good science, good friends
BABCP has provided an enormous amount for me throughout my working life, including conferences to keep me up to date and to challenge my presentation skills, endless new ideas, models of good practice and of good science, and a large number of very good friends.

Gillian Butler

On the inside

Earlier this year Patrick Regan, who resides in HM Prison Maidstone, wrote to CBT Today *Managing Editor Stephen Gregson about the specific mental health issues facing offenders, both in the prison estate and the community. Stephen, who previously worked as a Communications Manager for the Home Office and the Ministry of Justice, invited him to write an article on this often-neglected population*

Offenders entering prison have a myriad of social, emotional, behavioural, cognitive and psychological issues and needs. The Prison Service is reasonably effective in screening, diagnosing and treating offenders who have alcohol/drug problems, anger management issues, sexual issues, poor decision-making skills and those with special educational needs.

Disorders such as schizophrenia, bipolar, severe psychopathy or severe personality disorders are reasonably quickly identified and those offenders are filtered towards the appropriate treatment or specialised unit. These disorders make the offenders stand out so they quickly come to the attention of prison staff and their needs are catered for by the Prison Service to varying degrees.

Offenders in prison with mental health needs at the other end of the spectrum, such as depression and anxiety, have a tendency to fall through the cracks and are not effectively identified, diagnosed or treated. Depression and anxiety sufferers do not stand out and can be ignored. Some offenders may enter prison with pre-existing mental health issues or some may develop whilst in prison. Offenders with depression find it more difficult to cope being imprisoned, their performance on offending behaviour programmes can be reduced, resulting in the programmes being less effective in addressing offending behaviour. Depression (and other mental health issues) can be a factor in why an offender offended in the first place and, if left untreated, it can be a factor in that offender re-offending when released from prison. So it makes sense to identify and treat offenders who have mental health issues while they are in prison and in the community when they are released.

There are various psychological and mental wellbeing issues that offenders have that could benefit from psychological treatment services and the main issue are described below.

Imprisonment imposes stress on marriages and relationships and it is common for these to reach breaking point and end. Limitations on contact with partners, lack of privacy and time alone, sorting out problems long distance, the nature of the offence and fallout from that offence and issues such as losing a partner's income, losing accommodation or having to deal with debts alone are just some of the stresses that end relationships when one partner goes to prison. If there are children they will suffer as a result of one parent going to prison. The offender may lose all contact with their children. The longer the sentence that the offender has, the more likely their relationship is to fail.

Offenders who have a bereavement of a partner, family member or close friend will not only have to deal with the loss, but the grief is compounded as most offenders are not allowed out of prison to attend funerals. The offender may not be able to meet with family members, and so is left out on the margins and not able to provide comfort (or receive comfort) from family members.

Entering prison means that many offenders may lose their homes, much (or all) of their possession, lose their job and career and incur debts as a result of going to prison. If the offender has a family they could be rendered homeless, penniless and debt-ridden. Having these issues puts stress on the offender and, if it affects their family, they will be consumed by guilt at putting this on their family. Knowing you have no home, no career, no possessions and are in debt, and you will have to start over again with nothing when you leave prison takes its toll on mental wellbeing. If bereavement or relationship problems/breakups are added to the mix, the offender's mental wellbeing may reach crisis point.

The Indeterminate Sentence for Public Protection (IPP) sentence that some offenders have been given by the courts has been universally condemned and the government is in the process of abolishing it. For offenders already with the IPP sentence, it is likely their sentences will remain in place. IPP is similar to a life sentence – there is no release date, the Parole Board decides when to release and it covers minor as well as serious offences. It is not unheard of for prison staff to tell IPP offenders that they will never be released and they will die in prison, and as things stand at the moment, there is an undetermined number of IPP offenders for whom this is a real possibility. This knowledge can have a devastating impact on these offenders' state of mind. Many offenders with a life sentence are in a similar situation except that lifers have a significantly better chance of being released by the Parole Board than IPPs.

The prison estate has very few facilities for physically disabled offenders. They can be faced with problems such as having to climb stairs to reach their cells on upper levels of wings, not being able to use showers as they are not adapted and lack of ramps means some buildings cannot be accessed. Disabled offenders cannot access all the facilities or activities that able-bodied offenders can access. This leads to disabled offenders becoming isolated and also spending a lot of their time alone in their cells.

The number of older offenders in prison has significantly increased and is expected to continue rising due to longer sentences, large numbers of lifers and the thousands of IPP offenders. Pensioners in prison are treated the same as any other offender and very little provision is made for them. Once an offender

reaches pensionable age, they are not obliged to do any prison work activities and some may spend all their time in their cells only venturing out for meals. Loneliness becomes a problem as they become isolated.

Some offenders can have a combination of issues; for example, an older offender may also be physically disabled through illness/disease, may have a life sentence, lost all possessions and home, have debts, partner/family members/friends passed away, might not have any contact with anyone outside of prison and live an isolated life in prison.

There are military veterans in prison, some of whom may have PTSD. Other offenders may have been subjected to physical, mental and sexual abuse during their childhood which has impacted on their adult lives.

So it can be seen that offenders require psychological services for a variety of issues:

- Relationship, marital and family problems
- Bereavement
- Poor communication and expressions of thoughts and feelings
- Poor coping skills and managing problems
- Stress and not able to relax or switch off
- Lack of confidence and self esteem, negativity, lack of motivation and empowerment
- Becoming isolated and habit problems
- Lack of helpful activities and giving purpose to life
- PTSD and abuse
- Depression and anxiety

The Prison Service's approach to these issues is patchy. Some prisons provide certain services to these issues whereas other prisons do not. The quality of the provision varies considerably from prison to prison with some of the services provided in-house and some provided by outside organisations and individuals. Every prison has their own local policy of what they treat and how they do it.

CBT has an important role to play in treating offenders' issues and is used not only by the Prison Service but also by outside individuals and organisations that are brought into prison to provide services (eg psychologists, therapists, counsellors, charities and social enterprises). Some of the services provided by the Prison Service are no more than a box-ticking exercise and provide no benefit whatsoever to offenders. But some services in individual prisons are a beacon of excellence that greatly improves offenders' lives and, if rolled out across the prison estate, could make a significant impact. Continuity of care is patchy at best and absent at worst. If help and support continued in the community for those offenders who need it when they leave prison, it will not only benefit the offender but society benefits as well.

Offenders in prison with depression and anxiety have a tendency to fall through the cracks and are not effectively identified, diagnosed or treated – sufferers do not stand out and can be ignored

The first six months after release from prison are critical in re-integrating offenders into the community and giving them support as they adjust to release and start to rebuild their lives. If offenders do not have support, advice, help and someone to turn to when they are released, they are at risk of having a poor quality of life, being tempted back into crime, not breaking the pattern of behaviour that creates problems, being unhappy and their mental wellbeing suffering. Without support there is the risk of offenders returning to the same area they lived in before going to prison, associating with the same friends and criminal influences and re-offending.

Some offenders may have been disowned by their friends and family, or partners/family members/friends may have died while the offender was in prison or they have lost contact with friends and family or divorced. This means offenders can leave prison with no friends or family which can be a lonely experience. Coupled with this could be the loss of all their possessions and home.

Dealing with all these issues puts offenders under pressure so they need a support network of individuals and organisations to turn to for support, advice, help and sometimes just someone to talk the problem over with. The Probation Service will supervise many offenders for a period after release although their primary concern is protecting the public and not rehabilitation. So offenders need someone who is independent, unbiased and has no agenda who they can turn to, eg counsellors or therapists. Having a

Continued overleaf

On the inside *continued*

support network can consist of probation, counsellors, therapists, psychologists, psychiatrists, GPs, CPNs, self-help groups, charities, social enterprises, family and friends (if present), social workers and local authority departments such as housing or education. Providing this support immediately after release is a good investment that will pay dividends not only for the offender but also for society.

Some facts…

- Between 2000 and 20120, the number of prisoners aged 60 and over rose by 128 per cent and this is the fastest growing age group in prison.
- Over a quarter of newly sentenced offenders reported a long-standing physical disorder or disability.
- By March 2011 there were 6,500 offenders with the IPP sentence. Since 2005, just 320 in total had been released from prison.
- More than half of all elderly prisoners suffer from a mental disorder, depression being the most common.
- During their sentence 45 per cent of offenders lose contact with their families and many separate from their partners.
- 72 per cent of male and 70 per cent of female sentenced offenders suffer from two or more mental disorders, compared with five per cent of males and two per cent of females in the general population.
- 29 per cent of offenders reported emotional, sexual or physical abuse as a child.
- Men recently released from prison are eight times more likely than the general population to take their own life, while women are 36 times more likely.

(Prison Reform Trust Bromley Briefings Prison Factfile, December 2011)

Important notice

BABCP accreditation and advertising fee increases

With effect from 1 October 2012, fees will increase as follows:

Accreditation

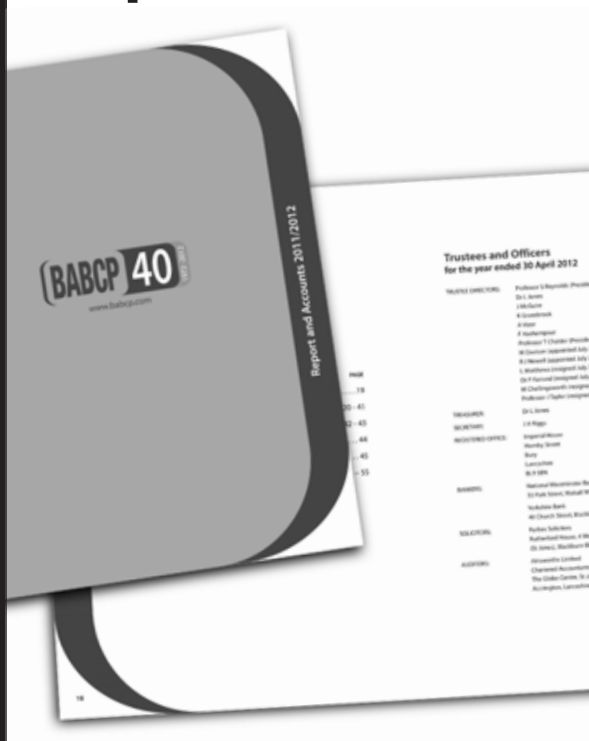
- Accreditation application fees - an increase of 20 per cent for new applications.
- CBT Register UK full listing - an increase of 10 per cent.
- Reaccreditation application fee - an increase of 10 per cent.
- Accreditation administration subscription - no change.

Advertising

- All advertising to increase by 20 per cent.
- Email distribution lists (non BABCP advertisers) - an increase from 25p to 30p per address.
- Email distribution lists (BABCP only advertisers, eg branches) - an increase from 15p to 17p per address
- Administration of branch events - an increase from £4.00 to £4.40 per delegate.

For full details on BABCP Accreditation fee increases, please visit http://goo.gl/qms0k.

BABCP Annual Report 2012



This year's BABCP Annual Report, which was presented to the AGM, held on 28 June 2012 at the University of Leeds, can now be downloaded from www.babcp.com/AR2012.
Any changes to the content agreed at the AGM will be included in the minutes, which will form part of the 2013 Annual Report.

CBT Today presents

Project 40

BABCP in 40 objects, images and memories

www.babcp.com

On 26 November 2011, the CBT Today *editorial team (pictured below) launched Project 40 at the British Museum in London. Here are 12 objects the team selected:*

1. British Museum

Of all the eight million items held within the British Museum, it is the building itself that represents all that the BABCP stands for. The building has an impressive neoclassical facade consisting of 44 columns, resonating strength, dignity and influence. People come and go, although some linger longer than others. Contained within the walls is a collection bringing together important ideas, scientific concepts and great schools of thought from all around the globe. It is guarded, which serves to protect and preserve the treasures it holds. New items are constantly being added to the collection.

2. Roman mosaic from Thruxton, Hampshire

The mosaic consists of thousands of tiles (the members of BABCP?), but is incomplete. Whilst many pieces are yet to be found, the depiction remains impressive and we are drawn to wondering how it will develop.

Continued in blue column overleaf

Unique and eclectic

As part of BABCP's 40th anniversary celebrations, CBT Today *invited members to participate in Project 40. The aim of this campaign has been to identify 40 objects, images and memories which, individually, say something about a particular member's experience of the Association. When taken together, they offer a unique, and typically eclectic, narrative about BABCP during its first four decades. The four best nominations will each receive a copy of Neil MacGregor's* A History of the World in 100 Objects, *on which Project 40 is based - look out for the winning rosettes.*

13. Annual General Meeting, 1992

A packed AGM when the BABP voted to become BABCP. This was a debate for the very heart of the Association - the C's won in the end.

David Veale, former BABCP President

14. Blossoming flower

It symbolises helping people to 'bloom'.

Carmella Cotterell

15. Drinks mat with logo from 1998 World Congress in Edinburgh

This is a souvenir of one of the greatest learning events of my career, in terms both of the amount learned in a few days and the numbers of people - speakers and delegates - present. If one missed a paper because of the large number of parallel sessions, one could pick it up in the bar afterwards. We heard and met in person many from the USA who were otherwise only named authors to us. Delegates came not only as themselves, but as representatives of a number of different countries from around the world. The papers gathered by the organisers, at a point when CBT theory and practice were taking off, have continued to underpin my work ever since.

Christopher Macy

16. Computer

BABCP has been supporting and promoting therapy through the years. Now it can be delivered online.

Sue Wright

17. Backpack

It covers lots of ground.

Neil Harmer

18. Fashion buyer for a shop

They look around and try to control the quality and also seem to try to keep some value in the items they sell.

Leslie Lotz

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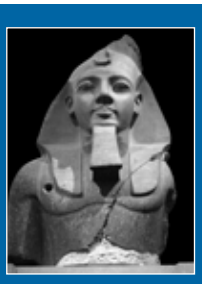

3. Statue of Ramesses II

BABCP has achieved an enviable stature in the field of psycho-therapy, generating admiration for promoting CBT as the treatment of choice across a range of psychological disorders. CBT could be seen as the 'Ramesses' of talking therapies, while the statue's construction reflects how BABCP has benefited from the varied contribution of a diverse membership.

4. *Cradle to Grave,* art installation

This art installation explores our approach to health in the UK today, telling the pharmacological story of four men and four women during a life span. Each length of fabric contains 14,000 lozenges and capsules, the estimated number of drugs prescribed in a person's lifetime. Alongside are photographs depicting significant life events taken by family members from 1930s to the present day. This piece of art could serve as an important reminder to BABCP that, as it continues to grow, it remains connected to the importance of individual experience.

Sarah Bateup and Patricia Murphy

5. Statue of Buddha

This statue represents both the healing role lived out by clinician members of BABCP, and the developing third wave therapies, such as mindfulness, which have links with Buddhist philosophy.

6. Orrery

This orrery represents a movement towards a scientific understanding of the world, reflecting the BABCP's commitment to evidence based psychological treatments.

19. IAPT

Even after 40 years, BABCP is still relatively new in the history of psychology. This is similar to the IAPT service, itself a new and evolving service which I hope will still be about in another 40 years in some form or another.

20. Psychological Wellbeing Practitioner

Similar to BABCP, the PWP role has evolved significantly since it was created. Consequently, I feel the PWP role and BABCP are a winning combination! I was pleased to gain accreditation as a PWP with an organisation that has really welcomed and appreciated our new workforce.

Sarah Woolsey, CBT Today *Diversity Editor*

21. Opening reception at conference

The sight of the masses of members at the opening reception on the first night of my first BABCP conference made me proud to be part of the organisation and secure in its future.

Sheena Hamilton

22. Elvis tribute at the Brighton conference

It balances fun with theory and practice.

Patricia Eschoe

23. Several bottles of good wine drunk at the Canterbury conference

BABCP is scientifically rigorous, but it can also party.

Ken Lewis

24. Photograph of me and Victor Meyer

TThe photo was taken in 2000 at Victor Meyer's 80th birthday party. My BABCP membership over the last 16 years has meant that I have had the privilege of being trained by some of the most prominent and influential leaders in the field of cognitive and behavioural psychotherapy like Victor Meyer. I have also valued being part of an association that devotes its energy to the advancement of CBT. Meeting up with colleagues (both past and present) at conferences and workshops always feels like a meet-up with family!

Marla Stromberg

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25. The moon

How things can feel so far away yet reachable.

Dawn Liddle

26. Accreditation renewal notice

This will stay with me because it provokes pride in reminding me of the high standards in my profession but also gives me a good three months of angst trying to gather up attendance certificates and getting my supervision log up to date!

Maureen McGroary-Meehan

27. *August and Everything After,* Counting Crows album

It was always being rehearsed by a band in the Music Department at the old Mickleover Campus, Derby University, when I was studying for the MSc in CBT 2001 to 2004. The MSc in CBT at Derby was the first ever BABCP Accredited course from 2006 onwards.

Mark Addis, Accreditation Liaison Officer

28. ACT workshop, Sheffield

Walking around with a person behind me being my 'brain' demonstrating self-talk.

Sue Walker

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29. *Las Meninas*, painting by Diego Velazquez

In this complex masterpiece, Velazquez captures the young daughter of Felipe IV surrounded by her servants in the Spanish royal court of the early 17th century. The painting is rich in perspective, and atmosphere. There is so much the eye does not - cannot - see, even while the painting envelops the viewer (stand in front of it at the Prado in Madrid to find out). I find this image incredibly analogous to my experience of BABCP, where there is so much going on beyond what is immediately surrounds you. A copy of this painting sits above my desk to remind me of my place in the BABCP universe during the more hectic moments.

Stephen Gregson, CBT Today *Managing Editor*

30. Spider's web

It's strong, supportive, enables wide connections, and can get bigger and bigger.

Amanda Cole

31. VCR video cassette

All my sessions are on them when I trained. Now I cannot find a video to play them anywhere. How times have changed.

Florian Ruths

32. The ABC of CBT

This photo signifies the beginning of my journey into the world of CBT. These were the days I was undertaking the High Intensity IAPT training to become a CBT therapist. My little daughter Shirel would often come up to me and ask what I was reading. When I replied, 'CBT', it is my guess that she likened it to a grown-up's ABC book because she would immediately get her own alphabet book and want to sit on my lap. She would then get absorbed in her own ABC book.

33. BABCP Conference website, 1998

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That the BABCP has grown in size and sophistication so much since 1998.

John Kentish

34. Light bulb

Early in the implementation of the IAPT programme, when everything was very hectic indeed, a BABCP Course Accreditation visit panel found itself in Cumbria. We arrived quite late at a seedy looking tavern, which had apparently been the recommended accommodation for the night. There was a slight smell of stale cigarettes and beer, with facilities that were somewhat basic. It had new owners who had only taken it on 48 hours before our arrival. My bedroom had no curtains, while the fire door was stuck open to the outdoors at the end of the corridor. David Clark had been to reconnoitre and found his room in darkness. So he returned to the bar, obtained a light bulb and cheerfully went to insert it himself. Definitely 'lightened' the mood.

Helen Macdonald

35. *Storm Clouds 3*, drawing by Patricia Pierce-Atkinson

In my early days in CBT in the 1970s working with children, CBT was very much facing 'storm clouds', due to substantial antagonism to the approach from established practitioners. In developing and running a service for schools, children and families, we were faced with opposition at all turns. Indeed many regarded this as a dangerous activity. Because we adopted a scientist-practitioner approach by testing and validating everything, we gradually gained recognition. So the clouds passed.

David Lane

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7. Marble relief of emancipated slaves

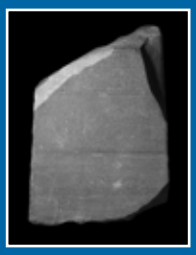
This marble relief, featuring former Roman slaves, represents BABCP as an organisation promoting a therapy which can help free people from their psychological suffering.

8. Shamanic rattles

These rattles, originally used by Native American shamen, suggest the notion of clinician members of BABCP as mediators who assist people in developing psychological health and growth towards a meaningful existence.

Chris Morgan, Tamsin Speight and Paul Green

9. Rosetta stone



This decree from a young pharaoh is conveyed in three different scripts, to bring Ancient Egyptian hieroglyphics to his entire kingdom. This could reflect the changes brought about in BABCP in terms of communication and understanding the fundamental needs of a diverse membership.

Catarina Duerden

10. Stone relief from the Apadana at Persepolis

The Persian empire reached an enormous size under the leadership of Cyrus the Great, developing the infrastructure to support its growing influence

Continued in blue column overleaf

36. Set of keys

They are something functional that we carry around with us everyday. Holding keys opens doors (for self and others), but also entails responsibility for keeping the keys safe.

Emily Tan

37. *Le Big Blue*, photograph

The 19th century German philosopher Arthur Schopenhauer said: 'The first forty years of life give us the text; the next thirty supply the commentary.' It feels like BABCP is starting a great new phase with lots of developments on the table. This photograph reflects a progressive look, though the lack of sharpness also indicates that we are not quite sure what that future will look like. The electric blue brings optimism and a sense of fun.

Maria Barquin

38. *The Times They Are a-Changin'*, by Bob Dylan

In 1974 I convened a symposium at the BPS Annual Conference in Bangor which was critical of simplistic treatments for homosexuality. I led with a paper on the treatment of 'so-called sexual disorders'. A gay psychologist spoke on life under stigma, despite the BPS committee rejecting his paper and topic! Another paper by a colleague described treatment with a gay male couple using Masters and Johnson techniques. I was anxious about the BPS, and fortunately Prof Gwynne Jones, the Association's first Chair and a psychologist, chaired our symposium and offered to support our strategy if the BPS admonished us. They did not! Very movingly, several gay psychologists who had not 'come out' spoke to us later. Gwynne was a great guy and a beacon of humanity and wisdom at the beginning of the Association. I thought of the Dylan song because that was often used by my generation when we challenged things.

Francis Lillie

39. Jiscmail

Good, lively debates.

Lorraine Barreau

40. Gaelic sporting equipment

Gaelic sporting equipment consists of a Gaelic football, sliotar, hurling stick, helmet, jersey, boots and Gaelic posts. These are the tools of the trade for the Gaelic Athletic Association, which is a family and community orientated organisation promoting the Gaelic tradition throughout the island of Ireland. Gaelic Athletic Associations have also been formed throughout the UK and around the world by members from Ireland and sometimes by people who just grew to love the sport. BABCP is also a family and community of therapists and researchers who promote CBT in the UK and Ireland. Like the Gaelic Athletic Association, BABCP also connects with other CBT associations across the world.

Paddy Love

(Right) Carryduff Gaelic Athletic Association member Aaron McEneaney on first leg of his gap year in India

including the creation of an opulent city named Persepolis. Due to ethno-cultural diversity of those nations under the rule of Persia, the empire's size and constant struggle for power by regional rivals, a professional army was created to maintain peace and enforce authority in cases of rebellion and foreign threat. This could mirror the challenges faced by BABCP in centrally managing the organisation while offering a degree of autonomy to the regions. Yet see what happened to the Persian empire! Currently known as Iran, it is isolated and treated differently due to earlier mistakes. So the last word is to move with the times and use your loyal soldiers!

Faramarz Hashempour

11. Chronometer from HMS Beagle

The chronometer symbolises scientific journey, discovery and exploration, as well as being an instrument of measurement and accuracy. This relates to BABCP's aim to promote the development of theory and practice of CBT through research, and disseminate research findings through academic journals and other publications.

12. Pillar of Ashoka

Indian emperor Ashoka was known for his ideas on the best way to govern, and placed great importance on the need for citizens and leaders alike to listen to one another and debate issues respectfully in order to arrive at a conclusion. This links with BABCP's aim to provide a forum for discussion and debate relevant to behavioural and cognitive psychotherapies amongst all helping professions.

Amy Hamilton

To view more images from the British Museum collection, go to www.bbc.co.uk/ahistoryoftheworld

Trauma site visits in the treatment of PTSD

The Vietnam War was still raging when the Association was founded in 1972. Other theatres of conflict have emerged in the intervening decades, as well as public and personal tragedies on varying scales. In turn this has led to a greater understanding of how trauma impacts on communities and individuals, while trauma-focused CBT is seen as the evidential treatment of choice for PTSD. But, what if a proposed trauma site visit seems too daunting or impractical for the patient? Carly Keyes, Katie Meharry and Nicholas Edwards, all of whom completed High Intensity training at the University of Reading last year, reflexively discuss options for graded exposure and virtual site visits

In their cognitive model of PTSD, David M Clark and Anke Ehlers reflect on the importance of exposure to avoided reminders of a trauma. For many patients, the most potent reminder will be the trauma site itself. According to the model, when patients avoid the site of the trauma, or avoid talking about it, they fail to contextualise the trauma memory and become unable to accurately appraise current danger. This leads to vivid, traumatic memories giving a sense of present threat, which results in distressing anxiety, and a maintenance cycle ensues. Additionally, the avoidance of the trauma site prevents patients from correcting erroneous beliefs about the event. Visiting the trauma site may provide evidence against patients' unhelpful peri-traumatic appraisals.

Carly Keyes treated a patient who developed PTSD from helping out in a fatal house fire during the patient's work in an emergency service, and was signed off work. The main reason the patient wanted to be off work was because she wished to avoid the town where she worked and where the fire happened. Her peri-traumatic appraisal was, 'It's my fault the person died, as I spent too long climbing the stairs'. The patient's goals included returning to the trauma site and continuing to work in that area.

From a therapist's point of view, the rationale for visiting the trauma site is to allow the patient to establish a time perspective and perhaps provide new information to help correct problematic appraisals. In this case, the patient was anxious about visiting the site, believing she would experience uncontrollable crying and be overwhelmed with guilt. Therefore, Carly and the patient set up the visit to the site as a behavioural experiment. As they both faced the building, the patient explored how 'then' the building was covered in smoke, how the pram and toys blackened and thrown outside and how the scene was filled with the sound of sirens. 'Now' the building was painted white, children could be heard laughing inside and the air was filled with the sound of birds tweeting. Visiting the trauma site also provided evidence against her peri-traumatic appraisal as she noticed there were more stairs than she remembered. Following the site visit, she no longer believed she was to blame for the fatality.

Katie Meharry treated a patient whose involvement in the Clapham Junction rail crash had left him with long-standing PTSD, having been one of the first police officers on the scene. He avoided photographs and video footage of the crash aftermath and had never returned to the trauma site. He attributed his PTSD to personal weakness, believing he 'should've got over this long ago'. The patient viewed photographs of the crash scene from online sources. He re-examined his peri-traumatic appraisals, and attributed his PTSD to the horrific nature of the crash and his employers' failure to provide psychological support, rather than any personal weakness. His treatment plan involved visiting the site, but the patient felt this would be too difficult to manage in front of members of the public. Google Street View was used to look along the stretch of track where the crash happened from the panoramic viewpoint of Battersea Rise. Aerial and bird's eye aspects also available online were used to provide visuals from as many prospects as possible to maximise exposure. He commented on how 'peaceful' and 'normal' the site now looked compared with his mental images of it. Resolution of this patient's PTSD was therefore achieved from the comfort and safety of the clinic.

Nicholas Edwards treated a patient who had developed PTSD following a single incident during a period of active service with the British Army during the war in Bosnia. A site visit to the area where he had served, while not impossible, would present difficulties. Together they tried to locate pictures of familiar areas with the help of Google Earth. Although they could not find the specific site of the trauma, the patient reported that seeing the familiar landscape helped in his treatment. He recognised the colours of the trees and some typical rural buildings, and was struck by the peacefulness of the scenes. The 'Bosnia of his memory' remained a dangerous, messy war zone. Seeing areas where he had fought now being at peace seemed to be cathartic.

As mental health services are increasingly obliged to deliver successful treatments within tighter timeframes, clinicians will need to employ creativity and resourcefulness to achieve positive treatment outcomes. Freely available technological advances, such as web mapping, may prove convenient and practical tools to make trauma sites remotely accessible for clinicians and patients. However, the importance of visiting trauma sites in person should retain precedence where possible in order to keep aligned with the evidence base.

Therapist, heal thyself?

In the final article in her three-part series, student CBT therapist and blogger Selina Khunkhuna considers how therapists get back in the profession after time out due to mental health

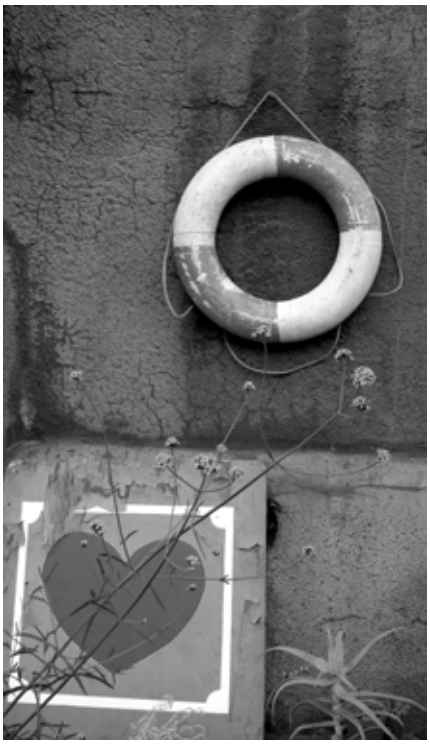
How do people get back into the profession after time out due to mental health issues? There are a few key words that spring to mind: persistence, passion, resilience. Like other illnesses, mental health issues can be treated successfully without influencing a person's everyday life. Once a person has fully recovered, there is nothing to say that they are unable to continue with their everyday life as normal healthy people would do. As I previously highlighted, it is these people who may be able to offer a distinctive insight on behalf of their clients. It is fundamental, therefore, that that recovery of a therapist is appropriately monitored and assessed before they return to practise. Their needs can be just as significant as clients' needs.

Aside from monitoring and support, therapists can also return to work in the profession by self-monitoring and seeking out additional support if and when it is required. Making the decision to return to practise following any bout of illness is a difficult decision. However, resources such as occupational health can help those who may have been particularly unwell, and this includes those with mental health difficulties, which are unfortunately becoming more common in working people. Talking to colleagues and even having some personal therapy can also support such individuals. Speaking from personal experience, local support agencies trained to deal with my illness and related issues have proved invaluable.

Once it has been decided for someone to return to the profession, rushing in and expecting things to be easy from the start should be viewed as unrealistic. Rather, it is appropriate for a therapist to ease gently into everyday functioning. Again, supportive colleagues, occupational health and management structures can all help make this easier for the therapist who has had some time out.

If there is an area of work deemed to be suitable for those returning following a bout of mental illness, every care and measure should be taken to place the person in an appropriate setting and with clients best suited to their capabilities. Fortunately, within the NHS, there are many policies in place for this to be implemented successfully. I am not familiar with any similar policies in the private sector, although they may exist.

Successfully returning to practise after a bout of mental illness very much depends on the individual, their reasons for returning to the profession, the support they have on offer and the environment in which they work. Such individuals should be mindful of certain 'triggers' and take care in regards to relapse prevention, making sure that they do not return to work too soon. The key message is that, despite the obvious risks, there is nothing to say that those who have suffered a mental illness are incapable of a return to practising effectively ever again. Conversely, the episode or bout of mental illness may provide the individual with greater knowledge and insight which could significantly enhance their practice.



Selina's blog can be found at www.safetobegay.com

Therapy worth talking about

One of the more recent developments in BABCP is to explore imaginative, but effective ways in which to raise awareness of and demystify CBT in the public sphere. This year BABCP convened a Public Involvement Panel, one of whose outcomes is the new public leaflet called CBT - therapy worth talking about, *issued with this magazine. In the following article, Sian Greenhead (pictured) talks about her experience of using CBT to reclaim her quality of life from OCD*

I have experienced OCD since I was 12 and I am now 29. The intrusive thoughts I experience are about contamination and illness, largely related to contracting HIV. A particularly vivid thought I have is about stepping on or touching a discarded syringe that has been used by someone with HIV and becoming infected as a result. I am scared of becoming ill myself, but more crucially I am terrified of contracting the disease and passing the illness onto someone else. I wouldn't be able to live with myself.

When I am ill with OCD I am in a constant battle to avoid this awful scenario and I develop rituals to reduce my anxiety and to avoid becoming 'contaminated' in the first place. It has always been the classic stuff really: washing endlessly; avoiding 'risky' situations (like using public toilets); asking for reassurance from family; ruminating and so on. It is exhausting, all consuming and terrifying - and not just for me, but also for those around me.

Until I managed to access the Centre for Anxiety Disorders and Trauma (CADAT) at the Maudsley, my experiences of accessing help from the NHS had been disappointing. When I first started experiencing OCD symptoms, there was little information or awareness about OCD, something made worse by having a GP who thought I would 'grow out of it'. When it was clear I wasn't going to, I was referred to a psychiatrist for family therapy and prescribed anti-depressants. The anti-depressants helped, but the therapy was awful. I would refuse to talk because I found the psychiatrist intimidating, and my mum would sit there and weep, blaming herself. We made no progress. We were sent off to various other professionals and had two sets of CBT which were ill-explained and consequently ill-understood. I became so exasperated that I decided that, if I wanted to get better, I would just have to do it myself.

I had a period of calm during my A-levels and at University. However, in my mid-20s, I became very ill again with OCD. I asked my GP for help. I was rapidly prescribed anti-depressants, but I was told that there weren't appropriate local services or therapy available and that, because I had received CBT previously, I was not a priority. If I wanted help, I would have to pay – which I did. I ended up paying a lot of money for private therapy which was ineffective.

I couldn't leave the house, I couldn't go to work; I was paralysed by anxiety. My boyfriend was at the end of his tether and I was convinced he was going to leave me. He didn't leave me; instead he tried to work out how to get me good treatment. It was my boyfriend who found out about the Maudsley.

After a battle with my local team, I was referred for an assessment at CADAT. The psychologist asked me sensible questions and she actually listened to what I was saying. A month after the assessment, I received a phone call saying that I had been accepted for treatment at CADAT.

I was worried about my first session, what it would be like, what I would I have to do, and whether I would get on with the therapist. I needn't have worried; Lauren was friendly, positive and professional. She put me at ease very quickly, treating me with respect rather than patronising me, not being afraid to laugh with me and show that she was human too. Most of all she treated me like an individual, with all my idiosyncrasies and complexity, rather than just defining me by the OCD I was struggling with.

I had around 12 sessions with Lauren. I knew they would be different to the sorts of therapy I had had before when I was asked to bring a notepad with me and something to record the sessions with. During sessions I wrote things down for my own reference, and I have recordings of all the sessions so that I can listen to them again when I need a boost. I wrote down a list of goals for treatment which included things I couldn't do (like not being able to walk down the street without holding my hands up by my chest). I had almost 30 goals on my list and Lauren made me feel that achieving all of them was within my reach.

The next step was understanding exactly what OCD was and the vicious cycle of OCD. We then put theory into practice; exposing me to things that I was avoiding, and helping me recognise that I could face my fears. This was done in a controlled and supportive way, with Lauren doing the exposure activity too. If I had to go traipsing round Denmark Hill wearing a pair of flip flops in the middle of winter (rather than the ridiculous hiking boots I had taken to wearing), then Lauren did it too. I liked the fact that we didn't just stay stuck in the same therapy room, but went out into the world. This made sense; the problems I was experiencing were happening in the real world, so why shouldn't we spend time in that world embracing the fears in their natural environment?

Lauren gave me homework to complete between sessions and she would always check how it had gone. Knowing that she would check up on the homework meant that I took it seriously – I didn't want to let her or myself down.

I think one of the most important parts of the treatment was the

Continued overleaf

Therapy worth talking about *continued*

opportunity to have a family session where my parents and boyfriend attended. Lauren was able to gain a clear picture of what was going on from their perspective, and it gave them the opportunity to ask her questions about my illness and, more importantly, how they could help me get better. My parents were finally given information about the illness, and how they could best help me to deal with it, from someone who knew about OCD and who also appreciated the strain that OCD could have on those closest to the person suffering from it. My boyfriend came away feeling empowered, knowing that by refusing to reassure me when I asked for it, or engage with my intrusive thoughts in any way, he wasn't being cruel, he was actually being kind and strong; helping me get better and stay well.

I was discharged from CADAT almost a year ago and I am doing well. I don't think that my OCD will ever disappear completely. This is not me being defeatist, just realistic and prepared. Thanks to the treatment from CADAT, I do now have the knowledge, understanding and skills (as do those who are close to me) to try and ensure that OCD doesn't bring me to my knees again. I think the success of the treatment lies in its ability to carefully combine theory and practice, the goal-orientated approach which enables progress to be measured and celebrated from the outset, and its willingness to adapt the treatment to the specific needs of the individual. And perhaps that is the crux of it; that I was treated like an individual with the kindness, respect and consideration that any individual deserves.

Sian was treated under the National Specialised Commissioning Team (NSCT) for OCD and BDD, which is commissioned to provide highly specialised assessment and treatment for patients experiencing severe OCD or BDD through outpatient, home-based, residential unit or inpatient services. The national OCD/BDD service delivers highly specialised interventions in conjunction with local mental health services and is available to people of all ages on the basis of need. Sian attended outpatient sessions with her therapist Lauren Callaghan at CADAT at the Maudsley. Lauren still works in the NSCT team and is now based at the Anxiety Disorders Residential Unit, which is part of the Maudsley but based at the Royal Bethlem Hospital, and is a unique service where patients can stay in a residential unit throughout treatment.

For questions about the outpatient service, email Dr Blake Stobie (blake.stobie@kcl.ac.uk); for questions about residential-based treatment, email Simon Darnley (simon.darnley@slam.nhs.uk).

Diversity matters

The importance of cultural competence in the delivery of CBT has increased exponentially in the four decades since the Association was founded, while CBT Today *is very much committed to facilitating discussions on equality and diversity issues in the pages of the magazine. For this commemorative edition, Chris Morgan - who covers religion and spirituality on the editorial team - examines the role of the Chaplaincy in the delivery of mental healthcare*

What is the Chaplaincy? According to Richard Allen, who chairs the Mental Health Resource Group for the College of Healthcare Chaplains, its primary role is to 'hold the humanity' of people through pastoral, spiritual, and religious care. Pastoral care is about helping people to rejoin, or remain part of a community, be that religious or part of wider society. Spiritual care has everything to do with the search for meaning, and helping others to find lost meaning. Religious care is helping people to continue to practise the things that give them meaning beyond their difficulties.

A greater insight into the interaction between the Chaplaincy, mental health and psychological therapies can be gained by talking to individual Chaplains. To this end I interviewed two Chaplains who work for the Trust I am employed by, Lincolnshire Partnership Foundation Trust (LPFT).

Reverend Harry Smart is the Lead Mental Health Chaplain for LPFT

Chris Morgan (CM): How did you come to be a Chaplain?

Harry Smart (HS): I did not come from an overly religious church background, but have always been interested in the question, 'how do we understand the world?', of which religion, faith, philosophy appeared to be one way. I was ordained at 26, spent five years working in parishes, then became a Mental Health Chaplain and have been doing this now for 13 years.

CM: What is the role of the Chaplaincy in mental health?

HS: There are lots of different roles. I do a lot of bereavement related counselling. Sometimes in relation to faith, sometimes just in terms of people piecing themselves back together again and trying to rebuild their lives. Surprisingly, the question about what happens after death does not come up that often. Mostly it is about people telling their stories, and coming to terms with living without the person who has died – being respectful to their memory.

CM: What do you see as the relationship, if any, between religion and spirituality, and psychological therapies?

HS: There is a relationship. A lot of psychotherapy goes back to religious tradition, such as the role of the Soul Friend, seeing life as a journey, and the question, 'where is God in my life?'. Both therapy and religion look at how the person constructs an approach to life, both explicit and implicit. Religion, for example, uses parables, stories and festivals to help people express their inner reality. Loss and recovery is a particular psychotherapeutic process prevalent in religion and therapy. One place where the relationship occurs, and in which I am involved, is in the Trust's mystery plays group. This grew out of enacting mystery plays in Lincoln, and explores the myths and faith stories of different traditions and people's own individual stories and experiences.

James Clarke is the Roman Catholic Chaplain for LPFT

CM: How did you come to be a Chaplain?

James Clarke (JC): I was born and grew up in Liverpool, but later became a well-known cyclist in the North West. I started my working life as an office boy in a corn exchange, and eventually went on to being the director of my own corn exchange company. Alongside all this I have found time to be a parish and district councillor, as well as being married for 40 years with two sons. After becoming a member of the Grail Society (a lay Catholic community), I was recommended for the Chaplaincy by both the Vicar General of the Catholic Diocese of Nottingham, and by Harry Smart.

CM: What is the role of the Chaplaincy in mental health?

JC: To represent the spirituality of the person within mental health. This means to give spiritual support to people who have mental ill-health, and help them to have spirituality play a role in their lives. I describe this as being 'by invite only' as people actually invite me into their lives. So it is very important how one approaches it, as some want it and some don't. However, within all problems, such as mental ill-health, there is still a person. So one must relate with compassion, understanding, and love to them as a person.

CM: What do you see as the relationship, if any, between religion and spirituality, and psychological therapies?

JC: I have just been to the Holy Land, and it is covered by buildings and all the trappings of the 21st century. We have to live in the world, but the reality of Jesus Christ as 'God made man' is still present. Who is God? Where is heaven? What will happen when I die? These are questions that still get asked. The relationship between religion, spirituality and psychological therapies is of a good balance between the medical model, a person's physical and chemical nature, their psychiatric problems, and their spirituality. Primarily, it is about relating to the person as a person, and with hope. People lose hope and they get lost in mental ill-health.

Together Harry and James represent two of the mainstream branches of Christianity practised in Britain today. But, according to the 2009 Department of Health document *Religion or belief: A practical guide for the NHS*, an equality-orientated health service must be aware of the needs of those who identify themselves within a diverse range of religious, spiritual, and philosophical belief (and non-belief).

If you are a Chaplain, therapist or service user and would like to talk about your experience of the interface between religion, spirituality and mental health, email Chris at chrispetermorgan@hotmail.com

Chester, Wirral & North East Wales Branch

www.babcp.com

Forthcoming Events

Winter 2012

Wednesday 19 September 2012
Evening Workshop 6.30-8.30 pm
DISSOCIATION, DEPERSONALISATION & DEREALISATION
by Susan M Darker-Smith
Venue: Chester Rugby Union Football Club, Hare Lane, Littleton, Chester CH3 7DB
Free for BABCP members, non-members £10. No need to book

Tuesday 2 October 2012
All-Day Workshop
CBT FOR CLINICAL PERFECTIONISM
by Roz Shafran
Fees (lunch included): Early bird rate until 24 August - £65 BABCP members, £80 non-members. After 24 August - £75 BABCP members, £90 non-members
Venue: Chester Rugby Union Football Club, Hare Lane, Littleton, Chester CH3 7DB
For booking information, please visit www.babcp.com/cpd or telephone 0161 705 4304

Wednesday 14 November 2012
Evening Workshop 6.30-8.30 pm
COGNITIVE BEHAVIOURAL ASSESSMENT IN PRIMARY CARE
by Nicolas M Hool
Free for BABCP members, non-members £10. No need to book
Venue: Chester Rugby Union Football Club, Hare Lane, Littleton, Chester CH3 7DB

London Branch presents

www.babcp.com

Behavioural Experiments in Clinical Practice

(advanced level)

with Roz Shafran

Wednesday 21 November 2012

British Psychological Society
30 Tabernacle Street, London EC2A 4UE
9.30am - 4.00pm

BAPCP/AREBT members - £85
Non members - £120

For further information please visit
www.babcp.com/london

North West Wales Branch

www.babcp.com

AUTUMN EVENTS 2012

Thursday 13 September 2012
Venue: Management Centre, Bangor Business School, College Road, Bangor LL57 2DG

Transdiagnostic CBT using 'Method of Levels'

Evening Talk by Keith Fearns - Start 6.30pm.
No need to book - free entry

Thursday 18 October 2012
Venue: Management Centre, Bangor Business School, College Road, Bangor LL57 2DG

Understanding Self-Harm

Evening talk by Dr Stephen Gregson - Start 6.30pm.
No need to book - free entry

Stephen Gregson is a past chair of the National Self-Harm Network, which offers support and advice services to individuals who self-harm and those relatives, friends and professionals involved in their care. Dr Gregson has written and spoken about understanding self-harm in the media and at clinical conferences, while his doctoral research explored images and narratives of self-harm in the public sphere. His professional background has included advising criminal justice and public health initiatives that address self-harm.

East Midlands Branch

Events

www.babcp.com

25 October 2012
Treating Disgust Across the Disorders
Speaker: David Veale
Attendance is £60 for BABCP Members and £75 for non-members

26 October 2012
Cognitive Therapy for chronic depression: Instilling hope and optimism in therapist and client
Speaker: Anne Garland
Attendance is £45 for BABCP Members and £55 for non-members

8 November 2012
Teaching Mindfulness-Based Cognitive Therapy in Primary and Secondary Care
Speaker: Tim Sweeney
Attendance is £45 for BABCP Members and £55 for non-members

1 February 2013
Understanding and Working effectively with GAD in Low Intensity CBT
Speaker: Marie Chellingsworth
Attendance is £20 for BABCP Members and £25 for non-members

Please contact BABCP to reserve and book a place
http://www.babcp.com/cpd

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Prof Janet Wilson, Prof of Otolaryngology head and neck Surgery Newcastle University

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Prof Trudie Chalder; Professor of Cognitive Behavioural Therapy, Kings College, London

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16 & 17 October 2012	**Awareness of depression and suicidal behaviour**	**Dr Ella Arensman** National Suicide Research Foundation
23 October 2012	**An introduction to a formulation-based approach to CBT for psychosis**	**Dr Craig Steel** University of Reading
12 & 13 November 2012	**A flexible treatment for multiple childhood disorders including anxiety, depression, trauma and conduct problems**	**Professor Bruce Chorpita** University of California
27 November 2012	**Brief Behavioural Activation (BA) for depression**	**Professor Carl Lejuez** University of Maryland
15 January 2013	**Single session treatment of specific phobia in the real world**	**Professor Lars-Göran Öst** Stockholm University, Sweden
29 January 2013	**CBT for social phobia**	**Dr Freda McManus** University of Oxford
26 February 2013	**Sleep well and live better: overcoming insomnia using CBT**	**Professor Colin Espie** University of Glasgow
4 March 2013	**Cognitive therapy for panic disorder**	**Dr Nick Grey** South London and Maudsley NHS Foundation Trust
5 March 2013	**CBT for PTSD: the evidence-based way**	**Professor Anke Ehlers** Institute of Psychiatry
11 March 2013	**CBT with older people**	**Dr Ken Laidlaw** University of Edinburgh
12 March 2013	**CBT to treat depressive rumination**	**Professor Edward Watkins** University of Exeter
18 March 2013	**CBT for OCD**	**Professor Maureen Whittal** University of British Columbia
15 & 16 April 2013	**Evidence-based psychological approaches to eating disorders and obesity**	**Professor Carlos Grilo** Yale School of Medicine
29 & 30 April 2013	**Cognitive therapy for complicated depression: from action to insight (and back again)**	**Professor Steve Hollon** Vanderbilt University, Nashville
15 May 2013	**Mindfulness for depression**	**Dr Melanie Fennell** Oxford Cognitive Therapy Centre
21 May 2013	**CBT for bipolar disorder**	**Professor Steve Jones** Lancaster University
4 June 2013	**An evidence-based programme for overcoming anxiety in children**	**Dr Lucy Willetts** & **Dr Monika Parkinson** University of Reading
11 June 2013	**Update on CBT for personality disorder**	**Professor Kate Davidson** University of Glasgow

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**

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5 Sep (half-day) Leeds	**Management of Schizophrenia – Beyond Clozapine**	**Dr Alison Brabban,** SMI National Advisor (IAPT) and Clinical Lead, Tees, Esk and Wear Valleys NHS Trust	£95
10 Sep Leeds	**CBT for Depression**	**Dr Paul Blenkiron,** Consultant Psychiatrist, Leeds and York Partnership NHS Foundation Trust	£175
14 Sep (half-day) Leeds	**Understanding Adult Offending Behaviour by Exploring Childhood Experiences**	**Dr Estela V Welldon,** Honorary Consultant Psychiatrist in Psychotherapy, Tavistock and Portman NHS Foundation Trust	£95
19 Sep (half-day) Leeds	**Survivors of Torture in Mental Health Settings**	**Gill Newman,** Psychological Therapist and Trainer; and Lynn Hiltz, Training and Capacity Building Co-ordinator, Freedom from Torture	£95
2 Oct Leeds	**CBT for Adults with Eating Disorders**	**Professor Glenn Waller,** Consultant Clinical Psychologist, Central and North West London NHS Foundation Trust and Institute of Psychiatry	£225
22+23 Oct (2 days) Leeds	**Working With Adults Who Were Sexually Abused As Children**	**Annette Morris,** Accredited EMDR Consultant and BACP Accredited Psychotherapist, South West Yorkshire Partnership NHS Foundation Trust	£335
6 Nov Leeds	**Working with People who Self Harm**	**Annette Morris,** Accredited EMDR Consultant and BACP Accredited Psychotherapist, South West Yorkshire Partnership NHS Foundation Trust	£220
13+14 Nov (2 days) Leeds	**CBT for Insomnia**	**Professor Kevin Morgan,** Director Clinical Sleep Research Unit, Loughborough University and Dr Maureen Tomeny, Consultant Clinical Psychologist, Nottinghamshire Healthcare NHS Trust	£375
4 Dec Manchester	**Pain Toolkit: Self-Management Approaches for Long Term Pain**	**Pete Moore, Educator,** Trainer and co-author of the Pain Toolkit and; Dr Frances Cole, GP, Pain Rehabilitation Specialist and Cognitive Behavioural Therapist	£195

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- Dr. Costas Papageorgiou (UK)
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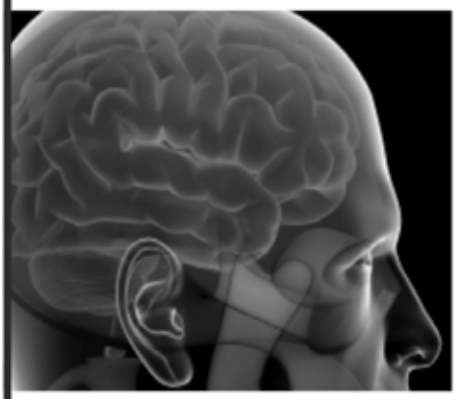

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Pre-Congress Half-Day Workshops (24 April, 2013):

Learn the latest treatment techniques with professional skills-based workshops
Wells: *GAD and worry;* | **Nordahl:** *Borderline PD;* | **Fisher:** *OCD;* |
Papageorgiou: *Depression;* | **Wells:** *PTSD*

Information & registration: **http://www.registration.no/mct2013/**

the five areas resource area

Ever fancied attending a WORKshop, that's skills based and efficient with a splash of fun and enjoyment at attractive and accessible venues?

Book training at www.llttf.com/training

MONTH	WORKSHOP	VENUE
Friday 7th September 2012	**Getting The Max out of the Five Areas** Maximise results when introducing and supporting people using the five areas books.	BPS London
Friday 26th October 2012	**Running the Living Life To The Full Classes** Join us for a WOW walk and more!	Bawtry (Doncaster)
Friday 2nd November 2012	**Introducing and supporting the LLTTF website** Support people using this popular and award-winning website and discover it's hidden gems.	Glasgow
Friday 8th February 2013	**Running the Living Life To The Full Classes** Join us for a WOW walk and more!	Bawtry (Doncaster)
Friday 5th April 2013	**Running the Living Life To The Full Classes** Join us for a WOW walk and more!	Glasgow

ALSO AVAILABLE:

Consultancy sessions: Bespoke individual sessions

For further information contact ann@fiveareas.com

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