

## EDITORIAL

### The Perversion of the Professional Caring Relationship

I have now been a therapist for over twenty years, and I never cease to wonder at the extraordinary nature of our work and at how much I have learnt about people, their way of coping with life's stresses and pain, their weaknesses and bravery. I am also amazed at how much I still learn about how the human mind works. It is, in fact, an extraordinary privilege to be allowed to get so close to individuals and to learn so much about them and their lives in such intimate detail. However, not only is it a huge privilege, it is also a huge responsibility.

I am very involved in the study of human violence. In my book on the subject, I devoted some space to the subject of the perversion of the professional caring relationship (Zulueta, 2006a). While other powerful individuals such as judges, military leaders, or police officers can all be involved in the perpetration of violence through the misuse of their power, it is misuse of power by those involved in the direct care of sick or disturbed individuals that is causing me increasing concern.

The professional-patient relationship lends itself to the re-enactment of childhood abuse as the relationship is very similar to the parent-child relationship. The doctor or therapist is entrusted with the care of his or her patient, whereas the patient is invited to regress to more dependent forms of behaviour because of the nature of the treatment. A surgical patient has to trust her doctor even when unconscious under the anaesthetic; a psychiatric patient needs to feel safe in the bewildering and painful confusion of a psychotic breakdown; a psychotherapy patient relinquishes old defences at the risk of feeling very vulnerable and helpless.

When any of these human interactions involves the re-enactment of an earlier abusive experience, the outcome can be devastating for the patient as a result of the unequal power relations that exist between therapists and their patients. Doctors used to address this particular danger when they swore the Hippocratic Oath: 'In whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm'. As therapists we do not have an equivalent to the Hippocratic Oath, and yet our power over

those we treat is in many ways every bit as great as that of the doctor's, the reason being that we specialize in the often painful exploration of our clients' defences within the context of a supposedly 'safe therapeutic attachment relationship' – which is at the heart of most therapeutic treatments.

### **Patient abuse**

#### **Patient maltreatment can occur unintentionally: benign re-traumatization**

As I have said on many occasions, it is almost impossible not to re-enact in some minor way the traumatic experiences our patients bring with them – hence the importance of supervision when treating patients with a history of abuse, trauma, and neglect (Zulueta, 2006b). Unconscious defensive and potentially rejecting reactions to a patient's painful or violent feelings are always possible, however many years of psychoanalysis or training an individual has been through. When this does happen, and is acknowledged and worked through by both therapist and patient, very positive changes can take place for the patient. By validating the patient's experience and being able to hear the pain and anger that stems from these awful feelings of betrayal, the therapist shows respect for the individual and enables reparation to take place, a new experience for somebody who has been made to feel that they are always wrong and unworthy of respect and concern. This can often lead to marked improvement in the patient.

#### **Patient maltreatment can be intentional: malignant and perverse re-traumatization**

Unfortunately, not all abusive experiences taking place in therapy are benign, as I have found out over the years. Many men and women have been referred to me suffering from the effects of being re-traumatized and even sexually abused within their therapeutic relationship. For such patients, not only do they have to suffer the pain and terror of reliving past traumatic experiences but they also do not have the ego strength to make a complaint and, if they do so, they often face a wall of disbelief.

This reaction on the part of psychotherapists and their institutions only compounds the damage done and replicates their earlier experience of not being believed and supported. In addition, these victims of professional malpractice can only rarely produce any evidence to substantiate their claims. Unfortunately, many psychoanalysts and psychotherapists know this only too well and get away with their destructive activities, which they will often justify by maintaining that they are 'saving' their patients from suicide or providing them with a 'real healing experience'. These perverse justifications are very similar to those used by paedophiles when grooming children prior to sexually abusing them.

For example, some psychotherapists treating very vulnerable patients with histories of child abuse will resort to a variety of unorthodox ways of giving them 'comfort', such as literally breast-feeding them. These therapists will justify their behaviour by maintaining that they are truly concerned about their patients' survival. Others will literally have sexual intercourse with them to prove their 'love' for them.

Unfortunately, some patients will collude with this offer of a 'loving breast' or 'sexual love'. These patients – often with a 'disorganized attachment' – are those who maintain a 'traumatic attachment' to their idealized parent in their minds, an attachment that can be so easily re-enacted with the therapist. How does this come about?

Children, and, later, adults who have lived in fear of their care-giver, will:

- (a) Maintain their attachment to their desperately needed care-giver by developing an idealized attachment to their parent and dissociating off their terrifying memories of being abused. This results in the creation of different representations of themselves in relation to their care-giver, or what Bowlby referred to as 'segregated different states or dissociation' (1980, p. 70). In such conditions, the development of a capacity for reflective functioning is severely impaired (Fonagy & Target, 1997).
- (b) Also hold on to the 'moral defence', whereby they will blame themselves for their suffering and thereby retain power and control as well as hope for a better parenting in the future (Fairbairn, 1952). This also results in reinforcing their identification with their abusing parent and their role as bad and dispensable.
- (c) So, when such an individual grows up, as Bowlby says, he or she will consciously maintain a 'wholly favourable image of a parent' but 'at a less conscious level he will nurse an image in which the parent is represented as neglectful, rejecting or as ill-treating him' (Bowlby, 1980, p. 71). He suggests that the young child does this to protect the vital attachment to the care-giver. However, the price to pay is often severe, he states, because people for whom defensive exclusion plays a prominent part 'are handicapped in terms of their dealings with other human beings compared to people for whom it plays only a minor part' (*ibid.*, p. 72). Such patients are likely candidates for therapeutic abuse by psychotherapists, who are well aware of their patients' weakness and of their longing for love, and they count on these clients' vulnerability and their 'moral defence' not to betray them.

### **What are the causes of such therapeutic malpractice?**

In my view, such professional malpractice is to be expected, since neither doctors or nurses are likely to be exempt from the type of formative experiences

which incline people towards acts of abuse towards themselves or others: as with therapists, men and women often go into medicine or nursing to help heal themselves in the 'other'. Johnson points out that: 'The literature on motivations to study medicine suggests that for some doctors, a component of their decision is a response to unconscious drives to compensate for childhood experiences of parental impotence or emotional neglect' (1991, p. 318).

One study on university students supports this view by showing that those who decided to study medicine, particularly in the high patient contact specialities like psychiatry, tended to describe their childhood as being less stable, their parents as more overprotective, and their home environment as more distant than the other students. The authors conclude: 'Some physicians may elect to assume direct care of patients to give others the care they did not receive in their own childhood' (Vaillant, Sobowale, & McArthur, 1972).

This professionally endorsed process of 'projective identification' in a vulnerable self works as long as the patient acts his or her prescribed part and the doctor/therapist can feel sufficiently successful and potent. However, it does also imply that some doctors will tend to become emotionally dependent on their patients. Being needed has indeed been found to be one of doctors' greatest sources of satisfaction, probably to maintain what Kohut would describe as a 'grandiose' sense of self and, at a more basic level, to satisfy a need to be loved. However, such a dependency can also generate feelings of anger in these same physicians (Johnson, 1991).

It is unfortunate that, as in medicine, many of those who choose to train in psychotherapy have themselves suffered from deprivation and/or abuse and that they will tend to deal with their own needs by projecting them and attending to them in their patients unless this possibility is worked upon in their personal therapy.

These potential 'compulsive carers', as John Bowlby used to call them, require a personal therapeutic experience which addresses the reality of their traumatic past if they are to avoid both denying and recreating their patient's own traumatic experience within the therapeutic setting. Otherwise, there can either be an unconscious collusion with the patient's own traumatic re-enactment, as happens sometimes with abused victims, or the therapist can unconsciously impose his or her own traumatic experience, re-enacted in this professional context from the point of view of the victimizer rather than the victim. The latter is particularly common with sexually abused women, whose tendency to sexualize their relationships with intimate others puts them at risk of being further abused by the very people who should be protecting them (Kluft, 1990; Fahy & Fisher, 1992).

## Prevention

In my view, this tendency on the part of therapists to re-enact their patient's abuse is due partly to a denial of the importance of psychological trauma and, in some cases, to the persistent belief in the overriding importance of the internal phantasy world of the patient. What is not consciously recognized can so easily be unconsciously re-enacted, especially if, in addition, the psychotherapist is also unaware of the potential impact of his or her own personal history of abuse.

Another way to minimize the damage that can occur between therapist and patient is to make it a professional requirement that all therapists have some degree of peer group supervision where they can share their work, however skilled they may be.

Finally, I am encouraging more and more the use of tape recordings of sessions for the patient's benefit, mainly in order to deal with their dissociative amnesia and any difficult moments they experience in therapy.

Although most caring professionals carry out their difficult and demanding work with considerable skill and sensitivity, there are few of us who have not also witnessed or been party to glaring examples of neglect or of abuse towards patients. We, both as individuals and training institutions, need to remind ourselves that abuse always involves a triangle in which abuser, victim, and colluder play their part. If there is no collusion with the abuser, the abuse usually stops.

If the potential for abuse were to be seriously acknowledged by therapists in general, their professional organizations could endeavour to make sure that preventive measures were in place to reduce the possibility of maltreatment occurring. This would involve research into the motivation and histories of childhood abuse in trainees on the one hand, and regular supervision, audit meetings, and appraisals so that therapists can be helped to look at their work and attend to the areas of difficulty that arise between them and their patients.

## Conclusion

The study of attachment relationships and the impact of abuse and neglect on this motivational system shows that any caring relationship, whether professional or not, is potentially vulnerable to becoming abusive. It should, therefore, come as no surprise to find that those men and women who choose to become therapists, nurses, or doctors in order to help others are perhaps at some risk of abusing their patients. The latter may become dehumanized 'objects' on to whom a traumatized therapist or doctor projects his or her unmet needs, disowned pain, and helplessness. Rather than berate this professional vulnerability or collude with it by attributing it simply to the misuse of power in some individuals, it could be more helpful to understand how such professional abuse can come about.

Most doctors and therapists do not go into medicine to misuse their power for non-therapeutic ends: their aim is usually to heal and help others, a task to which they normally devote themselves. If they end up tormenting their patients, something has taken place which is reminiscent of what occurs between child-abusing parents and their offspring: the caring parental relationship is perverted into one of power of the self over the 'other', a defence against the pain and the sense of helplessness that some children or patients elicit in their care-givers. An individual with a wounded attachment system and the accompanying narcissistic injury to the self will always be at risk of either being victimized or being the victimizer: the latter is more likely to take place in the therapeutic role.

At the time when I had just completed my training I had heard about 'bad things going on in the consulting room', but never really took it on board. Now I know it is happening quite frequently and, often, under our very noses. When the odd patient does get to be heard, the negative impact on our reputation as a profession is very bad, but that is not a reason to hide our heads in the sand. On the contrary, let us tackle the problem and be rightly proud of the skilled and wonderful work you all do for your clients.

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