The Dynamics of Caregiving: Why Are Professional Caregivers Vulnerable to Anxiety and Burnout, and How do we Support Their Well-being?

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Today we live in an ever more turbulent society. A society that is managing major social and political change. With the disturbance of populations due to civil and political strife there is a rise in migration across country borders. We are integrating major changes that have taken place in the position of women in western society during the last 100 years. The consequences in Western society of moving from a patriarchal culture to a more egalitarian one have affected patterns of work, family life, and gender relations. For many in the western world, men and women have had to negotiate as equals in terms of work, leisure, and aspirations. Access for women to education and job opportunities has given women freedom to choose and become people in their own right. But this is not the case in many parts of the world. For many cultures there is a desire to maintain the male gender as donant and to impose particular cultural, political, and social values on men, women, and children. There is a rise in fundamentalism in many religions. There is a rise in xenophobia.

Information is available to people at the touch of a button and people's desires are soaring in accordance—for good medical and social care, education, jobs, wealth, and prosperity, for equality between men and women. Alongside these aspirations and desires is that fact that for many people they can literally see their life bears no relation to these images of "success".

In Western culture, trust in our banks, religious institutions, social services, and educational services to protect and look after us, has shattered in the last twenty years. Blind trust that the other has our best interest at heart, and particularly where the "other" is a social or state institution, has taken a huge battering. Likewise, trusted individuals with national profiles such as Rolf Harris and Jimmy Savile hailed for public works and charitable causes have been found to

ATTACHMENT: New Directions in Psychotherapy and Relational Psychoanalysis, Vol. 9, July 2015: pp. 188–200.

be living a double life and abusing those they claimed to care about. Places one might have assumed offered sanctuary, peace, protection, and creativity such as religious institutions, colleges of music, elderly people's homes, residential facilities for distressed children have been found to be terrifying and unsafe places for some of those living within their walls.

There is a lot for our society to integrate and we know that this integration is taking place within the context of a country that has a debt of over three trillion pounds. What is alarming is that in this situation those in power are turning a punitive eye on the vulnerable: the poor, sick, disabled, and those who care for them. The recent intention to prosecute social workers and to threaten them with prison sentences if they fail to detect and act in the interest of children, is a horrifying departure from what one might have assumed was a caring, humane, and developed society, with a lot of resources to manage the present situation.

If John Bowlby (1957) has offered us anything, and particularly the work of his colleague Dorothy Heard, it is, that in terms of our evolution, we have to struggle with and overcome our primitive responses to threat. As a society, we seem to feel very threatened by the rapidity of political and social change, and we are reacting with the primitive system embedded within us to ensure our survival. I am speaking of our fear system, which is totally devoid of empathy and has the simple goal of our own survival at all costs. Our fear system impels us to respond instantaneously without access to our more developed capacities for negotiation and reflection.

John Bowlby was able to show the way in which instinctive responses between adult mammals and their young had changed over time from their reptilian forbears (Bowlby, 1988). In other words we have acquired the capacity to behave towards each other in a way that is supportive and companionable. Where the interests of the other are given as much weight as our own and where the order of the day in terms of conflict and difference is negotiation. Our more archaic fear-driven responses are fast and lead us to relate to others in a dominant way. We want to bully them into submission. We want to take charge. We do not want to negotiate. We want to lay down the law. And there is a corresponding instinct within people to submit and give in to this form of relating. So the dynamic remains in place until one of the parties can access a more exploratory mode of relating to the problem.

In his 1951 paper Bowlby made it clear that adult mental health was based on the experience of a continuous, warm, loving relationship with a caregiver in which both parties took satisfaction and enjoyment (Bowlby, 1951). Bowlby's influence on the nature of childcare has been extensive and has filtered into the field of health, education, social welfare, and social policy. Nevertheless, neglect and abuse by "would be" trusted caregivers is rife, and is being exposed in more and more places each and every day. As we write, there is a major investigation into the behaviour of members of parliament, the judiciary, and the police force

in relation to the gross abuse of vulnerable children in the 1970s and 1980s. While we have learned a great deal about the impact on children of less than ideal parenting, we have neglected the emotional dynamics and needs of *caregivers* themselves.

The lessons from attachment theory and research are that caregiving is an extremely complex, subtle, difficult, and important activity. It is a lonely, isolating activity and demands great courage and strength to constantly keep the needs of the other in mind. For example, neurological studies have illustrated that processing empathic concern may constitute a threat to the individual, leading to personal distress and compassion fatigue, and subsequently decreasing capacity to give care to others (Decety & Lamm, 2009). Similarly, it is possible, due to the nature of the situation that a mature caregiver who is able to take an exploratory interest in another person may be left in a situation where they do not receive empathy themselves. This is certainly true for those caring for children or adults who do not have, or who have lost, the capacity to hold the other in mind. So the basic challenge for a person aspiring to offer effective caregiving in this situation is how they manage this, and how they figure out how to get support for themselves. They cannot be left alone with this task. A caregiver who is driven to acting from a defensive part of themselves in this situation is potentially a source of danger for the person or people they are looking after. As a society, it is crucial we are alert to the dynamics of adult caregiving.

Supporting the dynamics of adult caregiving

We need to work out how we can support those in our society: parents, social workers, psychologists, teachers, psychiatrists, doctors, to name a few, who take on the work of caring. We need to work out how we enable them to thrive in this situation. We will not help our fellow human beings who wish to provide good caring services to others by threatening them, by increasing their levels of fear, and by continuously monitoring and auditing what they are doing. We need to pay attention to the impact of the work on them and how the work they are doing is making them feel inside themselves. Not to treat them like this is to treat them as less than human. We cannot have people we treat as less than human as our main caregivers. What kind of care are we expecting?

What do we know about the dynamics of attachment of those who offer to take professional responsibility for the care of others? A study of the early experiences of those who go into the "caring" professions would be useful to us in terms of helping us understand the nature of the task and the vulnerabilities and needs of those who undertake it. Why have we, as a society, given this so little priority? Even as professionals, those in the research end of the business seem to spend endless time refining categories of insecurity in children in relation to caregivers, when spending some of that time studying the dynamics of caregiving, the other

end of that two person, goal-corrected behavioural system—care-seeking and caregiving, might be absolutely vital to the well-being of our society as a whole.

While Bowlby concentrated on the degree of proximity between care-seeker and caregiver, in terms of gauging levels of security and exploration for the child, Dorothy Heard, his consultant colleague for twenty years, concentrated on the *nature* of the interaction between caregiver and child and whether it was sufficient to return them to the state of exploratory play. Later, Heard et al. (2009) developed the concept of caregiving and discriminated between effective and ineffective caregiving. Effective caregiving was defined as having four functions. These are:

1. to remain exploratory towards the needs of the care-seeker and not become defensive themselves in relation to the presentation of the care-seeker
2. to correctly identify the affect of the care-seeker and to regulate it
3. to identify the skills necessary to manage the threatening situation and help the care-seeker acquire them
4. to put the care-seeker in touch with their peers (Heard et al., 2009).

Ineffective caregiving, on the other hand, is defensive by nature. It is a response to unmet care-seeking needs. Its goal is to regulate the pain of not being seen and met by the person who matters most in one's life and from whom one expects and wants love. It (defensive caregiving) is designed to regulate the impact of this rejection on a person's sense of self, their sense of being worthwhile, of being welcome in the world, their self-esteem and their capacity to build good solid defences based on a sense of being loved, competent, and with potential. These experiences sometimes lead a person into the caring professions, where they have an insatiable desire to continue in a "helping" role, solving problems, "fixing" people. There is a need for constant positive feedback from those they seek to help. This need, combined with a small repertoire of helping practices, an inability to accurately assess what the other needs, and a vulnerability to getting angry, withdrawing, or becoming disorganised in the face of perceived rejection by those they seek to help, leads to a form of caregiving that is clearly unstable and could potentially be dangerous.

What is clearly needed now going forward into the twenty-first century is a much more detailed understanding of who goes into the caring professions, what sort of experiences in childhood they have had, and what are their vulnerabilities to practicing defensively or becoming burnt out? How do their early experiences of attachment relationships influence their capacity to co-operate effectively with other caregivers? Lack of professional co-operation, communication, and understanding has been cited in numerous reports and enquiries as the root cause of failure to adequately protect children and vulnerable adults (Department for Education, 2008; H. M. Government, 2004; Independent Inquiry into Child

Sexual Abuse, 2015). To what extent can this be linked and understood within an attachment frame.

Failure in inter-professional cooperation: could the dynamics of defensive caregiving play a part?

I suggest that one reason why interprofessional cooperation may be difficult is the fact that when the instinctive system for caregiving is aroused in a person, it is difficult for that person (caregiver) to accept that another person's form of caregiving will be adequate. This seems to be because, when caregiving as an activity has defensive roots, then the caregiver acts instinctively to protect the other (care-seeker) from an unprocessed part of themselves (i.e., an unmet need) and can attack or mistrust the care they see others providing (for more detail on the dynamics of attachment, see McCluskey, 2005).

Previous work (McCluskey, 2005) has described a series of experiments that I undertook designed to examine the process of affect attunement and regulation in adult psychotherapy. The results lead me to formulate the relationship between a caregiver and a person seeking care as an attachment relationship, arousing the dynamics of attachment internalised by caregiver and care-seeker alike. Evidence suggested that this was a goal corrected partnership and that in cases where there was no "goal-correction", both parties were distressed and dissatisfied. Evidence of this dynamic of caregiving and care-seeking as arousing instinctive systems deeply embedded in our biology could be seen when the systems met their "goal"—there was a shift in the vitality state of both. Following a detailed analysis of the pattern of interaction between care-seekers and caregivers, I distinguished a pattern of effective caregiving that consisted of a process of rupture and repair that I identified as "goal-corrected empathic attunement" (GCEA), (McCluskey et al., 1999). Effective caregiving could then be tracked as involvement in that process of GCEA, whereas ineffective caregiving left both parties in a state of distress.

The restorative process of attachment and exploratory interest sharing

Seeing that attachment dynamics were involved in effective and ineffective caregiving, I designed a course for professional caregivers that would give them the opportunity of exploring their own history of attachment and interest sharing as formulated by Brian Lake and Dorothy Heard. Heard and Lake (1997) had built on Bowlby's model of understanding human relations through an evolutionary lens and had added a further five instinctive systems to Bowlby's original two. Heard and Lake took the view that these seven systems worked together to form a restorative process to enable the individual recover as much well-being as possible following a perceived threat.

Over the last ten years, more than six hundred people will have participated in the restorative process programme for professional caregivers. They come from the fields of psychology, psychiatry, general medicine, paediatrics, social work, teaching, nursing (clinical and administrative), law (both solicitors and barristers), art therapy, psychoanalysis, psychotherapy from many schools of training, counsellors, probation officers, religious (priests from both the Catholic and Anglican tradition), occupational therapy, palliative care, housing, and many others.

Originally these courses took place over eight or nine months to give members a chance to explore each of these seven systems in depth. The seven systems are: care-seeking, caregiving, self-defence, interest sharing with peers, affectionate sexuality, the internal environment, and the personally created external environment (Heard et al., 2009).

I have spent many years studying how the restorative process (RP) works. It has taken me a long time to really see how it operates in people's lives. Three years ago I changed the structure of the courses I ran for professionals so that instead of exploring these seven systems that make up the RP over eight or nine months, the systems were explored over three days. This method has brought into sharp focus how a person uses all these instinctive aspects of themselves to keep themselves going as best as they can, especially when life has thrown up problems early on. A lot of this work has been transcribed by Jim Gunn who is the second author of this paper. Together we will bring you some of the findings from that work and particularly our findings that caregivers are vulnerable. Those who go into the professions, while they have a great capacity for empathy, need support, need to be understood, and the impact of the work on them needs to be understood. They themselves need to be empathised with and they need a containing environment where they can make sense of the turbulence of the often unprocessed feelings that they may be dealing with, both in themselves and in others.

Research findings

I have found that it is the exceptional caregiver that has an early life history free from overwhelming fear. In a recent investigation of the transcripts from five different RP courses, we found that fifty-five per cent of participants had experienced failed care-seeking while growing up. What we do not know is whether this is true for the general population or specific to those who go into the caring professions, comparable study would be worthwhile.

The following case illustrates the way in which the restorative process functions. This is the story of one of the professional caregivers who attended one of my courses. He described an experience aged two when he was in a life-threatening situation and knowing that his mother was not going to protect him. As a

young child he sought care, clearly not from his mother, but from adults in the local community. Some of the people he found were benign and helpful and interested, particularly one person who allowed him to spend time with him and who encouraged him in his reading, school work, and desire to make things. However, he also made friends with somebody who abused and sexually molested him. He was about six or seven at the time. He had a repeat of this experience when he was in early adolescence. One can already see that this person was learning that in general there was no support out there for him, that life could be dangerous, and that he would need to be vigilant, especially in his relationships and his reliance on other people. He learned that he needed to take care of himself. But he also learned that he could not trust his own judgement in relation to other people.

This subsequently played out in his life in the following way. It has made him reluctant to form close and lasting relationships. He has not been able to develop and sustain an interest other than his work as a caregiver (even though he has plenty of interests), and he has not been able to follow up his dream in terms of the home that he desires (even though he has absolute clarity about the nature, structure, preferred location, and functions of what his home would look like). Instead he shares a house with someone who was in need of financial support to have a home of their own. In other words, he carried his caregiving behaviour even into the way he manages and maintained his own created external environment. As he said on the course "I do not feel present in my own life."

While this life trajectory is particular to one individual, many of the 600 plus professionals who have taken my courses have indicated that their primary caregiver was unreliable and that from an early age they were required to care for their caregiver. For most, this has meant developing a self that does not seek care from others, moves into a defensive form of caregiving to others, and develops a system for self-defence that keeps this dynamic in place. For many, the result is an undeveloped interest sharing life, fear-filled forms of sexual expression even when in a long standing relationship, an overly critical and harsh attitude to the self or others, and an unresolved lifestyle in terms of house and home.

What may not be obvious from a quick reading of the above case history is the way in which the different systems of care-seeking, caregiving, self-defence, sexuality, interest sharing with peers, the internal environment, and the external environment are all working together to provide a certain level of well-being. However, as this person says, he does not feel he is participating fully in his own life. He is not present to himself.

Clearly this person is leading a less than fulfilled life. To some extent one might describe it as a defensive life. The person is still trying to care for himself as best as possible given not only a lack of support in childhood but active trauma and abuse. From the perspective of Heard and Lake's theory of the restorative process, they are maintaining as much well-being as is possible for themselves.

So what is going on and why does the formulation of a restorative process give us a guide for understanding what is happening for this individual? Given that my cohort of study is adult professional caregivers then it is surely important that we understand some of the process at work here.

From very early on, this person had learned that seeking care from his mother was pointless and possibly dangerous. But the need for care is embedded within us as a biological goal corrected system. In other words, it remains active until met by another person. This person (let us call him Harry) sought a caring response from adults outside the home. He went in search of care. He was both lucky and unlucky. He found a person who introduced him to interesting creative work and who took an interest in him. This will have engaged Harry's innate interest sharing system, the system that gives us all a sense of vitality and well-being. One can see that this system has sustained Harry throughout a lifetime and he is loath to reduce his investment in it by risking to engage more fully with the other instinctive systems within him, such as creating a home, engaging in a long term affectionate sexual relationship. This means that he is likely to remain investing in his work, which is of great interest to him, but other aspects of his life may remain unresolved.

The other thing that happened to Harry when he went outside the home seeking care was that he was sexually abused. This would have been very confusing for him to say the least. He is seeking care, someone assaults him and activates his sexual system. At once this reinforces for him that seeking care is dangerous and second it introduces him to sexuality prematurely and in an environment of secrecy. He describes in later life not knowing, not allowing himself to know that he felt sexual desire for another person. His later sexual relationships took place in a context where they could not be made public.

We now have someone whose care-seeking system remains unassuaged, but their interest sharing system has been activated and engaged. This may contribute to a sense of importance, capacity, possibilities, and a sense of becoming. All this will have built up a supportive place in Harry's internal environment, something he can draw on when under attack, sensing danger, or feeling shame. However, his care-seeking system has been grossly and cruelly misattuned to and he has had to make sense, consciously or unconsciously, of why seeking care has resulted in an unwanted, unwelcome, and disturbing sexual response. His own natural sexual system will be associated with the arousal of his fear system (part of his system for self-defence) and may lay down a pathway for him that associates sexual desire in himself or from without as a source of dread. With this dynamic in place one might predict that he would use (consciously or unconsciously) his sexual system to defend himself from intimacy rather that to enable the expression of affectionate intersubjectivity.

The consequences for Harry of having a caregiver who could not respond to him in a way that protected him from danger and assuaged and soothed

emotions, has been significant, as he says so poignantly, "I do not feel present in my own life." What Harry needs now is support for his care-seeking system, he needs support to help him identify who has his best interest at heart and who has not. In terms of his professional work as a caregiver, some settings might suit him better than others, such as those organisations providing rescue and protection services. However, Harry could still be vulnerable to not sharing cases with colleagues, feeling he should handle everything by himself, and not seeking support and supervision as often as he should.

The theory of attachment based exploratory interest sharing (TABEIS, Heard et al., 2009) suggests that with encouragement and support to seek and get good quality care, one can predict that the need for defensive caregiving will recede. This has implications for the support of those we entrust to care for us at all levels of society. Professional caregivers need access to someone who can give them effective care. That means someone who can remain exploratory with them and not go into defence themselves.

I feel we now have a clearer understanding of the dynamics of caregiving. Threatening caregivers with imprisonment, expecting more and more "productivity" from our doctors, nurses teachers, academics, and other professional caregivers without understanding the nature of the caregiving task, is to promote more and more defensive caregiving, burn out, and possibly dangerous practice.

Evidence that an increase in effective care-seeking is crucial to shift the dynamic of defensive caregiving can be seen from the following study we undertook two and a half years ago. In a survey of sixty-four professionals undergoing training in the restorative process programme, significant positive correlations were found between items assessing awareness of the impact of caregiving on well-being ("I am more aware of the effect on my well-being of how I give care to others") and changes in caregiving (i.e., "I have made changes in the way I give care"; $r = 0.64$, $p < 0.001$). Likewise, an increase in awareness of fear and its impact on the self ("I am aware of that [fear] beginning to change and that I am now less anxious") was also significantly correlated with changes in caregiving ($r = 0.67$, $p < 0.001$). Thus, an increase of changes in caregiving has been associated with increased awareness of the impact of caregiving on fear and well-being, thereby suggesting a shift in defensive caregiving. In terms of seeking care, an increase in awareness of how one seeks care from others when in distress ($r = 0.56$, $p < 0.001$), and awareness of what has made seeking care problematic ($r = 0.49$, $p < 0.001$) were significantly correlated with perceived changes in seeking care, such that increases in awareness of how one seeks care when in distress and how care-seeking has been problematic in the past are associated with more changes in care-seeking. More research is necessary to support these promising findings.

The questionnaire also asked respondents to rate their agreement with a series of statements, and to provide examples of changes resulting from their participation on the course. Seventy-nine per cent had changed the way they sought care

from others, with examples including: "I am more direct and straightforward in the way I ask for help, and less defensively aggressive." Eighty-nine per cent were more aware of help being available when under stress, "More able to recognise when to step back or take a break. More open in supervision."

These changes in care-seeking were reflected in eighty-two per cent of respondents who had made changes in the way they gave care, citing examples such as: "I am much more aware of my own fear system and the importance of grounding myself if my fear system is activated."

Seventy-six per cent of those who responded reported changes to interest sharing, such as:

> I am giving myself guilt-free permission to explore what it is I think I'd like and engage with that interest.

and

> I have made it more of a priority in my life and feel less guilty for spending money and time on exploring interests that are not directly associated with my work or family commitments.

Thus, this research illustrates changes in caregiving, care-seeking, and interesting sharing, and while these are important findings, more research is necessary to illustrate the underlying mechanisms of change during a restorative process programme.

We will conclude this paper with two charts. The first depicts the seven systems (see Figure 1). This can be used to help practitioners make a formulation of the nature of current levels of well-being in a client. It can also be used to help practitioners assess their own level of well-being, and their capacity for effective or defensive caregiving. Space prevents us exploring the model of supervision or practice.

The second chart gives a visual analysis of behaviour of members during the experiential part of the courses for professional caregivers, from which the data underlying this paper is derived. Each series of nine three-hour sessions were transcribed and graphs produced to give an at-a-glance overview of participants' activity. Sessions are divided into several sections, beginning with a backtrack of events since the previous session, continuing into the main experiential process, before finishing with reflections in surprises and learnings, and the applications people are seeing to their work (see Figure 2).

Activity timelines for each member record a circle each time an individual speaks, with the size of the circle proportional to the words spoken. From this graph it is possible to see when members first speak in the group, to which section of the group they contribute, whether some speak several hundred words uninterrupted (large circle), where others make smaller contributions in a dyad with the facilitator (cluster of smaller circles).

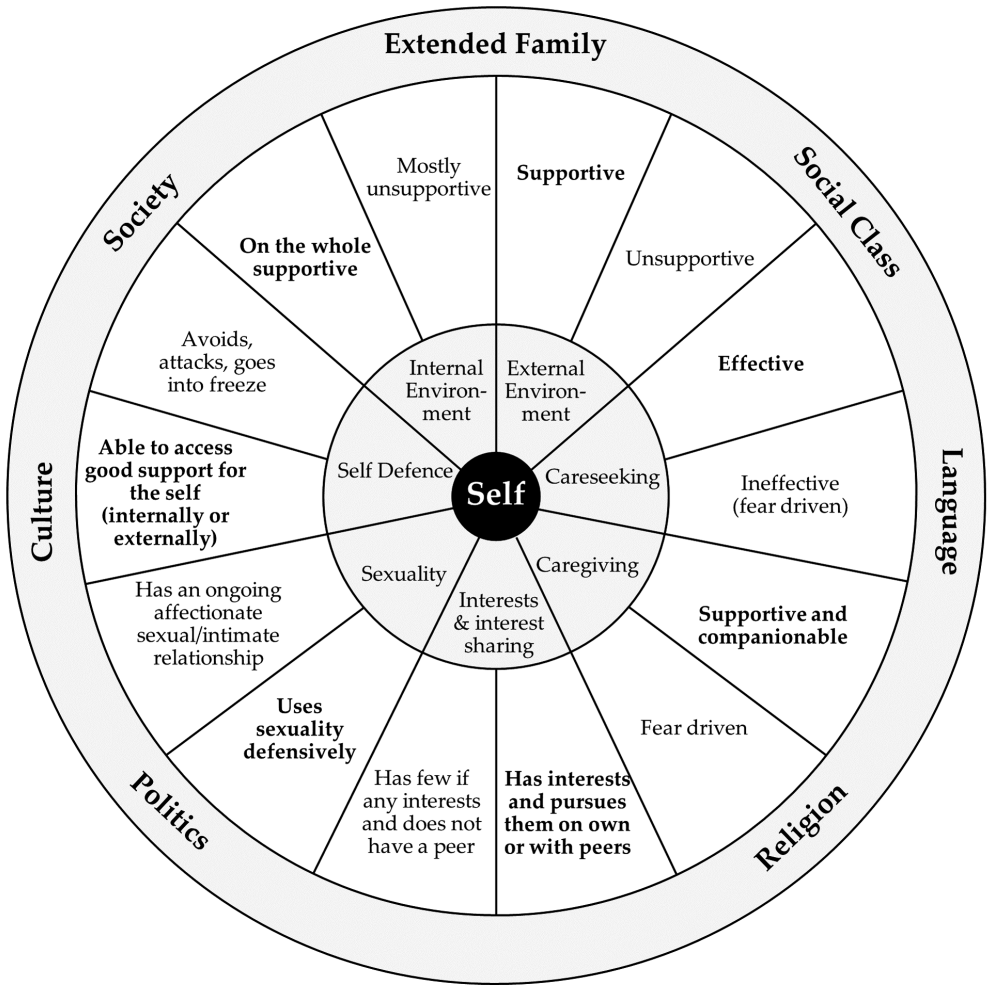

Figure 1: The McCluskey model for exploring the dynamics of attachment in adult life.

The example graph (Figure 2) shows that all participants spoke during the back-track section, and all contribute in around four or five clusters of speech, evenly distributed throughout the duration of the session. Analysis of several groups of nine such sessions, examining the number of times members speak, the total words each speak, and the order in which they first participate follow a similar pattern. One-way ANOVAs (analysis of variance) showed no statistical difference between individuals to indicate that certain members dominate the session by speaking more, or more frequently being the first to speak. Examining the transcripts at points when the speaker changes, highlights the role of the facilitator's moderation in bringing in quieter members and maintaining balance to participation.

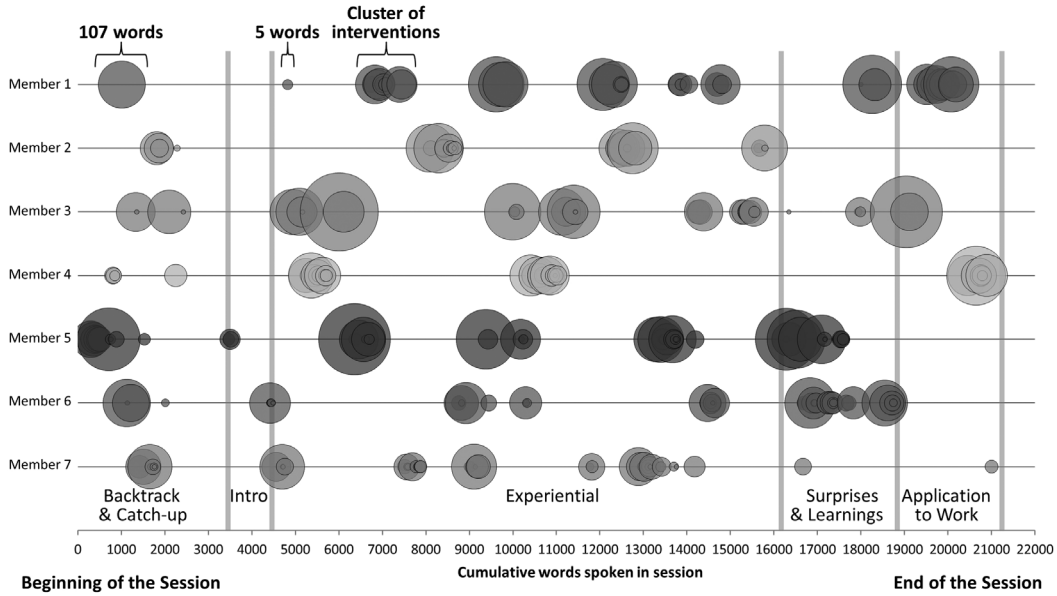

Figure 2: Visual analysis of members' behaviour during RP courses.

While it is impossible to go into any more depth on the structure and process of these programmes the results from the questionnaire do provide us with some evidence that becoming more discriminating in terms of seeking care correlates with an improvement in well-being and a reduction in fear driven or defensive behaviour.

It is the minority in our society who put themselves forward to care for others. We need to support them in this task. This paper is a step in trying to unravel the dynamics underlying effective and ineffective caregiving. We hope it will encourage others to take the work further.

Acknowledgement

Our thanks to Dr Ronan Conway, Academic Tutor, Doctorate in Clinical Psychology, School of Psychology, National University of Ireland, Galway, who did the statistical analysis and supplied us with the results.

References

Bowlby, J. (1951). Maternal care and mental health: a report prepared on behalf of the World Health Organization. *Bulletin of the World Health Organization 3*: 325–334.

Bowlby, J. (1957). An ethological approach to research in child development. *British Journal of Medical Psychology*, *30*: 230–240.

Bowlby, J. (1988). *A Secure Base*. London: Routledge.

Decety, J., & Lamm, C. (2009). Empathy versus personal distress—recent evidence from social neuroscience. In: J. Decety & W. Ickes (Eds.), *The Social Neuroscience of Empathy* (pp. 199–213). Cambridge, MA: MIT Press.

Department for Education (2008). *Haringey Local Safeguarding Children Board*. *Serious Case Review "Child A"*. London: Department of Education.

Heard, D., & Lake, B. (1997). *The Challenge of Attachment for Caregiving*. London: Routledge.

Heard, D., Lake, B., & McCluskey, U. (2009). *Attachment Therapy with Adolescents and Adults*: *Theory and Practice Post-Bowlby*. London: Karnac.

H. M. Government. (2004). *The Government Response to the Recommendations and Conclusions of the Health Select Committee's Inquiry into Elder Abuse*. Norwich: The Stationery Office.

Independent Inquiry into Child Sexual Abuse (2015). Independent inquiry into child sexual abuse. Available at: https://childsexualabuseinquiry.independent.gov.uk/

McCluskey, U. (2005). *To Be Met as a Person*: *The Dynamics of Attachment in Professional Encounters*. London: Karnac.

McCluskey, U., Hooper, C., & Bingley Miller, L. (1999). Goal-corrected empathic attunement, developing and rating the concept. *Psychotherapy*, *Theory*, *Research*, *Training and Practice*, *36*: 80–90.