ADDICTIVE CARETAKING
Part III in the Series
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I am not an addiction specialist but I'm struck by the similarities between what seem to be involuntary patterns of caretaking by caregivers and the compelling nature of most addictions. An addiction is a behavioral pattern that seems beyond our control and awareness. We even have difficulty realizing the nature of addictions until we start experiencing the effects in our bodies and in our relationships. We don't realize how compelling our addictive patterns are until we attempt to change them. We then start to realize how much fear and guilt reside at the core of our behavior.

I have observed a tendency to caretake clients in colleagues, in my students, and in myself over the years. Most caregiving professions have had to come to terms with the patterns of caretaking in practitioners because those patterns tend to undermine the therapeutic process and lead to occupational burnout. Without education clients/patients do not learn to take personal responsibility for their own healing. Without realizing the true etiology of their symptoms clients tend to blame the health care practitioner when things worsen or go wrong.

The mantle of authority that clients invest us with is very tempting because it feels like we're being given power, a sense of control over the therapeutic process. However by accepting that mantle of authority we impose a huge burden on ourselves. The burden we assume is twofold: responsibility for the treatment and responsibility for the outcome of the treatment. Addictive caretaking involves both aspects of this burden. We overlook the client's responsibility for how he/she receives our treatment and we overlook the client's responsibility for what happens as a result of the treatment.

Hidden within the exchange of authority for responsibility are the seeds of therapy gone awry. The therapy process gets stuck because it is mainly focused on symptomatic relief - no actual in-depth change has occurred. The practitioner tries harder and harder to produce results. The practitioner realizes that something is wrong. There is little satisfaction in carrying others' burdens especially when the burden includes guilt for what isn't happening. We tend to work too hard to satisfy our clients' needs and overlook their responsibility. As we strive harder and harder to take care of our clients' symptoms, we accrue more and more of our own symptoms.

This pattern of continually striving for control over symptoms but never quite achieving success parallels the patterns of addiction. We must keep raising the ante until we reach a place of burnout or come to our senses about the price we are paying in terms of our own health and satisfaction.

Many professional caregivers have childhood backgrounds that predispose them to this kind of addictive behavior... getting hooked on something that gives us a semblance of order. As children we learned that taking care of others gave us a sense of safety and meaning. We were praised, we received affection,

we experienced a respite from chaos and/or abuse, and we were able to assuage our feelings of guilt and/or despair. These temporary rewards as children reinforced behavior in which we played adult roles like ”man of the house,” family mediator, “daddy’s girl,” parents’ confidant, “mother’s helper.”

What constitutes an addictive pattern? First there must be some system of *rewards* for the behavior; e.g. every time I’m able to produce symptomatic relief for my client or fix my client’s problem I feel a sense of confidence and completion. My client also rewards me with money and praise. For a while the praise and remuneration for me and symptomatic relief for the client are enough to satisfy both parties. After a while the symptoms seem to be more recalcitrant. What worked in the past no longer works. We find it difficult to let go of the sessions that don’t produce symptomatic relief. We worry that we should have done something differently. Awkward feelings arise; foremost is the feeling of *helplessness* to change our behavior. Eventually both the client and practitioner realize that something needs to change. This can take years.

When we have a long-term relationship with a client that is based mainly upon symptomatic relief we both start to look elsewhere to produce the highs that were possible in the beginning of the relationship. Many of those client relationships will wind up the same way because of the tendency to caretake. As in any intimate relationship if both practitioner and client are willing to go into the feelings of frustration and doubt that arise, it is possible to break through to a level where responsibility is shared rather than assigned. But many if not most therapeutic relationships never reach that level of equality. Instead we maintain the relationship despite our feelings of dissatisfaction or we refer the client on to another practitioner. Either way the relationship has become a burden we carry. I find that I start to crave from other clients the rewards available at the beginning of the process because along with the rewards has come the burden of feeling that my client is dependent upon me... and helpless without my input.

Example

At first the sessions with Connie produce symptomatic relief. Connie praises Edna the practitioner and even refers her friends to Edna. Then Connie hits a wall and old symptoms start to reoccur. She implies that it is the Edna’s fault. “ I felt great for a few hours after our last session and then my body hurt so bad I had to go to bed and take pain killers. The next day I called in sick to work… I almost called you and cancelled this appointment.” Edna now works harder and longer to reproduce the original results and feels more and more guilty and anxious about her work with this client. She looks for other modalities, other possible explanations for what has happened… “I think she’s got some problems she’s not admitting to me. I’ll bet she’s done the same thing with other practitioners.” One tactic for self-preservation is trying to feed the implied guilt back to the Connie. “Did you remember to drink lots of water after our last session? I think you may be very resistant to change.”

SUMMARIZING

As caretakers we are used to satisfying our own needs indirectly just as we did as children. We do not ask directly for what we want because that is still not an acceptable behavior. We would be blamed for being self-centered and inconsiderate. This is one reason it is difficult for caretakers to charge for their services.

We fill our needs by playing roles that fill the needs of others. Our worthiness as persons and practitioners is determined by how well we service the needs of others. As I said earlier some of us have even adopted a belief system that helps us cope with the inequities in this situation: "It is through giving that we receive." And like children we believe that something or someone outside of ourselves will change our circumstances. The child-within feels helpless to change most of the ways she/he relates to clients and their needs. What seemed to work as children must still work. The same feelings of helplessness and inadequacy we had as children still hold us in their grip. They are very painful and so we work very hard to produce a solution that will make them go away. Like workaholics, we fill our days with clients needs to replace the pains of our own.

We are not aware of how compulsive our addictive patterns are and how little they are under our conscious control. We usually do not realize that we have been following the same *modus operandi* since we were children. It takes a deep level of self-searching to realize how much we depend upon the fix we get when we caretake and fix another. Like other addictions, caretaking promises us safety and control over our lives. Like other addictions caretaking offers only a temporary release from our fears and feelings of guilt and inadequacy. Like all addictive behavior we are convinced that more of what gave us that temporary feeling of release will give us a permanent reprieve. It never does. Intellectually we know the caretaking behavior is inappropriate because it cannot deliver: safety, control, and the growth of our clients and ourselves. At the most caretaking produces symptomatic relief for the practitioner and client. We get a small dose of adulation, and the incorrect feedback that the more we are in control, the more powerful the healing.

Caretaking produces side effects that diminish our capacities to be effective caregivers. Like substance addiction, caretaking depletes our vital energy and creativity. As our energy wanes so does our enthusiasm for our work. The caretaking practitioner can use continuing education classes just like new drugs on the street. New modalities offer new techniques to add to our repertoire that will make us more effective as technicians, and new certificates as well, "You can do what's never been done, you can win what's never been won."

We then must convince our clients and our colleagues of the need for the new tools. The implication is that we are not responsible professionals if we do not keep up with the new material. If we have entered burnout as caretakers we give up the pursuit of new approaches and just feel guilty for our lack of interest. Unconsciously, just like pushers and users, we are creating a co-dependent relationship in which dependency grows but maturation and individuation and empowerment stagnate.

In pointing out this hidden addiction, I'm not chastising others or myself for practicing this way. There are times when the client, like all of us, needs rescuing and re-parenting. And there are times, such as during psychological regression and childhood flashbacks when we all feel the need for a safe caretaking container no matter how mature we are. And we would not be human if we did not have a strong desire to give that care to one another.