

Needs and resources: finding what's there

Pamela Woodford describes how she works with the human givens approach – a holistic model that avoids artificial demarcations between different therapies

I work mainly with children and adolescents and treat a whole range of conditions from depression, anxiety, anger and eating disorders to self-harming, OCD, addiction and psychosis.

Before describing the way I work, I should explain what the 'human givens approach' means, since, as a therapeutic school, it is still the 'new kid on the block' (according to the BMJ¹ when comparing it favourably to psychodynamic, person-centred and cognitive-behavioural therapies). I was drawn to it after years spent as a psychodynamic counsellor growing increasingly frustrated at how my colleagues and I just didn't seem to be helping many clients effectively.

Human givens

The term 'human givens', first coined in 1997, refers to our fundamental physical and emotional needs and the innate resources we have that are there to help us fulfil them². These needs and resources are a form of accumulated knowledge that has evolved over millions of years and are our common biological inheritance, whatever our cultural background. It is because these needs and resources are incorporated into our biology that they are called 'givens'.

We all experience this knowledge as instinctive feelings of physical and emotional *need*, together with the *resources* we evolved to help us get these needs met – such as memory, so we can learn, and imagination, so we can solve problems and rehearse new behaviours. These innate feelings are the driving force that motivates us to find the psychological nutrition we need in order to flourish and succeed in whatever environment we find ourselves in. When these innate needs are met in balance people do not have mental health or behavioural problems. But when they are not, any child or adult will become anxious, angry or depressed, and then other behaviours might kick in, such as addiction, self-harming or compulsions.

The idea of innate needs is not of course new: Adler, Maslow and others had talked about them, but this presentation of their importance goes beyond anything I had heard before. It explains in biopsychosocial terms why these needs evolved, and shows us how to make practical use of this

information in therapy. I also found that studying human givens (HG) makes it possible to see why some counselling approaches work better than others.

Physical needs

The paramount physical needs are obvious: air to breathe, water, nutritious food, sleep. In addition we also need the freedom to stimulate our senses and exercise our muscles. These physical needs are intimately bound up with our emotional needs – the main focus of human givens psychology.

Emotional needs

In psychotherapy, it is the emotional needs we are mainly concerned with. Emotions create distinctive psychobiological states in us and drive us to take action. The emotional needs that nature has programmed us with are there to connect us healthily to the external world, particularly to other people, so that we can survive and thrive in it. When these needs are not met, nature ensures we suffer considerable distress – anxiety, anger, depression etc. Our expression of distress, whatever forms it takes, impacts on those around us. When psychotherapists and teachers really understand and pay attention to innate needs, they are at their most effective.

There is widespread scientific agreement as to the nature of our emotional needs. The main ones are listed below.

- Security – safe territory and an environment that allows us to develop fully
- Attention (to give and receive it)
- Sense of autonomy and control – having volition to make choices
- Being emotionally connected to others: friendship, intimacy – to know that at least one other person accepts us totally for who we are
- Feeling part of a wider community
- Sense of status within social groupings
- Sense of competence and achievement, so we don't suffer low self-esteem
- Privacy – for reflection and consolidating experience
- Meaning and purpose – which come from being stretched in what we do and think.



Along with physical and emotional needs, nature gave us 'guidance systems' – the innate resources we use to help us meet them

Resources

Along with physical and emotional needs, nature gave us 'guidance systems' – the innate resources we use to help us meet them:

- Long-term memory, so we can add to our innate knowledge and learn
- The ability to build rapport, empathise and connect with others
- Imagination, which enables us to creatively solve problems
- A rational mind that can check out emotions, question, analyse and plan
- The ability to 'know' – that is, understand the world unconsciously through metaphorical pattern matching
- An 'observing self' – that can step back apart from intellect, emotion and conditioning and so be more objective (aware of being aware)
- A dreaming brain that preserves the integrity of our genetic inheritance every night by metaphorically defusing arousal patterns (expectations) held in the autonomic arousal system because they were not acted out the previous day.

In addition, human givens therapists employ knowledge about conditioning and molar memories (see later) and how depression, addiction, OCD,

sub-threshold traumas and PTSD develop. We also become familiar with developmental conditions, such as Asperger's syndrome, which can be a causal factor in mental distress.

The method we use draws on insights and techniques from a wide range of counselling models, including person-centred, solution-focused brief therapy, CBT and hypnotherapy, but avoids all the artificial, cult-like demarcations people may make between differing therapy approaches. Instead, HG sets therapy in a holistic context of an understanding of what human beings really need. HG therapists link up with other agencies so that, for example, if a young person is depressed because they are unemployed and not being stretched (a vital need often met through work), the therapist will help them get on a training course. We all get our needs met in the environment we find ourselves in – in our family, school, workplace etc. When the environment fails people, it has to be tackled too.

Like many others, I found the profound truths in Griffin and Tyrrell's² analysis deeply motivating. Practice-based evidence is the watchword. They eschew theoretical models that do not produce results. I think this is why the best HG therapists quickly develop a reputation for moving people on quickly and attract the attention of organisations (such as PCTs, mental health partnerships, schools etc) who find HG ideas and skills help them get more out of their budgets.

Structure of a human givens therapy session

I begin therapy, as all good therapists do, by building rapport and striving to lower a client's emotional arousal so as to access more of their brainpower. I do this through reflective listening, reframing and relaxation techniques. Information gathering is quite specific. There are questions I need answers to, such as:

- What needs are not being met in this person's life?
- When did the problem start?
- What was going on at the time?

Then I help them set clear goals (fresh expectations for their brain to work with), agree a strategy for how to achieve their goals, and get them to rehearse the new behaviours using guided imagery. This is the RIGAAR model:

Rapport building
Information gathering
Goal setting
Agreeing a strategy
Accessing resources
Rehearsing success.

If someone has been traumatised by experiencing violent, abusive events



The rewind technique

The rewind technique used by human givens therapists is a considerably refined version of a technique originally adapted by Richard Bandler (co-founder of NLP) from studying how the American psychiatrist Milton H Erickson used to detraumatise people by dissociating them with the metaphor of a 'crystal ball'.

It is a non-intrusive, safe and highly effective psychological method for detraumatising people from single incidents that are still affecting them or from the effects of multiple long-term abuse or long-term illness. It is also used for removing phobias and has proved very effective as part of the treatment for OCD. It should be carried out by an experienced practitioner confident in using guided imagery and is only performed once a person is in a state of deep relaxation. It is not difficult to learn, however, if you have the aptitude for this work.

When they are fully relaxed, they are encouraged to bring their anxiety-making memories to the surface, enough to begin to agitate them, and then they are calmed down again by being guided to recall or imagine a place where they feel totally safe and at ease.

Their relaxed state is then deepened and they are asked to imagine that, in their special safe place, they have a TV set and a video player with a remote control facility. They are asked to imagine floating to one side, out of body, and become aware of themselves watching the screen, without actually seeing the picture (creating a double dissociation). They watch themselves watching a 'film' of the traumatic event that is still affecting them. The film begins at a point before the

trauma occurred and ends at a point at which the trauma is over and they feel safe again.

They are then asked, in their imagination, to float back into their body and experience themselves going swiftly backwards through any memories associated with the trauma, from safe point to safe point, as if they were a character in a video that is being rewound. Then they watch the same images but as if on the TV screen while pressing the fast forward button (dissociation).

All this is repeated back and forth, at whatever speed feels comfortable, and as many times as needed, till the scenes evoke no emotion from the client.

If the feared circumstance is one that will be confronted again in the future – for instance, driving a car or using a lift – the person is asked, while still relaxed, to see themselves doing so confidently.

Besides being safe, quick and painless, the technique has the advantage of being non-voyeuristic. Intimate details do not have to be discussed with the therapist, which many clients find comforting. A minority of people, those on the autistic Asperger's spectrum, do not gain improvements with this approach.

The technique works because the part of the brain called the amygdala that constantly looks for threats to its survival by surveying the relationship between incoming information from the environment, instincts and memories, is put in the position of saying, in effect, 'I'm so physiologically relaxed while reviewing these memories that there can be no danger in them.' Thus the traumatic memories are released into the higher cortex to become normal narrative memories.



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(many of the young people I work with have developed PTSD or compulsive behaviours as a result of emotional, physical or sexual abuse), I quickly detraumatise them with a simple technique known as the 'rewind' technique, which unhooks the emotion from the memories³ (see box, above). Progress in healing any psychological damage is usually swift once this is done.

I also tell a lot of helpful stories to my clients. The brain is a metaphorical pattern-matching organ and learns best through metaphors appropriate to the individual. Everyone responds to stories.

The HG approach looks on psychotherapy and counselling as a specialist branch of education, and much of what we do involves teaching distressed people about our emotional needs and what causes depression, panic attacks, nightmares, addiction, psychosis and so on. This is powerfully therapeutic in itself and works even with young children.

I find that they always leave a session with some positive expectation.

The following case history illustrates this educative element and shows how quickly progress can often be made.

Case study: Emily

I had an email from the mum of a 12-year-old girl whom I'll call Emily. Mum had heard about my human givens work with children via MindFields College (which teaches this approach). In the email, in painful detail, she told me how her daughter had developed OCD behaviours when quite young and had now become severely anorexic. 'We had to take her out of school, as she was hiding in the toilets and bouncing frenetically for half an hour at a time, and then feeling weak and faint. At home she became more and more challenging, running from one end of the house to the other



When your eyes are open you can only see what you're looking at. When you close your eyes you can see absolutely anything

continually for hours, screaming and throwing things if we came near. She was injuring herself, with repeated accidents and running into the streets in her underwear. We just couldn't cope and eventually forced the consultant to admit her against his will!

Emily spent six months in hospital, and seemed to stabilise, but when she got home she quickly spiralled downward. 'This week we found out that she has been taking painkillers to mask the injuries occurring through her over-exercising. She spends large parts of the day crying, refusing attempts to comfort her, and often says she wants to die.' Emily's mum was clearly desperate.

I saw Emily three times. She arrived looking pale and exhausted. She was extremely thin and quiet and sat looking up at me with such pleading and expectation for help. She, too, was desperate.

The first thing I did was check on what good things were happening in her life. I made a point of letting her see that I thought this was important by writing them down. So we had things like 'my mum', 'my hair', 'my friends' and 'I'm eating well'. Then we listed the things that were 'iffy' (I don't like saying 'bad'), which was 'home', 'Dad – he's grumpy and miserable, and always has been', and 'not sleeping well'.

Then I asked her: 'If you had to make a nice home what would you have in it?'

'Well, I wouldn't have my dad being so grumpy in it.'

My next question was: 'What would you like to change? It must be something that's possible to change because you can't "change" Dad.'

'I'd like to be normal, make more friends and not do as much exercise.'

So we had some clear goals early on.

Then I found out that she enjoys art, playing the piano and being with friends. We talked about home and school and other things. The brain is a metaphorical pattern-matching organ and so I explained about 'pattern matching' in an age-relevant way, ie if something frightening happened to you in a room painted orange, you might grow up hating the colour orange or even disliking the fruit oranges!

Story and imagination

Then I told her a story about 'the worst possible thing that can happen'. It was a metaphor for treating anxiety disorders and was about a little girl that I knew who was afraid to do anything and was even frightened that she might one day get an in-growing toenail, and how this little girl had an ability to create huge and overwhelming catastrophes out of something so small, as if she were a mad witch frightening herself.

I explained that we can use our imagination to invent and create things that were more fun than what this girl had done, like playing the piano or

drawing, but that some people say that if you close your eyes you can't see anything, but that I'd found out that it's the exact opposite. When your eyes are open you can only see what you're looking at. When you close your eyes you can see absolutely anything! So we ended the session with some relaxing guided imagery where I worked on the running compulsion and 'alien thoughts'. I told a story about magic spells and how the beautiful Sleeping Beauty was put under a spell to stay asleep for years until the prince awoke her, but that other people were under a spell to keep moving and not relax. And that the important thing was, to break the spell!

Before she left, I addressed her poor sleep by setting sleep hygiene tasks. Worry disrupts sleep by generating intense amounts of dreaming and upsetting the balance between REM sleep (when we dream) and recuperative slow wave sleep. (That's why depressed people always wake up tired – when you stop the worrying they come out of depression.)

When Emily came back the second time, I spent the whole hour explaining, with age-relevant drawings, how her brain worked: about the knowledge nature gave us that we feel as innate needs; about expectancy and its role in addiction, and that her OCD is an addiction. She was totally focused throughout, and when I asked her what she expected her exercise routines to do, she said: 'Stop me stressing.'

So I said: 'Now let's have a think about what they *really* do for you. Tell me how you feel when you've done all that running.' She stared at the brain picture, she looked up at me, she looked back down at the picture, and then she said: 'It wears me out and it makes me unhappy.'

I asked, 'What else does it do, Emily?'

She said: 'It makes me stressed!'

I said: 'Wow! It's the absolute opposite to what you thought it was doing,' and she looked at me as if to say, *What have we found out?!* It was an incredible moment.

So I said: 'Yes, it does the opposite. It's a bully. So we've got to find out how you can stop it bullying you! (Achieving this realisation that the anorexia and compulsive exercising is bullying her is what is known as 'separating the core identity of the person from the problem' and invariably marks the turning point.)

Before Emily left she sat for two or three minutes, staring at the brain picture. I let her be, while her brain processed the information she now had. I could almost hear it ticking, taking it all on board, saying, *I've been tricked all this time.*

I then suggested that she take the picture with her and explain about the brain to her mum: 'It will show that you really understand it.' This made perfect sense to her.

When she came in next time I was almost