MENTAL HEALTH

Dangerous therapy

After nearly 30 years advising patients on complaints I thought I had, as Shakespeare would say, "supped full with horrors". Trying to support and advise people after stillbirths, or surgical injuries, has never been exactly fun, though it can be rewarding to help achieve emotional resolution of a complaint so that people can begin to get on with their lives. I had, of course, dealt with a number of complaints of sexual abuse – usually the "groping in the surgery" kind – at the Patients Association, and had sat on cases as a lay member of GMC. I was well aware that even "minor" sexual assault could lead to long-term trauma. I also knew that there were serial abusing doctors who had got their technique of frequent or prolonged vaginal and breast "examinations" off to a fine art, never going quite far enough to get struck off.

None of my previous work had prepared me for the devastation I was to find when, in a foolhardy moment, I offered to help Mary Edwards and Jenny Papal, the two therapists who had founded Prevention of Professional Abuse Network (POPAN). I was so impressed by their knowledge and high ethical standards, that before I knew it, I was involved. Now with a modest Department of Health grant and an impressive committee, we are hoping to raise enough money to provide a service that will begin to cope with the overwhelming demand, and provide managers with essential information on how to protect the public.

Nowadays patients going to hospitals for endoscopy or prostatectomy are likely to receive an explanatory leaflet. Patients going for counselling or psychotherapy seldom have such written information, so they have no idea what to expect, and do not realise when boundaries are being crossed. They may have a feeling of unease, but are not confident enough to challenge.

Even if therapists are not abusive, serious damage can be caused by those who are inadequately trained and supported, or simply have the wrong personality for the job, or are wrong for that patient. Audit of outcomes in this area is essential, and managers' antennae should permanently be on alert for warning signs. We hear of nurses, after a couple of short courses on counselling, enthusiastically scraping away at emotional topsoil, not only unprepared to deal with what they may uncover, but incapable of recognising when they are way out of their depth. Clinical psychologists or psychiatrists are not always safer. I wince when I read of cognitive therapy being advocated as a panacea, with no mention of possible reactions! I have seen too many.

For example, intense emotional attachment to the therapist can occur, sometimes rapidly. It is a standard risk, and should be anticipated, just as surgeons are trained to expect and cope with haemorrhage. A common reaction of the untrained and unsupported therapist is to "panic, deny, and dump" – leaving a severely damaged patient. It is in effect abuse by ignorance and negligence. Surgeons expect to deal with post-operative complications or call in senior colleagues. Since resolution of the relationship with the therapist is a crucial part of recovery, practitioners who will not cooperate, compound the injury. When therapy has gone wrong, it is just as much the duty of the Trust to arrange for swift remedial help (if necessary from outside the district) as it is to deal with the broken leg that did not set properly.

The most serious damage occurs when therapists transgress emotional and physical boundaries to use patients for their own gratification. I now have no doubt that the severity of damage from abuse therapy and "counselling" can equal or exceed that of botched surgery. The mortality rate is unknown, but many of our clients are suicidal, a number have lost jobs or careers and some are housebound and have become seriously ill. They can no longer function as social human beings. Marriages and other family relationships have been destroyed.

Abuse can be physical, sexual, emotional or financial – or any combination. We see a wide range. Our most common abusers are likely to be psychotherapists, clinical psychologists, counsellors and psychiatrists with a fair number of GPs, osteopaths and alternative practitioners. We also have complaints about various denominations of the clergy, or others in similar positions of power. The most rapid growth area at present is complaints about male psychiatric nurses who are doing "counselling" and sexually or emotionally abusing their female patients. Managers who are not highly experienced in this area themselves, are simply not seeing what is under their noses. True clinical supervision from an experienced and senior counsellor is non-existent.

As we build up pictures of abused and abusers from case files, and slot pieces of jigsaw together, the spectrum becomes clearer. At one end are a number of inadequate practitioners almost unwittingly at first using patients to meet their own needs. Some patients say "I felt I was expected to become the therapist, to listen to his problems". At the other end are a number of serial abusers who have been grossly abusing patients in a carefully planned way for many years. We find it frustrating to supporting a client who is at last strong enough to pursue a lone complaint, when we have two or three other victims too traumatised to take action.

Abusers who are caught early are likely to be the less experienced. The others, like successful paedophiles, have spent years developing and honing their techniques. Their manipulative skills stand them in good stead when they want to get into senior positions and on to committees, thereby creating a strong defence against future accusations.

Surprisingly often they are active in their religion. Serial abusers may surround themselves with colleagues with similar ideas, so a whole department or private clinic can become toxic, and very difficult to investigate or unravel. Others have moved often – sometimes internationally.

Abusers do not pick on anyone. They target the most vulnerable and those least likely to be believed, and they choose their victims carefully. Patients who were abused in childhood are, of course, ideal, and may be abused by more than one therapist. Abusers can appear sympathetic, even charismatic, and may be seen by their colleagues as good practitioners. The sad, lonely client is delighted at last to have someone who understands and cares. Great emphasis is placed on trust, and barriers are broken down. By telling the therapist their most intimate thoughts and secrets, patients are handing over the keys to the inner safe and providing the means of their own enslavement. As one victim becomes less satisfying, the next is already being prepared, or a "harem" of several at the same time may be acquired.

The new NHS time limit for complaints is a farce. Can any manager afford to ignore allegations that an employee abused a patient more than a year ago? Serious complaints usually surface long after onset, when the victim has become at least partially aware and has only begun to realise that what took place was abuse. The weak do not always stay weak for ever – and then they may start talking, though with great difficulty. The problem is finding someone who will listen and understand. Great sensitivity is needed, because they are often still deeply emotionally entangled with the abuser, and the surgery of cutting themselves free is acutely painful. It may take months or years before they can tell the full story.

Few people on the outside understand the dynamics of control, and the potential to damage the patient's inner core which can occur in "therapeutic" relationships. If a woman allowed her doctor to use her as a free prostitute for months or years, surely she "consented"? How could a patient continue to visit someone who bullied him and continually lowered his self-esteem, persuading him – at least for a time – that black was white?

Emotional abuse without sexual contact is often seen as less serious by complaints officers and professional bodies, despite the profound damage caused. A therapist may create such powerful emotional dominance that all other supportive relationships in the patient's life are destroyed. It is the reverse of the empowerment patients hope to achieve through therapy. When I listen to victims I am reminded of Blake's poem:

O Rose, thou art sick!
The invisible worm,
That flies in the night,
In the howling storm,
Hath found out thy bed
Of crimson joy;
And his dark, secret love
Does thy life destroy.

Only when a number of POPAN clients get together and share experiences do they begin to see how the tricks were done. Like a music hall conjurer: now you see it, now you don't. They are often more successful at beginning to heal each other than any professional; which is just as well, since expert, trustworthy help for such cases is sparse. Many will make only partial recoveries. The worst cases are not even fit to travel to support meetings, and others cannot afford to do so.

Professional bodies have a poor record for dealing with abuse complaints, and POPAN will be monitoring progress. Complaints to NHS Trusts are seldom handled well. This is understandable, since most administrators will have had little or no experience of this kind of case, and CHC officers are often at a loss. Can this "disturbed" client be believed against the denials of a confident professional, who talks glibly of "transference"? In hospital complaints meetings, psychiatrists and psychologists tend to play the dominance game at meetings with the client – even if the complaint is not about them personally – and complainants can be further damaged unless they are well supported. One of POPAN's first tasks will be to contribute to training and information for managers.

Meanwhile it would be useful to remember the example of Southwark and Lewisham FHSA. When they received a complaint of sexual misbehaviour by a GP, they sent a sympathetic woman to interview a number of former patients to ask why they had changed doctors. She also interviewed former patients of other GPs. The information gained about sexual abuse enabled them to get him removed from the NHS list. An audit of views of current and previous patients might be a good place to start.

Thorough investigation is essential but it must be followed if necessary by swift action to protect patients – which does NOT mean merely encouraging the abuser to depart with a glowing reference. The angriest clients we have are those who discover, through their growing grapevine, that others had complained before them, but nothing was done. Everyone simply hoped the embarrassing problem would go away. Those clients are going hot foot to the best lawyer they can find.

Jean Robinson

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