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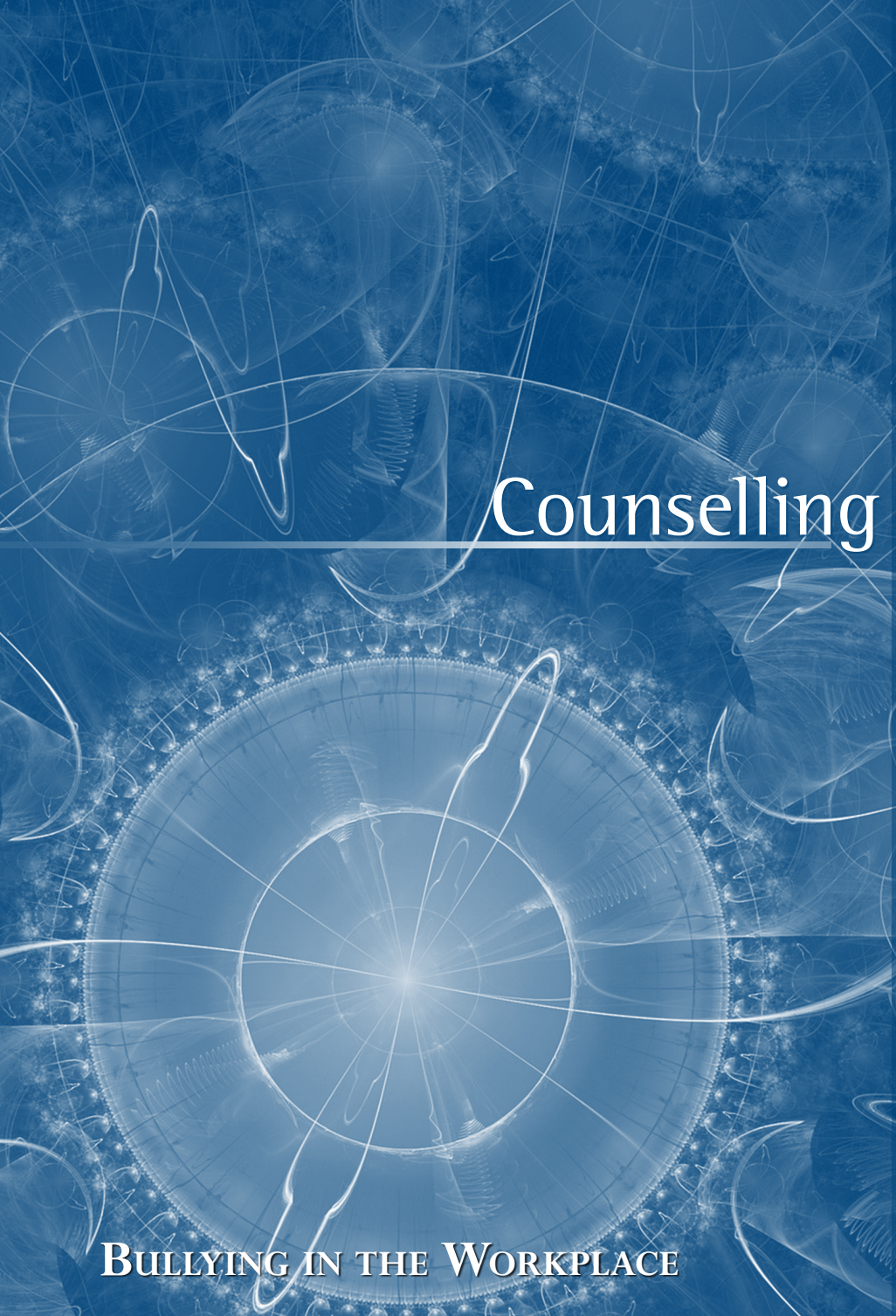

Bullying in the Workplace

Family Fortunes

Counsellors and Sex

The State We're In

Cognitive Remediation Therapy

COSCA
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Contents

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Editorial

John Dodds

It appears from feedback we have been receiving lately that many of you enjoy the mix of long and shorter articles in the journal. So for this issue we are pleased to offer another lengthier piece about counselling in relation to bullying in the workplace by Marijke Moerman. It's a subject, I feel sure, that most people are aware of, have witnessed or experienced first hand, and nothing about it is easy or straightforward - the experience of the "target" as Marikje puts it, is not only in relation to the bully but by the culture of the workplace, the attitude and amenability of employers (some of whom, to be fair, may be bullies themselves) and a host of other factors. During my two year period as a volunteer counsellor in Edinburgh I encountered time and again clients who were being bullied in the workplace and what I heard over and over again very much chimes with what is being expressed in this piece.

John Locke's piece, "Family Fortunes" looks at the subject of postnatal depression (something that, he points out, is not only experience by women but also by increasing numbers of men). He talks about his own experience as well as the work of his organisation, the Crossreach Perinatal Service. One of the things that struck me was the sheer pressure on the mother to take so much responsibility, something that was highlighted in a great film I saw recently called, "The Beginnings of Life" which looks at what separates us and what is essential to us all from the very start of our lives. One of the central theses is the idea that everyone, from mothers to fathers and extended family, friends and the wider community, should have responsibility for bringing up children, and it should not, in ideal circumstances, be down to one person. I loved John's description of their crèche facility being "alive and kicking with embodies visceral energy."

Anne Chilton in her piece, "Counsellors and sex: uncomfortable bedfellows," has brought up something about counselling that never really occurred to me, and that is the degree to which we feel comfortable and competent to talk to clients about sex. Outside of training in sex therapy, is it something that should be part of core training, or at least a component of courses?

In "The State We're In" several authors throw down the gauntlet about funding cuts in academia, stating: "a space cannot be found for the maintenance and continued investment in what has been a notably successful Scottish postgraduate programme of training in counselling."

Finally we have an article on a therapy that I only learned about quite recently, Cognitive Remediation Therapy which is broadly defined as "a behavioural training based intervention that aims to improve cognitive processes."

I hope you enjoy this issue and, if you are so minded, do send us feedback for the letters column. As ever, we are always on the lookout for more articles, and I hope some of you will consider pitching ideas and writing for the journal.

John Dodds, Editor

Bullying in the Workplace:

a silent malady

Marijke Moerman

Abstract
Bullying has become an epidemic and has long lasting effects and implications, not only for the victim but also for the organisation.

The purpose of this article is twofold. Firstly, it is hoped that reading this article heightens practitioners' awareness of the issues raised and secondly, by so doing may give practitioners the opportunity to contribute to the ongoing debate of bullying in the workplace, thereby bringing it further out of the shadows.

This article provides a short overview of workplace bullying based on available literature, and through professional and personal experience. The difficulties in defining workplace bullying, the profile of the bully, and target will be discussed. What has put them into that position, as well as the consequences of being bullied, and relevant legislation will be examined. Finally, suggestions on how to deal with workplace bullying are presented.

Introduction
The statistics available on bullying in the workplace paint a worrying picture. It affects one in four people in the workplace with 19 million sick days lost per year, consequently costing the UK roughly £13 billion per year (National Bullying Helpline). Workplace bullying is not only a UK problem but appears problematic worldwide. For instance, comparing these figures with statistics from the USA the numbers become even more concerning. More than 65 million US workers are affected by bullying in the workplace, equivalent to 72% of the combined population of 15 states (Workplace Bullying Institute, 2014).

Bearing in mind that the general population of the UK is approximately 60 million, of which it is thought that roughly 30 million are in work. If one in four report sick per annum due to work related stress brought on by workplace bullying, it would mean that possibly a thought-provoking 7.5 million workers a year may be off at least one day due to workplace bullying.

There is a cost to human wellbeing as well as organisational efficacy. Apart from official statistics, there is regular 'evidence' of workplace bullying being reported in the media, anecdotal 'evidence' conveyed by family members, friends or colleagues, and a growing body of research in the domain of workplace bullying. My network of counselling colleagues acknowledge that lately they have noticed an increase in clients presenting with issues relating to workplace bullying.

Those practitioners who have worked with clients affected by workplace bullying or have personal experience have agreed that workplace bullying flies under the radar...it is an insidious, toxic, isolating and shameful practice, often leaving long-term psychological scarring.

The havoc created on employees' lives by workplace bullying is more often than not underestimated and more worryingly, unrecognised by organisations. This lack of acknowledgement of the situation may also further victimise the target either knowingly or inadvertently (Lutgen-Sandvik, 2013). The target may well feel that bullying is encouraged, rationalised and/or supported.

Victims or those affected may feel humiliated, fearful, undervalued, intimidated, shameful, guilty at failing themselves, experiencing loss of confidence on personal and professional levels, often leading to feelings of worthlessness, paranoia and in extreme cases suicidal ideation. The target may feel powerless, silenced and secluded in an atmosphere of suppression, injustice and when invited to relate their story are unable to articulate their emotional pain.

Often bullying takes place on a one to one basis, suggesting it occurs in an atmosphere of silence and isolation with no witnesses present, and therefore not easily evidenced. However, this, of course, may not necessarily be the case in each instance. Isolation follows through the exclusion of the target in day-to-day proceedings at work on a professional and social level if work colleagues collude with the bully because of their own fear of becoming the next potential target. Thus, the target is not only targeted in silence but is consequently silenced. As such, they feel thwarted in explaining their situation because they find it difficult to pinpoint the moment it started (Field, 1996). Furthermore, subsequent incidents may initially feel insignificant to the victim and perhaps quite preposterous, or as one client once remarked that the whole process of finally recognising and admitting to self that bullying is taking place felt like "death by a thousand tiny stabs...".

The victim may fear people will not believe them as unfortunately their story is so often disjointed, incomplete and vague because of their inability to verbalise exactly the nature of the incidences, as they may appear insignificant when relayed, such as a look, a sigh, body language, which are of particular significance to the target. Another significant push into silence may be the victim's fear of the bullying becoming worse and unbearable, not being believed, and likely actions of revenge by the perpetrator(s).

This, a deafening silence, can only be addressed by making sure that initially the victim is given the opportunity and support to have their voice heard to start their healing process.

As practitioners, we are often confronted with the deeply distressed client who only presents when well into the bully-target/victim dynamic. The task of the counsellor/therapist will initially be to enable the client to articulate her/his experience, to hear their pain and hold the confusion for the client. In doing so the practitioner will validate the client's feelings of the behaviour being verbalised or labelled as bullying. Eventually, the destructive pattern of workplace bullying can be explored and support provided to develop strategies to understand and deal with their situation.

For the counselling practitioner to feel effective in supporting the client it is important to understand this dynamic as well as possible.

The most important part to focus on is, as mentioned, to primarily acknowledge and understand the emotions involved in order to recognise the negative effects of workplace aggressive behaviour on the individual's well-being, personally and professionally. There is a wealth of information available out there but may not necessarily be easily accessed as information is often offered through research articles or a compilation of these articles in books. They may appear on Google Scholar, at times to be accessed through university databases, which are not generally accessible when not liaised with a university. Even then the academic language used may be so laden with jargon that it becomes cumbersome to read.

Research on workplace bullying has considerably increased in the past two decades. For instance, Cowan and Fox (2015) on the role of HR; models to explain these dynamics (Tehrani, 2012, Poilpot-Rocaboy, 2006), the increasing incidence of cyber bullying (Privitera & Campbell, 2009), risk factors for employees (Salin, 2008, 2014), investigating differences in personality traits between targets and non-targets of bullying (Glaso, Matthieson, Nielsen and Einarsen, 2007), the impact of bullying behaviour on the health and wellbeing of employees (Cooper, Hoel and Faragher, 2004), organizational risks Salin (2003). Lutgen-Sandvik (2013), however, remarks that "most research, although identifying the harm caused to targets, gloss over emotional pain suffered by workplace bullying" (p88).

How to define workplace bullying?

Workplace bullying can be described as a far more complicated and sophisticated activity than the so-called playground bullying in schools. Also cyber bullying (or keyboard bullying), although mostly associated but not exclusively so with schools, has taken on an increasingly dangerous and complicated nature within workplace bullying, whereby the culprit(s) are able to remain anonymous for a long period of time even with the possibility of continuing to stay unmasked.

So, what then exactly is bullying, what is it not and how do we describe this concept?

As yet, there has not been a universal consensus on the concept 'workplace bullying'. It is an activity that is defined by the targeted individual's sensitivity, understanding and perceived intent.

It has been and remains a difficult task to identify a focused definition that will hold a tight legal position. At the onset, we could perceive and explain bullying as teasing the other with perhaps a slightly assertive slant on it which, unchallenged, can very quickly become recurrent, aggressive, repetitive, inappropriate and obscure in nature. This can develop in threats and assaults resulting in health and safety issues (Mayhew and Chappell, 2007) that can have extremely negative and long lasting effects on the target.

Although difficult to define bullying many definitions have been proposed. The first being attributed to Leymann (1990, p21) describing what he termed 'mobbing'.

"Mobbing explains negative communication against another individual by one or more persons which occur often and over an extended period of time and as such the relationship between perpetrator and target define".

The latest definition so far brought forward by Einarsen, Hoel, Zapf and Cooper (2011, p22) explains the concept of workplace bullying carefully, but the account which follows unfortunately omits the potential emotional impact bullying has on the target:

"Bullying at work means harassing, offending, or socially excluding someone or negatively affecting someone's work. In order for the label bullying (or mobbing) to be applied to a particular activity, interaction or process the bullying behaviour has to occur repeatedly and regularly (e.g. weekly) and over a period of time (e.g. about six months). Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts. A conflict cannot be called bullying if the incident is an isolated event or if two parties of approximately equal strength are in conflict".

In a previous review of the Scandinavian approach to harassment and bullying Einarsen (2000) refers to "the actual disintegration of an employee's fundamental self, resulting from an employer's or supervisor's perceived of real continual and deliberate malicious treatment" (p381).

Einarsen et al.'s (2011) classification of bullying can be considered a valuable tool to establish whether bullying has occurred or not, or whether the focus needs to be on a different form of harmful workplace behaviour. When defined by the person who has been bullied in a workplace setting we may find the focus is on the emotional impact of the experience and will infrequently reflect the technicalities of the occurrence as described in the definition of Einarsen et al. (2011).

As the experience of bullying behaviour in the workplace is subjective, what is considered to be oppressive, harassing, intimidating and hurtful behaviour for one may be experienced as for instance annoying, rude, ill-mannered, disrespectful and obstructive for the other to be dealt with on the spot. However, for the recipient of the former, it may eventually result in traumatic consequences.

These different experiences of workplace aggressive behaviour could be placed under different concepts of the same, such as incivility (disrespect, low intent and intensity), supervisor abuse (top-down, aggressive verbal and non-verbal, humiliating, insulting, defined by power imbalance, similar to bullying), interpersonal conflict (disagreements between staff, minimal to considerably major incidents) (Hershcovis, 2011). One may question whether it is useful to differentiate these various concepts of workplace bullying, or that it would dilute and hinder its explanation, however, again, it may explain the difficulty of arriving at a distinctive definition for what we, in general, understand workplace bullying to be.

It is therefore perhaps prudent to also have an understanding of who the bully is, how they may portray themselves, a profile of the target/victim and the consequences for the organisation the dynamic is played out in general and for the target/victim in particular.

Why does bullying occur?

Research has shown that there appears to be a direct link between bullying and for instance poor leadership skills, role conflict (Einarsen, Raknes & Matthiesen, 1994, Leymann, 1996). The findings of these studies are supported by more recent studies that show that autocratic leadership (O'Moore and Lynch, 2007), as well as laissez-faire leadership (Hoel, Glaso, Hetland, Cooper & Einarsen, 2010), were feeding into an atmosphere of bullying. In a study by Fevre, Robinson and Jones (2011) nearly 4000 interviews were conducted to gain an insight

into ill-treatment in the workplace. They found that "some of the more common forms of unreasonable treatment are experienced by nearly one in three British employees. Most unreasonable treatment originates with their managers and supervisors" (p4). Why then would managers and/or supervisors feel inclined to make life miserable for their employees one could ask. Salin (2003) offers a model in which she puts forward an explanation of three structures and processes, i.e. "enabling, motivating and triggers, which may aid bullying at work" (p20). A trigger may present itself when there is a change in the dynamic of the workforce, for instance, a new manager who aims to change the current way of work approach. For example, in my experience as a person-centred counsellor, I had one client who presented for counselling due to work related stress. She talked of enjoying her job and being experienced and skilful prior to the employment of a new manager. She explained that she often felt confused by the manager whom she described as giving contradictory information. Furthermore, the manager would also give her a row in front of the other employees for trivial matters and also checked her work and rechecked her work. While she did not say the words, what she described was being micro-managed. My client felt that her professional autonomy was reduced which in turn undermined her confidence and decision-making abilities.

Enabling factors may arise when in a particular area employment opportunities are very low, therefore the workforce becomes dependent on the few opportunities available, and managers may be put in the position to exert their powers abusing this dependency. Feeling threatened by others they perceive to be more competent and in order to save their position may be a motivator for bullying behaviour. (Salin, 2003).

Another three-point model focuses on the target, who is believed not to be able to cope with frustration, ensuing escalating interpersonal conflict, and destructive team and organisational cultures (Baillen, Neyens, De Witte & De Cuyper, 2009).

Although this is a short overview of models of bullying in the workplace and how bullying finds life within an organisation, the role the individual bully plays is the determining factor within the dynamic workplace bullying.

Who is the bully?

As mentioned before, within these models, the bully, as an individual, may behave out of fear of being seen as incompetent, suffering from low self-esteem and wanting to be seen as at least as competent as their peers.

The bully in the workplace can be one of the peer group, he or she can be a subordinate, a group of co-workers, but mostly top-down, from manager to subordinate. Field (1996) provided us with the following figures, "90% manager on subordinate, with 8% peer on peer and 2% subordinate on manager" (p79). Although these figures appear to be far from recent they are supported by more recent statistics from HR and Diversity Management Limited (2010-2011), who have added that 49% of managers have been bullied themselves. Studies from the USA, (Namie & Namie, 2009), suggest that perpetrators of bullying are men and women who make life difficult for all with no exception of age or race in any place of work with the majority of the bullies being male and the majority of the bullied target being female. Namie & Namie further imply that in 71% of recorded cases females target females.

Characteristics of the bully, be it male or female, are traits most of us are familiar with as from time to time we may display these ourselves, however in the bully they are shown on a more regular basis. Field (1996) delivers a list with around 50 traits he assigned to the bully. A few of the more poignant being: "envy, inconsistency, insincerity, mood swings, self-importance, shifting goalposts, untrustworthiness, vindictiveness" (p54). Envy, it is proposed, appears to be one of the most significant reasons for bullying (White, 2013). These traits bring confusion, fearfulness, and ultimately psychological pain.

The bully lacks what the target has, be it intelligence, material goods or success in the workplace.

To understand the development of the bully White (2013) draws from the psychodynamic views of Anna Freud (1936) and Winnicott (1971). The former's theory on the impact of introjection of an aggressive caregiver in infancy may be an explanation of future aggressive behaviour. Winnicott's theory of the "good-enough mother", whereby the child acquires balanced boundaries of "good" and

"bad", explains that this will set the child up to withstand difficult external influences. However, when these boundaries are weakened through aggressive, and or abusive parenting, the child will introject this behaviour and when it feels threatened by others in adult life, for instance through envy, will retaliate with aggressive behaviour.

It appears that the bully is adept at pinpointing a potential target's Achilles heel and home in to that vulnerability. McGregor and McGregor (2013) in their book *The Empathy Trap* state that sociopaths often target empathic people as posing a threat. Due to their empathic nature, empathic people are able "to sense and express that something is not quite right" (p36). Sensing an injustice they will address the difficult situation. And this, McGregor and McGregor explain, provides the sociopath with a luring adversary whose reactions are highly attractive to the sociopath. Empathy becomes the Achilles heel of the sociopath's target. Sociopaths have difficulties in finding empathy with others. (McGregor and McGregor, 2013). However, not all bullies are sociopaths...

However, bullying can also be perpetrated by groups of workers, who may gang up on a target, through perhaps fear of being the next victim, or passive bullying when co-workers stand by in silence and do not report, also for fear of repercussions, or being next on the list of the bully's abusive attention. A target's attempt at finding support by those in higher management will fall more often than not on deaf ears as the 'group' will protect their own, a phenomenon Namie & Namie (2009) call this "Groupthink, a group dynamic that inhibits witnesses of bullying to intervene or help targets" (p88). They explain if a bully is a member of a management committee, they are part of the 'group', a group that will stay rightly or wrongly loyal to each other. The target will not be given the opportunity to voice their concerns and the group will adopt a code of silence. In the end, the target's concerns will be brushed aside with others in the group stating that it is a "personality clash", or that the target will just "need to get used to a different management style", or 'be a bit more flexible and accepting...'

Who becomes the target of bullying?

Broadly speaking, targets can be those perceived by the bully to be a threat to their professional existence within the workplace, making them feel incompetent, as referred to earlier, and those regarded as being popular and competent. At first, perhaps oblivious of the dynamic, the target may begin to feel uneasy and confused after repeated unprovoked, isolated, psychological attacks. These attacks may appear minor and harmless as standalone incidents, for instance, a mocking or disapproving look, a humiliating remark, not including the target in an important meeting, however cumulatively this becomes aggressive behaviour that may chip away at the target's mental and psychological wellbeing (Hirigoyen, 2012). As they are difficult to define and verbalise in their isolated instances, the target may even be accused of being petty, over sensitive, or exaggerating.

The target may become more and more confused, anxious and isolated as colleagues around him/her become afraid of being next on the perpetrator's list. As one individual explained, it felt as if a cloak of secrecy descended over the team where nobody spoke about what was going on. Colleagues did not speak because they did not want to side with the target in case they also became a target, the individual felt silenced because they had no one to talk to about it, or not wanting to bring colleagues into a position that they felt they were being asked to choose sides. In the meantime the perpetrator may well make it appear that they are befriending other members of the team further isolating the target, who may now mistrust colleagues, often creating damage to the team and the individuals. Ultimately the other staff members may have unwittingly become passive bullies, as well as unsuspecting targets.

Therefore, the target is being bullied covertly, while at the same time the withdrawing colleagues bully passively. Over time when confronted face to face with the bully the target becomes more and more fearful and in extreme cases may be unable to enter the building the bully occupies. Their ultimately fragile emotional state makes it virtually impossible for them to fend off the bully, further encouraging the bully's destructive behaviour. The target is then seen as ineffective and inefficient, becoming increasingly more confused, and confidence rapidly deteriorating. (Hirigoyen, 2012).

Only when the target is mentally strong enough to counter mistreatment of this calibre will he/she be able to rebuke a bully. However, it would need a high level of confidence and a strong will (Field, 1996) to stand up to the perpetrator.

Tehrani (2012) introduces us to "the drama of bullying" (p254) in which she explains the role of the target/victim, who may play his/her own role in the bullying dynamic. A role that refers back to the earlier observation that the target by their very presence may present a threat to the perpetrator. The bullying appears to be context driven and person specific.

What are the consequences?

The behaviour of the bully may have a profound effect on an individual or group of people in such that they become suspicious of each other, may even feel paranoid and don't know who to trust, not even themselves. The bully succeeds in eroding the individual's self-worth leading to paralysing feelings of helplessness and decline of mental and physical wellbeing.

Those being subjected to workplace bullying may suffer long-term psychological, physical and professional harm (Lutgen-Sandvik, 2013). The bullied person may act in a different way leading to confusion and difficulties with close professional and personal relationships. Once outgoing, a person may become withdrawn and depressed, repetitively talking over the same incidences, unable to move on. They may become secretive, particularly if they feel they are not being taken seriously or heard, leading to a change in behaviour and mood becoming irritable, anxious, paranoid, suffering from self-doubt, and lack of trust, further leading to depression, chronic stress, unexplained physical aches and pains, stomach upsets, high blood pressure, cardiac problems, alcohol and/or drug abuse, and in more extreme cases Post Traumatic Stress Disorder (PTSD) and even suicide (Lutgen-Sandvik, 2014). A recent study by Nielsen et al. (2015) concludes that suicidal feelings and thoughts are one of the results of workplace bullying, and rule out the thought that the victim's behaviour may have provoked an attack by the bully. Some people will not be able to return to work for a long time, if at all. The bullying may have instilled a paralysing fear in the target/victim.

Linden, Baumann, Lieberei and Rotter (2009) propose that a bullied individual may be suffering from Post Traumatic Embitterment Disorder (PTED). PTED differs from PTSD where a life-threatening event has occurred which presents severe panic and anxiety, whereas in PTED there is an 'abnormal' reaction to a 'normal' life event, that may happen to anyone at any one time, such as bereavement, loss, divorce, or conflict at work. The event, Linden et al. (2009) state, evokes feelings of injustice, insult and humiliation evolving into feelings of powerlessness, rage, deep embitterment and revenge.

From an organisational point of view, there could be a loss of resources as experienced people leave, either out of fear of being targeted next, or feeling exhausted and drained by the toxic atmosphere in the workplace. Replacements need to be sourced, and trained, which is time consuming and expensive, therefore productivity and consequent turnover will be lowered. Relationships with family and friends may become strained, as well as disintegration of working relationships within a team, and friendships established within the workplace unduly tested or even lost. Working days lost through absence and sick leave, as well as litigation due to wrongful termination of contract will add to the cost. Furthermore, the good name of an organisation or company may be damaged losing the trust of their clients and/or customers. (Parris, T. 2007/2015). The cost of bullying to the victim/target is one of psychological and physical deterioration (Namie, 2003), whereas the cost to the organisation will be measured in monetary terms. To adopt preventative measures will, therefore, make sense financially. Putting in place tight organisational policies and procedures that cover bullying behaviour which are supported by specific laws would protect the employee, it is hoped.

How to deal with it?

As touched on before, being extremely confident, quite assertive and in possession of a healthy dose of steely nerves, the target may be able to ward off abusive behaviour. However, in practice, this will be a difficult goal to achieve, as bullying is often a cumulative process that may not always be instantly recognised as such. Support from friends family and colleagues will be invaluable to attempt to restore the target's belief in self. They can be proactive, (speaking up, looking for support within the workplace, or outside the workplace from family, friends and colleagues), or they can take on a passive stance, i.e. withdrawing, trying to live up to the bully's expectations. Zapf and Gross (2001) supported an earlier study by Niedl (1996) that targets would initially have an active voice in solving the problem but would ultimately end by leaving their job.

Unfortunately, as established, it is often difficult for the target to counter the bully's behaviour as their confidence, self-esteem and self-worth are severely weakened during an ongoing bullying situation. It is therefore proposed and encouraged to ask for support. A simple suggestion but in practice not easy to achieve as often the situation has deteriorated such that it has become emotionally impossible to ask and receive this in the workplace. Writing down a detailed account of the incidences, secure witnesses, dates, time, place and context will be helpful in evidencing the abusive behaviour. Being familiar with the organisational policies and procedures, in particular, with reference to bullying, will further support the target to address the behaviour.

Organisations such as ACAS, UNISON or Citizens Advice Bureau will be able to provide useful information and support.

There are several helplines available such as National Bullying Helpline and Bullying UK that can be accessed online or by phone.

Legislation in the UK and beyond

The UK lags behind several European countries and the USA in terms of anti-bullying legislation. Please refer for instance to the government's website, www.gov.uk and http://abusergoestowork.com/legislation/international-laws/. The government website quotes several laws, such as The Equality Act 2010, The Health & Safety at Work Act 1974 and The Protection from Harassment Act 1997. These laws busy themselves with explaining how certain behaviours, such as spreading of malicious rumours, unfair treatment, picking on someone, undermining a competent worker and denying a worker's training or promotion opportunities as examples of bullying and harassing behaviour. The Equality Act 2010 further states that harassment is considered unlawful, however bullying is not unlawful, which is puzzling as harassment is considered to be part of the sum bullying.

Under The Health & Safety at Work Act 1974, the employer has a duty of care to "ensure, so far as is reasonably practicable, the health, safety and welfare at work" of all their employees.

The European Union's social partnership organisations, the business and labour groups that negotiate EU employment policy, agreed a "framework agreement" in 2007. According to this agreement the EU Union members were obliged to apply zero tolerance to any form of workplace harassment. The agreement details guidelines for training, investigation and management for workplace bullying. (See: European Agency for Safety and Health at Work, European Risk Observation Report, 2009).

Conclusion

Workplace bullying is a complex dynamic that is difficult to define because of the human emotions involved, and how to quantify these emotive experiences and reactions is problematic. Emotional responses are subjective. They follow from the individual interpretations of an experience, and their verbal representations of these experiences are unique to each individual. Therefore, to assign a definition to bullying in the workplace, that covers all areas satisfactorily, is a difficult task. It is evident that without a singular consensus of a definition of bullying, a law to protect potential victims is some way off. As a result, the situation with all its implications and potential outcomes for the victim/target may stay deep, dark and dangerous. In my opinion, it will remain an unacceptable, substandard and costly state of affairs for organisations.

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Biography

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Family Fortunes:

reflections on working with perinatal depression and anxiety

John Locke

All my family are adult now and I have a good relationship with my partner, three daughters and one son. I am delighted when I hear about their adventures, still worry about them for no particular reason, as I always have, and am constantly grateful for their independence. The journey seems so very, very long, yet it all went by in a flash. The two opposites experienced with equal certainty. As a young father, I was clueless about bringing up children because I am an only child and I do not think that I had ever really been around babies, let alone held one. The whole thing was so far out of my ken then, but I was enthusiastic and committed.

This naivety and inexperience led me to accept the idea that "the women knew best" and early on grandmothers, understandably, had more authority than I did. It was not that I ever felt pushed out, I just recognised that the whole business was way bigger than I could imagine and had a long-standing tradition going back generations, with no doubt prehistoric roots. What could I offer?

I remember particularly the issue of swaddling clothes: the act of wrapping my eldest daughter in tight shawls "because it keeps her warm and secure". I was sceptical. Would she not over-heat? Was it not like handcuffing a baby; tying her up? Needless to say, I did not put up much resistance. I changed nappies, bathed and fed, but knew that I was an utter novice outside the circle of women who knew better. The swaddling stayed.

Such memories have been rekindled for me in the past year because of my recently joining the team at Crossreach Perinatal Service (formerly Lothian's Postnatal Depression Services Est. 1988), an agency offering counselling and psychotherapy to families in the perinatal period. We define this as during pregnancy and up until the youngest infant reaches the age of two years.

I was attracted to the specialism having worked for some 25 years counselling in various settings: firstly in the area of substance recovery, then student counselling and generic work; attracted because of their focus on working with the whole family. The percentages of mothers referring are clearly in the majority, often having been referred or encouraged by their Health Visitor. Nevertheless, the number of men referring is increasing at a steady rate. Fathers mostly refer on the premise of 'helping' their partner, but this is not always true. Slowly it is being recognised that men can experience perinatal depression and/or anxiety in their own right. This is a recognition that such disturbance is not always a reaction to any deterioration in the mental health or wellbeing of their partner, rather as sometimes emerging from their own pre-existing vulnerability to depression due for example to the opening of past attachment wounds, salted by the new 'other' joining him and his partner – his primary attachment. The potential for feeling fragile whilst "outside the circle" seems clear to me.

Studies estimate that 5–10% of fathers experience perinatal depression (Paulson and Bazemore, 2010). There is, however, to my knowledge, little research into what factors are predictive of paternal depression or anxiety in this context. Francine deMontigny et al (2013) note this and go on to find that three main psychosocial factors seem to contribute: "parenting distress, quality of marital relationship and perceived parenting efficacy…" (p47). We could argue however that each identified causal factor here may be an area which is troublesome because of the emerging paternal depression, rather than the other way round. Nevertheless, having doubted my own parental efficacy with my eldest child as a baby, it comes as no surprise to me that this is found in the wider population. Such doubt can lead to low self-esteem and alienation from the family. This is potentially

true of course for both the mother and father and that is why we seek to work with the whole family, offering couple counselling and psychotherapy.

I do not find myself too frustrated as a practitioner by the lack of predictors—perhaps because I have lesser need for such categorisations than a medical screening for risk in the antenatal period. I find that with the clients I have worked with in the service so far, and for both men and women, the issues of identity and meaning-making feature just as often. Now, I guess one could say that all counselling and psychotherapy is to do with meaning-making and that is true. What I am noticing, however, is a difference between my experience of counselling students, when I most often heard the question "who am I?" and my experience at Crossreach Perinatal Service where the question is also "who are we?"

Some time ago, Jim Lanz (1996:537) proposed that raising awareness of "Meaning Potential" and nurturing a "will to meaning" is the central task when working with families. Of course, with couples, it is well established that it is beneficial to work with the relationship rather than attend to each as isolated individuals (see 2002; Carr, 2014 & 2016 and Von Sydow et al, 2010). I have found however that in my own work I witness individual clients also focusing on what their family means to them. They recall past identities and express the impact that pregnancy and/or a new baby has had on their sense of selfhood and their sense of couplehood. This is compounded by the arrival of new daily (and nightly) tasks and responsibilities which were not required before the birth. Where the couple have remained in partnership, there is the need to renegotiate divisions of household labour. The pun is not unhelpful here, I suggest, as it does recall that we have a fixed biology and that tensions can arise from the natural demands on the mother, which the father cannot naturally meet. Again issues of identity arise both for the individual ("I am the one who …") and for the family ("we as a family aspire to …"). Working with the whole family gives the opportunity to explore what the joint vision for the family is or is not. Where there is conflict and where there is loss. This can be complicated whether the couple had deliberated to have a family or whether the pregnancy was unplanned. The former having the potential for needing to confront a previously idealised concept of their future family life with reality; the latter involving grief for the loss of the freedom of childlessness. It is necessary then to explore the different narratives which may be available to the couple and the family. What is the new meaning that is to be understood; what is the joint venture?

In parallel with a systemic outlook, our work is also informed by attachment theory. There is generally a foregrounding of psychodynamic perspectives, although we have counsellors and therapists from a wide range of theoretical backgrounds and both genders. We often find relevant both our client's own attachment history and the development of an integrated sense of selfhood, understanding that when old attachment wounds become stressed at times of upheaval, there is a risk of them coming apart at the seams. And, as I have said, this can be true for both mothers and fathers and unfortunately bonding with the newly arrived baby can be delayed and generational repetition possible. There is a growing body of work suggesting that there are comparable negative impacts on future generations' sense of wellbeing, arising from poor attachment to their father, as with their mother (see Bretherton, 2010 and Pleck, 2007).

This is not to say that we are committed, as a service, to keeping families together. We recognise that there are times when it is most appropriate that couples do indeed separate and we are comfortable in offering a service which can help them to do so with the least amount of pain and distress for themselves and the whole family; acknowledging also the significant changes in the configuration of many families in Scotland.

Contrary to previous trends, the population in Scotland is increasing significantly. The number of children under age 5 grew by 6% (293,000) over the ten-year period between 2001 and 2011 and still rises. It is true that family compositions are also changing and the 2011 Scottish Census (2014) found that:

"…of the 614,000 families with dependent children, 54 percent (333,000) were married couple families, 15 percent (91,000) were cohabiting couple families and 31 percent (190,000) were lone parent families... For cohabiting couple families, step-families made up 24 percent of families with one dependent child, 31 percent of families with two dependent children…"

Parents are also becoming older at the time of starting a family and in 2014 half of Scottish mothers were over the age of 30 when they gave birth for the first time. When reflecting on this, it is important to consider some of the mythology around risk associated with older women giving birth. There is an assumption that medical complications invariably arise when older women give birth and this is challenged by the argument (Kitzinger, 2005) that it is the medical profession who are more likely to intervene with certain procedures and it is those procedures, in themselves which can cause complications, rather than actual age of the mother. Kitzinger does reinforce her thesis with research in the field.

I have come to understand in more depth the complexity of the specialism of working with clients in the perinatal period. I am not claiming that the most important overall argument is that men too can experience postnatal depression in their own right, although I am aware that much work is still to be done in raising awareness of this. I firmly believe that there continue to be assumptions made in this regard, as there are about women who experience perinatal distress. Postnatal depression in women is not severe 'baby blues'. It can be a severe condition occasionally requiring hospitalisation for postpartum psychosis. Currently, Scotland has only six beds in each of the two mother and baby units for specialist intervention, both in the central belt. The Mental Health Commission for Scotland (2016) has found that a third of women requiring care were admitted into non-specialist hospitals, where they were separated from their baby, with all the potential impact that can have on healthy bonding.

It is also clear to me that early attachment trauma can be re-awakened in the perinatal period, as both mothers and fathers ruminate over the meaning of parenthood, for themselves and for their partnership embarking on a shared venture. Notwithstanding that, as France (1921: Pt. II. Ch.4) says, "All changes even the most longed for, have their melancholy; for what we leave behind us is a part of ourselves: we must die to one life before we can enter another!"

Lastly, I want to mention another aspect of our client group's difference from the other groups that I have worked with: on the whole, I have found a high level of motivation to engage in the therapeutic process. This is due, I believe, to primal drives that demand the family's health and wellbeing are prioritised. I have noticed this often co-existing with a sense of shame. We can go back to Winnicott (1964) and realise that the need to reinforce concepts of "good enough parenting" still pertain. This all takes place, of course, in a climate where child neglect is constantly reported in the media. I am not saying that this is not necessary, it probably is, but it also has the consequence of fostering a paranoid attitude towards social services. The fear can be almost Orwellian and we do observe families who are terrified that their distress could be interpreted by statutory services as putting their children at risk. There are no easy political answers, I fear. It is what it is.

In conclusion: for all its complexity, I have no regrets about choosing to specialise in this area of work, which I find to be powerfully moving. With our crèche available, filled with cries, laughter, whimpers and shouts, it is an environment alive and kicking with embodied, visceral energy.

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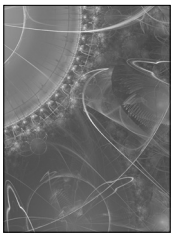
Counsellors and sex: uncomfortable bedfellows?

a personal reflection



Anne Chilton

How often do you ask clients about their sexual lives? Is it something you feel comfortable doing or is it something you don't see the need to do? If you do ask, how comfortable and competent do you feel about dealing with what you might hear? I only ask because I am interested in how counsellors are both taught about sex and how it impacts on their work with individuals and couples and because when I do talk about this with other counsellors their response is, "we didn't do sex on my course".

To set this in context I should mention that I am a trainer, supervisor, counsellor and a sex therapist. I work with individuals and couples with relationship and sexual difficulties. I talk about sex a lot with clients and I am going to talk a lot about sex in this article. Not about sexual development which many courses cover; the sex I am talking about is the basics of sexual expression, what people do sexually and what can go wrong. About how sex fits into our lives and how we feel about what we do; about when it works and what we can do when it doesn't. And what I hope you will gain from reading this piece is maybe some knowledge, maybe some reassurance, and maybe it will stimulate a little bit of curiosity about finding out more.

What areas are we talking about that we might not be comfortable with in the counselling room? Many courses cover the development of human sexuality, how we develop a sense of gender across the female to male spectrum and all the variations between. Courses might also cover sexual orientation, who we are attracted to and the implications for opposite or same sex attraction and they might even cover how our orientation can change as that it too is on a spectrum with fluidity of expression. However, few courses will look at sexual practices, the sexual response cycle or how sex is affected by many of the other issues covered in courses, such as anxiety and depression.

Sex is a normal and fundamental part of life and like many other aspects of our life will develop, change and adapt, across our lifespan and in relation to how we feel about our self and who we are with at the time. It's not something that is fixed, it's mutable and flexible. Our sexual self is something that can be both personal and shared. In our self-awareness as counsellors we might explore and gain understanding of our angry self, our sad self, our needy self, and our compassionate self, but how familiar are you with your sexual self? Again, I only ask as it's quite important we understand our own sexual self so that we can be aware of what it might be experiencing or noticing in the counselling room. After all, it is usually the unknown and unexplored aspects of our various selves which are the ones that can get us into bother.

What sort of things should we be learning about to feel competent about working with sex?

Now sex is a funny thing as most people feel they either know about it or that they should know about it. I believe that mostly, though, unless we have a real interest, will usually only know about it from what we learnt, maybe in school or from friends, or from what we see in the media or what we read. Many of us have very little understanding of either how our bodies work sexually or what we need to do in order to help them work as best they can. Sex is a bit like food and eating: we need to understand what causes us to eat, why we need to eat, how different nutrition can aid or hinder us and what to do if eating gets outwith our control. And whilst we might feel perfectly comfortable reading up about food, trying new recipes, talking about food, we don't have the same approach to sex. Yet sex is as much a part of our natural functioning as eating.

If you have problems with food there are plenty of resources you can tap into. Fed up with eating the same thing night after night? Then pick up

a recipe book, watch a programme; it's easy to spice things up. There's no shame in saying you don't know how to cook, you can easily learn, with a celebrity cook on every channel just waiting to show and teach. And if it doesn't work then plenty of tasty ready meals at the supermarket. Fed up with your sex life, things not working as well as they did? Well, what do you do then? Lost your desire or appetite for sex, not finding it satisfying or is it painful? Well, that's likely to feel embarrassing at best, shameful at worst. And then there's the challenge of who you go to for help. You don't want everyone knowing your erection isn't working as well as it did or that penetration is painful or that you have never managed to have sex yet. So, who do you talk to? You may talk to friends, you may go to your doctor. However, doctors have very little training and they may well refer you to a specialist sexual problems clinic where you may have to wait upwards of a year for an appointment.

If things are not resolved, then your difficulties with sex may start to affect your mood, you might start to feel a bit down, and your relationship might become strained. You might decide to seek counselling for your low mood. So, whilst you talk about your low mood you might not mention your sexual problem unless that is your counsellor offers that opening. Something as simple as asking if the current difficulty affects a person's intimate/physical or sexual life can be all it takes to give the client permission to talk. They might not do it there and then, however, just by saying that this is a door that is open for the client to come back to if they want is all some clients need.

If the client chooses to walk through that door we then need to have an understanding of how sex interacts and impacts on our sense of wellbeing. Anxiety, depression, low self-esteem, all issues that come into the counselling and all can have an impact on sexual functioning and on how we see ourselves as sexual beings. Medication taken for any of the above can also impact not only on sexual functioning but also levels of sexual desire. Sex does not exist in a vacuum—it is linked to, and has an impact on, all aspects of our lives and by ignoring its presence or significance limits our view of the whole. It is inextricably linked to our feelings and thoughts about self; our self-image; self-worth and our bodily self. We look at what clients bring into the room in terms of their life experiences, their background, their difficulties and triumphs, their pain and their joys.

A quick word about sex and how it works

Sex is a complex interaction of feelings, thoughts and physical responses. Sex starts in the head with thoughts and feelings which stimulate the release of hormones which cause changes in the body which need to happen for sex to occur. It's physical, emotional and psychological and problems can occur at any time in any of the three elements.

For example, if someone is really not interested and their 'head' is elsewhere, (thinking about shopping, football, someone else) or they are tired, bored or not connected with their partner, then it might not be the best experience. If either the head or the heart isn't in it then the body might not work either. For some people with sexual problems talking about how they feel about sex, about their desires and needs might be enough. For others understanding how they think about sex, linking it to how they learnt about sex might be enough. Enough might also be giving clients the right information about how their bodies work and helping them explore what they need for sex to be good. Maybe getting them thinking back to how much time they spent anticipating and preparing for sex in the early days of a relationship, compared to the brush teeth, jump into bed routine at the end of a long day they now experience.

Offering clients the space to talk about sex might be all that's needed. Especially if it's linked to other emotionally-based issues. However, for others, though the difficulty might be more organic and physical. Not being able to maintain an erection could be about tiredness, age, the recent loss of job or relationships, not feeling appreciated, not wanting to be with the person you are with or it might be something more physical to do with the 'mechanics' of sex and sexual functioning.

Alongside an understanding of the impact of sexual difficulties on mood and self-esteem, we also need an awareness of how people have sex, be that with a partner; through self-pleasuring; in groups, with a significant or insignificant other. If it's open or covert in expression, if it's with real or virtual people, face to face, over the phone or via the internet. In books, indoors or outside, safe or risky. Alongside the knowledge, though, we must also make space to explore how we feel about all these things as well.

A brief word about sex therapy

Sex therapists work with all manner of sexual difficulties related not only to the physical but also the emotional aspects of sex. They work in the main with 'dysfunctions' such as erectile difficulties; pain on penetration; lack of penetration; and losses of desire along with orgasm problems. They also work with clients whose sex lives have been affected by illness, such as cancer, Parkinson's, disability, trauma and abuse or assault. Most sex therapists also work with the relationship and how sex sits within and is expressed.

A qualified sex therapist will usually be a member of COSRT (College of Sexual and Relationship Therapists) and is also often a member of other professional bodies such as COSCA as well. Training is either a two year post qualifying Diploma or a four year Masters level.

And then there's our own self awareness

We look at client's profiles through many faceted lenses, anger, loss, deprivation and disappointments; how often though do we also look through the sexual lens? Or do we feel that it's too much like voyeurism, a step too far, and what might we feel if we do see something we maybe don't understand or approve of or that maybe excites us. Is this a step too far, to acknowledge that some of our concerns about working with sexual feelings might draw us to a difficult and even scary edge within the client/counsellor relationship?

This I feel is a neglected area of learning, how we deal with our own feelings of attraction and desire within the counselling room. Erotic transference is not something that only happens for clients, transferences work both ways. A client talks about food and we feel hunger, a client talks of loss and we feel sad, a client talks about sex and we may well feel something sexual. It isn't wrong, however, as with all things we need to understand the significance in therapeutic work and we need to discuss in supervision. The more open we can be the safer is the client.

Conclusion

If we don't ask then how do clients know they can tell? If supervisors don't ask then how can counsellors share and if we don't teach how can we explore and understand the issues we may face with our clients. And that applies to sex as much as it does to any other aspect of counselling.

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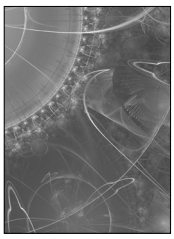

The State We're In

Mary MacCallum Sullivan, Dr Alison Brown,
Dr Anne Marie Coleman and Dr Gail Taylor

It is a sad reflection on the state of our universities that a space cannot be found for the maintenance and continued investment in what has been a notably successful Scottish postgraduate programme of training in counselling (Smith, K & McLeod, J. *Counselling Training in Higher Education: where do we go from here?* Counselling in Scotland, Winter/Spring 2016). It is a sad reflection on our current models of HE 'standard pedagogical structures' (ibid, p. 21) that there is no room, in light of the pressures on higher education institutions to cut costs and increase cohort sizes, for the experiential and emotional learning that is increasingly recognised as vital for the development of human creativity[1].

We commend the invitation to dialogue in relation to "where we go from here", and agree that it is vital to preserve professional and clinical training within a Higher Education landscape. That is not to say that trainings outwith the university cannot also demonstrate, through credit-rating processes, that their standards comply with the relevant academic criteria and professional benchmarks.

However, without the research skills and resources located within the university, the capacity for independent training organisations to support research programmes is severely limited; moreover, the gold standard of the randomised controlled trial (RCT) requires conditions that are often incompatible with the priorities and financial constraints of 3rd sector organisations providing clinical services.

It is no longer the case that counselling and psychotherapy[2], jointly understood to be an emerging profession, are ambivalent about and resistant to the value of research. In the US and UK generally, a critical mass now exists of distinctive quantitative and qualitative research that demonstrates good outcomes in psychological therapeutic approaches[3]. Counselling and psychotherapy are developing new knowledge at the leading edge of the science of human relationality, and research output from Strathclyde University has been at the forefront in this. There is also widespread use in Scotland of clinical practice audit and outcome measures such as CORE. Such evidence seems not to be widely visible to those responsible for commissioning services such as support for survivors of childhood sexual abuse and gender-based violence, or for the NICE and SIGN guideline teams. As Smith and McLeod note, initiatives that elsewhere in UK have "breathed a new lease of life into counselling training" (p.22), have not, thus far, resulted, in Scotland, in stronger and more direct links between NHS and the relevant stakeholders.

It is worth noting, as Ballinger (2013) does, that women vastly outnumber men within the profession of counselling and psychotherapy, and we may, justly, wonder whether this fact contributes to the lower status, if not actual 'invisibility', of the profession in circles of power and influence. It is well understood that predominantly 'feminised' professions are generally less highly valued, recognised and paid than those with a higher dominance of men, such as psychology.

We contend that there is evidence in Scotland of a bias towards applied psychology and against the recognition of counselling and psychotherapy training as adequate in relation to the delivery of

1 The challenge faced by counselling studies in universities is a UK-wide problem, as attested to by Ballinger (2013).

2 For the purposes of the current discussion, we don't believe it is helpful to draw a distinction between the two descriptors; there is such a discussion to be had in another context.

3 See, for example, BACP (2013), *Evidence for Counselling and Psychotherapy*, and also http://www.bacp.co.uk/research/; Shedler, J., *Efficacy of Psychodynamic Psychotherapy*, American Psychologist, February–March 2010.

talking therapies. It may be this that lies behind the new policy of Strathclyde University, which could be perceived as having decided to throw in its lot with the perception of psychology as a superior discipline.

It is striking that the NHS Education for Scotland (NES) *Matrix–a Guide to delivering psychological therapies in Scotland* (2014), describes applied psychologists as "the staff group with the highest level of psychological expertise within the workforce by virtue of their 7-year full-time academic and Doctoral level clinical training" (p.29).

Within the NHS workforce, despite stated NES policy ("it will be necessary to maximise the contribution of the various disciplines to the delivery of Psychological Therapies in order to meet the HEAT (Health Improvement, Efficiency, Access to Services and Treatment) access target", p.28), while counsellors are mentioned, psychotherapists, with precisely similar levels of education and training, are not and are thus rendered invisible and excluded from the possibility of utilising their specialised training and skills in the delivery of 'evidence-based' treatment approaches in line with NHS and Scottish Government policy.

COSCA (Counselling and Psychotherapy in Scotland) is the umbrella body for the (joint) profession in Scotland. Yet the general absence in the literature of the "and psychotherapy" is notable, and, together with the general adoption of the term "psychological therapies", we would argue, adversely impacts the readiness of the NHS and other commissioning bodies to include non-psychologists such as highly-qualified counsellors and psychotherapists in their workforce planning.

The Scottish Government policy is that treatments such as counselling and psychotherapy can still be recognised as being of benefit to patients; that the absence of evidence in the literature does not mean that an approach should not be used, nor that it does not count towards the psychological therapies target (COSCA, 2014); there is recognition that it may be that the evidence base is not 'evident' enough!

The Matrix, despite its acknowledgement that, for psychological therapies, "[t]he vehicle for delivery is a complex interpersonal interaction, and treatment sessions often take place over extended periods of time, usually on a one-to-one basis" (p.28), remains grimly wedded to a prescriptive medical model of medicine, whereby patients receive a diagnosis, for which the prescribed treatment is a particular, manualised set of interventions comprising an "evidence-based treatment model", delivered by someone with the relevant, particularized training. The possibility of a larger vision of health, and of higher-level clinical competences (proposed as vital elsewhere in the document) and specialist qualifications, is strikingly absent. The NES training master plan notes: "Staff from any discipline who have the appropriate training, and can demonstrate the relevant competences may be involved in delivery and supervision of care, and of related teaching and training" (ibid). However, there is considerable anecdotal evidence that the NHS has become a 'closed shop' to highly trained counsellors and psychotherapists. What a waste!

As protagonists over many years in the field of postgraduate-level training in HE-accredited and professionally validated counselling and psychotherapy programmes, we have sought to marry the independence of the stand-alone professional organisation with the academic standards and rigorous assessment criteria and procedures of the university. We have considered the engagement with this tension to be essential to the perception of the profession as a valid enterprise and to its development, frankly.

The diversity of theoretical approaches has not helped, because different modalities effectively find themselves in competition; in small-scale Scotland this represents a question of, not just sustainability, but survivability. Yet this diversity is the very lifeblood of the profession, because it creates and promotes our passion and commitment to a range of perspectives on what it means to be human. When we lose that devotion to the personal and the interpersonal, the particular and unique, the richness and the complexity of each professional interaction, we fail in our commitment to the work and to our own professional and clinical development.
So surely there is merit in the idea of support for statutory recognition of HE-accredited postgraduate (Masters and Doctorate level) qualifications in counselling and psychotherapy? At least one Scottish university could be supported by NES and the Scottish Government to 'host' such accreditation. As long as the programmes meet the requisite SCQF level 11

and 12 criteria, appropriate quality assurance standards and professional requirements[4], they can be academically accredited in a creative and collaborative partnership between university and independent training organisations on an 'arms-length' basis. NHS Education for Scotland (NES) recognises the UK-wide 'Skills for Health' competences that are key to the effective delivery of psychological therapies, and the generic QAA Subject Benchmark Statement: Counselling and Psychotherapy Benchmark (QAA 2013) also supports a range of modality options towards an award recognised throughout the UK.

The challenge of counselling and psychotherapy

The practice of counselling and psychotherapy constitutes a new 'technology', a living craft, a set of relational skills, a process; it is both a methodology and an ethics of human subjectivity and intersubjectivity. It offers an ethical framework for a powerful interpersonal dynamic, and a means to recover from trauma and mental ill health, to change the structure of the brain, to enhance the capacity to flourish. It offers guidance in the project of maintaining healthy relationships and of living "a good life"[5].

The focus on a 'hard' scientific basis for all human activity may have the unintended consequence of excluding from view evidence that presents a more qualitative exploration of personal experience, where the differences between people, and their relational experiences, render outcomes research evidence more complex and less clear-cut. Such a focus also undermines a 'values-based' approach that underpins commitment to an ethical stance, a truly person-centred approach, that privileges the lived encounter itself, within a care-full professional environment that is respectful of each individual person and their unique experience. This therapeutic attitude often conflicts with our deep-seated, adaptive tendencies towards self-preservation and self-defence; it is, to a degree, an unnatural stance, and it takes courage and, arguably, considerable training and supervisory support to be able consistently to overcome that defensiveness, the fear of being 'real'. The emphasis on manualised approaches, with their goals and outcomes, may promote a practice that complies with the protocol, rather than be person-centred, in whatever modality. In order to be able to practise out of hope, not fear, a key learning outcome for counselling/psychotherapy training should be the formulation of a personal practice-based ethics of relationality which will constitute the frame that offers a safe space for both participants and also a personal/professional 'internal regulator' for the work[6].

The 'invisibility' of the profession is really interesting. More counselling is done in Scotland through the voluntary sector than through primary or secondary care. This may have something to do with the strong historical connection in Scotland between the churches and counselling/pastoral provision. There is also a strong connection between COSCA and the volunteer agencies. Yet training as a counsellor/psychotherapist may cost individuals upwards of £12,000, with very little funding support available, and after the training, individuals have to be entrepreneurs to make a living from the work, the culture and expectation often being that counsellors will work on a voluntary basis.

This is a recipe for an almost exclusively white, largely female, middle-class workforce. A programme such as that suggested above may be the only way to begin to address this marginalisation and deplorable lack of diversity, together with a greater formal recognition of the profession by the NHS and Scottish Government.

Mental health is one of the three national clinical priorities of the NHS in Scotland. The Mental Health Strategy 2012-15 (now, we notice, out of date!) sets out the Scottish Government's priorities in this area. The focus is on "prevention, anticipation and supported self management" in taking forward mental health policy in Scotland, and the strategy sets the ambition for care to be person-centred, safe and effective. The Government is also committed to reducing the prescription of anti-depressants and to increasing access - within 18 weeks from referral—to psychological therapies, and is finding additional funding to support services, particularly in relation to children and young people. There is also recognition of the need to develop constructive early intervention for people suffering from complex emotional, mental and trauma-related distress.

4 Professional validation by COSCA, BACP, UKCP and BPC, meeting national and international standards.

5 See Cooper, M (2004) *Towards a relationally-orientated approach to therapy: empirical support and analysis* British Journal of Guidance & Counselling, Vol. 32, No. 4, November 2004

6 This is in addition to the external regulation of the various professional registers by the Professional Standards Authority.

We suggest that funding support for and statutory recognition of, HE-accredited postgraduate (Masters and Doctorate level) qualifications in counselling and psychotherapy would not only provide a work-force already qualified to deliver evidence-based talking therapies, but would also more widely influence and support good mental health services, spreading skills and good practice across a range of people-facing and caring professions - nursing, psychology, emergency medicine, police, social work, prison service, and, of course, voluntary agencies.

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Cognitive Remediation Therapy:

enhancing employment outcomes in vocational rehabilitation

Inga Davidson, Aleksandra Atanasova and Liz Gibson

Cognition in mental health

The prevalence of cognitive impairments in schizophrenia is well documented (Fioravanti et al., 2012) and the awareness of this in other mental health conditions is growing (Ruocco 2005, Castaneda et al., 2008). Within schizophrenia, cognitive impairment is seen as a core feature, with impairments evident in many of the domains. Bowie & Harvey (2006) highlight that most people with schizophrenia will have some cognitive impairments (including impairment in attention, working memory, verbal fluency, verbal learning and memory, and executive functioning) but like many of the other symptoms, the severity and frequency vary from person to person. Cognitive impairment correlates with poor functional performance (Green 1996). Executive functions tasks are the best indicators of occupational functioning in schizophrenia (McGurk et al., 2003). Executive functioning refers to a number of cognitive processes resulting in purposeful, goal directed behaviours, including cognitive processes such as planning, problem solving and decision making.

Even within first episode psychosis there is evidence of cognitive impairment. McCleery et al., (2014) found that the profile of cognitive impairment in first episode psychosis is similar to that observed in chronic schizophrenia, although social cognition and working memory may be more intact in the early phases of the illness.

Cognitive impairments in other mental health conditions are beginning to be more widely recognised. A review of cognitive impairment in depressive and anxiety disorders in young people by Castaneda et al., (2008) found that cognitive impairment is common in major depression, with impairments in executive functioning being most evident. Within anxiety disorders, the profile depended on the sub type, with obsessive compulsive disorder being associated with deficits in executive functioning and visual memory.

Effective treatment for cognitive impairments in schizophrenia is limited. Cognitive Remediation Therapy (CRT) is recognised as a behavioural intervention which aims to treat cognitive impairment. As cited by Wykes et al., (2011), Cognitive Remediation Therapy for schizophrenia was defined at the Cognitive Remediation Experts Workshop (Florence, Italy, 2010), as "a behavioural training based intervention that aims to improve cognitive processes (attention, memory, executive function, social cognition or metacognition) with the goal of durability and generalisation".

A meta-analysis completed in 2007 demonstrates that CRT does have a positive impact on psychosocial functioning including greater improvements in obtaining and working competitive jobs and the quality of and satisfaction with interpersonal relationships (McGurk et al., 2007). Moreover, in recent meta-analysis by Wykes et al., (2011), the findings indicate that CRT does produce improvements in cognition and functioning, and CRT is more effective when delivered alongside other psychiatric rehabilitation. Therefore, literature indicates that CRT is effective in improving cognition (Wykes et al., 2002; McGurk 2007 et al.,) and that these improvements are durable and generalised (Wykes et al., 2011). This has led to a B grade recommendation for CRT within the Scottish Intercollegiate Guidelines Network (SIGN) for the management of schizophrenia (SIGN, 2013).

CRT can also be used as precursor to other psychological therapies. Drake et al., (2014) explored the use of CRT preceding Cognitive Behavioural Therapy (CBT) and found that CRT prior to CBT results in fewer sessions of CBT, making this a more efficient way of delivering CBT.

Fife Employment Access Trust (FEAT) is a leading mental health and employability charity in Fife. FEAT noticed first-hand the impact that cognitive impairment was having on individuals who were trying to access and maintain meaningful work roles. This led to a collaboration between FEAT and NHS Fife mental health directorate to look at planning a project that would meet this need.

The Employ Your Mind Project

Employ Your Mind (EYM) is an innovative project, funded by the Big Lottery. The project is delivered in partnership between FEAT and NHS Fife Mental Health. This project aims to benefit adults who have severe and enduring mental health conditions and who have multiple barriers to return to or enter the workplace.

EYM is a 24-week modular programme, run in 4 phases, of six-week blocks. Phase one sessions are delivered once a week for 45 minutes with one Learning Coach (FEAT staff) and an NHS Fife Mental Health Professional and are focused on building trust with the students. The remainder of the project is delivered three times a week for two hours with two Learning Coaches and are group based sessions. These phases are in a community setting and consist of pre-employability work to increase confidence and self-esteem, employment and vocational guidance, work experience and volunteering within local organisations.

Students have the opportunity to complete a Scottish Vocational Qualification (SVQ) qualification which covers personal development as well as a 20 hour work experience placement.

CRT is embedded within the project. During phase two, three and four students are working on completing CRT exercises for 30 to 45 minutes each session. Students are presented with a variety of different CRT exercises, such as pen and paper, computerised games, practical puzzles or group exercises. During phase one students explore their learning styles, based on those results, students are presented with the best CRT exercises for them. Students also complete an Audio Recorded Cognitive Screen[1] (ARCS) (Schofield et al., 2010) towards the beginning of the project and again at the end. Students receive individual feedback on their results, as well as a discussion based on how CRT can link to personal goals. The idea behind it is to be able to show to each student the benefits of CRT in everyday activities and encourage metacognition. The CRT exercises help students increase functional capacity. These strategies focus on developing core skills used in daily activities, including attention span, concentration, memory, and the ability to plan and organise, all to support clients as they pursue educational or employment opportunities.

Innovations

Since the inception of EYM, we have worked to expand the scope and delivery of CRT within our service, looking for innovative methods of delivery as well as seeking to develop links with international partners and to expand the remit of services that we offer.

We have worked with other agencies as far afield as Melbourne, Australia where we have replicated the EYM course. Our Occupational Therapist, Inga Davidson, was also invited to present at the Cognitive Remediation and Psychiatry conference held in New York last year and had the opportunity to visit and learn from the team at Columbia University, headed by Professor Alice Medalia, an esteemed professional and pioneer within the field of CRT. Closer to home, we have continued to develop close ties with Kings College London, which has included Dr Clare Reeder appearing as guest speaker at our highly successful CRT conference, *Thought Matters*. The conference was designed to present information on the understanding and treatment of the cognitive deficits that commonly occur in many psychiatric conditions.

Following on from the conference we have begun to offer training in CRT to other agencies looking to set up and develop their own CRT service. The training provided consists of an intensive two day course covering everything from the rationale behind CRT to the practicalities of setting up and delivering a CRT service.

As an organisation, we specialise in employability services and have always looked to combine CRT with the practical goal of improving employability outcomes. There is a growing evidence to indicate that, even with the best evidence based employability services, clients with cognitive deficits find it harder to gain and retain paid employment. In light of this we are leading the way in Scotland by developing a CRT provision within the Fife Individual Placement and Support (IPS) service. IPS is an evidence

1 Developed by the Hunter New England Neuropsychiatry Service, NSW, Australia

based form of supported employment which has been shown to have significant success rates in helping clients with severe and enduring mental health problems to gain competitive paid employment. We will be the first service within Scotland to provide CRT integrated within an IPS service to allow our clients to have the best possible outcomes in terms of achieving their employability goals.

We continue to explore different methods of delivery for CRT, often encouraging group participation as well as one to one input. We are constantly reviewing the methods used to ensure they are as client centred and engaging as possible while at the same time allowing the opportunity for success and strategy development. Key to this is always the ability to link back the cognitive skills and strategies developed to real life situations. Having CRT embedded within our EYM course has provided a unique and important method for achieving this and is something that we would hope to be able to replicate successfully in our delivery of CRT within the Fife IPS service and any future projects.

CRT is now a widely recognised therapy which looks to be gaining continued recognition. FEAT are proud to be at the forefront of the future development and delivery of CRT services within Scotland.

If you are interested in any of the services that we offer, including training in CRT, please contact either Inga Davidson (inga@journeytowork.co.uk) at Fife Employment Access Trust www.feat.org.uk

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COSCA's Register of Counsellors and Psychotherapists and New Members

COSCA's REGISTER OF COUNSELLORS AND PSYCHOTHERAPISTS

ACCREDITED COUNSELLOR MEMBERS
BROWN, ALISON
BROWN, KAREN
DAVIDSON, EWAN CHRISTOPHER
HUTCHISON, CRAIG

ACCREDITED (BACP) COUNSELLOR/ PSYCHOTHERAPIST MEMBER
GAULT, CHRISTINE

ACCREDITED (OTHER UK PROFESSIONAL BODY) COUNSELLOR/PSYCHOTHERAPIST MEMBERS
FERRIE, CAROL
MULLER, REBECCA

PRACTITIONER MEMBERS
BOYD, VERA
COLLINS, DIANNE
DOHERTY, JOHN
HALFHIDE, ELSPETH JEAN
INNES, SANDRA
MACQUEEN, ELSPETH
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MILLICAN, JANE
PROUDFOOT, LISA
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SMITH, ALYSON MAY
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SUBSCRIBERS
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Details of all events are on the COSCA website:
www.cosca.org.uk
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2016

21 September
COSCA Annual General Meeting
STIRLING

3 October
Scottish Voluntary Sector Counselling Practice Research Network Event
GLASGOW

2017

7 March
COSCA 9th Ethical Seminar
'Online Presence: ethical perspectives'
STIRLING

COSCA
Counselling & Psychotherapy in Scotland

VISION

A listening, caring society that values people's well being.

PURPOSE

As Scotland's professional body for counselling and psychotherapy, COSCA seeks to advance all forms of counselling and psychotherapy and use of counselling skills by promoting best practice and through the delivery of a range of sustainable services.

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