__Emily Lindsey-Clark__ describes how the human givens approach has provided a practical focus for working with women struggling to cope with everyday life.

From self-harm to self-belief

WHEN, at a conference on recovery attended by nearly 200 mental health professionals, Angela Western stood up to speak, she was a little nervous, as any presenter always is. However Angela is not a professional and had never addressed a professional audience before. But what she had to say held them spellbound. She told them about her experience of self-harm and the impact on her life of the unhelpful attitudes taken by mental health and other health professionals during the many long years she had spent in and out of hospital. Now in her 50s and long ago, as she felt, 'written off' as suffering from borderline personality disorder, she spoke of how she now felt for the first time more in control, more confident, a sense of status, a desire for meaningful achievement and an awareness, at last, that she is not defined by self-harm (see "I was Angela long before I became a self-harmer", page 36).

It is no coincidence that she spoke in terms which represent powerful human givens ideas, for the human givens approach provides the framework for our work at Lavender Lodge, a community residence for women in East Sussex with complex mental health needs, one of whom is Angela. Although we know it as Lavender Lodge, to anyone else it is just an ordinary house in an ordinary street (designated for post office purposes by its number and the street name). However, we are able to house women (six at any one time) who might otherwise have been held in hospital under a section of the Mental Health Act, and offer 24-hour nursing care and a rehabilitation programme involving a multi-disciplinary team.

We work with women who have struggled with living independently and with managing relationships and their emotions. They often use self-harm as a way of coping; many have suffered severe trauma or abuse in the past and can be abusive or violent towards others. Currently, the age range is from 22 to 56. Although we don't work with diagnoses ourselves, the majority of the women have been labelled with borderline personality disorder and have experienced many, many years of institutional care.

Our service was set up two and a half years ago, in line with two key government guidance documents.[1,2] It is based on a non-medical approach of hope and recovery, with the emphasis on building good relationships with clients and encouraging self-responsibility, rather than relying on physical security and restriction. The recovery and empowerment approach challenges negative views, previously held by mental health staff and society at large, about the prospects of those affected by mental ill health[3] and personality disorder, and emphasises that such people can and do recover and live satisfying lives, by learning to manage their difficulties. The individuals who recover, it has been shown, tend to be those who have people who support and believe in them, and the essential components of recovery are client empowerment, reintegration into the community and a normalised life environment.

So our service aspires to enable people to take back responsibility for their own lives, to make their own decisions and to develop self-efficacy. It draws on a variety of theories including attachment theory and transactional analysis, as well as the human givens. It is highly hands on. During the day, there are around five members of the multi-disciplinary team present – always a nurse and two support workers, plus two occupational therapy staff and an assistant psychologist. Others involved include a psychiatrist, consultant forensic psychologist and management team. At night, one nurse and one support worker are on duty.

We are all strongly committed to what we are trying to do. And yet, we all also found it difficult to explain what exactly we were about, when talking or presenting to staff in other services, or even to the women themselves. The notion of recovery, laudable as it is, doesn't explain what it is that we actually do or how we arrive at it. What is it that makes a person able to feel empowered and live a normal life in a normal setting? I was already studying the human givens approach. It was when I started thinking about how we could bring it into the service that everything clicked into place.

A helpful framework

I soon spoke to our service managers about framing (and explaining) what we do in terms of meeting needs. Unlike some other models, which are seen as the province of particular health disciplines, the human givens idea of innate needs and resources resonated across the board because it is simple and concrete. Everyone was keen to work with it. We realised, however, that we would need to use it therapeutically in some way other than one-to-one therapy. The women we work with have commonly spent so many years in institutions where they have not felt listened to or genuinely cared for by staff that they find it

extremely hard to trust anyone. Most are highly sceptical of one-to-one therapy and are unwilling even to be helped to relax, as that itself takes trust. So we tried to be more creative in how we integrated the human givens ideas into our daily work.

In some teaching sessions, I discussed with my team colleagues the basics about essential emotional needs, such as those for security, control, emotional and social connection, attention, achievement, status, friendship and fun, and meaning and purpose, and then we brainstormed how we would work with these. We came up with the idea of explaining, in the welcome pack we give to professionals and clients, that our goals are to help women who join us to meet these needs. We also decided to adapt our recovery plans to incorporate them.

What we call the recovery plan is traditionally known as the care programming approach (CPA) plan, in which a detailed plan is created to ensure that all professionals and agencies involved know what is being done in any individual case. They review the programme regularly, so that people at high risk of self-harm or harming others don't slip through the net. The plan is based around a standard form, which has to be completed by the client and team involved in their care and covers areas such as housing needs, mental and physical health and social needs. However, these plans are often written by health professionals without consultation with the client.

We had already varied this by asking the women to imagine a preferred future and come up with their own goals, based on working towards this future. Once we had decided to incorporate the general principles of the human givens approach into our plans, we asked the women at Lavender Lodge to tell us what they considered basic human needs to be, and drew up a list together. (The idea was to put them in control of this new way of viewing things, rather than imposing yet another new theory or therapy model on to them). Their list, unsurprisingly, turned out to match very closely with the human givens list of emotional needs, outlined above: for instance, "having contact with my family and friends", "getting a job / going to college", "feeling like I matter", "feeling like I'm in control of my life, not the staff" and "doing fun stuff that makes me feel good".

We then explained basic emotional needs, as defined within human givens thinking, and presented each person with a laminated sheet, which had these needs listed vertically on the left. Next, we asked them to review their own recovery plans and decide which needs they thought were being addressed by their current goals, and also where the gaps were. We made this active, asking the women to snip out their goals from their recovery plans and stick each alongside the need they thought it would meet. The completed sheets made it instantly clear, for each person, which important needs were not even being addressed. For instance, need for status was largely unaddressed (a few women felt that, in the house, they counted but none felt that they mattered much to anyone outside of it).

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We typed up new plans using this format (with needs running vertically and the corresponding goals running horizontally), ticked the needs that were already met and, at each six-weekly review meeting, we now routinely check progress towards the others. In effect, we have used the list of needs as a template to shape the recovery plans around, so that we can be sure we are working together to set goals to address them all and thus provide maximum opportunity for our clients to get them met. One woman had resisted looking for work, so this had not featured as one of her goals. When we reviewed her plan, it was immediately clear that her needs for 'achievement' and 'status' were unmet and she realised, for the first time, that she did need to do something to enable her to meet them. She chose to visit Workability, an organisation that helps people with emotional difficulties get back into work, because she could now see that an essential need would remain unmet until she took action. The effect on her has been highly positive: having a role as a student has boosted her self-esteem immeasurably.

Managing self-harm

Everything we do is geared around helping the women we work with to meet their needs. For instance, one way that their need for control over their own lives is addressed is by their being entrusted to manage their own self-harming behaviour. In previous units, if people self-harmed, anything sharp and therefore potentially dangerous was removed from them, which could be experienced by them as punitive and intrusive. They would be subjected to one-on-one observation by a staff member. So, effectively, a person in great distress might be left in a bare room,

stripped of anything meaningful and being constantly observed by someone she might not know that well, who might not even converse with her. In terms of meeting needs, this is clearly counter-productive.

At Lavender Lodge, people are given back control. The whole multi-disciplinary team carries out a thorough risk assessment when someone first joins us, agrees a management plan, and reviews both regularly, so we are confident about giving the women a high degree of autonomy. Every woman has a locked box

"I was Angela long before I became a self-harmer"

"TODAY I am going to talk about self-harm and how different methods of dealing with it by professionals has affected me. Self-harm is still a taboo subject, but I have tried to be very honest in what I am saying.

"I can't remember when I first started self-harming; it is just one of those things in a long line of events that are muddled up in my mind with no time scale to go by, because everything seems to blend together. Why do I do it? People do it for many different reasons. For some, it is a way of making people pay attention to them, but I don't think this is my reason because I rarely tell anyone that I have done it. It's a secret between me and my razor.

"It's a way of relieving the stress that has built up inside me. Sometimes I know why I am feeling stressed and sometimes, only sometimes, I am able to work through it without self-harming by keeping my hands busy by making cards or doing crosswords or reading. This also stops me thinking about self-harming because I am thinking about what I am doing and it can help relieve the pressure. But, sometimes, the feeling comes from nowhere and the feeling is so overwhelming that it will not go until I have self-harmed.

"It is at these times that being prevented from self-harming can be very negative, as the need just builds up and up, until at the first opportunity you self-harm and usually end up self-harming a lot worse than if you had been allowed to do it at the beginning, when you were more in control of the situation. Sometimes you can even end up being suicidal, because you feel your life is out of your control and there seems little point in continuing living. The reason for these feelings is not always evident and even afterwards I do not know where they came from. They are buried too deep inside me.

"At first, it is really scary being given back that control, especially if you have spent long stretches of time in places that take all control away from you (such as hospital), but it is the only way forward if you are to cope with living in and being part of the community.

"Sometimes we have these feelings because we feel we no longer matter; we no longer have a place in the world of so-called normal people. The one thing that most self-harmers have in common is that they have very little or no self-esteem or confidence. Maybe we feel that our bodies, like our feelings, are worthless: that, by self-harming, we are somehow making our bodies equal with our minds because, to us, they are ugly. Our thoughts are bad and we feel that our bodies are as well. It is a way of telling people to beware of us because we don't fit in with society's views of how people should think and behave.

"People are very quick to condemn and isolate things that don't comply to the 'norm'. Because they cannot see mental illness they put everyone in one pigeonhole, as if we are all going to be axe murderers and in the end we believe there is something wrong with us. I cannot hurt other people, so I hurt myself [but] thereby perpetuate that view in society that I am dangerous. After all, if I can pull a razor through my own skin, what's to stop me doing it to someone else?

"But we also self-harm because, when we draw blood, it somehow removes all the pressure in our heads, sometimes just for hours, sometimes for days or weeks. People, including mental health professionals, put us into little boxes. I am a 'self-harmer' – but I am also Angela, and I was Angela long before I ever became a self-harmer. Here, at Lavender Lodge, I am Angela first and I wish the philosophy of Lavender Lodge could be bottled up and given to all professionals, and especially to all students who are starting with a blank slate, because this is the way forward in mental health – to give people back their status in life and then perhaps end that overwhelming need to mutilate ourselves because we end up feeling that what everyone else thinks of us is true. We can begin to feel that we are people again and not just second-class citizens.

"In Lavender Lodge, we are people with a status and the staff look beyond the self-harm and the negative behaviour and try to find the individual you once were and help you achieve some of the things you used to do. You might never be able to do all the things you used to do, but they teach you new skills, new ways of coping with life and, most important of all, they try to help you like yourself again. It's a long bumpy road but, as you begin to like yourself a bit more, the incidents of self-harm do lessen. They might never go away completely but you are reminded that just because you took a step backwards today doesn't mean that tomorrow will be the same. You are reminded of the good days you have had and often all you need is that little reminder and you feel that maybe, just maybe, there is hope; there is a way out of this self-mutilation because you are being given back your life in a way you can cope with.

"Taking the first few steps is the hardest but they do say that the longest journey starts with the first step – and I think I have made that step."

Angela Western

containing her medication (for which she has the key). Whether it contains one day's supply or one month's supply depends on how responsibly she uses that control. If someone expresses a wish to self-harm, we spend time with her, helping her to think about other ways of coping or distracting herself. However, if a resident ultimately chooses to go through with the self-harm, she has to take the responsibility for dressing her wound with the first aid kit, kept in each bedroom. If staff feel a visit to the accident and emergency department is advisable, the resident is encouraged to go and transport is provided. If the incident is judged serious or potentially life threatening, however (for instance, very severe cutting or overdose), staff's duty of care means making the decision for appropriate medical intervention. On rare occasions, this may mean the police have to be called to take the person to hospital.

Balancing attention needs

Focusing on the need for attention has been very helpful. As we know, attention needs must be met in balance but, as one of our clients observed, "My need for attention is huge and it doesn't get met!" She has been able to learn, however, that attention received may be more satisfying if sought appropriately. For instance, women who feel starved of affection may yearn for simple physical contact, such as a hug, but in traditional institutional settings such contact is taboo. It is not so surprising, then, that, when the hug is not forthcoming, a woman may resort to acting violently in some way, to ensure the need for physical restraint – and, therefore, contact. We work in a different way. If a woman who is upset asks in an appropriate way to be cuddled or have her hand held, the staff member, if comfortable, will comply. The result has been that the need for such attention lessens and is asked for much more sparingly.

There is a major emphasis on fulfilling the need for emotional and social contact, as our aim at Lavender Lodge is to help women settle back into the community and to be a part of it. We encourage attendance at courses and social groups, so that women don't need to depend upon our unit, once they have moved on, although they are always welcome to spend a night on the sofa if they have a crisis of confidence. Most of the women are excited to move on to supported housing (usually a housing association flat, where they are visited by a staff team who check they are shopping, cleaning and managing their bills) but it can also be frightening suddenly to be alone. (We have just been granted funding to set up our own supported housing, consisting of six supported flats, and this is going to give us a great opportunity to base this new service around meeting human givens needs from the outset!)

Moving on

To help our residents manage when they move on, we created a skills-based course, designed around the human givens. We call it a community living skills course, rather than a group, so that the focus is firmly on learning rather than 'therapy' and reinforces skills for those already attending college courses, or planning to, thus helping to meet needs for meaning, wider community involvement and achievement. The course lasted a pre-set number of weeks (10), so that women knew exactly what they were letting themselves in for (helping meet needs for security and control). It was held in the local community centre in town, to which the women travelled independently (helping meet the need for autonomy and feeling part of the wider community).

Attendance was voluntary, as we wanted participants to take responsibility for their own learning and to be motivated to learn (meeting the needs for control and status). To that end, too, they were asked what they wanted to learn on the course. The participants were encouraged to undertake to organise a social event to celebrate completion of the course.

We sent each participant a formal, introductory letter and a special ring binder, dividers and lined pad and pen, so that the material learned could be clearly organised and easily accessed long term. Most of the material was developed through brainstorming and group discussions, rather than being presented as a fait accompli (again to increase sense of control and status). We covered a variety of topics – from filling out forms, making official phone calls and shopping and cooking for one, to more emotionally challenging areas, such as assertiveness, raising confidence and self-esteem, meeting new people and responding to difficult or invasive questions, structuring time alone and self-management plans for times of crisis.

Participants gained a lot, even if not everyone's personal aims were achieved in full. Comments included, "I have been able to use assertiveness skills to arrange an important meeting with my daughter's social worker in regards to her care"; "With staff support, I was able to use my self-management plan during a time of crisis"; "I was able to explains the scars on my arms to a young girl at church when she asked me what they were. I was able to tell the truth in a way that didn't scare her" and "I thought it was like looking on the outside world and that helped a great deal for me, for when I leave here".

Colleagues at our sister service, Amber Lodge, a medium-secure unit for six women, have also begun to embrace the human givens approach themselves and plan to write it into their own philosophy. I am currently working with them to introduce the concepts, which they believe will help them develop a very different, more effective style of forensic service, within constraints we do not have at Lavender Lodge. For instance, we try, in consultation with our highly supportive consultant psychiatrist, to get people off their Mental Health Act 'sections' as quickly as possible – all as part of giving them back self-

REFERENCES

1 *Department of Health (2003).* Mainstreaming gender and women's mental health: implementation of guidelines. *Department of Health Publication, London.*

2 *The National Institute for Mental Health in England (2003).* Personality disorder – no longer a diagnosis of exclusion: policy implementation guidance for the development of services for people with personality disorder. *NIMHE.*

3 *Barker, P (2003).* Psychiatric and mental health nursing: the craft of caring. *Hodder Headline Group, London.*

control. But, because some of the women at Amber Lodge have committed crimes and are on what are known as 'Home Office sections', their movements are restricted and they do not have the opportunity to integrate into the community and meet their needs for achievement and connection so easily. However, just identifying essential needs has given the team a clearer structure for successful work in their more restricting setting. For instance, the team is working hard to provide opportunities for the women to experience achievement through tasks, such as individually cooking a meal for the whole house. For some of the women there, it is the first time they have ever achieved anything that brings them both admiration and personal satisfaction. Residents are also being given control over their self-harming behaviour and, even though self-harm there is generally more severe, it is now reducing.

Overall, staff within the service have really appreciated the input from the human givens approach, as they feel it gives them clear guidelines about what they are aiming to achieve with clients, and how to get there, rather than feeling submerged in vague and amorphous ideas of 'recovery' and 'hope'. We are also using the human givens as a template for supervision of staff, using it as a focus for discussion. One manager suggested it could be a way of identifying when things are not working as well as they could. For instance, if, after three supervision sessions, someone is still not getting sufficient sense of achievement or status from their work, they might need extra support. New workers undergo a thorough induction when they start with us but those who have never previously worked in mental health may have limited knowledge about the type of challenges our clients face and how best to help them. If their sense of control is revealed to be low, it may be a signal that they need to learn more about handling difficult behaviours.

As a result of all this, we have all seen a huge difference in women, who had felt themselves to be pretty much written off by other services. Comments from them include, "I can see I will move on from here"; "I get the attention I need, staff time and help with the things I need to do"; and "I'm starting to achieve new things all the time". Women who had continually been involved in fracas, ending up shouting and lash ing out in police stations and psychiatric hospitals, are now involved in training courses, voluntary and paid work, forming good relationships and becoming more socially skilled. Two women who have been with us since we opened are now moving on. One had been in institutional care, including prison, for almost 20 years. Now she has her own flat, and she is loving it.

The women we work with have very many difficulties to overcome, and working in such a setting can be quite a rollercoaster. I've lost count of the times I have left work on a Friday afternoon, with everything operating peacefully and have returned on a Monday morning to chaos and mayhem because, over the weekend, someone has become extremely distressed and seriously self-harmed or threatened violence or run away. At such times, having the human givens needs as a template to refer back to, to check we are on the right track and to keep us focused, is a welcome stress-reliever! ■

BOOKS

A Mind of its Own: how your brain distorts and deceives

Cordelia Fine
Icon Books £9.99

FIFTY years ago, Alice Stewart, an American physician, concluded that a single X-ray of an unborn baby doubled the risk of childhood cancer. Her findings were supported by a substantial body of evidence. So, was the practice of 'zapping' pregnant women abandoned forthwith? Well, no, it wasn't.

The 'radiological establishment', committed to the belief that X-rays were largely benign, attacked Dr Stewart and her conclusions. One radiobiologist commented, "Stewart used to do good work, but now she has gone senile." A later, clearly flawed report that failed to connect prenatal X-rays with childhood cancer was accepted with glee. In the mid-1970s, when it had become impossible to ignore the evidence, the US authorities still refused to act, going so far as to argue that the link between X-rays and cancer was due to the 'fact' that obstetricians were X-raying babies they "somehow *knew* would get cancer". It was not until 1980 that the US called a halt to prenatal X-rays, with Britain following suit somewhat later. This fascinating account of the human tendency to hold fast to cherished notions in the face of compelling evidence is used by Cordelia Fine to illustrate the machinations of what she calls the 'pigheaded brain'.

In *A Mind of its Own*, Fine, whose background is in experimental psychology and criminology, describes with wit and clarity, and without wasting a single word, the brain's capacity to mislead and distort. It is an expert, valuable, if whistle-stop, guided tour of what cognitive psychology reveals to us about the human condition (my sole reservation being that I wouldn't want to limit my approach to just this one dimension, however fascinating it is).

In her chapter entitled "The deluded brain", Fine questions whether it isn't just the clinically deluded who tend to conclude that some outside influence, such as an alien force, is controlling their brains, when they experience highly perplexing events that don't fit with their understanding of how things ought to work. She cites the case of some volunteers, who, while tracking a target with a joystick, were tricked into seeing a false hand in place of their own. This 'alien hand', although moving in time with the volunteer's hand, didn't quite obey their commands, purposely missing the target. When asked to explain their poor performance, a proportion of these mentally healthy volunteers came up with the following: "It was done by magic"; "My hand took over and my mind was not able to control it"; "I was hypnotised"; "I tried hard