Wash and brush up?

By Peter Bates

As a society, we have never spent more money and time on our personal hygiene than we do these days – applying cosmetics, washing and replacing our clothes, refitting our bathrooms and watching TV adverts on how to look good and smell even better. Perhaps grooming is one way to 'put on a brave face' and confront the consequences of global recession, But despite all this effort, a number of citizens remain unaffected, seemingly unaware that their greasy hair, malodorous breath and dirty fingernails are hazardous to health, status, relationships and access to services.

It seems that almost everyone knows someone who troubles the eye or the nose in this way - perhaps a neighbour, a work colleague, a customer or a family member. It seems to affect a small minority of people at every age, often mediated through cruel stereotypes such as the snot-nosed, friendless child, the hormonal teenager and the unkempt pensioner. Its impact on life opportunities can hardly be overstated, as potential friends choose to sit somewhere else, lovers withdraw, relatives stop visiting, professionals shorten the appointment and employers choose someone else. Is this a neglected face of exclusion, a hidden cause of isolation, inequality and misery?

Some of these excluded individuals use mental health services where many staff feel baffled and helpless, unsure how to act and what to say in response. Sometimes we hear defensive talk about poor hygiene as a lifestyle choice, a consequence of personalisation, but this misses the point that our society is fiercely critical of those who do not wash and consigns them to an isolated existence with few opportunities and many risks. This results in a loss of the person's contribution to economic and social capital and, in the long term, an increase in the cost to the Exchequer. Even more important is the danger of being treated unfairly and the corresponding delay in recovery.

The neglect of neglect

Despite the prevalence of the issue, poor personal hygiene remains under-researched and poorly understood. Studies of wellbeing have ignored rather than tested the folklore belief that if you smarten up you will feel better, while investigations of 'lookism' and power dressing have considered the favouritism that

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is given to beautiful people, but neglected grooming as an aspect of appearance. Why might this be? There are at least five reasons.

Firstly, human beings have an inbuilt physical reaction known as the 'disgust response' that triggers flight when faced with potentially fatal sights and smells, a physiological reaction that is so powerful that we may not even want to think about the stimulus. Secondly, care of the body may be gendered and seen as trivial or cosmetic rather than as a serious topic for research investment or practical intervention. Thirdly, poor hygiene is not often considered to be a substantial issue in itself, but appears instead as a peripheral issue alongside more important problems such as suicidal depression, verminous property, hazards to children or limited mental capacity. Fourthly, literature is scarce, and so we remain intuitive rather than analytical. Finally, experience suggests that it is hard to make a difference, so ignoring the problem is less demoralising than the alternative, especially when we genuinely do not know what to do and previous attempts have failed.

This catalogue of reasons for the neglect of self-neglect also points the way forward, by showing that we need to: acknowledge our own emotional responses; reflect on our own cultural beliefs regarding gender, hygiene and related matters; focus on poor hygiene as an issue in itself, rather than simply using it as a warning flag for other concerns; seek out theoretical models and empirical data; and adopt a solution-focused rather than a pessimistic approach.

Multidisciplinary approaches

The table below imagines that a multidisciplinary team has been gathered around the person to offer a wide range of perspectives on the problem of poor personal hygiene. It collapses the broad, holistic approach of each discipline into just one or two questions and thus does injury to their best practitioners, but it has the advantage of providing a reasonably simple set of questions that can be used by anyone from any discipline or none. The table widens out the usual array of skills within a traditional team in mental health services to embrace a diverse range of disciplines, each of which offers a question or two that forms a starting place for further inquiry. As well as reinstating the usual professions of social work, occupational therapy and so on, others that might be added to such a list include dietician, finance adviser and pharmacist.

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Perspectives on neglect of personal hygiene.

Think about yourself as a...	Ask this question....
1. Advertiser	What impact does culture and media have on the person?
2. Advocate	What does the person want to say about themselves, society and their aspirations? Does the person have the power to express and act on their preferences?
3. Counsellor	What trauma or distress has the person experienced?
4. Dentist	Is poor oral health leading to halitosis?
5. Doctor	Is there an illness or disability that makes parts of the body smell or that means it is hard to get and stay clean?
6. Environmental Health Officer	Is there a nuisance or hazard for other citizens?
7. Historian	How was the person in the past? What influences did the family, neighbourhood and community exert?
8. Lawyer	Have laws or contracts been broken? What formal responsibilities are borne by the person and other people?
9. Speech therapist	What message is the person's speech or behaviour trying to send to whom?
10. Teacher	What skills, beliefs or behaviours has the person been taught? What could be taught?

Some of these disciplines have considered the needs of people who neglect their personal hygiene, but the paucity of research means that little is known about the efficacy of interventions. The following paragraphs build on a few local activities by outlining some starting points for further investigation.

Competencies for personal hygiene

In one English town, a further education tutor ran a programme for young, unemployed, learning disabled adults to teach them how to select cheap clothes from second hand shops, as well as how to care for the clothes, combine them in fashionable ways, and use cosmetics appropriately. Similar programmes for people with mental health issues may exist and such a competence-based approach would specify what people need to be able to do in order to manage their personal hygiene in particular contexts, measure the skills gaps, and then support learners to develop

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their understanding and abilities. Beyond education, and perhaps within care or recovery planning, it would provide an unambiguous way to support the person to complete a self assessment of their own behaviour, an audit of the demands of specific environments, and develop a personal action plan.

Linking poor hygiene with other problems

Poor hygiene is sometimes linked to neglect of the home and both can be a response to depression, the distraction of obsessional or compulsive preoccupation with other matters, and the negative symptoms of schizophrenia. Environmental Health Officers have a wide range of legal duties that underpin their duty to respond to squalid housing conditions. They have found that domestic squalor and poor personal hygiene are independent variables that co-exist some of the time, but not all of the time. We might guess that neglect of the body is associated with neglect of the home, as it may be linked with poverty, unemployment, living alone, low self esteem, psychiatric problems and visual impairment, but the extent and strength of the relationship is poorly understood, thereby increasing the likelihood that stereotypes will cloud the judgement of professionals and others.

Conceptual models

While considering the contribution of environmental health professionals, we also note the significant work they have done in developing a definition and model for understanding dangerous hoarding. The point here is not to try and link hoarding with neglected personal hygiene (although there may be connections), but to highlight the value of model building as a way of improving understanding. Environmental health officers recognise *accumulators,* who have no strong feelings about their belongings, but don't get round to throwing anything away; *collectors*, who positively value specific items and deliberately acquire them; and *hoarders*, who hold an emotional attachment to their belongings and cannot bear to part with them. No doubt this model of hoarding would benefit from further testing and elaboration, but it has immediate potency and highlights the lack of a similar framework within mental health services for understanding poor hygiene.

How the problem develops

Serious Case Reviews are undertaken in situations where people have died or been significantly harmed. In some of these events, the person concerned has neglected

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their personal hygiene and also refused help from statutory agencies, failed to eat or care for others and refused medication or other healthcare. Severe self neglect and service refusal are not always associated with poor personal hygiene, and it remains unclear whether these extreme cases share common characteristics with people who have milder self-care issues, whether mild problems lead on to more severe difficulties over time, or whether preventative work would slow or stop escalation.

Rationing limited resources continues to be a challenging task for social care agencies, as shown by the Supreme Court decision in 2011 to refuse stroke survivor Elaine McDonald a carer at night time and instead to advise her to use incontinence pads. At present, we have no idea if a small investment of public funds targeted at supporting self-care will prevent larger problems developing in the future, or whether the growth of personalised care will make the issue more or less common.

A Housing Officer recently worked with a tenant who had been recently discharged from hospital. The tenant wanted repairs and improvements, which the Housing Officer authorised in stages as the tenant met a series of targets for cleaning up his flat. Anecdotes aside, we do not know if such preventative interventions generally work with people who have mental health issues, with personal care as well as with property maintenance, or whether they help to maintain wellbeing and assist with recovery. Improving our understanding of the development of hygiene problems over time might lead to effective prevention work.

Changing hygiene behaviour whilst respecting cultural differences

A brief glance at the social history of the last eighty years reveals substantial changes in the cultural norms surrounding personal hygiene and especially rapid changes over the last few decades. Many English people now living grew up without domestic showers, without deodorants, without a daily change of clothes, and so they 'washed what showed' and took a bath no more than once a week. Some homes had no bathroom, and those that did exist were commonly unheated and badly insulated (in common with bedrooms), and so personal hygiene was often an uncomfortable, perfunctory affair, a far cry from the shrines to hygiene, pampering and luxury that many enjoy in the 21st century. Older people may remember these experiences and the feelings that went with them, while some families may have transmitted such attitudes to their children and grandchildren.

There are many places where cultures clash, creating opportunities for the abuse of power. Such places include settings where younger staff provide personal care for older people, or staff who grew up in one country or cultural community provide care

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to people who were socialised into a different set of norms. Where staff have received little training, provide 24 hour care and are isolated from other services, as is the case in some privately run mental health residential care settings, such risks increase.

In addition, the fear of infection has radically changed the hospital environment in recent years and spread the use of alcohol gel and protective gloves into many care settings. Increasingly, social and healthcare staff in mental health services insist on a particular way of doing things in relation to personal hygiene, imposing their standards on the people in their care. We do not know if mental health support staff are changing the self-care hygiene behaviour of the people they visit at home, whether a short stay in a psychiatric hospital or a residential care environment has any enduring effect, or much about the techniques which might be most successful with people from specific communities and cultures.

Homelessness

A growing number of people in the UK have no home, job or secure income and experience extremely high levels of vulnerability to physical and mental health issues, crime, substance misuse and reduced life expectancy. Their route to a more stable lifestyle may be influenced by their access to personal hygiene facilities – toiletries, a safe place to wash, smart clothing and laundry facilities.

Services for homeless people have championed this perspective to personal hygiene for many years. For example, Emmanuel House in Nottingham provides access to a warm, lockable place to get undressed, a shower, a haircut, a rack of clean clothes and a washing machine, which can make all the difference to someone who has no fixed abode, while the offer of permanent housing and the support to take it up can provide a longer term solution.

Stories emerge from Emmanuel House and elsewhere of how providing access to hygiene facilities and clean clothes can support the government's goal of improving mental health and enabling excluded people to gain paid employment; while giving out 'Just add water' kits of toiletries can provide a boost to the recipient's dignity and self-respect. Rather than being reluctant to wash, many people have limited opportunity and take up the chance to improve their personal hygiene if it is offered. There is much to learn about the impact of these small-scale interventions on life opportunities and mental wellbeing for the most severely excluded citizens.

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Health interventions and poor hygiene

Doctors, dentists, pharmacists and allied health professionals such as dietetics and occupational therapy can assist in a variety of ways. For example, certain diets and several of the medications used in psychiatry increase sweating, and so people can be advised of this and encouraged to shower more often. One imaginative programme in a psychiatric inpatient unit offered a 'toothbrush exchange', and demonstrated improvements in dental care, reducing halitosis levels. Treatments are available to help individuals who have particularly active sweat glands, and adaptive technologies may assist people who have difficulties with self-care routines, perhaps because of physical impairments.

We know that older people and people with learning disabilities or mental health issues often do not receive equal treatment in relation to their general health needs. This is partly as a result of the process known as diagnostic overshadowing, where the person's disability or age is given undue prominence as the cause of all other symptoms. We need to find out if poor personal hygiene is inadvertently viewed as an inevitable part of disability or age for some (continence problems can be misunderstood in a similar way) rather than an issue that is deserving of attention in its own right.

Experts by experience

One of the most surprising gaps in the literature is the silence from people themselves. While the notion of 'experts by experience' has permeated mental health services and the government has adopted the mantra 'nothing about me without me' as central to its social and healthcare delivery, the voice of the person is almost entirely unheard in relation to self-neglect. Perhaps no-one wishes to identify themselves with this issue, or perhaps it is a problem in the eye of the beholder only. But if our understanding is to improve, there is clearly a need to explore the meaning of poor personal hygiene to the person themselves.

We might surmise that personal appearance is a kind of communication, perhaps a signal that the person rejects the image-conscious superficiality of current celebrities, or perhaps they oppose the forces of convention that drive people to use clothing and appearance as a means of blending in rather than standing out. Perhaps the person is concerned with their inner world or has an overwhelming preoccupation that has distracted them from daily routines of dressing, washing and cleaning. Or again, perhaps they are punishing their body, mortifying the flesh, actively scribing

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their sense of worthlessness or moral dirtiness on the canvas of the skin. Maybe the person has given up any hope for the future or feels visceral pleasure in dirt. We cannot know unless we ask about the impact of depression and anxiety, delusions and beliefs.

Conclusion

We stand in a place that is full of contradiction. Those with a foul smelling body, clothes and breath cause the most violent of gut reactions, while some people loudly declare that it is their choice. Some notice the most profound isolation arising from poor personal hygiene, while others relegate it to a matter unworthy of research interest, professional attention or eligibility for service. Smell may be the first thing we think of when bringing the person to mind, but we dare not speak of it to the person themselves.

So how do we support staff in social and healthcare settings, as well as relatives, friends and others in their attempt to offer support? A literature review and case studies gathered by the National Development Team for Inclusion (NDTi) suggest that change is often frustratingly slow, but depends on forming a genuine bond with the person. Focused effort and research are urgently needed if people are to have the opportunity to escape from the personal rejection, social exclusion and danger that accompanies a lifestyle of poor hygiene.

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