

# Counselling *at work*

## Cancer in the room

work, identity  
and mortality

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**Combat zone to  
Civvy Street:**  
working with veterans

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**Plasters for the mind:**  
mental health  
first aid

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**Conversations:**  
what to prioritise  
at work

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**Work-related stress:**  
how do you work  
with it?

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**T** 01455 883300  
**F** 01455 550243

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### Editor

Nicola Banning  
[counsellingatwork@bacp.co.uk](mailto:counsellingatwork@bacp.co.uk)

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# First words

Whatever conclusions you draw from the result of the 2017 General Election, a significant factor appears to be the public's opposition to austerity, cuts and pay freezes borne by the public sector since 2010. How often it jars, when I read, yet again, that the UK is the fifth richest country in the world, given what I hear in the counselling room working with those on the frontline of our society.

In the wake of the terrorist atrocities in Manchester and London, and the tragic fire at the Grenfell Tower, a spotlight has been shone on the vital work of our public services; in particular, fire fighters, the police and the health service. Experienced nurse, Joe O'Brien spoke movingly about her night shift immediately after the Manchester bombings: witnessing injuries she'd never seen before; about how the team got on with the job they are trained for; and how, at the end of the shift, she went home and cuddled her dogs.

As the nation becomes more informed about mental health, it seems that the media interest increases in how our first responders cope in the aftermath of traumatic incidents and terrorist attacks. There's a terrible irony that the same public sector workers subjected to the impact of cuts and pay freezes since the crash, are unfailingly there for us when our society needs them most, picking up the pieces and healing the wounds. If the Government really has woken up to the unacceptability of this, it's long overdue.

As a community of workplace practitioners, we too are part of this cycle, providing essential emotional and psychological support when stretched employees and their organisations need us. Too often we work in a parallel climate of economic uncertainty and insecurity about the future of our jobs and the services we manage. Against this backdrop, I welcome the nation banging its collective drum recently to increase awareness about mental health. But the voices calling to move beyond awareness and for increased action, and more specifically more resources, are growing louder.

During the General Election campaign, BACP committed to nine policy priorities, one of which was the provision of workplace counselling for all employees across the UK. BACP reported that while this didn't receive any concrete support to improve access to workplace counselling, there was a commitment in the Conservative manifestos (UK, Wales and Scotland) to work with employers following the review to be carried out by Lord Stevenson and Paul Farmer, to look at improving workplace support for mental health.

Meanwhile, you'll find a conversation I had with two advocates of employee support in the workplace. Medical psychotherapist, Penny Campling talked to me about her recommendations for the health service and the potential role for therapists to be involved. Andrew Kinder, a past BACP Workplace Chair and new member on the BACP Board of Governors, has an interest in the employability of counsellors and spoke of the needs and challenges facing business.

In 'Cancer in the room', Caroline Feldon Parsons reflects on her work with Macmillan, drawing attention to how employers can help or hinder an individual's recovery and transition back to work. Worryingly, she reports that 71 per cent of employers are not even aware that, legally, cancer is defined as a disability. I've known clients to come to counselling months after the ordeal of treatment is over, when they are back at work and needing to make sense of what happened and who they are. Talking about mortality and imminent death is something that some loved ones can't face – but the counselling space offers a bridge to where others can't go.

Former naval officer Alexandra Gillyon has hung up her uniform and used her valuable understanding of being in the armed forces to undertake some research into therapists working with ex-military personnel. She highlights the need for the armed forces to develop a help-seeking culture while acknowledging this is a balancing act. Organisational knowledge such as this, is

valuable to our profession, so that we can best respond and meet the needs of clients and their organisations.

Pushing a trolley on the weekly shop, I noticed a supermarket employee stacking shelves and crying. On the verge of asking if I could help, a friendly and competent staff member arrived, asked the employee if they were OK, and then, gently, took them off the shop floor. It may have been a good friend, or an example of the growing mental health first aid movement in action. I'd heard Poppy Jaman, the Chief Executive of Mental Health First Aid England, on BBC Radio 4, explaining about a programme to train staff members as mental health first aiders, able to spot the signs of mental ill health and signpost employees to appropriate support. 'Plasters for the mind' explores their work providing training programmes accredited by the Royal Society for Public Health in schools, colleges, workplaces and the military.

I'm an advocate of anything that increases emotional literacy in our society and workplaces, but if you have thoughts on this article, or any of the topics covered in *Counselling at Work*, I'd encourage you to get in touch. These pages are your pages; so whatever you're facing in your work, drop me a line so we can continue to represent your interests.

Nicola



**Nicola Banning**  
Editor,  
*Counselling at Work*  
[counsellingatwork.co.uk](http://counsellingatwork.co.uk)

# Notes from the Chair

## Attachments at work Nicola Neath

The terrible events in Manchester and London unfolded as this issue of *Counselling at Work* was in production. We wish to pay our respects to all those affected and also to pay tribute to the many helpers and supporters, professional or otherwise, who stepped in and who often do at times of crisis. A humane and compassionate response to violence is both humbling and inspiring.

The summer is now in full swing following a memorable General Election campaign during which all the political parties declared their policies and pledges for mental health. What a remarkable change it is to have our work and the needs of our clients finally feature in mainstream politics at a national level. This is thanks to all the hard work that happens across the entire profession, and despite these most challenging of times, it proves that change can happen. We need to keep speaking up for our clients, and the contribution our work makes to maintaining psychologically healthy workplaces. Let's see what this Government might do for us, and remain active and present in our engagement.

It's with considerable regret, we say 'farewell' to Alison Paice, who is stepping down from our Executive Committee. Alison has brought a tremendous vibrancy to our work on the Executive, and has contributed so much to the success of the BACP Practitioners' Conferences. We shall all miss her but we are delighted that her growing business, supporting workplaces, requires more of her attention. We wish her all the very best in the future.

At the beginning of May I attended and presented at the 8th International Conference For Exploratory Goal-Corrected Psychotherapy (EGCP)<sup>™</sup> in Northern Ireland. This conference arises from the work of Una McCluskey, who has developed a model of individual and group psychotherapy exploring 'The Dynamics of Attachment in Adult Life.'<sup>™</sup> It's specifically for professional care-givers and the process of

interacting is called Goal-Corrected Empathic Attunement (GCEA)<sup>™</sup>. Through her organisation, Una provides training and research into the model, and the conference brought together delegates interested in using it in different organisational settings.

I have been exploring and learning about the McCluskey Model for the last five years – and have recently had the opportunity to operationalise it in my workplace. It was a most vibrant and motivating experience to spend time with dedicated professionals whom I admire, working creatively and across such a broad spectrum of fields, including palliative care, severe mental health conditions, private practice, prisons, couples work, and of course, inevitably, many who are working with employees. Like me, these professionals are all taking the principles of this model into their lives and work. I am currently writing a book with Una McCluskey on the experience of operationalising it in my workplace – hoping it might inspire others to do something similar. I remain passionate about using psychological theory to improve our understanding, and our experience, of what we need to give to and get from professional relationships at work.

Interestingly, attachment theory is rarely used, either systemically or relationally, within the field of professional organisational leadership in the UK.<sup>1</sup>

And yet, in my opinion, it is both valuable and applicable to organisations. As part of my role at the University of Leeds, I design and innovate proactive training for all staff, including formal and informal leaders, and professors and directors in academic and non-academic roles, all of whom have the possibility of impacting the organisation in a positive way. The modern workplace recognises that engaging with the creative potential of human beings and ensuring supportive collaborative work relationships are crucial for the survival of the organisation.

Having worked in organisations for over 25 years, I've experienced, and understand the deep attachments that can be made in teams. I am interested in the systems which people formally or informally create to make sense of their working practices and their needs. I've seen fear affect relationships, health, productivity and organisational culture. I understand how important rooms and office layouts can be for self-worth and creativity, and how the strength of bonds, sexual or otherwise, can be formed. This model offers a coherent system, a framework with which we might support managers and leaders to help them navigate the landscape of humans at work.

When we hold on to our beliefs about our ways of working, share our expertise and interests, support and inspire each other, foster good and real relationships, talk and influence wherever possible, then I think we do a most magnificent thing for our society. Keep talking, look after yourselves and be proud of the work you do.

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- 1 Harms PD. Adult attachment styles in the workplace. Lincoln: University of Nebraska; 2011. <http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1084&context=managementfacpub> (accessed 31 May 2017).



**Nicola Neath**  
Chair, BACP Workplace  
[n.e.neath@adm.leeds.ac.uk](mailto:n.e.neath@adm.leeds.ac.uk)

# Workplace matters

## To err is human; but not at work? Sandi Mann

Sana, a 38-year-old accountant, was referred to me by her employer for what was described as 'anxiety'. On taking her history, it quickly became apparent that Sana was actually suffering from quite severe OCD that saw her checking and re-checking her work to such an extent that she was simply unable to let anything go. She had stopped trusting her own judgment and was taking hours completing simple tasks. Most times, she could only stop by double-checking with a colleague that she had done the task correctly. Moreover, she was coming home and ruminating about mistakes she may have made and had become unable to function effectively at work; the OCD was taking over her working life.

Such fears and anxieties are becoming more common as our workplace cultures become increasingly intolerant of mistakes that might cost them money or reputation in an ever more competitive world. This organisation-led intolerance of mistakes means embarrassment, frustration, stress and fear as the 'perpetrator' frets over the consequences of their actions. This fear is ever more pronounced in today's culture of insecurity, where a missed deadline or wrong number might result in our competence being questioned at the next appraisal.

The problems with such cultures of fear is not only that employees become risk averse (which may be good in safety-critical industries, of course), but that they can become so fearful that they are paralysed from doing their job properly. Of course, not all will become as dysfunctional as Sana, but fear creates its own inertia that rarely benefits anyone. Even doctors, where mistakes can mean life or death (it was famously estimated that 44,000 to 98,000 deaths per year – the equivalent of a jumbo jet a day – result from medical errors!), have to take some risks sometimes; to err on the side of caution can sometimes lead to worse outcomes.

Management guru Peter Drucker put this starkly when he suggested that rather than companies firing people who make mistakes, they should fire those who never make mistakes, because if someone never makes a mistake, he or she never does anything interesting.<sup>2</sup> Moreover, mistakes aid learning, so a company whose employees are afraid of getting it wrong may lack growth; as an article in the *Harvard Business Review* explained in 2002, 'business can't develop a breakthrough product or process if it's not willing to encourage risk taking and learn from subsequent mistakes.'<sup>3</sup>

A recent report suggests that nurses in Irish hospitals are claiming that they are losing sleep over fear of making mistakes and they feel that the increased likelihood of making mistakes is linked directly to too few resources and too much work. One nurse said, 'Every nurse goes into work with serious concerns that we'll make a mistake, that we'll forget to do something or we'll omit something important because we are juggling so many jobs at once.'<sup>4</sup>

The more juggling stressed employees need to do and the less time there is for reflecting, thinking and consolidating, the more chance there is of forgetting to do something, of doing something wrong or of missing something important. As the Royal Society for the Prevention of Accidents (RoSPA) states, 'Workers experiencing high levels of stress may be more liable to commit errors in their work (whether slips, mistakes or violations).'<sup>5</sup>

Given the high stress levels of so many employees, you'd be forgiven for thinking that mistakes would be an acceptable part of work life – collateral damage as a result of the increased workloads and fewer resources of today's climate of austerity. But when companies are constantly looking to reduce costs and minimise 'deadweight', there is sometimes the expectation that those who make mistakes are dispensable. This leads to increased fear of erring, reduced entrepreneurship, reduced likelihood of

owning and reporting mistakes and reduced learning from errors.

Sana's OCD did not respond well to CBT, partly because, even though she could learn to accept that to err is human, she still lived in very real fear of making a catastrophic mistake at work. EMDR was more successful, but the reality is that if her organisation did not treat mistakes as crimes, but as learning tools, Sana would never have needed expensive and extensive therapy in the first place (which, ironically, her company was paying for).

Where there are humans, there will always be errors. Companies should take every step to minimise and catch mistakes, but they also need to be more forgiving, both for the mental health of their employees and their organisation.

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**Dr Sandi Mann** is Senior Psychology Lecturer at the University of Central Lancashire and Director of the Mind Training Clinic. She is author of several psychology self-help books including *Manage Your Anger*, *Overcoming Phobias and Panic Attacks* and *The Upside of Downtime: why boredom is good*.  
[smann@uclan.ac.uk](mailto:smann@uclan.ac.uk)

# Talking purple

## Purple networkology Sarah Simcoe

Change is ubiquitous. I've learned during my career that the best kind of change occurs when we can organise people around a common goal and have a shared understanding of what we are trying to achieve and why we are trying to achieve it. It's known as the 'and' game and the 'end' game. This can be said of any kind of change, whether at an individual, organisational, or cultural level.

One of the most powerful ways an employer can engage with their employees to enable those with disabilities, health conditions, mental health conditions or long-term injuries to feel included, enabled and respected in their workplace, is to establish a disabled employee network (DEN). The DEN is a direct line in engaging disabled employees and accessing the voice of the lived experience. In my workplace, Fujitsu's DEN has given us the opportunity to really connect with our employees, to understand and use that experience when it comes to building and driving our disability-confident agenda, forming a strategy underpinned by goals and objectives that will deliver real sustainable change. Other large corporations such as KPMG, Barclays, the Civil Service and Shell all have similarly well established networks.

However, I'm often asked, why? Why would we set up a DEN and what real value can that add to the business? From first-hand experience, I know that a network can help an organisation move into the space of driving real sustainable change for its employees, with the following benefits:

*It enhances communication channels* – A network provides a mechanism for disabled employees to share their thoughts on the types of systemic adjustments that the organisation needs to make. It helps to create a shared understanding about key priorities for change and provide a forum for discussion that enables employees to feel valued and heard.

*It provides peer-group support and networking* – A network can provide informal support for those acquiring an impairment

during their working life or for those whose existing health conditions have worsened. It may also help people to consider their own personal strategies for overcoming barriers to getting reasonable changes to the working environment or to getting promotion. The personal story and learning from those who have experienced similar journeys can be powerful.

*It encourages career progression* – There is a vast pool of purple talent out there and networks help to create an environment that encourages disabled employees to develop their skills, pursue career opportunities and provide role models and mentors.

*It promotes diversity* – The active support of a DEN is a direct demonstration of an employer's level of commitment to disabled employees. It signals a real drive to build a diverse workforce, assists the organisation to demonstrate how it values its employees and might well help to attract and retain talented disabled employees. This is evident in Fujitsu and it has helped to increase the number of disabled employees recruited, retained and who are now comfortable in sharing their disability or condition.

*It encourages compliance with employment law* – This is important and not all organisations understand the consequence. The Disability Discrimination Acts of 1995 and 2005 make it unlawful to discriminate against disabled people at work. Between 2004 and 2007, over 15,000 cases went to employment tribunal. A DEN can be one of the best ways an employer has of demonstrating their strategic intent to address discrimination against disabled people in the workplace.

*It broadens consultation channels* – A DEN can be a valuable route for consultation on policies, practices and procedures. It can be a good source of information about the challenges in the workplace and a helpful reference point for personnel, training providers, diversity officers, procurement advisors and facilities managers.

Furthermore, an employer which publicly recognises the value of its disabled employees

is likely to reap the rewards of increased interest from disabled customers and clients. Organisations that are involved in delivering a service to the public can use the DEN to help build a better picture of the needs and expectations of disabled customers, to improve its products and services. It will become increasingly important for organisations to anticipate the aspirations and requirements of disabled customers, and what better way than by tapping into the knowledge of a DEN?

The benefits of a DEN are clear, but creating successful networks requires skill, hard work and innovation. It is more than 'a nice to have' and is about creating a real vehicle to supporting cultural change in an organisation. It takes a good understanding of where you want to get to and how you will engage and excite others along the way.

You have to know what you are talking about and network leaders (including myself) need to talk to disabled employees, who can help to answer key questions: what is going well? What is not going well? What needs to be improved? How can the network support change? Where should we prioritise our efforts? To assist with your DEN journey, there are some excellent resources available, and in my role leading the network, I regularly check and balance our approach with two PurpleSpace publications, *In the Chair* and *Purple Stories*. To find out more, you can visit the PurpleSpace website below.



Sarah Simcoe is Head of Business Planning EMEA at Fujitsu, Chair of SEED, Fujitsu UK and Ireland's Disabled Employee Network and a PurpleSpace Ambassador.  
sarah.simcoe@uk.fujitsu.com  
www.purplespace.org

# Cyberwork

## Diversity

### Sarah Worley-James

When we meet a client in person for the first time, diversity issues such as race, ethnicity or disability may be apparent immediately. However, the invisibility of the online client can potentially lead to these issues being overlooked, affecting the relationship, our understanding of the client's worldview and the client's capacity to make the most of the counselling.

Online disinhibition may help the client feel more comfortable explicitly sharing and exploring these differences. Using email and instant messaging (IM), the client can meet the counsellor in ways that *they* choose; as opposed to knowing that areas of difference will be involuntarily disclosed in a first face-to-face encounter.

### *'I seek clues about my client's diversity in the ways that they express themselves in writing'*

Working together online, I find it helpful to check with the client whether there are difficulties that need addressing in order for them to gain the most from online sessions, such as shortening the sessions, knowing what to do if communication abruptly ceases for non-technical reasons, or simply being aware that it may take longer for the client to express themselves in an IM session. For example, some physical disabilities may mean the client is uncomfortable sitting in one position for the length of a session, or they have a condition where they can become unwell suddenly, or perhaps they utilise speech recognition software that may affect the speed at which they communicate.

Other physical attributes, such as accent, style of clothing and any adornments are clearly visible to the face-to-face counsellor,

and they combine to give clues about the client's background, religion, gender, sexuality, race and education level. Being aware that these differences influence how the client communicates and engages with therapy, I am sensitive in how I ask about and acknowledge diversity when meeting the client in cyberspace. It can be easy to make suppositions about someone's race, religion, sexuality, gender or socio-economic background from their name, which may be erroneous and, potentially, patronising and disrespectful.

Clients tend to write their full official name on forms, and it is especially important when working online to check out what name and pronoun the client prefers to be called by. What we call someone has a huge impact on how comfortable and respected they feel, and therefore how open they are to connecting to the therapeutic process. The counsellor's cultural background may lead them to automatically abbreviate names or always use the full version, and without visual clues or the client saying something, they may unwittingly be causing the client to cringe every time this abbreviation is used, hindering the development of the relationship.

One of my interests (some would say obsessions!), is how we use words, and the effect one word can have on the meaning and feelings triggered by that phrase or sentence. The choice of words used by the counsellor can unwittingly create a barrier, or quickly engender trust. I learnt a great lesson in my early career when I used the word 'girlfriend' when referring to my client's, as yet unnamed, partner; only to be informed their partner was also male. I have never forgotten my embarrassment at such a simple error, and I always use the non-gender specific word 'partner' until I know what gender to refer to.

As well as paying attention to what my style of writing might tell the client about me, I seek clues about my client's diversity in the ways that they express themselves in writing. Their choice and use of language, grammar and style creates a sense of who they are, in explicit and implicit ways. It may be apparent

from the client's name and the way they use English that this is not their first language. This alerts me to consider more carefully the words and phrasing I use, without altering their experience of who I am. This also applies to clients who are on the autistic spectrum, as I need to be mindful that metaphors and analogies could be confusing, and to be prepared for potentially more direct language from the client.

As we all know, text-based communication can be fraught with misunderstandings – directness can be read as abruptness, anger, frustration or hurt, whereas this may simply be how the client expresses themselves. It may not have been appropriate or felt relevant for them to disclose that they are on the autistic spectrum, so the first indication may be in their style of communicating. The counsellor needs to have their internal supervisor switched on, check whether this is the natural writing and communication style of that client, and how they can 'meet' the client openly and meaningfully.

Writing this column, I'm struck by how varied the indications of diversity are when we work with clients online. The online counsellor needs to be alert to new ways of picking up on issues of diversity, while remaining as open, interested and enquiring in how they work with the client as any face-to-face counsellor would be.



**Sarah Worley-James** is current Chair of the Association for Counselling and Therapy Online (ACTO). She is a senior counsellor and Co-ordinator of the Online Service at Cardiff University. [worley-james@cardiff.ac.uk](mailto:worley-james@cardiff.ac.uk)



# Cancer in the room

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Over 100,000 people of working age (age 16–64) are diagnosed with cancer in the UK each year. **Caroline Feldon Parsons** reflects on her work with clients with cancer

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The day before my friend died of cancer, I visited her. She was spending most of the time asleep, her husband sitting with her. As I walked into the room, she woke up, saw me and smiled. I leaned over and kissed her. Her eyes grew troubled.

'He won't let me talk about it, you know, what's going to happen. He never wants to talk about it. None of them do.' I knew what she meant, because she'd mentioned it before: she wanted to talk about her death, and people kept changing the subject. I looked at her husband, who was sitting silently with tears running down his cheeks. He shook his head. I didn't want to upset him further. So I leaned in to her and said into her ear: 'Don't worry, they have all been talking about it. Just not in here.' She looked at me and smiled again. Then her eyes closed. She died the next day.

I often think about that moment. Should I have sat down with her and said yes, let's talk about it now, when her husband so obviously didn't want to? Should I have tried to send him out of the room so we could talk about it? Would it have helped him or made him more upset? I will probably never know. What I do know, though, is that this dilemma is at the very heart of why I am now working alongside Macmillan – to help clients with cancer and their loved ones talk about these kinds of issues. In the last nine months, I have met an amazing group

of people. They have all been going on cancer journeys: their own, or alongside their partners or family members. To protect their confidentiality in this article, I have anonymised, changed and merged details, and changed genders. In addition to my friend, several of my close friends and family have been affected by cancer. Some have survived, and some have not. The statistics are bleak: there are now 2.5 million people living with cancer in the UK,<sup>1</sup> and that number is increasing by three per cent every year.<sup>1</sup> According to Macmillan research, over 100,000 people of working age (age 16–64) are diagnosed with cancer in the UK each year; more specifically, 327 every day.<sup>2–5</sup> This means that there are currently over 700,000 people of working age living with a cancer diagnosis.<sup>6</sup> Part of the reason I became a counsellor was because I wanted to make a difference to my clients, and when I began working with this client group, I knew I wanted to give something back.

### A new identity

My friend died a few years ago, but her issues around talking about her cancer and death remained with me. And in my work, this is what I hear over and over again – the clients who find that, once diagnosed, they feel isolated. Their new identity as a cancer patient affects not only



them but the way they communicate with others. Many clients tell me that, after diagnosis, some of their friends and family simply 'disappear'. They don't hear from them at all, or very intermittently, and the dialogue is awkward and uncomfortable. It makes the client feel unloved, unwanted, rejected. They hear that people 'don't know what to say' or begin by being supportive, and then gradually back off when the going gets tough. One client who lived alone, likened it to begging for crumbs of affection from her family, some of whom lived here in the UK and some abroad. She didn't know whether to stay here to continue with her treatment, but where her family were very unsupportive in spite of the cultural expectations that her uncle would look after her; or to go home to her remaining family and take up treatment options there, in the hopes that her family there would be more kind and caring to her.

The opposite may also occur, when the client prefers to deal with the cancer by minimising it. They may refuse to talk about it because people get upset when they do, or because if they don't talk about it, then it simply isn't happening. One client described the way his life suddenly changed overnight to become a 'soap opera'. He dealt with the situation by not reading any information about his cancer, not reading any of the leaflets issued with his drugs, not talking about it to his children. He put up a front for ages, pretending everything was OK and that the cancer was no more than a slight inconvenience. He hated the phrase, 'How are you?' and would turn around and walk off if someone said it. Apparently, I was the only one who was allowed to use it – and that was because I was at the end of a telephone, anonymous, and behind an acceptable barrier.

In both of those cases above, the clients wanted to keep their original identity as 'people' and not just become 'cancer patients'. Most of the work I do with my clients is aimed at helping them to work through various types of loss: the loss of their original identity, the loss of the relationships they thought they had, perhaps the loss of the life that they were expecting to have, and the emergence of a 'new normal' that they can work with and come to terms with. One client who had presented with his own diagnosis of cancer, and who was also struggling to get over the death of his wife 10 years earlier from cancer, was really helped when we discussed the idea that his wife would have been going through her own loss for him, in advance of her own death. Sometimes, if clients are really struggling to deal with their loss, I suggest that they can

'schedule' themselves in some time to deal with it, say between 3pm and 4pm every day, or at a time to suit them. During this time, they can make sure they are alone, and give in completely to the grief or misery, knowing that there is a 'stop' time. Putting boundaries around the time when they allow themselves to feel miserable seems to stop the worst of the feelings from leeching into the rest of the day. Discussing what clients' expectations were of themselves following the illness, and managing other people's expectations and judgments of them, is also a large part of the work, as is normalising the clients' feelings and the apparently rejecting behaviour of their loved ones. The client can lead in these interactions, letting their friends/family/colleagues know that it's OK to not know what to say or do, and that they can figure out a new 'script' or way of being together.

### Challenges at work

Loss of identity can also be a problem in the workplace, where clients, who had previously felt they were part of a 'work family', may now be suffering from a lack of interaction with their team, or of information about structural changes or new projects taken on. For these people, work is important in terms of normality, routine, stability, social contact and income. What really made a difference to my clients who were off sick from work was the attitude of their workplaces towards their illness. While some clients reported positive experiences, such as one client who had received lots of phone calls, flowers and letters on a regular basis from her work colleagues, unfortunately this is not always the case. One client who

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*'Talking about, and making plans for, their eventual death has also been a part of the work: thinking about who they want to be there, where they want to be, and even what they want to wear; so that the unknown can become, in some small way, known'*

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had been off for nine months with skin cancer had had little or no contact from his manager or colleagues, even though he had tried to stay in touch. He didn't hear anything until he had a letter from HR telling him that he

*'You would sometimes turn up to find her wearing a ball gown, or a cocktail dress and gloves. The choice of how to respond to your situation is always yours, and clients find it a relief to discover that there is another option'*

was able to qualify for long-term disability, but if he chose to take that, it would affect his pension and pay. He described how he had been made to feel like a 'faceless person'. This was compounded by a phone call informing him that, while off sick, his whole department had been restructured, he had a new boss, and that he didn't qualify for the Access to Work that he was expecting.

In England, Scotland and Wales, employees with cancer are protected from discrimination in the workplace by the Equality Act 2010. The Disability Discrimination Act 1995 and its extension, the Disability Discrimination Order of 2006, protect workers in Northern Ireland. Cancer is legally defined as a disability, but apparently 71 per cent of employers are not aware of this.<sup>7</sup> In theory, responsible employers should have policies and practices in place to ensure that all employees with cancer are treated fairly and appropriately. However, according to some of my clients, their managers and colleagues were not confident about how to support them. This is upheld by more Macmillan research, which states that almost half of people living with cancer and in work when diagnosed (47 per cent) say their employer did not discuss sick pay entitlement, flexible working arrangements, or workplace adjustments, when they informed them of their diagnosis.<sup>8</sup> Those who have returned to work after cancer may also face challenges. Around four in 10 people who are working when diagnosed have to make changes to their working lives after cancer, with almost half changing jobs or leaving work altogether; while of those who give up work or change jobs as a result of their diagnosis, 43 per cent give up work because they are not physically able to do it.<sup>10</sup> One client had a phased return to work, but she felt she had to deliver her job immediately after her return, almost to behave as if she hadn't just had cancer. She described a sense of guilt about the time she had had to take off to deal with her illness. Her colleagues were also reluctant to talk to her about what she had been through, and because her body had changed as a result of surgery, she felt like an oddball. Eventually, she changed her job.

There are some specialist cancer EAP providers. Those workplaces who offer this or internal counselling services show a duty of care; and for clients who can access these services, this is a bonus. Whether it is face-to-face, telephone or online counselling, the fact that this can be dovetailed with HR procedures, alongside their team, will help to create feelings of inclusion. Some clients have been signposted following their workplace support when they have needed further assistance, commonly

after a changed prognosis. Their initial EAP counselling has been valuable to these clients.

### **A question of choice**

Whether in the workplace or at home, clients often feel that they have no choice about what is happening to them. I look at this through a different lens: in the client's world of limited choices, what choices do they have? This is an interesting philosophical point, which I often address with the help of Viktor Frankl.<sup>9</sup> 'When we can no longer change a situation,' he says, 'we are challenged to change ourselves.' His idea is that in a world where you have no choices at all, the one freedom that can't be taken away from you is the way you choose to respond to the circumstances in which you find yourself. I have often discussed this with clients and found that in some cases they are already doing it. One client was recently diagnosed as terminally ill, with a secondary cancer on the liver, but he was choosing to concentrate on the best way to spend his remaining time. He reacted to his situation by getting a new job and working alongside a friend, painting greetings cards, which he had always wanted to do. He wondered if there was something wrong with him for wanting to do this, but when looked at through the lens of choice, he was able to make sense of his actions. Another client, after we had discussed this choice, decided that she would stop lying awake every night and panicking about what was going to happen to her, and instead get up and start the novel she had always wanted to write. My friend, who I mentioned at the beginning, exercised her choice of how to react to her terminal cancer by making sure that she wore everything in her wardrobe that she had been saving for a special occasion. You would sometimes turn up to find her wearing a ball gown, or a cocktail dress and gloves. The choice of how to respond to your situation is always yours, and clients find it a relief to discover that there is another option.

### **Terminology**

We talk about cancer as a 'battle' which must be 'fought' and the disease must be 'beaten'. The cancer is attacked with knives in surgery, poisoned with chemotherapy or blasted with radiotherapy. Cancer patients may have 'lost their battle' or have 'survived' the attack. Make no mistake, to be living with cancer is to be living in a war zone. However, usually it's not the fighting talk that I hear from my clients. It's more likely to be anxiety, depression, worry about family, accompanied by a heavy use of



euphemisms for cancer. In addition to 'The Big C', which most clients hate, I have heard them talk about abnormal growths, a cluster of cells, maybe a large mass or seedlings. Although a study has found that even though these kinds of terms are often used by doctors and patients instead of that big, scary word 'cancer', the employment of euphemisms and the general ambiguity generated by their use can cause more anxiety than the actual word itself.<sup>10</sup>

I have also found that clients, when they first present, are very 'medicalised', due to their interaction with a series of hospital professionals. They usually want to tell you the story of their cancer and treatment so far. They see me as yet another professional, and as a result, they use a lot of jargon, which for me, with my journalistic rather than clinical background, can be baffling. Terms such as lumpectomy, which I had heard of, and mucositis, which I hadn't, cropped up. I got confused between MRI, CT and PET scans. There are more than 200 types of cancer, each with its own name and treatment. I felt overwhelmed with the sheer amount of information that I received when I was doing my initial training with Macmillan. No wonder my clients felt the same.

I realised that I had to find a way of working with the cancer in the room. It had to have its own space, to almost sit in the empty chair. I often externalise it, asking clients to give me a visual picture of how they see it, or feel it in their body. Descriptions have ranged from 'a grey slug', 'an alien inside me', 'a black cloud', feeling 'under attack', 'rotten in my chest with cells going everywhere' and even 'an inconvenience'. Clients have talked about their bodies betraying them, their cancer holding them back like a harness, and have even given it a name such as 'Matilda' or 'Bert'. Once they can 'see' it, talk or shout at it, or even decide to make it smaller or more transparent, it becomes less threatening. It becomes a real thing rather than an all-encompassing menace; something that can be fought, or recognised and accepted.

Ultimately, some of my clients are staring death squarely in the face, but would struggle to talk about that too. More euphemisms were used by the clients' loved ones and their doctors. I heard 'kicking the bucket', 'to pop one's clogs', 'pushing up daisies', 'to bite the dust', and my personal favourite: 'to become living-challenged'. Almost anything rather than use the word 'died'. I have noticed, particularly when doing genograms, that people often use 'passed away' for someone close to them who has died recently, and keep 'died' for an event that happened a while or a generation ago. As a therapist, I would often be the one to use that word before the client did, even if they found it shocking, so that we could then begin to open up a dialogue about what death means to them, how it has

been dealt with in their families, and inevitably to talk about the concept of a 'good death'. Clients have found it helpful to be able to talk to someone about their worries around dying alone, dying in pain, dying in fear, and how it might look and feel at the end of life. Some clients have been used to talking about death in relation to others, either as part of their job if they worked in a medical setting, or because others in their families have died; but are surprised that they struggle to talk about it in relation to themselves. A couple of clients wanted to talk through their fears of suffering in the same way that they had seen someone else suffer. I find that, when you are talking about almost certain death at an unknown time,<sup>11</sup> it is useful to help the client to set goals that they can work towards, so that they have some sense of achievement. One client wants to live long enough so that her grandchildren are old enough to remember her. As the disease progresses or the goals are achieved, new goals can be set, with shorter lead times, so that there can still be a sense of satisfaction. Talking about, and making plans for, their eventual death has also been a part of the work: thinking about who they want to be there, where they want to be, and even what they want to wear; so that the unknown can become, in some small way, known.

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*'Most of the work I do with my clients is aimed at helping them to work through various types of loss: the loss of their original identity, the loss of the relationships they thought they had, perhaps the loss of the life that they were expecting to have, and the emergence of a "new normal" that they can work with and come to terms with'*

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### Closing thoughts

Providing this space, where it is OK to talk, and safe to suffer, means that as a therapist I need to look after my own self-care. The work that I do is relatively short term, usually eight sessions or less, so it feels as if you vividly but briefly dip into the client's journey while they come to terms with what is happening to them. Clients also drop out of therapy for various reasons, such as denial, or treatment. I have regular supervision, of course, and sometimes I have simply dumped my feelings at my supervisor's feet. One thing I do find useful is to type short process notes when I get home. Once I have emptied my head onto paper – and I am a fast typist so it doesn't take long – I find that I don't carry my clients around with me too much. But sometimes, no matter how well prepared

you feel, a client's story can shock you or make you tearful. Today, I shed a few unexpected tears in the room with a client as we talked about facing death. Last Friday, I found myself welling up as another client talked about how she had now come to think of death as a 'state of mind'. In the interests of congruence in these situations I always acknowledge my feelings to the client, and they seem to appreciate this.

Of course, most of the time and as with most clients, you will never know the end of the story. Some people will recover, some will return to work successfully, some will manage without taking much time off work, and others unfortunately don't survive. If treatment is successful, work can provide a constancy and security, whereas for others, it's a time to do something else or a time to make sense of what has happened. I would like to think that eventually my clients and their loved ones will be able to talk about their feelings to each other. It's OK to be human, after all.



**Caroline Feldon Parsons** MBACP has been a practising counsellor with Relate for four years. She currently works with individuals, couples and families, and alongside Macmillan with clients and families affected by cancer. Before that, she worked at the BBC for 28 years as researcher, producer and director within various network radio and TV departments.  
[caroline.feldon@hotmail.co.uk](mailto:caroline.feldon@hotmail.co.uk)

### *Your feedback please*

If you have thoughts about any of the issues raised in this article or would like to write an article of your own, we would like to hear from you. Please email the editor: [counsellingatwork@bacp.co.uk](mailto:counsellingatwork@bacp.co.uk)

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# From combat zone to Civvy Street

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## If you've not encountered an ex-military client yet, it's likely that you soon will. Veteran **Alexandra Gillyon** talks to therapists about their work with this client group

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**B**efore training as a counsellor, I spent 10 years serving in the Royal Navy as a marine engineer officer, deployed in a conflict area at sea off the coast of Iraq and in Southern Iraq in the post conflict reconstruction effort. This article is based on my Counselling MA research, which explored the experiences of therapists working with military veterans and aimed to learn more about the common themes in their work. An unexpected outcome was that it also helped me make sense of my own experiences as a veteran.

While serving in areas of conflict and during peacetime, I experienced the loss of friends and colleagues, and saw others who were deeply affected psychologically by their experiences. The pastoral care of troops in my section was the aspect of my role as an officer that I most identified with. I saw that members of the forces who needed psychological support did not always admit this and often did not get it. When I left the Royal Navy, I embarked on a part-time psychology degree and started my own counselling training.

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***'I saw that members of the forces who needed psychological support did not always admit this and often did not get it'***

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My specific research question was: What are the experiences of therapists working with military veterans? How such a contextual factor might influence therapy was something I wanted to explore more in my study. It was a qualitative study from a social constructionist perspective, using semi-structured interviews, with six therapists working with ex-military clients (including one therapist who was also a veteran).

With British troops recently engaged in operations in Iraq, Afghanistan and Northern Ireland, our awareness of the psychological impact of war on our troops has grown. This field is now a significant area of interest within UK academic research, via the King's Centre for Military Health Research.<sup>1</sup> Although most troops do not experience long-term psychological issues, there is a significant

minority that does<sup>2</sup> and these mental scars can be as debilitating as any physical injury.

The sheer number of military veterans in the UK is also significant. Approximately 5.5 million men and women have served in the UK armed forces at some point.<sup>3</sup> A UK veteran is defined as one who has served in the Armed Services for at least one day.<sup>4</sup>

### **Research into counselling military veterans**

Previous research has looked at military veterans to learn more about their experiences of therapy and the services available to them.<sup>5-7</sup> Most of this research in the UK is co-ordinated through the King's Centre for Military Health Research.<sup>1</sup> This research includes a cohort study looking at the impact of deployment on mental and physical health, using over 10,000 armed forces personnel.<sup>1</sup> A significant amount of research has been carried out into the treatment outcomes for the psychological problems of UK military personnel.<sup>8</sup> The other side of the therapeutic encounter, however, has not been subject to the same level of exploration – namely, the views of therapists. By hearing therapists' views, I wondered if it might be possible to provide more insight into improving services as well as helping therapists to learn from the experiences of others within this specialist field.

### **Media coverage of PTSD in the military**

The media frequently report on the apparently high rates of post-traumatic stress disorder (PTSD) among returning troops. However, Professor Simon Wessely<sup>9</sup> argues that this is perhaps not as prevalent as media coverage would lead us to believe. Not all soldiers involved in a particular incident are affected by trauma in this way, suggesting that other factors may be at play. Moreover, a significant proportion of veterans presenting with PTSD have not had combat experience.<sup>10</sup> There is further evidence from the organisation Combat Stress, of delayed reactions to combat trauma, with difficulties arising decades later among veterans of Northern Ireland and the Falklands.<sup>11</sup> The media's over-reporting of PTSD<sup>12</sup> means that much more common issues in veterans, such as depression and alcohol abuse, are not as well known to the public.<sup>13</sup> Combat Stress found, in its own study, that 62 per cent of its patients presented with a range of complex symptoms,

including alcohol use, depression, and concerns about physical and social issues.<sup>11</sup>

However, war does not always lead to trauma, damage or to 'moral injury'. For some, it can even be a positive experience. Wessely<sup>9</sup> writes how war can often intensify emotions and experiences, including positive ones, such as friendship and excitement, with normal life sometimes even seeming 'boring' in comparison.

### Vulnerability factors and stigma

Lecturer and writer Steven Walker<sup>13</sup> found that, in addition to combat trauma exposure, there may also be other factors, such as emotional immaturity or a poor socio-economic background, which may predispose some members of the armed forces to experience later mental health issues. There may be a risk of developing PTSD, or longer-term mental health problems, even after leaving the armed forces.

For Wessely,<sup>9</sup> the stigma within the military about help-seeking is a serious factor preventing forces personnel from coming forward when they experience difficulties. It may present even more of a barrier to their seeking help compared with a civilian population.<sup>13</sup> In his discussion of military culture, veteran and therapist Wynne Jones<sup>14</sup> described core military values as being resilient and stoic, which can make admitting to being vulnerable and seeking help all the more difficult for some to overcome.

### A help-seeking culture

This reluctance to get help, both in and after service, highlights the need for the armed forces to encourage a help-seeking culture. But a balance is needed between this and encouraging troops to be resilient, which is essential for their job. However, by not seeking help for psychological issues, there can be longer-term personal, medical and social care costs, highlighting the need for quicker and more effective treatments once problems have been identified. Wessely<sup>9</sup> suggests that veterans could also be supported by increasing the availability of services. However, ex-military clients can sometimes feel that they are not understood by civilian therapists, which could present a challenge for therapists to overcome.

### Services for veterans

When troops leave the military, through the Government commitment in the Armed Forces Covenant,<sup>4</sup> the NHS assumes responsibility for their care. Charities have also historically supported a significant proportion of the veteran population seeking help.<sup>3</sup> Writing in *Military Medicine*, Richard Pinder and co-authors<sup>5</sup> explain how, previously, the NHS had identified veterans as an IAPT special interest group, with regionally based programmes for improving access to the talking therapies. In recent years, collaboration between services, such as the NHS and Combat Stress, has worked towards developing more community-based programmes for veteran mental health services.

In the UK, NICE recommendations for trauma in military veterans focus largely on trauma-focused CBT and on EMDR.<sup>15</sup> However, there have been studies arguing

that a much more holistic view of veterans' needs should be encouraged.<sup>16</sup> Some veterans have claimed that the NHS is not well equipped to deal with their specific needs as soldiers.<sup>2</sup> In one study, it was found that some veterans felt that non-military therapists would not be able to understand what they had been through,<sup>17</sup> highlighting the importance of civilian therapists understanding military culture.

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*'Veteran clients often assumed that their therapist would not understand them, because their life in the military was outside normal civilian experience. Sometimes this was because the therapist was female or civilian'*

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In 2015/2016 an NHS England Veterans Survey captured the perspective of veterans and families, including some of these issues.<sup>18</sup> Following their survey and pilot studies, NHS England has now commissioned the £9 million NHS Transition, Intervention and Liaison (TIL) Veterans' Mental Health Service.<sup>19</sup> Launched on 1 April 2017, it aims to be an entry point to other NHS services, third sector and local authority services. This will hopefully move veteran health provision in a positive future direction.

### My research project

Ethical approval was given by the University of Manchester and informed by BACP guidance for counselling research.<sup>20</sup> Six counsellors, from a range of modalities and work settings, were selected, on the basis that they had worked with military veterans. Three main themes were identified, and will be discussed in more detail.

### Significance of military service

All the counsellors talked about the need to understand how having served in the armed forces may have had an impact on their ex-military clients. This included the likelihood of being exposed to potentially traumatic situations. Clients' early histories and their reasons for joining the military were part of the overall picture. It was also important to understand how life in the services can influence issues presenting later in therapy.

'But we cannot blame their childhood, which is what the Government wants to do... we can't because the army or the military consolidates these coping mechanisms that they built up to survive' (Charlotte)

Another common issue was that the clients' vulnerability might be exposed on leaving the armed forces. Counsellors talked about how leaving the military could be a significant factor in influencing clients' difficulties, or in exacerbating their trauma symptoms.

Therapists described how this transition can often be the catalyst for problems being revealed, as veterans leave an environment in which their difficulties have previously been safely contained. One therapist talked about a client



who was only now experiencing symptoms of PTSD from experiences in Northern Ireland decades ago.

Veteran clients often assumed that their therapist would not understand them, because their life in the military was outside normal civilian experience. Sometimes this was because the therapist was female, or civilian. Therapists talked about the ways in which they could try to identify more with their clients, perhaps through them being ex military themselves, having other personal connections with the services, and how they worked through these barriers with their clients by exploring the issues.

### Complexity of military trauma

This theme explored the different issues associated with working with military trauma and how work with veterans could be a complex process. The counsellors talked about having to separate out the different aspects of clients' traumas, such as early life experience, pre-trauma and the latter's impact on their life. Veterans might also present with other issues which, in turn, have influenced the main trauma:

'...There was a lot of stuff he brought into the army with him and also a lot of stuff that was going on at home, so trauma just blew everything else up.' (Barbara)

Counsellors conveyed how the complexity of veterans' presenting issues meant that finding the right way to work with a veteran client was of key importance.

### Organisational care of veterans

Therapists talked about the benefits of more effective co-ordination of services for veterans. Recognising that transition can be a significant difficulty for many veterans, more co-ordination between services was needed:

'And one of the issues is the whole networking thing, and I'm not sure how strong the networks are. Hundreds of service charities... but I'm not sure how joined up they all are in terms of recommending each other and helping each other.' (Patrick)

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***'As more veterans reach out for support and hopefully an increased availability of services to support them, understanding more about this client group may become increasingly relevant for therapists across all sectors'***

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Sometimes veterans had negative experiences of specialist services and the therapists described some of the problematic aspects their clients encountered:

'Some of my clients who've had to do group therapy... have become traumatised by the other patients' experiences.' (Beverley)

There was also a view that NHS-endorsed treatments may not be suitable for all ex-military clients:

'So what a lot of therapists do, it seems, is they provide NICE treatments, and that is excluding of other things.' (John)

Some services and charities had different funding criteria for veterans needing support. Counsellors referred to an apparent lack of support sometimes for those clients experiencing difficulties with alcohol abuse:

'It's "No, we'll talk to you if you're a hero, we're not going to talk to you if you've fallen off the wagon"... so this particular guy had asked for help from various forces charities. They didn't want to know.' (Patrick)

All those taking part talked about how they, or their clients, had experienced links with other services, including, prison or probation services, or other larger charities, which could contribute funding for clients. The interviewees suggested that even though veterans are no longer in the armed forces, the MOD may still have a role to play, particularly in recognising potential vulnerabilities at the recruitment stage.

'It's brought up quite a lot for me about how we go about recruiting for the forces and where these people come from' (Claire).

### Conclusion

The commonality between veterans is the clear significance of their life in the armed services. The therapists acknowledged the difficulties their clients often face during transition to civilian life. An important consideration for therapists when working with this client group is having awareness and understanding of the different terminology, language, beliefs, values, and the range of emotions attached to serving, the sub-cultures within the military, and their significance. The ethical importance of understanding the wider role of culture is already well recognised within the counselling profession.<sup>20</sup>

It is important to be more aware of pre-enlistment vulnerability factors for mental health problems facing ex-military clients, including PTSD, attachment issues, abuse, and neglect. The most common mental health issues for veterans are not limited to PTSD, but include depression and alcohol misuse. For those veterans for whom the main NICE-approved approaches do not work, an awareness of different approaches to working with trauma could be vital.

The themes around service co-ordination suggested more could be done. NHS England may have drawn similar conclusions in their review of veteran health provision, which has now led to the commissioning of the new NHS England TIL Veterans' Mental Health Service.<sup>19</sup> Hopefully, this will be the start of a new approach to veteran healthcare across England, and may help support the need for this across the UK. This will hopefully help provide veterans with effective, swift support which is more able to deal with complex cases. It will hopefully also mean working more closely with the third sector, providing more holistic support with a broader range of services accessible and available to all veterans.

### Personal reflections

My research provoked a lot of reflection around my own emotional responses and, in particular, 'moral injury' was a topic that resonated very strongly with me. During the writing of my literature review, the Chilcot Iraq Inquiry



was a frequent topic in the media<sup>21</sup> and this brought my past experiences in Iraq very close to the surface. I had always struggled with the morality of going to war in Iraq, with my own guilt and powerlessness at being unable to influence the political events which led to UK forces being mobilised. When I was deployed for a second time to the region, I worked directly with Iraqi nationals in reconstruction projects. I felt a huge sense of personal responsibility for the damage that had been inflicted on the people and their country.

Even though I had never carried out a combat role or been personally responsible for damage, wearing a UK Armed Forces uniform was enough for me to feel guilt and responsibility. Reading about 'moral injury' in the literature made me realise that this was something I was personally continuing to struggle with. I felt a strong sense of empathy for the soldiers described within studies on the subject, but also a sense of relief at the impact of such difficulties being recognised in what I was reading.

Looking ahead, I hope to make use of both my military experience and counselling training. In understanding more about the complexity of working with trauma, my future training plans include acquiring more skills that can help equip me to navigate this, in areas that also interest me personally, such as EMDR and mindfulness-based approaches. As more veterans reach out for support, and hopefully with an increased availability of services to support them, understanding more about this client group may become increasingly relevant for therapists across all sectors.



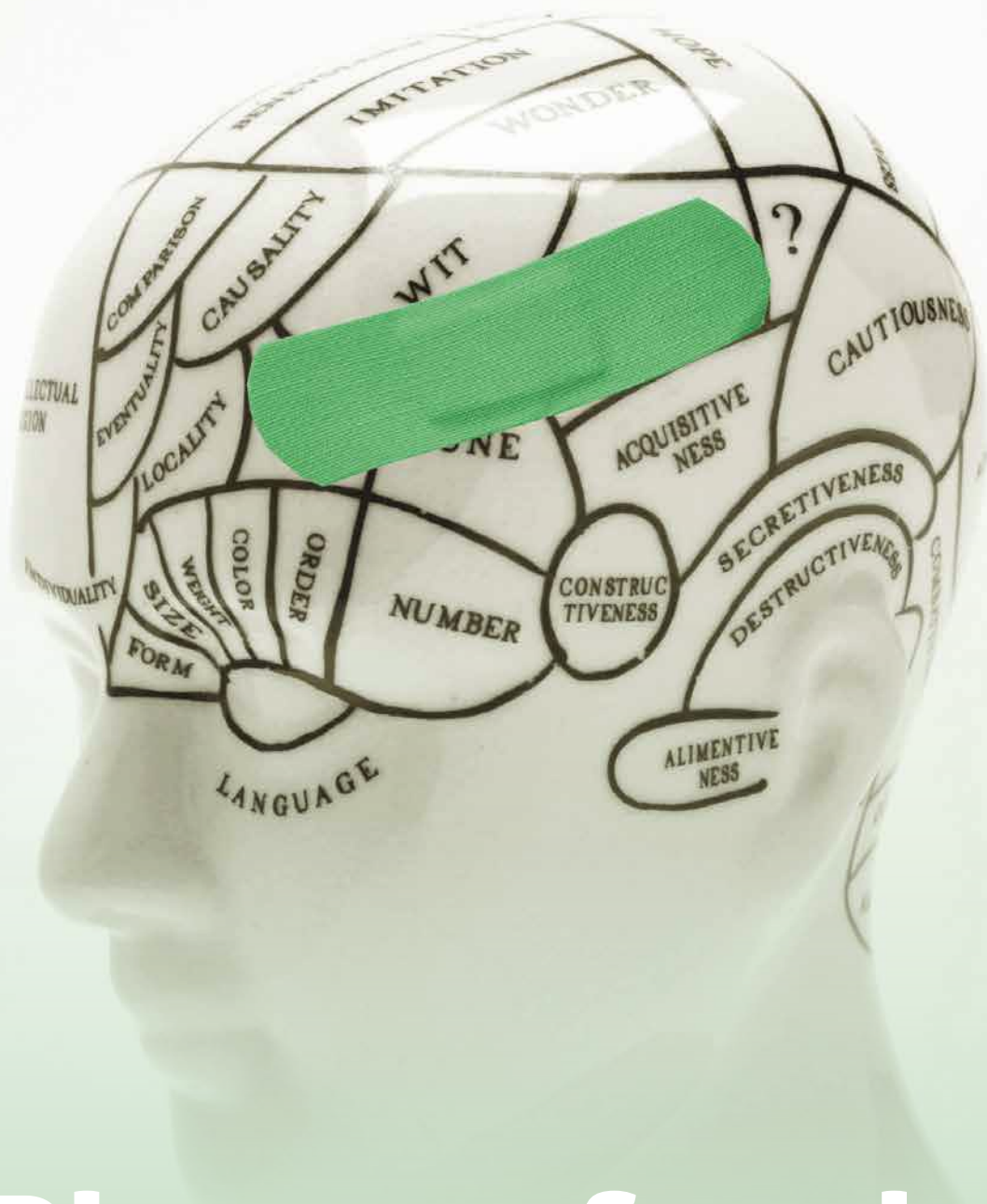
**Alexandra Gillyon** is an integrative counsellor. She served as an Engineer Officer in the Royal Navy prior to training as a counsellor. She now works for a young people's charity in Cheshire and in private practice in Manchester.  
[alexandra.gillyon@gmail.com](mailto:alexandra.gillyon@gmail.com)

### Your feedback please

If you have thoughts about any of the issues raised in this article or would like to write an article of your own, we would like to hear from you. Please email the editor: [counsellingatwork@bacp.co.uk](mailto:counsellingatwork@bacp.co.uk)

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# Plasters for the MIND

## Mental health first aid at work has arrived. Nicola Banning finds out how businesses are investing in training staff to aid prevention and spot the signs of mental illness early

It's estimated that the cost of mental ill health to British business is £26 billion per year, which equates to an average of £1,000 per employee.<sup>1</sup> We spend around a third of our lives at work and with growing demand on our health service, it makes sense to focus on prevention and how we make our workplaces more mentally healthy. Creating environments that are more emotionally literate and psychologically aware is central to the preventative work of not-for-profit Mental Health First Aid (MHFA) England.

The idea was born, so the story goes, nearly 20 years ago in Australia, when a couple with an interest in mental health were out walking their dogs and realised that what was needed was first aid for depression.<sup>2</sup> They went on to develop training courses in mental health first aid to teach participants to recognise the signs and symptoms of mental health illness and to know how to respond appropriately. The training is now internationally recognised in 24 countries and MHFA England has to date trained over 1,300 instructors in England and delivered courses to over 188,000 people in schools, workplaces and the military.<sup>1</sup>

Put simply, the approach to mental health first aid is that it should be on a par with standard first aid. Just as every school, community and workplace has first aiders, they should also have mental health first aiders, who can help identify the early signs of mental ill health and signpost individuals to support before it reaches crisis point. MHFA England is clear that it is not teaching people to become therapists but is committed to developing emotional literacy to bring about a culture change in how we see mental health, including at a legislative level.

Chief Executive of MHFA England, Poppy Jaman, described 'a wave of change coming in mental health'<sup>3</sup> with the roll-out of training courses in MHFA to support young people in education with mental health issues. The need for more support in schools as teachers and pastoral workers face increasingly complex mental health issues in children and young people, has been covered previously in *Counselling at Work* as too many are dealing with the consequences of austerity and the cuts to provision.<sup>4</sup> Recent figures from the Office for National Statistics reveal a worrying trend in the public sector, as female-dominated occupations, including primary school teachers, nurses and care workers, are showing a higher risk of suicide than the national average.<sup>5</sup>

Training in MHFA in both the public and private sector is now well established and is tailored specifically to meet the needs of the organisation. Working with a wide range of industries, Caroline Hounsell, Director of Product Development, Partnerships and Training at MHFA England, was one of the first MHFA England instructors to be trained and joined the national team in 2007: 'We have delivered MHFA courses to the likes of Unilever, WHSmith, EY, Crossrail, Royal Mail, BBC, and Channel 4; there has also been an increasing uptake in the public sector – with NHS England and Public Health Dorset having recently rolled out large-scale MHFA programmes. Many companies we work with have cited the role of MHFA in helping them to tackle mental health stigma in the workplace and to create environments where employees take better care of themselves and each other.' This is to be welcomed, given that Public Health England estimates that in the NHS alone, the cost of staff absence due to poor health is £2.4 billion a year – excluding the cost of agency staff to fill in gaps and the cost of treatment.<sup>6</sup> 'A culture change can mean staff feel more able to report mental health issues as a reason for sickness absence, which in turn allows more accurate collection of data on staff wellbeing, so that more effective wellbeing strategies can be developed,' says Caroline.

### Employability

Therapists familiar with working upstream with employers, will understand that the provision of counselling is just one part of the role; training, coaching, reflective practice, responding to critical incidents, advising on mental health strategy, can also be part of our work. The employability of our profession is of significant interest to BACP Workplace and with the versatile skills that we have as organisational practitioners, we are well placed to train as recognised MHFA trainers. However, as with all continuing professional development for therapists, it costs, unless you have an employer that is willing to fund you. Caroline explains: 'Therapists can and do train as MHFA instructors – I am a trained psychotherapist, still very much practising, and I am also an MHFA national trainer. Our seven-day instructor training programme teaches people how to deliver their own courses independently, whether in their spare time, as part of

their own training business or within a place of work. Many employers we work with also choose to train staff as instructors because it is a cost-effective and sustainable way to share MHFA skills widely within their organisation.'

This was the case for Ros Jiggins, an experienced counsellor and EAP case manager in Bristol with a background in the pharmaceutical industry. Committed to improving wellbeing in her organisation, Ros said: 'I've long been an advocate of mental health and physical health having parity, and although we've come a long way with reducing stigma around mental health, there's a very long way to go.' Initially Ros attended a two-day MHFA course, along with a diverse group of people, with varying degrees of knowledge about mental health. She followed this up with a seven-day instructor training to become an MHFA instructor qualified to deliver courses to adults.

I was curious to know how much Ros had learnt, given her previous knowledge and experience as a therapist. Ros is clear: 'I gained both knowledge and an increased confidence in understanding the full range of mental health issues, including anxiety, depression, eating disorders, psychosis, schizophrenia and suicide. The training is in depth, using mixed media and involves narrative from people who live with really challenging mental health conditions. It went way beyond anything that is routinely taught in counselling training.' Ros says that she now puts this knowledge to good use in her regular triage sessions with employees, and is using her MHFA instructor training to deliver training in both her workplace and externally, to help reduce the stigma people still feel about mental ill health at work.

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*'Just as every school, community and workplace has first aiders, they should also have mental health first aiders, who can help identify the early signs of mental ill health and signpost individuals to support before it reaches crisis point'*

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In a climate where so many of us are used to the philosophy of more for less, I can't help but wonder, if there's a danger that mental health first aid could be used as an alternative to the provision of counselling at

work. Ros doesn't think so: 'Mental health first aid will never replace high quality, boundaried, confidential talking therapies.'

As a BACP accredited therapist, Caroline recommends that therapists are advocates for as many people as possible receiving mental health first aid training. She explains: 'In raising awareness and increasing help-seeking behaviours, this training has an important part to play in breaking down the stigma around receiving therapy and therefore helps people to feel able to approach us. If people aren't aware of mental health issues – the fact that we all have mental health, or the sources of support available – it will only serve to keep therapists' doors closed.'

### Training line managers

The training is aimed at all staff, line managers and senior leaders, though Caroline recommends that line managers are best placed to train as Mental Health First Aiders: 'If someone experiencing a mental health issue has a line manager who is skilled in talking about mental health and knows what support to provide or signpost people to, that employee will feel better supported and is more likely to be able to continue working successfully. Line managers are also ideally placed to create a climate that is conducive to the wellbeing of their team and to spot changes in behaviour or performance that could indicate an underlying mental health issue.'

'We also know that line managers feel that this is something already in their remit, but too few feel equipped to manage these situations. *The Mental Health at Work Report*, published last year by Business in the Community, stated that although 76 per cent of line managers believe employee wellbeing is their responsibility, only 22 per cent of managers have received some form of training on mental health at work,' says Caroline.<sup>7</sup> The term 'wellbeing' has multiple meanings – from apples to pedometers – and, so too, often mental health may not feature sufficiently in an organisation's understanding of what contributes to wellbeing.

### Psychological safety

So much of the mental ill health that we witness is exacerbated by a lack of psychological safety at work, including a lack of financial security, short-term contracts, zero-hours contracts, uncertainty, targets and cuts to



staff and resources. Acknowledging this, Caroline suggests: 'In this post-recession era where many employers are under pressure to do more with less, I think our workplace relationships and cultures have become more important than ever before. Coping with tougher targets, heavier workloads and tighter deadlines may have become a standard in many offices, and while this may not be ideal, I think employers that are managing this best are those that have the most progressive approaches to workplace wellbeing.'

Making the business case, Caroline draws attention to the cost to UK employers of mental health-associated absences at an estimated £26 billion per year: 'It makes financial sense to make our workplaces more mentally healthy. This requires that employers make the link between being better able to manage these challenges and improved approaches to wellbeing. Creating a psychologically healthy workplace needs to be seen strategically as a way of improving many areas of a business and not just as a time-permitting, superficial measure to enhance an organisation's reputation. We know that recruitment, engagement and loyalty, as well as productivity, benefit from a mentally healthy workplace, and that failing to create this kind of culture is damaging to the bottom line.'

Despite increased openness and less stigma around mental health, I put it to Caroline that there may remain people in the workplace who are hard to reach, and who may find admitting to a mental health problem at work, particularly challenging: 'When we talk about employees who are hard to reach, we have to ask, why is it they're hard to reach in the first place? We know that men are harder to reach than women, for example, when it comes to talking about mental health, so perhaps there is something about ensuring that we appreciate that different genders might need different approaches. We also know that age can make a difference to attitudes towards mental ill health. But regardless of these insights, I do believe it lies in the organisational culture and the kind of workplaces where employees feel less inclined to disclose their mental health issue for fear of being demoted, missing out on promotions, or being judged negatively by their co-workers.'

### Changing culture

It's a view shared by workplace specialists engaged in the task of working with clients and their organisations to bring about systemic change. What's significant about the work of MHFA (England), is its potential to develop emotional literacy through training programmes accredited by the Royal Society for Public Health in so many areas of public life, from workplaces, schools, colleges and the military. 'Changing this culture means taking "a whole organisation" approach – this entails a recognition that long-lasting change around employee wellbeing means involving the entire organisation. MHFA training can be a key part of this in that it helps open up conversations, breaks down stigma, encourages mental health resilience and creates enthusiastic advocates for "a whole organisation" approach. This culture, coupled with

the awareness that trained Mental Health First Aiders are close at hand, also enables those who were previously hard to reach to feel able to come forward.'

### Leadership

Referring to a recent report, *A Little More Conversation*,<sup>8</sup> published by The Institute of Directors, which explores the ways that we tackle mental health at work, Caroline explains how one recommendation caught her attention: 'It's the idea of having a non-executive director working to ensure that openness around mental health is culturally instilled. Evidently this only works for businesses of a specific size; however, having that outside perspective, even when the leadership team are on board with the concept, can be invaluable.'

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*The Mental Health at Work Report, published last year by Business in the Community, stated that although 76 per cent of line managers believe employee wellbeing is their responsibility, only 22 per cent of managers have received some form of training on mental health at work'*

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'Having leadership buy-in also entails writing approaches to mental health and wellbeing into workplace policy. I think almost as important as this, however, is the proactive internal communications needed around these policies, to ensure staff are aware of them. It's obviously no use having great policies that support the creation of a psychologically healthy workplace if your employees don't know they exist!'

The case studies, collated by MHFA England, of industries which have trained employees in MHFA in recent years, make interesting reading: 'Changes which are introduced are specific to the needs of the employer, but initiatives include increased participation in tea and talk drop-in days; the introduction of 90-minute coaching sessions; growing a mental health ambassador network; and noticeably, increased reporting of mental health sickness absence which feeds into the wellbeing policy and strategy.'

There's a significant emphasis on self-care in the training and how we look after our own mental wellbeing, and the importance of encouraging others to do the same. 'When delivered well, I believe this knowledge can make a massive difference to people coping with everyday stresses and strains, who previously might have thought of mental health as something that doesn't apply to them,' says Caroline. The numbers of people who have little or no concept of self-care and how this leads to ill health, particularly in the helping professions, makes this an essential component. Identifying the specific problems for health workers in looking after their health, former medical director Steve Boorman, honorary professorial fellow of the Royal Society of Public Health, identified that

staff trained to put patients first, struggle to tend to their own needs, highlighting the need for a systemic approach to bring about a cultural change.<sup>6</sup>

### Looking ahead

MHFA England is optimistic about Theresa May's pledge to roll out mental health support to every school in the country, and to ensure that mental health is taken far more seriously in the workplace. Caroline explains: 'Our current Government's pledge to amend the Health at Work Act so that first aid regulations specifically refer to mental illness would be a fantastic step to advance a culture shift towards psychologically healthy workplaces all over the country. We have been campaigning for this for a long time and so the implementation of this policy, and the implications for the Mental Health First Aid movement, would be a considerable achievement.'

The Government has also pledged to amend the Equalities Act to prevent workplace discrimination against people experiencing mental health issues, a move welcomed by mental health campaigners, and Caroline is positive about the future direction: 'Currently, this legislation only protects those whose conditions are continuous for 12 months. However, this change would consider the fact that mental health issues can be intermittent. This again would be a great achievement for those of us campaigning for improved approaches to mental health in the workplace.'

As an advocate of any measures that contribute to society's understanding of mental health and improving organisational cultures, I find both the clarity and the simplicity of the Mental Health First Aid movement appealing. There's a growing appetite for more knowledge, understanding and resources in response to the demands of modern life, and plenty more work to do. Caroline says: 'I think that we still need to improve the way we approach resilience as a society to aid prevention – in education, in organisational culture and in how we go about our daily lives. We can't get away from the fact that we live in a stressful world at times, with lots of commitments and responsibilities to live up to. We can, however, do more to manage this by creating a system that builds in, teaches and encourages resilience at every opportunity. When people realise that they have mental health just as we have physical health, it's often a light bulb moment.'

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**Nicola Banning** is a BACP accredited counsellor specialising in working with individuals and organisations, and is editor of this journal. She has a background in broadcasting with the BBC and writes on counselling, mental health at work and professional development.

### Your feedback please

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# Conversations

After all the awareness raising about mental health, what happens next? During the General Election campaign, BACP made it a policy priority that all employees should have access to workplace counselling, supporting employees and reducing costs to businesses. **Nicola Banning** talks to **Penny Campling** and **Andrew Kinder**



**Penelope Campling** is a medical psychotherapist. She was a clinical director in Leicester for 20 years. Her interest in groups and her passion for therapeutic communities has led to an interest in healthcare institutions and how they can be organised in a way that brings out the best in all involved. Her most recent book is *Intelligent Kindness: reforming the culture of healthcare*, which she wrote with her husband, John Ballatt.

## What's your response to the increase in awareness around mental health?

It's really important that the general population are becoming more psychologically aware, so I'm pleased it's happening. But I think it's just the beginning. Prince Harry spoke recently about his grief after his mother's death, and Professor Simon Wessely, President of the Royal College of Psychiatrists, said he thought that by speaking out, Prince Harry had achieved more in 25 minutes than he had in his entire career.

I think there's a danger, however, that the push to normalise mental health problems and the focus on common conditions, means there are less resources and understanding for people who suffer from severe mental illness.

We could be at risk of missing out the people who are severely disabled by mental health with psychotic conditions, for example. To assume that everyone is going to 'recover' is idealistic and risks neglect; although, of course, there are lots of good things about the recovery ethos.

***'Everyone in the system needs to understand that emotional work is an integral part of the healthcare task, not a luxury. If you don't help staff to reflect on the work and the feelings it gives rise to, patients, clinicians and organisations pay a price'***

## There's an increasing understanding of the mental health of employees and how the organisational culture impacts. What are you witnessing in the health service?

Generally, I think people are tired, overstretched, and frustrated that they can't do the work as well as they'd like to. I know of young mental health nurses in their early 20s, who, after a couple of years working, are feeling disillusioned and already thinking

about other careers. It's not because they don't love nursing: it's because they don't feel enabled to do the work they were trained to do. There's not much sense of them being looked after either. For example, work rotas are computerised and there's very little flexibility. I've heard of junior doctors being told when they must take their holidays. In the past, we would negotiate who would work over Christmas, for example. It's just one example, but these types of organisational issues and high-handed control, build resentment and make an enormous difference to how people feel about their work.

## What role do you see for therapists to play in shifting organisational culture?

I think therapists need to be more involved in running reflective practice groups; while it happens a bit, it's not nearly enough. I'd like to see reflective practice groups introduced during training so that all clinicians understand the value of this way of thinking about the work. It makes sense to do this before we get set in our ways, and we are perhaps more open and less defended when we're still training. Everyone in the system needs to understand that emotional work is an integral part of the healthcare task, not a luxury. If you don't help staff reflect on the work and the feelings it gives rise to, patients, clinicians and organisations pay a price.

I think there are advantages if people from outside the organisation do this work. They bring a fresh perspective and don't get so sucked into the dynamics of the organisation.



It can feel uphill work but there are always people who are really appreciative. It constantly amazes me that just doing very obvious things, like giving people a bit of space, valuing them, and bearing witness to their experience, can make a significant difference to how they feel and their capacity to go on at work.

**Have you got any advice for therapists on understanding the culture of the health service?**

I think therapists have to be able to start where people are at, and to understand their world and their work patterns. I think there's a lot of scope for therapists to be involved, with the proviso that they have some sort of training in what working within an organisational context like healthcare means and, of course, good supervision.

Staff who work in healthcare are under much more scrutiny and micro-managed more than ever, so it's important to keep up with that culture change. A lot of healthcare organisations are actually quite toxic, with staff reporting increasingly high levels of stress and fear. But there are also well led, well functioning teams, even within toxic umbrella organisations. I think that anything that helps to put people back in touch with their values is helpful, and being part of a reflective practice group can help *change the conversation* in the right direction.

**You've said that finding a way to frame the problem in terms of primitive anxiety and its perverse effects on individuals and organisations would be a good start. Can you say more about how we might do this when we work with individuals, groups, or leaders?**

Generally, I think it would help if more people were aware of anxiety and how it drives us. I think that anxiety in healthcare is inherent in the work. It's work that puts us in touch with our deepest fears of helplessness and mortality, so it's impossible not to be anxious. But in addition, the healthcare worker has to manage anxiety that is passed down from

those at the top, including those in Government. This anxiety increasingly seems to be driven by mistrust. Staff have to do things in a particular way that's dictated to them, and can sometimes feel they are not free to use their initiative and to do the best they can, so there is a conflict too about following the rules.

Ideally, we need people to be reflective across the organisation, regardless of where they sit in it, and most importantly, including the CEO and the Trust Board. I think the NHS is highly regarded by the nation and is something of a national treasure, and that provokes anxiety for those who are charged with leading it.

**What would you like to see introduced to support the mental health of employees in healthcare?**

That's easy: the NHS needs more staff. And staff need better training and more support. The 'more for less' philosophy has been applied relentlessly, particularly in mental health services. There is all this talk about mental health awareness but the mental health teams that I know of have been cut drastically. Reflective practice and supervision are essential in healthcare, but they are always the first things to go when there are cuts.

What we need are better trained and better supervised staff, and managers who are better trained and supervised, and who don't simply pass their anxiety on to others. Staff are spending more and more time accounting for themselves, which is often distracting and counterproductive. Nurses tell me that what keeps them awake at night, is worry about whether they've filled in a form properly. That's not where their anxiety and energy should be focused. A strong health service needs people to be well trained, and for staff to feel well cared for so they can get on and care for others. If resources were spent on this rather than yet another layer of regulation, everyone would be happier – and I believe it would also be safer for patients.



*Andrew Kinder is Professional Head of Mental Health Services for OH Assist and Optima Health. He is a senior accredited member of BACP, a chartered counselling and occupational psychologist and a Fellow of BACP. He is the immediate past Chair of the UK Employee Assistance Professionals Association and a member of the BACP Board of Governors.*

**How have you responded to all the recent mental health awareness in the media?**

I've worked in the area of employee support for over 20 years now, so I'm delighted that the public are now talking about mental health at work. Years ago, the focus of health at work was on musculoskeletal health, so we've come a long way. Employers now understand that they need to be involved in educating and supporting their workforce to stay both mentally and physically healthy. There's a captive audience at work and the potential to make a real difference to people's lives. Employee assistance providers are able to package up the counselling into a programme of benefits that's easy for employers to purchase. It means that employers can buy in what works best for them and it is low risk in terms of their investment.

**It was welcome news, I imagine, that during the General Election campaign, BACP made it a priority that employees should have access to workplace counselling, giving both support to employees and reducing costs to businesses?**

Absolutely. I'm a proponent of the enormous difference that counselling makes to people's lives. I also have long-standing experience that providing employee support is good for clients and their employers. Organisations benefit from knowing that if something does go wrong at work for one of their employees, there are experts who can provide support both to the individual and the organisation, to help them come through it. If there's a sudden death or a trauma at work, (whether a major

*'What we need are better trained and better supervised staff, and managers who are better trained and supervised, and who don't simply pass their anxiety on to others'*

terrorist related incident or a smaller-scale issue), managers need help and reassurance that there is someone there that they can turn to for advice. In this way, the workplace counsellor needs to also work with the organisation or 'organisational system' as well as the individual clients.

If you consider what happens in the life cycle of an organisation, for example, when an employer decides to downsize, there will be higher anxiety at an individual level, which leads to lower performance and lower output. So it makes sense to invest in the survivors so that they feel supported and can focus on what they can control in their working environment. At an organisational level, Brexit is bringing so much uncertainty, and this can leave employees feeling anxious. Even a few

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*At an organisational level, Brexit is bringing so much uncertainty, and this can leave employees feeling anxious. Even a few sessions can help employees who have concerns'*

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therapy sessions can help employees who have concerns. It allows employees to be listened to and to also listen to themselves, which helps achieve a more healthy perspective.

**What do you see as the big issues that employers are facing in terms of workplace support that our profession needs to be aware of?**

One of the big challenges for many organisations is how they are going to achieve efficiency through automation and technological change. Most of us have smart phones and too often our own personal technology can be more advanced than our workplace technology. The recent cyber attack on outdated systems in the NHS is a good example of this, being due to a lack of investment. I think within the field of counselling, there's an opportunity to make things more digitally relevant for clients and these kinds of services will continue to grow.

**Are there any challenges for our profession to overcome?**

Counselling training tends to be rather purist; and that is a problem for the workplace sector. Workplace counselling isn't about simply working with the issues that clients face, but about understanding the context from which they come, and that is their workplace. Counsellors need to understand how to work

with a limited number of sessions and they need to have a good understanding of organisations and how they work. Previous experience as an employee is important, and as a counsellor you need to understand that employees within an organisation may have many support systems available to them, for example, internal networks, HR, an EAP helpline, and so you need to know how these can be accessed.

In the workplace setting, even when working as an EAP affiliate, there are different professional standards that apply; for example, you need to pay attention to your dress code, and know whether your appearance is appropriate for that organisational culture. In this context, there are certainly some things to avoid, such as having personal effects,

including those denoting political or religious affiliations, or things like crystals, in your counselling room. When the client's employer is paying you to deliver professional workplace counselling, the premises need to be clean and presentable, as though they were an employer's premises. It is also important to have an understanding of the legal/ethical issues, such as what to do if the client or their solicitor requests a copy of your notes, how to ensure good record keeping, and how to deal with someone who is potentially suicidal or saying they will harm someone in the workplace.

**So, how well are training providers training counsellors for the work that lies ahead?**

It needs to be better. We need counsellors to understand that when you engage in workplace counselling or mental health provision in the workplace, you have a range of different contracts in place: the contract between employer and employee; the contract between organisation and the counselling provider, and the contract between client and counsellor – so it's not a simple two-way relationship. Trainees are still largely trained in working one to one, when, in the workplace setting, it's so important that the counsellor understands how things are set up, why they are set up and how they are resolved. However, one of the benefits for counsellors who do

provide workplace counselling is that you are part of a team structure and the governance that goes with that and so it's not as isolating as private practice can be.

**In the last issue of *Counselling at Work*, I wrote about an EAP offering paid training placements to provide workplace experience for trainees. Could EAPs play more of a role in the development of the sector?**

It was an interesting example, and I recall that a clear contract had been agreed with the customer, so that the organisation knew that they were paying a reduced rate for a trainee and that the trainee was being well managed and supervised. Of course, it needs to be carefully considered and the counsellor carefully recruited, ideally with past experience of working in organisations as an employee. Newly qualified counsellors who are looking to develop links in the workplace, who have their diploma and relevant experience, could talk to EAPs or occupational health (OH) and find out about opportunities to work, such as on the EAP helpline, providing information and guidance. It's not a direct counselling role, but it could provide a firm base of experience and allow counsellors to become known to the EAP, to build relationships and to develop expertise, as well as gain paid employment.

**I know you're interested in the employability of counsellors. What would you like to see happen that would improve this situation?**

I think there's an increasing place for counsellors to be involved in coaching, personal resilience and stress management as these are growing areas and may suit those therapists looking to expand their portfolio. It makes sense to offer counselling and coaching, and to be clear about the differences. It's fair to say that managers traditionally don't use the counselling service as much as employees, but introducing coaching can reach these groups and increase take-up of our services.

Other than working with clients one to one, there are opportunities for counsellors to be involved in awareness raising, in mental health first aid, running training groups and working with organisations in policy development, to help them become places where being emotionally intelligent is valued.

*Your feedback please*

If you have thoughts about any of the issues raised in this article or would like to write an article of your own, we would like to hear from you. Please email the editor: [counsellingatwork@bacp.co.uk](mailto:counsellingatwork@bacp.co.uk)

# Q&A

We often hear from you about the issues you face in your client work with organisations. This issue we address a typical example

## Q

### How can I work with clients coming from the same company and all experiencing debilitating work-related stress?

*I am an affiliate counsellor with a particular EAP that makes quite a number of referrals to me from one company. Of these referrals, a large percentage is suffering from work-based stress, much of which appears to arise from unachievable targets. These targets seem to be put in place simply to achieve cost savings, regardless of the human cost.*

*The anxiety and depression these clients are presenting with stand little chance of being resolved, if they remain in the same job. This situation also means, of course, that my own job satisfaction is impacted as, unless the client has the option of changing job – and they mostly cannot as they have worked for the company for many years and feel they are too old or lack the confidence to move on – there can be no resolution, particularly as the clients are only given short-term counselling. The client is unlikely to achieve fitness for work in such a short time, especially when no attention appears to have been paid to the issues which caused their symptoms in the first place.*

*I doubt that the culture of this particular company will ever change.*

## A

### Open up the communication

**Keith Baddeley, Clinical Lead,  
Help Employee Assistance**

This is an interesting scenario which illustrates just how tricky organisational counselling work can be. I think that 'work stress' can be a particularly vague term and so it's helpful to drill down to try to understand how the organisation is set up and why it's resulting in this being such a common presenting issue for clients. An excellent resource is the HSE (Health & Safety Executive) Management Standards, which can be found at [www.hse.gov.uk](http://www.hse.gov.uk). The HSE categorises work stress into six areas: demands (workload); control; role; support; relationships; and change. Working with the client to identify which areas are particularly problematic can be useful as it allows the client to challenge the issues directly with their line manager. If they don't feel confident about doing so, they might be able to via an Occupational Health referral or a stress risk assessment, which many organisations will have as a routine part of their procedures.

For example, unreasonable targets may be the presenting issue, but the underlying issue may actually be the lack of support or the insufficient training for the task in hand. Alternatively, the issue may be the role, whereby the employee is engaged in several unrelated jobs which interfere with each other. Identifying the exact underlying category problem areas is useful to help the employee start to address their concerns with the organisation. A GP's fit note to highlight

these problem areas to the organisation is also worth discussing with the client. (This warrants an article on its own as there is a lot that can be done to help clients with this aspect of their working lives.)

I'd recommend the counsellor provides feedback to the EAP that work-related stress, in this company, is a recurring issue. The EAP will have regular opportunities to highlight recurring themes and problems to the organisation at a higher level, and part of their remit will be to suggest options and solutions to the organisation's HR team. These might include a departmental stress evaluation, or coaching for local managers in identifying and addressing common mental health issues and working with stress in the workplace. It's worth remembering that managers are human too and they may be struggling with job designs and performance management and would benefit from support in this. Having presented many of these types of workshops and subsequently had the chance to revisit employees at the site on a future occasion, I can see these options are really effective, and are useful for affiliate counsellors to be aware of.

As a general point, if you're concerned by recurring issues and spot a pattern, it's worth giving your EAP clinical lead/case manager a call to discuss it. The joy of working with an EAP is that you're not just limited to the client in front of you, but can feed your experience back and potentially drive some higher level change that will positively impact a wider number of clients/employees in the future.



## Normalise the anxiety

**Nicola Neath**  
Staff Counselling and Psychological Support Service, Leeds University

When we're repeatedly meeting clients who are highly stressed, anxious and depressed by the impossible demands being placed on them, it's hard not to pick up some of the sense of disempowerment that they are experiencing. Reflecting this back to the client is important, as is normalising their emotional response to what they are experiencing at work. I believe compassion and genuine understanding are crucial, particularly if staff have little of this in their own workplace. Too often, the stressed individual is pathologised and blamed 'for not being up to the job' when their difficulty may well be an indicator of a systemic problem in the organisation. Providing a safe space in which the client can hear and understand this, is a powerful act in itself, and will enable some healing to take place.

*'If the client is off sick, try to pace the sessions to ensure that the client is supported before, during and after their return to work and make sure that you contract with them on this basis'*

If the client is off sick, try to pace the sessions to ensure that the client is supported before, during and after their return to work and make sure that you contract with them on this basis. The client could then engage in conversations with their employer about what needs to change in order to ensure that their workplace is a safe place to work in. Remember that the organisation is also the client, and ultimately is paying for the counselling; so it's worth thinking about what would help them (as you would the client), for example, to avoid poor staff retention or the

risk of litigation, and feed that back to the EAP case manager.

I notice that the counsellor's job satisfaction is impacted because the chances of successful resolution for the client are so unlikely. This is a difficult place to be. While there may not be any easy answers for the clients, affirming their experience of the impossible demands they face could strengthen their capacity to choose how they respond. Working with clients and their organisations is demanding work. I'd always recommend finding an excellent supervisor who is skilled at organisational and EAP work to support the counsellor to work with these complex dynamics.

## Parallel process

**Nick Wood, BACP Workplace Executive**

This example reminds me that when working in the context of an affiliate counsellor for an EAP, there is actually a four-way contract at play between employer, employee, counsellor and EAP. I sense a frustration, not only on behalf of the employee for how they are treated by their employer, but also on the part of the counsellor toward the EAP. There appears to be a parallel process and perhaps the key to unlocking this unsatisfactory situation as it currently stands is to encourage the counsellor to take up the situation with the clinical lead at the EAP. In this way, the counsellor, by finding his or her voice, can role model the self efficacy they feel is currently beyond the reach of the clients they are seeing from this particular employer.

I would encourage the counsellor to ask how feedback about the EAP clients is collected and given to the employer. Most contracts between an EAP and an employer will contain regular meetings where trends in presenting issues can be discussed. I would anticipate the EAP using the feedback given by its counsellors to provide the employer with potential solutions to help reduce the stress levels within the organisation; for example, by providing stress management workshops.

The affiliate counsellor, like the clients she describes, sounds isolated and perhaps overwhelmed by a situation that is bigger than they are. My advice would be to seek the support of the EAP through two-way dialogue and make it clear that there are organisational level issues to be worked on here *within all parts* of the four-party contract. As

counsellors, we can only influence the part where we have direct contact, but it is a start, and movement in one place can often result in a shift somewhere else.

*'The joy of working with an EAP is that you're not just limited to the client in front of you, but can feed your experience back and potentially drive some higher level change that will positively impact a wider number of clients/employees in the future'*

### Your feedback please

If you have a query or issue about your work that you'd like some help with, please email the editor: [counsellingatwork@bacp.co.uk](mailto:counsellingatwork@bacp.co.uk)

# EAP MATTERS

## EAP work: is it for you? Amanda Smith

GPs are increasingly advising patients to check whether they have access to workplace counselling because of the rise in demand for counselling services, the postcode lottery of accessibility through the NHS and the long waiting lists for outpatient psychological support. As a consequence, EAP counsellors and psychotherapists are seeing more complex and high risk cases. As workplace counselling requires a specific set of skills and experience in addition to standard counselling training, I'm often asked to outline my advice for strengthening your portfolio of work and working to best practice.

Clients will present with a wide range of issues interwoven with the organisational complexities about managers, HR and workplace policies, which may additionally impact. While the EAP triage process will assess the complexity and risk of each case, once the initial presentation of a client has been assessed, counsellors will have six sessions (on average) to manage complicated and sometimes enduring mental health conditions. The EAP may have additional specific measurement tools which they require affiliates to complete. As these may vary with each individual organisation, you may find it useful to have your own client measurement. This is not necessarily a skill taught or covered in general counselling diplomas, and counsellors using assessment tools can feel that they are being asked to be judgmental or diagnose. However, tools such as Corenet (available free to practitioners) can assist you not only to assess risk and clinically manage accordingly, but also give a baseline at client point of entry and enable clients to see their progress during therapy.

Affiliates benefit from a multidisciplinary therapeutic approach and EAPs are often looking for therapists with experience of CBT and solution-focused approaches, as well as training in time-limited counselling. Knowledge

of systems theory and organisational culture, alongside past experience of working within organisational settings, may help therapists to quickly understand the context of the client presentation, especially when it is work related.

In my experience of employees presenting for workplace counselling, work can often be cited as the major contributing factor, but further exploration may identify a number of historical, behavioural or bio-psychosocial factors. We can often manage to remove ourselves from the work stressors by being signed off work, but it is much harder to initiate swift change when it comes to home, financial or family difficulties.

Affiliates will also benefit from having a working knowledge of general mental health diagnosis, types of psychiatric medications and what this may tell us about a client's current presentation and previous history to support the current issues they are facing. It helps to know your locality and the support services that are available so you can signpost your clients for advice and information for themselves, or for family members, whose mental health may be a contributory factor. As affiliates, we are often sign posters, supporters and enablers rather than delivering the core therapy ourselves, so researching what is out there can be really useful to clients. Ongoing CPD and training/workshops in areas such as stress reduction and mindfulness, and national downloadable smart phone apps are also excellent support tools for you to pass on to clients for use outside of sessions.

Understanding the types of HR policies your client's organisation is likely to have in place can also be useful. Clients presenting from local government or the public sector, will have a range of options that are not necessarily open to smaller private companies. Find out whether the organisation has a conflict resolution policy or internal routes which you can signpost employees to if they

are struggling with workplace difficulties. Acknowledge that some clients – for example, those presenting with trauma – may require more specialist intervention, and it's good to highlight this while supporting the client in the number of sessions available.

It's good practice to nurture working relationships with EAPs where you feel you are ethically aligned. There is no point working within a three- or four-session model if your clinical belief is that you need at least eight sessions to provide what you consider to be the best type of psychological support.

I'd recommend having a variety of work from different EAP providers or adopting a portfolio approach to your workload; for example, three days' affiliate counselling and two days' employed work.

While affiliate work can be rewarding in many ways, it can also be isolating and lonely, so new affiliates need to review their support networks. Regular clinical supervision with a supervisor who understands the EAP model, as well as peer group support options, can be valuable. This is something UK EAPA would be interested to discuss with counsellors, particularly if it is something we could help to facilitate in the future.



**Amanda Smith** is Secretary of the UK Employee Assistance Professionals Association. She is also a therapist and Head of Health & Wellbeing at Work at Mersey Care NHS Trust and Honorary Associate at the University of Salford.

# Practitioner MATTERS

## When your client is dismissed Patrick Quinn

Once in a while, a client's worst fears become real: they get sacked. This may become a more common issue in our work, as we seem to be supporting more clients suspended during disciplinary investigations. Others have noticed too: including a Manchester GP quoted in a recent interview: 'Businesses are cost-cutting and sick day rules are harsher. Disciplinary processes are instituted more easily, so people are struggling with the pressures'.<sup>1</sup>

Being dismissed is not only a devastating outcome for the client: it can bring a rather abrupt ending to the counselling relationship. There may be a brief 'period of grace' between the 'verdict', and the termination of employment, (for example if the client decides to go to appeal). Either way, there are potentially *two* 'endings' for the client to face at once. A lot will depend of course on the specific counselling contract arrangements with the employer; in our service we specify that we will offer one to two follow-on sessions after employment is terminated (for any reason, even voluntary), on the basis that this is the only ethically acceptable way to end a professionally contracted relationship. Being able to inform the client of that, in advance, goes some way to decrease their expectation of being 'dropped', and just never coming back to see us (which happens). This is a common shame reaction when people have been found 'guilty' – who will want them or trust them now? Like their work colleagues, who may now seem to treat them as 'untouchable'. If we can genuinely treat them as still acceptable, as people worth caring about, that may make a difference, during the brief time left.

I have rarely found that the conduct being investigated warrants the extreme sanction clients are threatened with. My hunch is that really untrustworthy bad apples are unlikely to subject themselves to the personal exposure that counselling involves; so maybe only the more typically flawed human beings

tend to end up with us? Of course, the client may not be telling us the whole story, or facing up to the truth. But just as court cases can lead to miscarriages of justice, we may be trying to help people come to terms with the consequences of flawed, over-punitive, or even vindictive human processes. And all within a session or two.

I recall a couple of examples, which illustrate some of the issues (heavily disguised to protect the clients' identities). One client fought the dismissal for two years through an unfair dismissal claim with the help of a solicitor, risking losing his home and even his relationship (he was threatened with punitive costs by the employer), to end up finally with an out-of-court settlement that rescinded the dismissal but gave none of his costs back. He often reflected with me during the process, on whether it might just be causing him and his family more psychological damage to fight on. Another client, a divorced parent, as a result of dismissal for 'gross misconduct', was so ground down by the process that they could not face going to appeal, despite the fear of losing their mortgage and home.

In these situations, we too can go through a sense of abrupt disempowerment in the counselling role – we are not allowed to continue, no matter what we feel the client needs. We may find ourselves re-living the emotions and thought processes that derive from our own experiences of injustice. We are always faced with our own doubts about the client's behaviour: are we being naive? What do we believe? If the judging panel decided they are 'guilty', have we been taken in? Is our empathy being abused?

Intense dramatic human situations like this, can lead to intense defensive reactions, such as 'splitting'. We may either instinctively withdraw into a defensive, distanced stance, from someone tainted with the mark of shame; or end up in over-identification and confluence ('you're just a victim of the

system'). Ideally, the workplace counsellor will have an experienced supervisor, wise in the realities of the modern-day world of work; a supervisor prepared to explore these intense reactions, to help us as supervisees separate out our own emotional issues, and to settle inner anxieties and frustration, so we can still be as emotionally available and congruent with the client as we would like to be. That supervision needs to be available pretty quickly when the timescales are short.

I think the client may be gauging our reactions, to see if we too are condemning them, or dissociating from them, as they expect everyone else to. They may be acutely sensitive to our tone of voice, body language and comments. I have even had the experience of clients wanting to 'save me' from having to be nice to them, and I have had to strive to show them that I did not feel that way. Whatever the world thinks of them, at least as *counsellors*, we do not have to decide innocence or guilt, or take sides. We can truly put the client first, being with them in all their self-doubt, anger and shame – which may be a special gift we can offer, in a situation where all other power is taken away.

### Reference

1 The Big Issue North. Issue 1183; 15.5.17.



**Patrick Quinn** is a psychotherapist and supervisor, with 25 years' experience in NHS mental health services, and 20 in staff counselling. He enjoys leading training workshops in personality disorders, trauma, adult bullying and workplace counselling. [itspq@24west.karoo.co.uk](mailto:itspq@24west.karoo.co.uk)

# Feedback

We welcome readers' letters and comments. If you've read something in *Counselling at Work* you would like to comment on, please do get in touch: [counsellingatwork@bacp.co.uk](mailto:counsellingatwork@bacp.co.uk)

## Dear Editor

I appreciated Peter Jenkins' article 'The culture of work', Issue 92 of *Counselling at Work*. It crystallised some thoughts I've had while working with EAPs as a counsellor and a coach. My work has been with lower to middle management and employees where role culture is the predominant structure. I think there are some benefits for counsellors in working with clients who are so often employed within a role culture.

The role culture of organisations is reflected in the way EAPs often have a referral and case management system that has a stringently applied set of procedures. I've found that this has acted as a very useful buffer between me and the employee's organisation and their management structure, and, at times, the employee client, themselves. For example, a manager from the client organisation might want to know details of their staff member's sessions, believing they would be 'helping' the employee to return to work as soon as possible. EAP case managers can act as very useful intermediaries by challenging the expectations of workplace managers. The expectations of the client employee at the initial allocation stage can also be managed by EAP case managers or the counsellor at the initial assessment, providing some information about what EAP counselling can offer, explaining that it is short term and that missed sessions will count.

The work has clearly structured boundaries, (usually six sessions), and the kind of issues that clients present with tend to be of the 'worried well' variety, rather than long-standing mental health issues. This approach also helps both the client and the counsellor to be focused on the presenting problem, with a full or partial resolution as the expected outcome. If longer-term issues are uncovered, then it is usually an EAP's policy to refer a client on to a local mental health support service, sometimes with a letter jointly devised by the client and their counsellor for the client's GP. I think that the role culture, with its aversion to risk, can help counsellors to practise safely and ethically within their remit. If we work for agencies as counsellors, be it EAPs, the NHS, schools, colleges or in the private sector and if we can understand the dynamics of the role culture, we can be free to use our expertise, to work creatively with clients and to do our best.

An old book, which I still find useful, is: *Organisational Consulting: A Gestalt Approach*, by E Nevis (Cleveland GIC Press, 1987). It was essential reading for a therapists' course in Organisational Consultancy, run by Berndt Legraf from the Whittington Hospital.

Once again, thank you for the article as it certainly has had me thinking.

**Jen Popkin,**  
MSc Counselling, senior accredited counsellor and a coach

## NOTICEBOARD

### Calling all writers

*Counselling at Work* is your quarterly journal, written by counsellors and practitioners, covering specialist articles about counselling provision in the workplace, best practice, and all aspects of our emotional and psychological health at work. If there's a topic you would like to see covered in *Counselling at Work*, please don't keep it to yourself, send Nicola Banning a brief paragraph outlining your article idea, to: [counsellingatwork@bacp.co.uk](mailto:counsellingatwork@bacp.co.uk)

### Have you joined our JiscMail groups?

The BACP Workplace JiscMail is a great way to share ideas, news and to stay in contact with other counsellors working in the sector. Nick Wood, BACP Workplace Executive Committee member, explains: 'Recently, we had seen a steady rise in referrals to the in-house counselling service where I work. I put a message on jiscmail to ask if this rise was being repeated across other services and EAPs nationally. I was really pleased with the number of replies that I received and the comments that were shared from fellow practitioners about the reasons that business levels were increasing. Common themes included the increased media attention to mental health issues that stemmed from the work of Princes William and Harry; waiting times for NHS provision and the uncertainties surrounding Brexit. JiscMail helps me to feel connected to a wider workplace counselling community and is a great feature of divisional membership. I would encourage everyone to join the conversation.'

BACP Workplace Members and BACP Workplace Managers are the two JiscMail groups for networking, information and advice. You can ask questions, share successes or ask for guidance. To join in or start a conversation about any of the issues you are facing in your work, simply email the BACP Workplace Chair, Nicola Neath: [n.e.neath@adm.leeds.ac.uk](mailto:n.e.neath@adm.leeds.ac.uk)

### BACP Workplace Executive Committee

#### Nicola Neath, Chair

[n.e.neath@adm.leeds.ac.uk](mailto:n.e.neath@adm.leeds.ac.uk)

#### Tina Abbott, Past Chair

[tinaabbottcounselling@gmail.com](mailto:tinaabbottcounselling@gmail.com)

#### Keith Baddeley

[keith.baddeley@ohassist.com](mailto:keith.baddeley@ohassist.com)

#### Julie Hughes

[juliehughes@mindmatterscounselling.org.uk](mailto:juliehughes@mindmatterscounselling.org.uk)

#### Nick Wood

[nick.wood@gloucestershire.gov.uk](mailto:nick.wood@gloucestershire.gov.uk)

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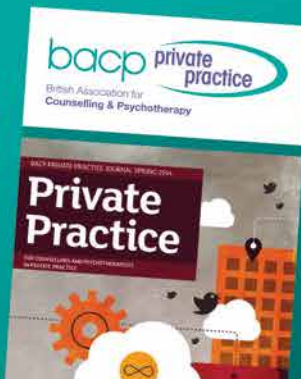
## Healthcare Counselling and Psychotherapy Journal

This quarterly journal from BACP Healthcare is relevant to counsellors and psychotherapists working within healthcare settings.



## Private Practice

This journal is dedicated to counsellors and psychotherapists working independently, in private practice, or for EAPs or agencies, in paid or voluntary positions.



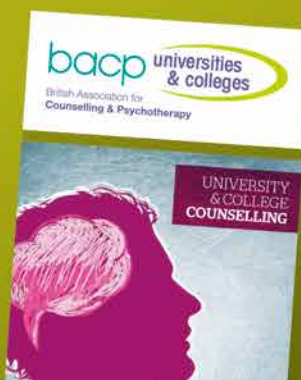
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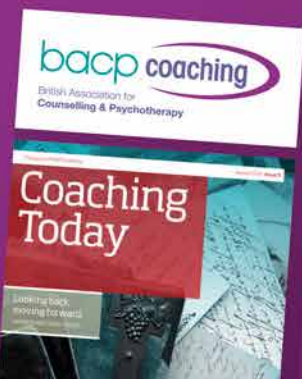
## University & College Counselling

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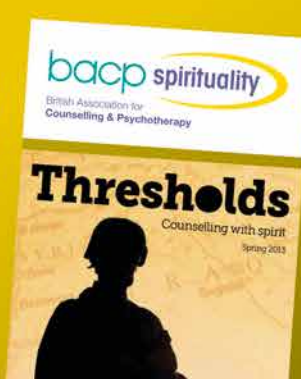
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