Street Talk

A THERAPY SERVICE FOR WOMEN ON THE STREET

Core client group: women selling sex on the street, in addiction, rough sleeping, in the criminal justice system, NRPF

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NOT ANGRY BUT HURTING

I want to give the opening words of this presentation to one of the women I have had the joy of working with over the last twenty years:

“When women are shouting like that Pippa, they are not angry. They are hurting.”

THE NEED FOR A SPECIALISED SERVICE FOR WOMEN ON THE STREET

- Invisible.
- Not registered with a GP.
- Fear of professionals, often with with good reason.
- Unable to attend an appointment.
- Behaviours driven by underlying PTSD interpreted as anti-social.
- Professionals assuming the women’s life-style is a choice, therefore they are not deserving.
- The women have no sense of entitlement to help.
- Waiting lists add to distress.
- NRPF (increasing fear of immigration detention centre prevents engagement).
- English not a first language used to withhold therapy.

THE NHS RESPONSE in 1990s

As an NHS psychotherapist throughout the 1990s, the obvious starting point was to try to establish a service for vulnerable women was within the NHS.

I was met by a resounding response from all those I approached in the NHS:

“The women you want to work with do not have the capacity to engage in therapy”

FIRST STEPS: first woman to come to Street Talk

In a spirit of experimentation, I started to offer therapy at Maze Marigold drop-in centre for women on the street in Hackney where I met **Mandy** (name changed).

Had no documents, birth certificate, National Insurance number, etc, did not know her own name, date of birth, age, ethnicity, family heritage or why she had been removed from her birth family and placed in the state care system.

Developmental difficulty almost certainly as a result of childhood trauma, childlike in her thinking, problem solving and decision making.

Entirely in the grip of “uncle” (part pimp, part punter, part boyfriend, part drug dealer).

Rough sleeping in a shop doorway or staying with “Uncle” in a crack house. Not in receipt of benefits. Not registered with a GP.

Complex physical health issues including HIV positive and Hep C / active TB / pins in legs from being run over while selling sex on the street / ulcers on legs from injecting / pregnant. Only health intervention the nurse who visited the Maze Marigold each Wednesday.

Extremely fearful of professionals. Intermittent voluntary mute.

Learning about the complexities of the lives of women on the street

Mandy had run away from a children's unit as a teenager without documents such as a birth certificate.

No sense of being entitled to benefits, or that she could be helped to find her date of birth, etc.

She ran into the arms of "Uncle" who got her addicted to make her dependent compliant, then pimped her out. When she was a "good girl" he gave her crack and when she was "naughty" he threatened to withdraw it. "Uncle" didn't allow her to register with a doctor because he didn't want his violence and other criminal activity reported. He also prevented her engagement with any services and moved her around to obstruct engagement.

Repeatedly abused, she had come to believe that she deserved abuse. She had been dehumanized. The therapeutic goal was for Mandy to encounter her own humanity in the relationship with the therapist.

LEARNING FROM THE WOMEN

The women **do** have the capacity to engage in therapy when the service is provided on their terms.

Only the service users can show us how to design and provide a service which meets their needs.

It is never time to give up on someone. Anyone can make a full recovery, which is different from saying everyone will make a full recovery.

The healing happens in relationship.

Small acts of kindness sometimes bring about almost miraculous recovery from trauma. Anyone can do a small act of kindness. Any member of your team, no matter what their role.

PRACTICAL ADAPTIONS TO THE THERAPY SERVICE

- Therapy takes place in spaces where the women already feel familiar: drop-in centres and hostels.
- The therapist becomes a known member of the team.
- Length of sessions adapted: sometimes five minutes is enough that day if a woman is exhausted or in pain.
- Long term work with no fixed number of sessions, which would set women up to fail.
- No waiting list.
- Partnership model to provide holistic care.
- Drop-in rather than appointment.
- No consequences for missed sessions. After an absence the therapist takes up the work where it left off.

ENGAGEMENT

> **“[Therapy] is not an easy option. It requires demons to be confronted: many women find it harder than prison.”** Baroness Jean Corston

It is important not to lose sight of how hard therapy is for people who have survived trauma. It takes immense courage.

The most significant learning took place at about the twelve year point, after working over the long term with about a thousand women. Looking back over all the case notes, something fascinating emerged. The women had a particular pattern of engagement which they roughly all shared.

Once we were able to identify that pattern of engagement, we were able to frame a model of therapy which worked with it, rather than against it.

We named the model ***Therapy of Presence*** because the presence of the therapist at those times when the woman herself wasn’t present was fundamental.

THERAPY OF PRESENCE

Therapy of Presence has four distinct stages of engagement.

Identifying those four stages, allowing the therapy to progress from one stage to the next at the women's own rhythm and pace enables long term therapeutic work.

Over the long term, women are able to understand how they came to be on the street, what made them vulnerable. Only when you understand how you got somewhere can you find your way out.

Women who have been trapped in trauma from abuse and losses in childhood, compounded by violence, abuse, loss, addiction and marginalization in adulthood, have used this model of therapy to find their way live in safety and with dignity.

First Stage
The Seed of a Therapeutic Alliance

“How do I know I can trust you?”

Women come to therapy in response to an immediate crisis, often persuaded by a support worker or one of the other women.

They come very unsure whether they can trust the therapist, posing questions which don’t have easy answers. Almost all ask “*How do I know I can trust you?”* A great question.

Women usually come for four or five sessions until the immediate crisis has passed.

They don’t say they are not coming back, they drift away, so there is no ending. When there is no ending there is a sense on both sides that the door is somehow left open.

The beginning of a therapeutic alliance is formed.

Second Stage
Passive creative

"You didn't give up on me."

This stage most distinguishes the *Therapy of Presence* model from other models. It is the stage of the therapy which ultimately enables long term engagement.

The drift away from therapy can last weeks, months or years. Throughout that time the therapist is present, available and prepared to take up where they left off and, importantly, the women know that.

Women check that the therapist is still available to them, perhaps sending a message with another woman, or putting their head round the door, having a word in passing in the common room of a hostel. "The gentle knock on the therapist's door"

Sooner or later all those women who survive come back.

The fact that the therapist remembers what they said, has not given up on them and welcomes them back, irrespective of how much time has lapsed, creates a profound therapeutic alliance. The therapist has passed the test.

Third Stage
Turning Point

"I know why I am here"

At a moment when a woman finds her motivation, possibly years after the initial brief engagement knowing the therapist is still present, she returns to therapy, unprompted on her own initiative. This stage is always triggered by a significant life event which motivates women, but they have to find that for themselves.

When women have been offered alternative therapists from other services, perhaps because they live in a different part of the country by then, they have always chosen to return to their Street Talk therapist.

The trust built up over the first and second stage enables high quality work to take place over this stage, which typically lasts between one and three years. Engagement becomes regular and consistent, demonstrating that the women do have the capacity to engage in therapy.

It is during this stage that the woman encounters her own humanity, in relationship with the therapist. When a woman feels entitled to live in safety and with dignity many positive changes occur.

Women say "*I know why I am here."* They are able to see the causal link between their trauma in childhood and their current situation. They understand what has happened to them and are able to see their way out.

Fourth Stage

Working from a more peaceful place

Post recovery, when goals have been achieved and other services have withdrawn support, can be a vulnerable period when women are at risk of relapse.

Frequently rehoused in a different area, sometimes living alone for the first time in their lives, rather than in community, with completely new and sometimes overwhelming sets of responsibilities, budgeting, running a home, managing mundanity, parenting, trying to fit in with a community where you feel you stand out.

Although living independently, becoming abstinent, getting children back from foster care, etc looks like success to professionals, it can feel lonely, frightening, overwhelming and an anti-climax.

When women are well supported through this transition it can become a period of rich post traumatic growth.

Group work

Establishing a successful group takes patience and, like individual therapy, gets off to a chaotic start but it is worth persevering.

A group of peers creates a safety enabling women to share experiences which are usually taboo or from which they feel they have to protect the therapist.

The outcomes from our groups have exceeded the outcomes from individual therapy.

Challenges

- Bearing witness to the injustices the women we work with encounter.
- Taking responsibility for the therapists who take on this work. The short life expectancy and the dangers the women are exposed to weigh heavy.
- Finding people who have the training, skill, experience, compassion, patience, flexibility and resilience for this work. None of us have been trained to work with this model.
- Funding the work, never knowing whether the service will be there to fulfill the promise of long-term work.
- Defending the model. In the early stages this work does not look like therapy. It looks a mess.
- Increasing numbers of women on the street and increasing vulnerability among those women, this work feels ever more Sisyphean.

LATE FRAGMENT

“And did you get what you wanted from this life, even so?”

I did.

And what did you want?

To call myself beloved,

To feel myself beloved on this earth.

Raymond Carver

LAST WORDS

I worked with a young woman who had been trafficked at the age of fourteen and had been held in a brothel for six years. I started work with her in the safe house the day after she was rescued and worked with her over two years. When our work together ended, she made a card for me. Inside she had written,

“You looked at me Pippa”