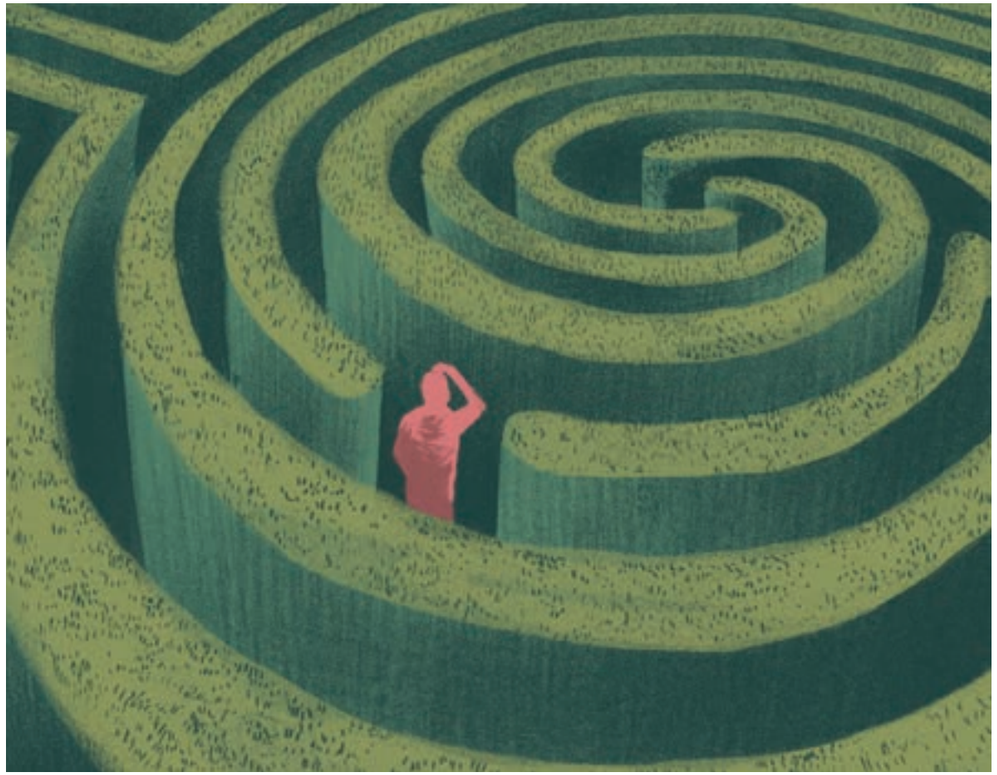
‘Specialist psychotherapy is vital for women with complex needs’

INTEGRATIVE PSYCHOTHERAPIST **ERENE HADJIIOANNOU** BELIEVES A NEW APPROACH IS NEEDED TO HELP SOME FEMALE CLIENTS



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Between 2014 and 2018 Erene created and delivered two specialist third-sector psychotherapy services in women-only spaces within Leeds: Together Women Project, and Support After Rape & Sexual Violence Leeds

As a psychotherapist, I believe the therapeutic endeavour is of little value if it cannot be applied outside the consulting room. My clinical experience with female offenders and survivors of sexual violence includes an active engagement with the reality of their lives, to maximise the effectiveness of psychotherapy.

We assume women are able to find a specialist women-only therapy service, and access it when they are ready to engage. But this process is hindered by what we can offer: usually time-limited psychotherapy following a long wait. The impact this delay has is devastating. We know the demand for psychotherapy outweighs provision, and the difficulty of working within time-limited funding periods.

Sometimes we cannot offer therapy because a client’s needs exceed what can ethically be provided. We know that clients will have to navigate the mental health system, wait, and potentially deteriorate. That is, if there are any suitable services for them to access. This context is sometimes the main challenge in providing the work, not the work itself. But I believe that there is a strong argument in favour of specialist psychotherapy for women with complex needs, despite the obstacles.

The service provided at the Together Women Project was delivered by me on an unpaid basis. As I could only sustain this for two years, the service began and ended with me. Working from a volunteer model devalues the client’s presenting issues as well as our profession. The best we can offer should not be a service that may suddenly become unavailable. Therefore, ring-fenced funding is key, especially as statutory services refer into the third sector for specialist work.

For female clients who cannot afford private psychotherapy, there are additional barriers that affect engagement such as: the unavailability of free childcare, low income, and limited women-only spaces for gendered issues. Being at continued risk of harm from others and to themselves intensifies this, and rarely creates a straightforward therapeutic process.

Female survivors often describe being turned away from services at the point of disclosing sexual violence, or being unable to engage because they were allocated to a male practitioner. If they have reported the crime to the police, there is often little understanding about how therapy can help or hinder the criminal justice process. With female offenders I have encountered, physical violence in relationships sometimes goes both ways as a form of communication, in addition to the more dominant male-to-female sexual violence within that relationship.

The lives of these women are marked by fear and violence, often leading to traumatically re-living the past – distressing memories, flashbacks, and hyper-vigilance (1). With 48 per cent of female offenders re-convicted within one year of leaving prison (2), and 90 per cent of sexual violence occurring from a known person (3), their worlds become very small.

Working successfully with female offenders, I framed core difficulties from an integrative perspective. These included affect dysregulation, disempowerment, violation and mistrust in relational contact, and are experienced by clients between different facets of their internal self and external society. Viewing offending behaviour as an extension of self and self-experience is vital to working effectively.

The offer of psychotherapy is not always taken up easily. Within the Together Women Project, provision of each appointment was clinically informed, allowing for flexibility in responding to individual ways of relating. This was crucial as every woman I worked with had a diagnosis, or traits, of Borderline Personality Disorder. Within psychotherapy I am aware of the space I occupy in a client’s world, both in actuality and in the transference. I reflect on what aspects of society enter the room with us. For female offenders, one of my aims was to avoid collusion with the idea that engaging with psychotherapy was a purely rehabilitative intervention. Working from the principle of ‘who are you, and what do you need?’ enhanced autonomy.

Consistent engagement was important with a client who had committed a violent crime against an ex-partner. We focused on alleviating the traumatic impact of domestic violence, and understanding her personality. Containing her projections using techniques such as the Masterson principle of confrontation (4), we made progress but she did not attend our last appointment.

In non-attendance cases, I consider psychosocial factors must be playing a part in their realities. The meta-communication of absence is a way to further understand complex needs. I sought to make contact even if clients couldn’t, via a phone call or a letter, more than doubling attendance rates.

Survivors of sexual violence have had something done to them, so psychotherapy shouldn’t replicate that. It’s difficult to facilitate the idea that women can master their lives and bodies when this has been disproved in their experience, either through rape, or by a lack of accessible help. Collaboratively managing somatic symptoms is often the start of feeling empowered.

Re-framing how we think and talk about sexual violence assists in understanding it from a gendered perspective without falling into the sexism trap. Society telling women to ‘be careful’ misplaces the responsibility onto survivors, is damaging to men, excludes those who don’t identify within gender binaries, and misrepresents sexual violence as a purely heteronormative issue. An awareness of modern feminist discourse, and of government policies on matters such as sex and relationship education, can help. This is vital as 33 per cent of survivors requesting specialist support are aged under 25 (5) and, in my experience, are more likely to self-identify as ‘feminists’ and use language such as ‘consent’ to process what happened.

I am certainly not the only psychotherapist to encounter all this. A collective ethical responsibility is obvious, and we should stand alongside our clients, as much outside the consulting room as within it. ●

References and reading

- (1) World Health Organization. (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines.* (1992). Geneva: WHO.
- (2) *Prison: The Facts.* Bromley Briefings Summer 2017. (2017). The Prison Reform Trust.
- (3) *An Overview Of Sexual Offending In England & Wales.* (2013). Ministry of Justice, Office for National Statistics, and Home Office.
- (4) Masterson, J. (2004). *A Therapist’s Guide To The Personality Disorders.* Arizona: Zeig, Tucker & Theisen Publishers.
- (5) www.rapecrisis.org.uk/statistics.php