

The psychotherapist as a secure base - professional sexual misconduct from the attachment theory's perspective

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Abstract

In one of his articles (A secure base, 1988) Bowlby described five principles, which a psychotherapist needs to achieve in his/her professional work. The first and probably most important is that the therapist should serve as a secure base for the patient. Often patients, searching psychotherapy, suffer from attachment problems, resulting from caregiver instability, physical or sexual abuse. These patients constantly question their therapists' constance and presence.

This presentation focuses on attachment theory, and the model derived from it, to explain the dynamic interaction between victims and abusers in a professional setting, when inappropriate sexual contacts occur. Patients, suffering from attachment problems, are at a greater risk of being sexually exploited in certain situations. Their weakened ability to set clear boundaries, places them at higher risk. However without a corresponding professional deficit within the therapist, no sexual abuse can take place. Therapists may also suffer from attachment problems themselves, which weaken their abilities to maintain professional boundaries intact. Responsibility clearly rests with the therapist, as only he or she has a professional duty that should not be violated.

Both attachment theory and psychotraumatic research provide a framework for understanding the devastating effects of PSM (professional sexual misconduct) on victims and their relatives. The salient feature of the healing process for victims of PSM requires a focus on attachment interventions. This presentation also emphasises the importance for the professional community to pay close attention to the space of trust upon which every patient-therapist relationship is based.

glossary

AAI The Adult-Attachment-Interview was developed by Main and coworkers (1985) to describe the attachment behavior of adult persons. The AAI is based on a semistructured interview on attachment related questions.

PSM The term *Professional Sexual Misconduct* describes any form of sexually inappropriate behavior occurring in a professional-patient relationship. Three forms can be distinguished: direct sexual intercourse and genital stimulation, sexual behavior in a larger sense

e.g.looking at, touching, showing intimate parts of the body, and sexually colored remarks and dating.

1. The therapeutic relationship from the attachment theory perspective

In my presentation I will describe a theoretical framework for understanding PSM, which I have been developing for the past fifteen years. From a theoretical perspective, I probably will not provide a new concept, but rather I will use a new approach that can be compared to a kaleidoscope, which you turn and then presents you with a new picture (Tschan 2001). My experience is based on counseling and treatment of victims and their relatives in the aftermath of PSM, and also on treatment of offender professionals. To clarify my approach, it is important to note that I will never treat both the victim and the offender in a given case. I either treat the victim or the offender. Often, an accused colleague denies the facts, or only partially accepts it, excluding the sexual exploitation (Coverdale et al. 1995). However, the victim is often blamed for either not telling the truth or taking revenge of some kind (Herman 1992). "It was just a hug, nothing else .. ". In my daily practice I often see an attempt to confront accused colleagues by what they have heard from victims with the hope of solving the problem. A confrontation carried out in this way leads to a silencing of the victim in most cases. We therefore address this approach as „reconciliating sadisms“, which leads to a retraumatization of the victim, and which only helps the accused professional to believe that everything is settled. The resulting narcissistic feelings of grandiosity among those who believe that they have solved a huge problem is completely misleading (Gabbard 1996).

The topic of PSM is often neglected in professional approaches to sexual violence. For example, the recently published World Report on Violence and Health (Krug et al. 2002) does not even mention the issue, although a considerable amount of literature on PSM is already available (Samuel et al. 2001). The absence of professional knowledge and scientific discussion about the issues lead to an egregious perception among decision makers in the health care system (Bridges 2003). PSM is not considered as a severe problem among the health care systems (Fahy et al. 1992); rather it is seen as a rare criminal problem, which, therefore, does not concern the professional community. Unfortunately, current available data contradict this view (Disch et al. 2001). According to the latter study, abuse by a medical professional appeared to be the most damaging among the different forms of PSM, contrary to the prediction that all sexually abused persons would be similarly affected. Meanwhile, from the quality management perspective, PSM is considered as a major problem in health care (Tschan 2003). Patients' safety is of major concern worldwide (Kohn et al. 2001).

The framework delivered by this paper can be divided into two parts: the first describes the structural power-imbalance of every therapist-patient relationship based on the findings of Attachment Theory and the resulting psychodynamic effects. The second part illustrates the consequences for the professional community and how preventive models can be applied to clinical and practical work.

1.1. The Attachment Theory Paradigm

The first aspect of Attachment Theory, as described by John Bowlby (1977), is the universal need to form close affectionate bonds between human beings. Bowlby's theory provides a normative model of how attachment patterns interfere with individual developments. The interaction, in its paradigmatic sense, between mother and baby, is a mutual process which is created in an ongoing reciprocal relationship. Attachment is therefore not something that parents simply do to their children (Levy et al. 1998), but rather a creative process involving both the infant and the mother. The attachment bond may also be seen as the context within which the infant learns to regulate its emotions (Sroufe 1990). Empirical data derived from animal stress models (LeDoux 1996, Liu et al. 1997) and research of the impact of sexual violence (Heim 2000, 2002) support this hypothesis.

By developing the strange situation, Mary Ainsworth (et al. 1978, 1985) provided an empirical model for evaluating the theoretical concept. A number of studies exist, showing a 60-75% continuity of attachment patterns along the circle of life, which lead to the adaptation of this model for adult attachment behavior, as described in 1.3.

Infant relationship behavior can be classified into one of four attachment categories (as they are described in the literature, see e.g. Cassidy et al. 1999) :

- the secure infant
- the anxious or avoidant infant

- the anxious/resistant or preoccupied infant
- the disorganised/disoriented or unresolved infant

The availability of a reflective caregiver increases the likelihood of the child's secure attachment, which, in turn, facilitates the development of a theory of mind (Fonagy et al. 2002). The child perceives that the caregiver views the child as an intentional being, and this interaction also facilitates the creation of an image of him/herself. The "self" constructs itself always in relationship to an "other".

1.2. Inner Working Model

According to his or her experiences, the infant develops an internal working model of the interaction pattern with caregivers, which is in most cases - but not necessarily - the biological mother. The internal working models are mental schemata where expectations about the behavior of a particular individual towards the self are aggregated (Fonagy 2002). As a result of these inner working models, the growing child, and later the adult, develops a metacognitive capacity to understand the merely representational nature of his or her own behavior and that of others, towards one another. It was Dennett (1987) who described "*the intentional stance*", where he pointed out how human beings try to understand one another in terms of mental states - thoughts, feelings, desires and beliefs - in order to anticipate one another's actions. In a larger sense, the infant develops a model how the world is organised and what can be expected in terms of relationship behavior, from oneself and from others.

1.3. The adult attachment relationship

The research initiated by Attachment Theory documented the evidence that the attachment pattern, acquired early in childhood, provides stable interaction behavior in adulthood. Adult attachment patterns play a crucial role in intimate relationships and in parenting (Shaver 1999). The AAI (Main et al. 1985) is a scoring system to classify adult attachment qualities, according to one of the four following categories :

- autonomous, secure attachment
- dismissing, insecure attachment
- preoccupied, insecure attachment
- unresolved, insecure attachment

Many studies have demonstrated the effects and clinical manifestations of adult attachment patterns. Those with an insecure attachment suffer from loneliness and depression (Hazan and Shaver 1990), they also suffer from a lack of self esteem, and their intimate relationships tend to be of shorter duration (Hazan and Shaver 1987). Data also show an influence on the choice of partners (Collins and Read 1990) and on the self reported satisfaction in marriage (Kobac and Hazan 1991). It is also interesting that persons with insecure attachment patterns, especially those with a dismissing pattern, consider their job to be the most valuable and important aspect of their current life, whereas persons with a secure attachment consider their close relationships as the most important facet of their life. Furthermore, empirical evidence is growing that individual development is highly influenced by childhood attachment patterns. Research on sex offenders has indicated a connection to personal development and subsequent offending patterns (Marshall 1989, Marshall et al. 2000, Rutrecht et al. 2002).

The sexuality of adult persons with a secure attachment pattern is embedded in a context which is based on self-esteem, trust in each other, and mutual respect for one another. People with insecure attachment patterns do not experience this in their intimate relationships. Their sexuality is not based on mutual respect, but influenced more by their negative emotions and inner working models derived from experiences in their childhood. Especially in persons with insecure and disorganised attachment patterns, the use of force and violence can be found. *Sexual offending is not only a behavioral disorder but also a relational disorder. It is an extortion of intimacy in an attempt to restore damaged self-esteem* (Anechiarico 1998). Exerting control over the other person seems to be the only way how these persons can express their sexuality. They have no experience with reciprocal relationships in which they can expect the other person to be concerned with their needs.

1.4. The therapeutic relationship

A patient undergoing any form of treatment - whether it is psychotherapy, medical treatment, physiotherapy - expects the health care professional to be a person with certain knowledge and skill (American Psychiatric Association 2001). Each patient - professional relationship can be characterised by a power imbalance (Charter on Medical Professionalism 2002). It is the professional, who sets the limits, who has the diagnostic and therapeutic knowledge, and who in most cases - with the exception of some emergency situations - determines the place of the procedure (Derek 1994). The patient, on the other hand, in search of help and support is in a position where he or she is told to trust in the professional's capacity (Committee on Physician Sexual Misconduct 1992). This view is supported by professional bodies, by health care authorities, by legal requirements and guaranteed by professional training and licencing procedures (Gonsiorek 1995).

In Bowlby's description, the attachment behavior can be regarded as a system which is activated in case of danger and need. Therefore, any professional-patient relationship can have similar effects as early childhood relationship experiences, especially if someone feels he/she is in danger or needs medical or therapeutic help. It was Bowlby himself, who compared the therapeutic relationship as analogous to that of a mother (see quotation below). He also compared the therapeutic role to that described by Winnicott as "holding" and by Bion as "containing". Under optimal condition the therapeutic interventions lead to a change in attachment behaviors, e.g. from an insecure towards a secure attachment feeling (Main 1991). Interested readers should consult the handbook of attachment interventions (Levy 2000).

The professional - patient relationship can be differentiated from common relationships by three aspects: (1) time frame or limited duration, (2) one-sidedness or lack of reciprocity, and (3) non-erotic and non-sexual nature. This clear role model helps to provide what Bowlby addressed as the secure base of any treatment situation. In health care, the professional relationship is considered as a fiduciary relationship based on two main ethical principles, "do the best for your patient" and "do not harm your patient". One of the core elements of malpractice suits is the breach of duty owed to the patient : "*The breach of duty element, which defines the standard of care, assumes that there is a line of competent practice below which no professional should descend*" (Brown et al. 1998, p. 527). The therapeutic obligation to the clients clearly afford a separateness - "*excessive intimacy is thus likely to be considered a breach of trust on the part of the professional, regardless of who initiates a boundary crossing*" (Plaut 2003). "*When sexual interaction occurs between any health care professional and one of his (or, much less commonly, her) patients, there can be absolutely no doubt that this behavior constitutes a supremely deceptive form of clinical (mal)practice*" (Samuel et al. 2001).

2. Bowlby's five tasks - a secure base

In the Seventies, John Bowlby (1977) first published his ideas on the therapeutic implications of Attachment Theory. He described the ways a patient's earlier experiences affect the transference relationship. Furthermore he discussed the therapist's aim as being that of enabling his patient to reconstruct his working models of himself and his attachment figure(s) so that he remains less under the spell of forgotten miseries and is better able to recognize present companions for who they are. The second draft of that paper, by Bowlby himself considered as an amplification of his earlier one, was written as the chapter "Attachment, Communication, and the Therapeutic Process" in Bowlby's (1988, pp. 137-157) oeuvre "A Secure Base". Although Bowlby addressed his consideration to the individual analytic psychotherapy, it delivers a universal approach for all contemporary psychotherapeutic models, and which can be used as a framework to describe any form of professional-patient relationship in health care.

The five tasks according to Bowlby (1988, p. 138-139) are :

1. The therapist as a secure base : *The first task is to provide the patient with a secure base from which he can explore the various unhappy and painful aspects of his life, past and present, many of which he finds difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance.*

2. Exploring current relationships : *A second task is to assist the patient in his explorations, by encouraging him to consider the ways in which he engages in relationships with significant figures in his current life, what his expectations are for his own feelings and behavior and for those of other people, what unconscious biases he may bring when he selects a person with whom he hopes to have an intimate relationship, and when he creates situations that go badly for him.*
3. Exploring the therapeutic relationship : *The third task is to examine the relationship between the two of them. Into this, the patient will import all the perceptions, constructions, and expectations of how an attachment figure is likely to feel and behave towards him, which his working models of parents and self dictate.*
4. Exploring current metacognitive models : *A fourth task is to encourage the patient to consider how his current perceptions and expectations and the feelings and actions to which they give rise may be the product either of the events and situations he encountered during his childhood and adolescence, especially those with his parents, or else as the products of what he may repeatedly have been told by them.*
5. Questioning current belief systems : *The fifth task is to enable his patient to recognize that his images (models) of himself and of others, derived either from past painful experiences or from misleading messages emanating from a parent, but all too often in the literature mislabelled as 'fantasies', may or may not be appropriate to his present and future; or, indeed, may never have been justified.*

Bowlby (1988, p. 140) finished this part with the words : *By these means the therapist hopes to enable his patient to cease being a slave to old and unconscious stereotypes and to feel, to think, and to act in new ways.* Further in his paper, Bowlby notes : *Nevertheless, unless a therapist can enable his patient to feel some measure of security, therapy cannot even begin. In providing his patient with a secure base from which to explore and express his thoughts and feelings, the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world. The therapist strives to be reliable, attentive, and sympathetically responsive to his patient's explorations and, as far as he can, to see and feel the world through his patient's eyes, namely to be empathic* (Bowlby 1988, p. 140).

Bowlby then describes the mutual and reflective process of the therapeutic alliance : *A patient's way of constructing his relationship with his therapist is not determined solely by the patient's history : it is determined no less by the way the therapist treats him. Small wonder therefore, if, in reviewing his attachment relationships during the course of psychotherapy and restructuring his working models, it is the emotional communications between a patient and his therapist that play the crucial part* (Bowlby 1988, p. 141).

3. Who is at risk of being sexually exploited? A patient's perspective

Although there has been some extensive attempts to describe the aftermath of PSM and its effects on victims (e.g. Penfold 1998, Disch 2001), little has been published from an Attachment Theory perspective. The following hypothesis is based on my personal experience in treating victims of PSM or from supervision of my colleagues' case presentations. One might assume that the ability to maintain intact boundaries is somehow related to individual attachment patterns. According to this theoretical conception, patients with a secure attachment may be more likely to competently reject a boundary-crossing professional than a patient with an insecure attachment.

Research has thus far failed to show patient variables, which predict PSM. The outcome depends only on the professionals' capacity maintaining boundaries intact (Bates and Brodsky 1990). A woman behaving in a seductive way, will not be exploited, if the professional addresses this particular behavior as a problem of their professional relationship, which they have to solve together and which may be part of the treatment needs of this specific patient. This is more or less similar to the situation of a gynaecologist, which does not take the nudity of the female patient as an invitation for a sexual intercourse, but rather as a treatment condition to perform the required pelvic examination.

Clinical experience leads to the assumption, that not all of the patients are at the same risk of being sexually exploited by their health care professionals. A patient's needs and expectations, and his reactions towards the professionals attempts to cross boundaries may provide us with a conceptual framework to decide, who is at risk. The sexual exploitation should not be considered as a single event,

but rather as a process that begins with minor boundary crossings (Simon 1995) - known in forensic research as seemingly unimportant decisions (Salter 1995). The therapeutic setting provides an ideal place for a predator who seeks access to victims. Therefore, the dynamic element may have an important influence.

Patients with insecure attachment patterns and who may be undergoing therapy for that reason - may feel ambivalent towards the professionals behavior. Having experienced an unpredictable mother, such a patient may feel comforted by a professionals' attraction towards him or her. They may be experiencing for the first time in their lives, that someone is paying close attention to them. What an overwhelming feeling for a person who has never experienced this before. And then, if the health care professional suggests that they address each other on a first name basis, and if he later begins disclosing personal things, the patient may feel pleased, and somehow unable to keep up boundaries. If the patient hesitates, abusive professionals use tactics, e.g. "I will help you overcome your poor self-esteem, and your anxiety of being touched; I will improve your distorted body-feeling - you're a beautiful person, you're sexually attractive, and I will prove it to you ...". The manipulation only works with certain patients - we know this from the treatment of professional-offenders, when they disclosed their tactics during therapy. They attempt to manipulate their victims, and if it proves too risky, or if it is too difficult to overcome their patients' resistance, they usually target another victim.

It is important to keep in mind that the description of the dynamic interaction in the case of PSM does not blame the victim of being responsible for the abuse. The professional only has a code of ethics (and criminal laws in several countries), which he violates when committing PSM. An analogous situation is that of the child vis à vis the caregiver in which the caregiver is always responsible for any sexual abuse. A number of studies have clearly demonstrated the devastating effects of PSM (overview of current literature see e.g. Disch et al. 2001). Empirical data on stress regulation in trauma victims give evidence for long lasting biological, neuroendocrine and psychological implications in case of sexual abuse (Nemeroff 2003).

4. Who is at risk of sexually abusing his or her patients?

The topic is not an easy one, because it deals with weakened professional capacities (Walzer 1993). The first question which we have to answer is, why does a health care professional sexually abuse his or her patients at all? Put in other words: why does he choose a patient as an intimate partner? This question per se represents a misleading, however. A patient can never be seen as a sexual partner - they are victims of his or her exploitative behavior. This complete misunderstanding by many professionals of the nature of the patient-professional relationship is the result of a cognitive distortion, which enables the abuse on the other hand. The circle of abuse (Wolfe 1984, Sullivan 2002) serves a model to explain, how the sexual abuse takes place. How can this behavior be linked to the Attachment Theory?

Corresponding to the conditions described in paragraph 3, the answer is probably : those professionals with insecure attachment patterns. Some preliminary research supports this hypothesis. Sexual offenders are over-represented among persons with insecure attachment patterns. From a theoretical point of view their abusive behavior can be explained and understood. Therefore it might be interesting to look at therapists' attachment patterns and what is known from the literature. A German paper recently showed that, contrary to the general assumption, only about 10% of the psychotherapists in the sample were classified as having a secure attachment pattern (Nord 2000). A questionnaire was mailed to 150 therapists, 86 were returned. There were 46 women and 34 men; 63 were psychologists, 21 were medical doctors. 57 of them worked with a psychodynamic approach, whereas the rest used non-psychodynamic approaches (Gesprächspsychotherapie). The sample was compared with a general population group (N=402) in regard to the distribution of the different attachment categories. The study design used a category of "relatively secure", which is not described in classical Attachment Theory. This type of classification for therapists can be described as persons with an open, empathic approach to others, and at the same time a decreased awareness of their own needs. The job corresponds with the inner working model, which suggests that many therapists compensate their deficient experience. According to the study, 80% of the investigated therapists can be classified among the insecure or relatively secure (48.8%) attachment pattern. There was no significant difference between different therapeutic approaches, neither was there a gender difference or a difference between physicians and psychologists.

Although there is only one such study available investigating attachment patterns in psychotherapists, the result is noteworthy because my hypothesis, that professionals with an insecure attachment patterns are at risk of not being able to maintain their boundaries intact, is supported. The author of the study concludes that the number of professionals suffering from burnout syndrome, the classical risk factor among therapists, suggests, that professionals have a decreased awareness of their own needs and imbalances. The study of boundary violation demonstrated years ago, that burnout syndrome in therapists can be considered as an important risk factor for the sexual abuse of patients (Schoener 1989, White 1997). Further research is needed to examine this hypothesis.

The topic of PSM and the resulting risk for health care professionals to become involved in boundary crossings has not been integrated into the curricula (Blackshaw et al. 1992, Quadrio 2001, Tschan 2002). As many studies demonstrate, all kind of health care professionals can be involved in PSM. Contrary to the general assumption, gynaecologist are not at greater risk of getting involved in PSM compared to ear, nose and throat specialists (Wilbers et al. 1992). Within the health care system, psychotherapists seem to be at highest risk for becoming sexual offenders towards their patients (Disch 2001). It is crucial, therefore, to consider PSM as a severe problem in terms of quality management, patient safety and professional liability (Tschan 2003).

5. Conclusion

Understanding the dynamic interaction, which leads to PSM is extremely helpful for victims and their relatives. How the victim's attachment pattern fits with the hypothetical one of the offender-professional, helps to answer the question: "Why did he (or less common: she) do it to me?" Victims in the aftermath of PSM are so confused that they often blame themselves to be responsible for the sexual abuse that happened. Understanding, therefore, helps to reduce these feelings of guilt and shame. It also helps the professional community to understand PSM better, and it helps to conceptualise the forms of intervention which will have a preventive effect on PSM. More research is needed on the topic to better identify risk factors which leads to PSM.

Current knowledge clearly shows that treating victims in the aftermath of PSM challenges therapeutic strategies and techniques (Tschan 2001). Due to the nature of the former abusive professional relationship, all subsequent therapeutic settings inevitably become a phobic-like connotation. Consultations with health care professionals, especially with the same gender and discipline as the abusive professionals, turn out to be potential triggers for anxiety, flash backs and avoidance behavior (Van der Kolk et al. 1996). It is crucial, therefore, to provide basic information about the nature of a professional relationship to be presented in writing, if possible. This helps to clarify the role of the subsequent practitioner so that the patient begins to understand that sex with a professional has disturbing effects on belief systems and on personal issues.

Therapists treating victims of PSM need special knowledge about treatment strategies, especially in handling patients who are filing complaints, with all the ups and downs and insecurity of the outcome. They also need some forensic knowledge about sexual offenders, their strategies, and treatment possibilities. Of crucial importance, however, is a sophisticated understanding of the circle of abuse and how the offender-victim interaction and the attachment patterns contribute to the boundary violation in each case.

Furthermore, therapists with intact professional boundaries tend to believe the clients; they are willing to acknowledge their own mistakes; and serve as educators about abuse; they support clients' empowerment strategies; have good supervision in place; and have access to legal information related to complaint proceedings (Disch et al. 2001). It is also crucial that patients are told about professional boundaries and their rights. This work should be carried out by consumer protection services, health care authorities and professional bodies.

From the perspective of health care professionals, three main avenues lead to prevention (Arbeitsgruppe 2002) :

1. professional training and formation
2. consequences
3. specific help for professionals

In concordance with Gordon et al. (1996) this topic has to be integrated into basic training and formation, and in continuing education later in a professional career (Bridges 1998). By implementing clear consequences, health care professionals' regulating authorities play a crucial and important role in guaranteeing patients' safety. As Cullen (1999) described, only a zero tolerance standard is applicable in the health care system. Based on a assessment (Marshall 1996, Schoener 1995) professionals accused of PSM must deposit their licence temporarily (Bloom et al. 1999), while they undergo a rehabilitation program (Abel et al. 1995, 1999, Irons et al. 1999, Jorgenson 1995, Prochaska et al. 1992, Tschan 2002) which will help them to achieve practice reentry, while being monitored for a certain amount of time (Walzer 1993). And finally, the professional bodies should offer help and support for those who either are at risk of violating or already have violated their professional boundaries (Bok 1993, Tschan 2003).

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