James Hooton describes how human givens principles help him in his work as one of the new mental health practitioners in primary care.

When time's not on our side

SOMETIMES, when people ask what I do for a living, they look bemused when I reply that I'm a mental health practitioner. For I am one of a relatively new breed, spanning the divide between secondary and primary mental health services, in a role which has been developed as part of the drive to improve primary mental health care.[1] As the rationale for my presence in primary care is to help more patients receive effective treatment quickly, I am highly grateful for what I've learned from the human givens approach, which enables me to accomplish a lot in a limited time.

Two years ago, in Bognor Regis, where I work, two mental health practitioners were appointed for a pilot six-month period to work across four GP surgeries and see all patients within a fortnight of referral. The idea was to find out whether providing direct, speedy access to specialist workers in primary care would be clinically and cost efficient and result in a cut in referrals to secondary care, reducing the over-burdened community mental health team's workload. As I was overseeing the project at this stage, I sat in on a number of sessions with different GPs in different surgeries, to gauge just how much of their work involved dealing with mental ill health. Without exaggeration, poor mental health was an issue – whether directly or indirectly presented – for 90 per cent of people consulting their doctor. GPs know only too well that, if someone keeps coming in with different small ailments every other week, something bigger is the problem – whether home or social circumstances, lack of employment or family difficulties. But not only do they lack the time, and perhaps the expertise, to manage these concerns themselves; most haven't had access to quick and efficient treatments.

Our pilot project was such a huge success that there was no question but to roll it out across the whole region. The project was carried out with no extra funding – we had just reconfigured the service by moving secondary care workers into GP surgeries – and brought such financial as well as emotional health benefits that it received the instant blessing of both the primary and secondary care trusts. By this time, one of our mental health practitioners had moved on and, as I wanted to be a full-time clinician again, rather than a manager, I applied for the position and was really pleased to be offered it.

It is hard work. If people have any image of Bognor Regis at all, it is as a run-down seaside town, with, as its greatest claim to fame, King George V's disparaging cry, "Bugger Bognor!" In fact, the area is a mix of urban and rural, of all social classes and income levels. What is notable is the huge gap between the better off and those living in the very deprived areas, a mix that could predict a higher level of dissatisfaction with life circumstances. As we still have just two mental health practitioners to cover the whole area, we had started out as a triage service. We'd see patients for just 20 minutes, looking at symptom management and prioritising referrals – to the psychiatrist for someone hearing voices or to the clinical psychologist for someone with obsessive-compulsive disorder (OCD) – or directing them somewhere else ("The Citizens' Advice Bureau is really good at helping with debt" or "Your husband died two years ago and you still see him sitting in his chair. Have you thought of contacting CRUSE, the voluntary organisation that helps the bereaved?")

But it became clear very quickly that this was not what people wanted. Although we do still refer people with employment and debt problems to experts in those areas, most people see us because of depression, anxiety and post-traumatic stress, along with phobias, OCD and eating disorders, and they want us to be able to help them. With trial and error, we have settled on 45-minute sessions per patient.

Negotiating NICE guidelines

I feel comfortable about treating most people but, because I am not a private practitioner, I have to follow the NICE guidelines where appropriate. So, for someone who is moderately depressed, I have to go along with the prescription of antidepressants by the GP. If someone has severe OCD, NICE tells me I must refer the person for cognitive-behavioural therapy. I satisfy NICE guidelines in the following way. When people see me for eating disorders, moderate to severe depression, OCD, post-traumatic stress or severe phobias or anxiety, I tell them that the Government recommends cognitive-behavioural therapy in their cases. I then offer them the choice of seeing me for a few sessions, to see how we go, after which I'll make the referral, or my making the referral straight away but still seeing them for a few sessions in the interim. The usual outcome is that either I no longer need to refer or the referral gets cancelled. This seems to me an efficient approach, with clear cost and health benefits and well within the guidelines.

I also see some patients with psychotic disorders and do not make the assumption that, just

because someone has the written diagnosis of schizophrenia, I must instantly refer them on. People labelled as schizophrenic get stressed, depressed and anxious, just like anyone else. However, if people are hearing voices telling them to harm themselves or others, I involve the crisis intervention team, which can offer immediate help and protection. Similarly, I would involve them in the case of someone with severe depression who is having seriously suicidal thoughts, or in any case of high risk.

The friendly approach

I have to make the most of every minute of my time with patients. Some come in looking calm and almost businesslike, but I know that they are anything but calm inside, and that this will get in the way of any work I try to do. Some are obviously distressed. So I try to lower their anxiety straight away. I don't sit behind a desk, even though I use a doctor's surgery for my sessions. I approach people to welcome them, make eye contact, and match my actions to theirs, to start building rapport. My aim is to be professional but friendly – as if I am about to serve them a drink. I've experimented with dressing casually (but not in jeans) and with wearing a suit and tie, and both seem to work equally well. My feeling is that most people are so relieved to be able to talk that it doesn't matter what I'm wearing; it is the friendliness that counts.

When working in such short sessions, I find it useful to normalise people's experience as quickly as I can. The tension can drop right down for an OCD sufferer when I tell them that most people have some kind of obsessional behaviour or that, in psychiatry, we come across their problem a lot and that, although it feels as if it is ruling their life and will never let go, we know treatment works, because we've done so much of it. Commonly, people with OCD have had it for years before they seek help and they are terrified that there is something seriously wrong with them. It helps at once simply to talk of OCD as a gremlin on their shoulder or a bully. Similarly, if people tell me that they are having panics, I will deal with that straight away, by explaining the causes and showing them how to cope.

People in difficult life circumstances that aren't magically going to vanish tend to be close to the end of their tether by the time they see me. They may complain that it all gets so much that they can't think straight or that they get completely overwhelmed and confused. In such cases, of course, learning effective anxiety management techniques is key. I like to use the image of an egg-timer to help calm people down: "All that pressure in your head, making you giddy and confused – imagine it as sand in an egg-timer that has just been flipped up, so that all the sand is scrunched into the top. And you can let it start running down, because that's what sand in egg-timers does, just run down, so that you feel more safe and supported and balanced, and you won't topple over."

Guided imagery

When difficult circumstances can't be changed, I really value guided visualisation as a means of helping people get back a true sense of their strengths and resources and motivating them to carry on (while also trying to build some respite into their situation). In other cases, I have been amazed to find how guided imagery alone may prompt someone into a life-changing decision. One patient, Ruby, was 46 and had been married for 23 years, for most of which time her husband had been an alcoholic. She had stayed with him because they had three children and she hadn't wanted to break up the family. In the last few years, however, he had lost his job because of his alcoholism and had started to drink and behave drunkenly in front of their teenage children, which had shocked and upset them. He had refused all help and made Ruby's friends unwelcome at the house.

Ruby took care of her appearance and had a responsible job as a school secretary but she was in a constantly heightened state of emotion and her sleep was badly affected. At the time she came to see me, she was in a terrible state and trying to decide what to do. I had never met anyone who was so unaware of her own worth and abilities as a person, because her self-esteem by that time was so low. After calming her down, I used guided imagery with her to bring to the fore all of her considerable achievements – keeping the family together, emotionally and financially, at the time when it mattered, having children who had grown up feeling safe and confident because of her, holding down a job that demanded both efficiency and kindness, having and keeping friends, caring enough to keep up appearances for the sake of others, and so on.

Swift changes

I am still amazed that she changed so dramatically after that one session. When I saw her again, she had got her husband to leave the home and had contacted her solicitor, to start divorce proceedings. I saw her four times over a couple of months and, by the last, she was open to thinking about the future and meeting someone with whom she might want to share her life.

The quick reframe or new perspective, so integral to the human givens approach, is always a wonderful tool in a setting like mine, where I am so time limited. Twenty-three-year-old Nick sweated so profusely in his extreme anxiety that he had to take paper towels wherever he went. His anxiety, which had started at college, had gradually escalated, until he became a virtual recluse and spent much time alone smoking cannabis. Speaking on the phone was so anxiety inducing that he avoided doing even that. He wanted to work in IT and had been offered a job on leaving college, but had turned it down because he was so anxious about it. His goals were to be able to make phone calls and to feel okay going out.

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Making the phone call was the hardest thing for him to handle. I said to him, "If you pick up the phone and call someone, what is the worst that can happen?" That simple question opened something up for him. He couldn't even think of an answer, except that perhaps the person at the other end mightn't reply. It enabled him to view his dilemma from his 'observing self' and get it into perspective. The last time I saw him he had been to a gig with friends – a huge achievement – and had totally reduced his cannabis use, although we had never directly addressed it.

100 per cent improvement

In a mini-survey that I carried out with patients, to rate the difference between how they were at the start of treatment and how they are at the end, there was a 100 per cent increase in improved feeling on a scale from 1 to 10, a rise of 4 to 5 points not being uncommon. What was most noticeable was that it was the whole process that made a difference, including the quicker access and being seen in the familiar GP surgery, and the normalising affect that this had.

One of my biggest challenges, however, has been Evelyn, a 60-year-old widow who has had a lifetime of treatment for anorexia. In a period spanning more than 40 years, she had experienced several episodes as an inpatient, forced-feeding, drug treatments, dietary measures and weigh-ins, and different behavioural approaches, a great deal of it in specialist mental health services. The people who worked with her no doubt did their best to help her, but she experienced it all as abusive. This highly intelligent woman, formerly a solicitor, still struggles emotionally with her appearance and her weight. If anyone she meets says, "You are looking really well! Have you put on weight?" she feels almost suicidal, and usually reacts by shutting herself away for a while. That makes her feel worse because her way of keeping her mind off how badly she feels about herself is through busying herself with voluntary work. Evelyn's GP, who has known her for many years, referred her to me, after she had failed to cooperate with the community mental health team, as she had felt dissatisfied with her treatment.

Knowing this, I asked Evelyn, when I met her, what she thought or hoped I could help her with. She gave a deep sigh. "What I want is to be able to sit in my garden and read for half an hour without a negative thought," she said.

At her worst, she told me, she felt just one step away from killing herself, although she knew she would never resort to that. "When was the first time you felt that way?" I asked her. "When chubby little Evelyn had been naughty again," she said. She had felt her parents were cold and critical of her and had cared more for her brother than for her. The messages she internalised were "You are fat because you are naughty" and "You are naughty because you are fat". Whenever doctors and dieticians asked her to stand on the scales, she felt like a naughty child and experienced the terrible anguish all over again.

Undoing old damage

I felt that I had to take it very, very carefully with Evelyn. I would have liked to use relaxation and guided imagery with her, and perhaps the rewind technique, to deal with the memories of all that 'abuse' and to uncouple the pattern match between weight and being bad – so strong that being told she looked well could spiral her into despair. I had a hunch, however, that in her many years in the mental health system, relaxation techniques might have been tried in some form or other, and, therefore, form part of her memories of abusive treatment. I was right. She loathed being made to relax.

I have, therefore, concentrated on inducing trance indirectly, slowing my voice and working hard to focus her attention. (She tends to jump around a lot in her thoughts and her speech, perhaps to protect herself from the bad feelings.) I learned that she was interested in redecorating her home, so I told her the true story of a friend whose relative bought an old nuclear bunker and transformed it from being a place where people would hide away, fearful that, when they came out, they would find their world had become an ugly, frightening place, into a beautiful home, with huge windows spreading light and looking out onto a peaceful landscape. She seemed to enjoy it.

We have also talked about how, if she feels bad about a compliment or chance comment, she can choose to pause, slow her breathing and reflect on the fact that her bad feelings might not be appropriate to the current situation ('looking well' does not mean 'fat').

Even with this limited approach, I have seen marked changes in Evelyn in just a few sessions. I have asked her to find out information about the rewind treatment (she has a curious mind and enjoys learning about things), in the hope

REFERENCE

1 *Care Services Improvement Partnership (CSIP) and the National Institute for Mental Health in England (NIMHE) (2006).* Improving Primary Care Mental Health Services. *Department of Health, London.*

that she may, as a result, choose to undergo it, rather than experience it as something 'abusive' she is subjected to. It is a work in progress. Evelyn has had 40 years of treatment and she is still the same weight as she was at the start, and still emotionally disabled in many ways. She has been doubly traumatised – by her childhood experiences and by her experience of the mental health services. I come across many people whose experience of an unwieldy and unsatisfactory psychiatric system has set them back rather than moved them forward, and I am glad to be part of the new approach to meaningful care.

Many years ago, I was a plasterer. I did what seemed, to outsiders, like the same job every day and yet each job called for something individualised because of the nature of the materials I was working with. It's something like that with people, I think. Everyone has a different surface and a different interior, and there is an individualised human givens approach that is appropriate for each. ■

BOOKS

Social Intelligence: the new science of human relationships

Daniel Goleman
Hutchinson, £20.00

DANIEL Goleman has done again what he did in his ground-breaking book *Emotional Intelligence*: found the perfect phrase for a mass of new scientific discoveries, this time "social intelligence" – a term originally coined by American psychologist Edward Lee Thorndike in the first half of the 20th century but one which, amplified by Goleman's synthesis of the findings, will slide into the language as if it had always been there.

Human beings (and other mammals) are wired to connect, he reports. We already know from our own experience how necessary and important our relationships are – but in fact they have a more primary and profound impact on *all*, and *every*, aspect of our lives than we are consciously aware. We are designed for sociability, constantly engaged in a 'neural ballet' that connects brain to brain with those around us. Our daily encounters with parents, spouses, bosses and strangers shape our brains and affect cells throughout our bodies, *right down to our genes*. The information, mainly from biology, psychology and neuroscience has been arriving piecemeal in research journals and newspaper articles for some years. But now, assembled between two covers and with Goleman as our guide, it blows to smithereens any idea that our minds are independent, separate and isolated.

Readers of this journal may be aware of the phenomenon of mirror neurons: that, if we observe another's actions, the part of the brain activated in the other person will also activate in us. Swedish researchers have established that merely seeing a happy face elicits fleeting activity in the muscles that pull the mouth into a smile – which, as we know, brings with it 'smiley' feelings. It also works the other way: we mirror angry faces or sad ones and feel those emotions too. This is true in groups as well as individuals. The swiftness of shifts in the behaviour of crowds looks suspiciously like mirror neuron coordination writ large.

But the reflections go well beyond what we can see. A Stanford University experiment brought two women, complete strangers, together after watching a harrowing documentary about the aftermath of the atomic bomb dropped on Nagasaki. Both were deeply disturbed by what they had seen, but, when they spoke, one was utterly frank about how upset she was, while the other (briefed by the experimenters how to behave) suppressed her emotions. In doing so she felt tense and ill at ease, and predictably her blood pressure rose steadily as the conversation went on. What was unexpected, however, was that the other woman exhibited the same steady rise in blood pressure.

The moment we start to associate closely with someone, in fact, our reactions begin to chime with theirs. Researchers at Berkeley, for example, tracked the emotional responses of new roommates as they separately watched some short films, including a tearjerker and a Robin Williams comedy. On first viewing, they reacted as differently from each other as any pair of strangers would. But, seven months later, when again separately shown some films, their reactions had strikingly converged.

Our responses are, as always, part unconscious, operating at hyperspeed; part within conscious control but slower: two routes which Goleman calls the "low road" and the "high road". We have a built-in capacity consciously to set aside the mirroring and tuning in. Were it otherwise, surgeons couldn't operate or soldiers fight.

Goleman describes with admirable clarity the various areas of the brain involved in our social and emotional responses. As always, however, variation, as well as outright damage, occurs. Anomalous circuitry can result in the social difficulties of people on the autistic spectrum, who lack what Goleman calls "mind-sight". And he also warns of the "dark triad": narcissists, machiavellian types and psychopaths, who have little or no circuitry for empathic mirroring, and who can exploit and endanger us. He quotes in this context philosopher Martin Buber's concept of the exploitative I–It relationship, rather than the equal, connected person-to-person I–Thou.

Therapist readers will be interested to have confirmed that in a successful therapy session "a hidden biological dance" glides beneath the visible interactions. Researchers wired up the participants, the wires yielding a stream of readings transformed into coloured lines on the screen, and saw that when therapist and client are in rapport they fly "like birds information, a graceful ballet of coordinated movement". Reframing, too, has a noticeable effect within the body. A woman was shown a picture of someone waiting outside a church for what she interpreted as a funeral, and her appraisal activated the circuitry for sadness. But the instant she changed her mind and reframed the picture as someone waiting for a wedding, a cascade of mechanisms were initiated which quietened the agitation of the amygdala and related circuitry.