Moved to tears, Moved to action

Solution focused brief therapy with women and children

Jane Lethem

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Introduction
"It looks different when you do it"

A female family therapist who had observed my work commented that Solution Focused Brief Therapy looked different when being done by a woman and that the experience had overcome some of her reservations about the approach. I assumed she was referring to a comparatively rare opportunity to observe a female role model and that different features of the method had been highlighted when watching a female therapist in contrast to those she may have noticed when watching a male therapist or hearing a male exponent of the approach. I am not exactly sure what she meant and, in retrospect, I wish that I had asked at the time. I have been preoccupied since then by the issues raised by her comment, issues concerning women as therapists and clients of an approach which I have found inspiring.

Solution Focused Brief Therapy emphasizes clients' talents, resources, and existing problem-solving abilities. It is goal directed and generally more concerned with the present and future than with the past. The principles of the approach are as relevant to supervision and consultation as they are to therapy and counselling. Although some aspects of solution focused work, illustrated in the chapters which follow, should be familiar to any therapist or counsellor, its underlying assumptions challenge many of those associated with other processes designed to help individuals and families who are experiencing problems.

Women are the major consumers of mental health services[1] and the majority of those practising counselling are female[2]. The reasons for these gender imbalances are complex, some representing constraints upon women, some suggesting helpful opportunities for them. Definitions of mental health remain predominantly defined by men[3] with different criteria being used for men and women to be judged in need of help, making it likely that more women than men will be advised to seek help, either for themselves or for their children. The special stresses on women[4] may make more of them experience a need for help. The fact that women are socialized to develop sensitivity to the feelings of others and to take responsibility for making relationships

work[5] leads to therapy or counselling appearing a more 'natural' activity for both clients and therapists who are women.

Personal problems, family problems, and couple problems have a way of colouring individuals' views of themselves, and of leading to preoccupation with failure, helplessness or self-blame. Many clients arrive for therapy feeling little more than "a case for treatment", rather than a whole person, and expect to be labelled and even blamed by the therapist. This is especially so for women, accustomed as they are to looking after relationships. As one female client said of herself, "Isn't it usually the mother's fault?"

Most of my colleagues in the National Health Service are women; most of my clients are women, young people or children. Since 1984 I have been involved in developing and sharing in the provision of clinical psychology services for children and adolescents and their families in two inner London districts, a process which has confronted me daily with the injustices faced by women raising or caring for children, especially those coping with financial hardship, violence in the home and/or racism. My work has brought me into contact with largely female staff groups in day nurseries and children's health clinics as well as with many women raising children as single parents. The expectation of blame and a sense of embittered helplessness have often been strong themes in the accounts both mothers and carers give of their attempts to meet the emotional needs of children and to cope with problems which arise.

My therapeutic orientation has shifted over this time, from Cognitive-Behavioural[6] and Problem Focused Brief Therapy[7] approaches to a greater emphasis on Solution Focused Brief Therapy. However, there has been a common strand running through my contact with children, parents and carers, that of the need to recognize and find ways to make explicit the contribution of social injustice to the problems for which psychological help was being sought. In this respect, I have shared concerns which preoccupy many feminists, attempting to find common ground between beliefs about social justice and therapy, and those therapists and counsellors who have been trying to make their therapy sensitive to differences of gender[12] and ethnicity.

I have found some liberating and helpful ideas in the Brief Therapy literature, the sources of which I shall go into in more detail in the

chapters which follow. Firstly there is an emphasis on ways of revealing and affirming the strengths of clients who may have been feeling helpless. Secondly, the framework offers scope, if the therapist and client wish to take the opportunity, to develop a narrative about the client's past, present and future which includes issues of gender, sexual orientation, ethnicity and class.

In 1986 I spent a month participating in the residency programme of the Mental Research Institute (M.R.I.) in Palo Alto, California. I spent as much time as possible with the members of M.R.I.'s Brief Therapy Center. During my stay, I attended a workshop entitled 'Brief Therapy with Women' given by Phyllis Nauts, an M.R.I. trained therapist[8].

She was the first person to draw my attention to the special value for women, and also children, of approaches which celebrate achievements which have been taken for granted. The accomplishments of women or children may seem modest unless account is taken of the adverse circumstances in which they have occurred. She highlighted the need to clarify those aspects of the client's life which are within and those which are outside the client's control. For example, the final decision about a single parent's housing may lie with an official of the local council and may not reflect the extent to which the family needs or deserves housing. A therapist should acknowledge both the adverse effects upon family life of poor accommodation and the fact that the family is in no way to blame for inadequate municipal housing. The therapist and client may then go on to discuss aspects of family life over which the client has an influence, thereby enabling the mother to clarify those things she is already doing for herself and her children and those she would like to do, wherever they live. The therapist might also explore with her whether she has done all that she would like to do to try to influence the official's decision. "Empowerment", her term for this process, was novel to me at the time. I found her ideas helpful in answering the question "What has therapy got to offer those whose problems are largely the result of social injustice?"

In 1989 Harvey Ratner, Social Worker at the Marlborough Family Service in London, telephoned me. He had been in California on holiday staying with relatives and had visited the M.R.I. After a stimulating day talking with Richard Fisch, the Director of the Brief Therapy

Center, and Karin Schlanger, a member of that team, Harvey asked whether they had many British visitors. They replied that there had been few but that a British woman who had completed a month's residency with them in 1986 had written quite recently to say she had moved job to St. Mary's Hospital in London. Her name, you can guess. St. Mary's and the Marlborough Family Service are about a mile apart.

On his return to Britain, Harvey invited me to visit the Brief Therapy Project, based at the Marlborough Family Service. I met Harvey and his colleagues Ann Stevens, Evan George and Chris Iveson, and observed their work together one Wednesday afternoon. The visit quickly led to an invitation to join the Brief Therapy Project. Change can happen quickly with the right catalyst. Thank you, Dick and Karin. I was welcomed both as a potentially like-minded therapist and as another woman for a team which needed to become more balanced in terms of gender.

The Brief Therapy Project exists as one of a number of specialist projects within The Marlborough Family Service, a multi-disciplinary mental health facility which offers a range of outpatient and day patient services for children, adolescents, and adults. The Project started with the aim of putting the ideas of Steve de Shazer[9,10,11] and colleagues of the Brief Therapy Center, Milwaukee, into practice in a multi-cultural inner London context[12].

During the course of working together, we have also been influenced and frequently encouraged by the work of other therapists, referred to in later chapters, as well as by colleagues, most notably Saleha Islam, who joined the Project temporarily during her Social Work training. Although de Shazer's model of therapy does not address differences of gender, race, class or sexuality directly, these were already issues of concern to each of us, prior to the setting up of the Project. Along with many Health and Social Services professionals, we had a growing awareness of our responsibility to recognize the deleterious effects on mental health of inequalities associated with such differences and to incorporate a sensitivity to differences, in staff as well as clients, into our work.

In 1989, Chris Iveson, Evan George and Harvey Ratner, with the assistance of Richard Gollner, set up The Brief Therapy Practice. This is a freelance organization which provides teaching and consultation in

Solution Focused Brief Therapy. As well as hosting presentations by internationally known brief therapists, the founder members participated in a nationwide programme of workshops and consultations. It expanded in 1993 when Di Iveson and I joined the Practice. To date it has taught in excess of 3,000 therapists and counsellors to at least an introductory level in the approach.

This volume concentrates on my own experience of the way our ideas and practices have evolved with special reference to issues which affect women and children. Chapter 1 is intended as an introduction to, or reminder of, the theory and practice of Solution Focused Brief Therapy together with an outline of developments within the Brief Therapy Project. In Chapter 2, I state the advantages, as I see them, of the approach for women clients and therapists and for therapists of either gender who wish to bring a sensitivity to gender to their work. Chapters 3 to 6 concern particular client groups: single parent mothers, children, clients who have been sexually abused in childhood, and clients with experience of violence in the home.

The groupings are somewhat arbitrary as Solution Focused Brief Therapy does not categorize clients on the basis of problems or demographic details. The issues covered are far from comprehensive but reflect the client groups with which I do most of my work: children, adolescents and their families. Older women are largely missing from the following pages until my mother and grandmother make fleeting appearances in Chapter 8. The majority of my women clients have children who are still at home. However there are a number of examples of therapy with single women who live alone. The names and some personal details of clients have been changed to protect confidentiality.

Chapter 7 is a reflection on my experience as "my female colleague", consulting to male colleagues. It outlines my perspective on the development of the Brief Therapy Project. Chapter 8 seeks to celebrate therapists' individual qualities in the practice of Solution Focused Brief Therapy.