Malignant Alienation:
Overcoming Barriers to Professional Practice

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Introduction

The purpose of this article is to make practitioners more aware of malignant alienation, why it occurs, how it affects our work, and the best way to manage it. Given that the focus of much of our work is on building and strengthening the therapeutic relationship, this phenomenon is of critical importance. Malignant alienation can have a significant impact on the way we perceive individuals and consequently the level of care we provide them with. Therefore, it is vital that we try to prevent this process from occurring in the first place. The theoretical framework for this article comes from the Low Arousal Approach, which is a "person-centred, non-confrontational method of managing behaviour" (McDonnell, 2019; p.114). A key element to this approach is reflective practice. By becoming reflective practitioners, we can learn to more effectively identify and manage the strong negative emotions we may feel towards certain clients, rather than ignore them and allow them to build momentum.

What is Malignant Alienation?

Malignant alienation is a term that was coined by Morgan in 1979 (Watts & Morgan, 1994). It refers to the progressive deterioration of the therapeutic relationship, when a practitioner effectively starts to dislike the individual they are supporting. It is often accompanied by a reduction in the sympathy and level of support provided. As Pembroke (2009) says, it is the "worst possible place a relationship can reach." This phenomenon is characterised by "powerful negative feelings" that are felt towards a patient, but that are often ignored and avoided (Watts, 2004; p. 459). When working with an individual who provokes these strong negative feelings in us, it can be difficult to remain objective and can cause difficulties to arise as we continue trying to support them. Watts and Morgan (1994) identified different elements that contribute towards

the alienation process, including staff-specific factors, patient-specific factors, their interaction and the care environment in general. These different components can trigger intense emotions that can be emotionally draining and significantly affect our work.

Despite the severe impact malignant alienation can have, in some cases resulting in fatal outcomes, it is a construct that is still largely excluded from the literature and from clinical practice (Watts, 2004; Pembroke, 2009). The unconscious feelings of aversion that we have towards our client may play out in our behaviour, for example serious neglect of our client's needs (Watts & Morgan, 1994). Practitioners may feel disillusioned by their efforts to help the client, and consequently label them as hopeless or undeserving of their care. These responses can be spread to other staff members through the process of emotional contagion (Elvén, 2010), and can increase the likelihood of behaviours of concern occurring more frequently (McDonnell, 2019; Petitta *et al*., 2021). To look at a real-life example of this, we can consider BBC panorama's coverage of Winterbourne view (Cafe, 2012). This case-study highlights how staff members' dislike towards their clients resulted in malignant alienation and emotional contagion amongst staff. These in turn can be seen as contributory factors for the institutional neglect and abuse that took place. As practitioners, we are all vulnerable to malignant alienation but if we can become more aware of the process of malignant alienation and the significant effect it can have on our work, we can take proactive steps to avoid it altogether, and to manage it when it arises. This in turn will improve our own emotional well-being at work, and also have a positive impact upon the well-being of those we support.

Why Does Malignant Alienation Occur?

A number of factors have been identified in the literature that can contribute towards the process of malignant alienation. Some of these are universal factors that explain why people dislike others in their everyday lives, such as resenting an individual due to differences in their attitudes, beliefs or values, an apparent lack of cultural competency or personal habits that you find difficult to tolerate (Natwick, 2017). However, some factors that contribute to the process are more work-specific and are related specifically to the job. This may involve individuals overstepping boundaries or questioning your professional competence. In this article, the focus will be on some of the key factors that may contribute towards malignant alienation specifically from our field of work, which involves working with individuals with autism, intellectual disabilities and other neurodevelopmental conditions.

Difficulties Forming Relationships

Individuals with autism or other neurological conditions can experience difficulties with social communication, which may contribute to difficulties forming and maintaining relationships and can result in higher levels of social isolation. Social communication is complex and challenging, especially for an individual who has a more limited understanding of social cues, social imagination and differing levels of empathy. These difficulties in forming “warm, interdependent relationships” can put individuals more at risk of experiencing dislike from the practitioners who work with them (Watts & Morgan, 1994; p.11). However, at this point it is worth noting that difficulties forming relationships are not one-sided, as relationships are a two-way street. This is summarised well by Milton’s (2012) theory of the ‘double empathy problem.’ In relation to the autistic community, Milton states that, while people with autism may have social

understanding difficulties and lack insight into social nuances, “it is equally the case that non-[autistic] people lack insight into the minds and culture of autistic people” (Milton, 2012; p. 886). Neurotypical practitioners may struggle to empathise with autistic individuals, and as a result label their behaviour as pathological and in need of ‘fixing,’ rather than recognising the functional purpose behaviours may serve for the individual (McDonnell & McCreadie, 2019).

Interdependency can be a difficult construct in care environments, as often there is a perceived power imbalance in the therapeutic relationship. This can put the neurodiverse individuals we support at greater risk of malignant alienation as a perceived power imbalance can stand in the way of them forming meaningful relationships with staff. As Pitonyak (2005a) highlighted, it can be very difficult for individuals when their only meaningful relationships are with professionals who spend time with them as part of their paid role. These relationships can feel one-sided, as the individual may feel that while they depend heavily on their care staff, this dependency is not reciprocated. This can be very detrimental to the formation of safe and trusting relationships, as “we all need to be needed” (ibid.; p.5). These difficulties can be confounded by the inconsistency and high staff turnover that is unfortunately often prevalent in care environments. People with disabilities or mental health concerns can have a vast number of professionals coming in and out of their lives over the course of their lifetime. It is no surprise that individuals may struggle to trust staff members if they are consistently absent or changing. This can make the individual’s world more unpredictable than it needs to be, and can increase the frequency of behaviours of concern.

Difficulties Communicating Needs

Those who have "an inability to express directly dependency needs" may be at higher risk of experiencing malignant alienation from the staff who support them (Watts & Morgan, 1994; p.11). Individuals with autism, intellectual disabilities or other neurodevelopmental conditions may have verbal communication difficulties, whereby they struggle to articulate their needs and wants to those around them. For many of these individuals, the world is an inconsistent and unpredictable place that they are trying to navigate (McDonnell, 2019). Without the ability to effectively communicate their needs, they may feel that they are navigating this unpredictability alone. As a result, they may become hypo- or hyperaroused, and might engage in behaviours of concern as a way of communicating their unmet needs. As Tyrell (2021) notes, we should be meeting individuals where they are *at* rather than focusing all our attention on where we think they *should* be.

Beliefs and Biases

The way practitioners perceive behaviours of concern can also be a critical component to the malignant alienation process. When an individual engages in a behaviour of concern to express their needs or wants, staff often perceive these behaviours as "provocative, unreasonable or overdependent" (Watts & Morgan; 1994, p. 11). This is particularly true when individuals are displaying physical aggression, as staff are much more likely to categorise them as *difficult to treat* (Watts & Morgan, 1994). This limited view of behaviour implies that individuals always have a large degree of control over how they react to a situation. Trying to find narrow and surface level explanations of behaviours can negatively impact interpersonal relationships (McDonnell, 2019). For example, if staff continually see a behaviour as *attention-seeking,* they are not

focusing on the unmet need behind the behaviour. By adopting this lens, staff are more likely to use punitive consequences in response to the behaviour and refrain from giving the individual what they have requested, as they may see this as 'rewarding' the behaviour and 'giving in.' Let's consider the example of a teenager who engages in self-injurious behaviours. If we viewed this behaviour as attention-seeking or manipulative and punished the individual, we would be narrowly focusing on the physiological side of the problem. This unhelpful understanding of the situation would fail to recognise the unmet emotional needs that underlie and drive the behaviour. For some individuals, self-harm may serve as a "survival strategy" and might be their best attempt at communicating their struggle to others (Hadfield *et al*., 2009; p. 755). The more control we attribute to an individual for their behaviour, the more negatively we perceive them and the less willing we are to help them (ibid.). This can result in an increase in malignant alienation as we see individuals as being capable of deliberately deciding whether to engage in a behaviour or not. Furthermore, the more we blame and humiliate an individual for their behaviours of concern, the more likely the behaviour is to reoccur in the future (ibid.).

The perceptions we have of clients may result in harmful language being used between staff members when speaking about the individual when giving handovers or writing case notes. Language such as "violent," "dangerous," and "targeting" can create an atmosphere of fear amongst staff members. In addition, when individuals are labelled as difficult to work with they may be perceived as less worthy of treatment. Not only can fear and anger disrupt our ability to engage in empathic practice, they can also result in damaging reputations, emotional contagion and can ultimately fuel malignant alienation amongst other staff members.

Unrealistic Expectations

Practitioners may have unrealistic expectations of what individuals are capable or not capable of doing. This can be a key factor that fuels malignant alienation. The standards they set for individuals may be inflexible, unrealistic and may not adequately account for their complex needs. Take the example of an individual with a diagnosis of a severe intellectual disability: they may be at a different social developmental stage and may not have the capacity to understand what is being asked or expected of them. Expectations that this individual should always arrive on time to the sessions, ready and willing to engage in activities recommended in therapy, may be unrealistic and unhelpful. In this scenario, it would be unhelpful to view this individual in a negative light because they have failed to meet these expectations, as they may have different levels of competency and unfulfilled needs. If practitioners take an inflexible approach to working with clients who are highly vulnerable and distressed, they are likely to feel frustration if their expectations are not always met.

Malignant alienation may also occur as practitioners often have unrealistic expectations of themselves. They may expect to be *all healing*, and capable of liking and helping every individual they care for. However, this is not always the case as practitioners are only human. We all have our likes, dislikes and triggers, and unfortunately it is not as simple as turning these off when we go to work. When practitioners do not meet their unrealistically high standards, they may feel disillusioned with their ability to help and with the work that they do (Hadfield *et al*., 2009). If change is happening much slower than they expected it to, they can attribute the limited progress to the client, label them as hopeless and be more inclined to give up on them (Pembroke, 2009). Often as practitioners we are unwilling to acknowledge experiencing negative emotions towards our clients, and as a consequence can be

unconscious of the process of malignant alienation. This intolerance can be dangerous for the therapeutic relationship, as we are not being emotionally honest with ourselves or our clients.

What Can We Do About It?

When malignant alienation occurs it is extremely challenging for practitioners, and we must be mindful that our negative emotional response to a client does not affect our behaviour towards them (Natwick, 2017; p.20) There are six strategies that have been suggested by Watts and Morgan (1994) for detecting and managing the process of malignant alienation. These have been incorporated below and have been developed and expanded upon with insights from other practitioners on how to effectively deal with malignant alienation. These are all in keeping with a Low Arousal Approach.

1. Become familiar with the process

Firstly, it is important to understand the process of malignant alienation and the impact it can have on us as practitioners and those we support. A strong therapeutic rapport is central to the work we do, and is key to developing and maintaining positive relationships with our clients. It is therefore extremely important to be aware of the potential barriers and obstacles that may stand in the way of the development of these relationships. By familiarising ourselves with the concept of malignant alienation, we can better tune in to the emotional and stress reactions between people. Emotions are contagious, and it is therefore essential that we become more conscious of the strong negative emotions that may arise as a result of malignant alienation. If we are more attuned to this process, we can take the necessary steps and prevent these strong emotional responses from being played out in other ways, for example through neglect

of our client's needs (Watts & Morgan, 1994).

2. See behaviours of concern as a way of communicating needs

We should start by reframing behaviours of concern as a way of communicating unmet needs and emotional distress, rather than narrowly focusing on trying to reduce them. All behaviours are "meaning-full," and are messages to us that something important is missing for this individual (Pitonyak, 2005a; p.2). To shift our focus, we can begin by asking ourselves the following questions; Why does this person *need* to engage with that behaviour? And how can I meet their unmet needs in a different way? By simply including the word *need* in the question, we have already approached the behaviour from a different, more trauma-informed stance (Pitonyak, 2005b). Consider the difference between the following two questions: Why does John hurt himself? Why does John *need* to hurt himself? John might engage in this behaviour in an attempt to self-regulate, as a way of communicating to those around him that he is struggling, or in an attempt to avoid hurting others. There are numerous possible underlying causes, highlighting the importance of focusing on the *meaning* behind a behaviour rather than simply behaviour reduction. The more we try to step into the other person's shoes, the better we can understand their stress signatures and support them going forward.

3. Open discussion and reflective practice

Care environments are often not conducive to openly discussing the negative feelings or dislike we can experience towards a client, potentially because practitioners might worry it would be perceived as unprofessional and inappropriate. However, Winnicott (1949) believed that there was a power in being able to recognise and label these strong emotions, as well as a danger in leaving them unsaid. If we can open up the

discussion amongst staff and encourage them to share these negative feelings, we then allow ourselves more of an opportunity to try to understand and process these emotions. It is important to investigate these feelings rather than ignore them. As a note of caution, these conversations should always be done in an appropriate setting and for the purpose of reflection and learning, rather than to complain about clients or speak poorly of them to other professionals.

An investigation of these negative feelings can be done during debrief sessions where practitioners can talk to their colleagues, reconcile their emotions and receive emotional support. It can also take place during individual supervision. This allows practitioners to reflect on their personal experiences and look deeper at what aspects were the most challenging for them (Hadfield *et al*., 2009). Getting an outside perspective can help practitioners process their emotions and distance themselves from them. It can also reveal important information about the power dynamic in the relationship. This process is often very beneficial in moving the therapeutic work onwards. It may also aid early identification of a lack of therapeutic alliance, which will be discussed in more detail later.

Team reflective practice sessions are another important resource that can be used to support staff to look at themselves, their beliefs and reactions (see section 4 below), as well as to look at the situation from the client's perspective. This allows staff to evaluate together why the individual they are supporting *'needs'* to engage in particular behaviours, so they can then start to develop a shared understanding of the individual and of their behaviours of concern. Meaden and Hacker (2010) talk about the usefulness of staff teams developing a shared understanding of a client's internal world, the function of the client's behaviours and staffs' own beliefs and attributions about their behaviour. They advocate for team supervision and reflective practice as

a way to develop this shared understanding.

4. Look at staff vulnerabilities and expectations

Often as practitioners, we are too quick to assume that the problem lies within the individual we are supporting, rather than looking at our own vulnerabilities. By shifting the focus to our own responses and behaviour, we can start to evaluate our expectations of clients, the power messages we might be communicating, and the way we are interacting with the individual. It can be very difficult to remain objective when individuals we are supporting provoke negative emotions in us that are related to our personal experiences (Natwick, 2017). By fostering a greater self-awareness of our own vulnerabilities and insecurities, we can better identify situations that may be challenging for us. This allows us to prepare in advance for how we would like to deal with them when they come up, and cope with them afterwards. We also need to explore our own coping mechanisms, and evaluate whether these are harmful or sustainable (Hadfield *et al.,* 2009). It may be a case of re-evaluating these and developing more positive and workable ways of managing our difficult emotions, such as debriefing with other staff, engaging with reflective supervision and taking time for self-care to prevent compassion fatigue and burn-out.

5. Early identification

It is important to identify individuals who are struggling to progress and take time to make any improvements. The earlier we do this, the better. When practitioners start to develop negative feelings towards an individual because they are not progressing at the pace they would like or expect them to, they often try to turn their countertransference hate into the opposite (Watts & Morgan, 1994). In simple terms,

they become very anxious to help the client and develop a tendency to "over-prescribe and over-hospitalise" (Watts & Morgan, 1994; p. 13). As Natwick (2017; p.22) said, practitioners must not over-diagnose and give an "inappropriate diagnosis based on their own feelings about clients." When working with difficult clients, it is unprofessional and unhelpful to allow our own biases and heuristics to affect our clinical judgements (Merten *et al*., 2017). Instead of over-relying on diagnoses to explain behaviours, we need to start asking ourselves a number of key questions, such as *'Why does the individual need to engage with that behaviour? Am I helping them in the best way I can? Am I making the situation worse for them?'*

Another key factor to identify early is whether there is a lack of therapeutic alliance between you and the individual you are supporting. Relationships need a balance between compassion and acceptance, and can take time to develop (McDonnell, 2019). There can be advantages to persisting with a client and giving the relationship time to develop, even if there are difficulties along the way. As practitioners, we can learn a lot from a rupture in the therapeutic relationship, and often the process of repairing this can be powerful and go on to strengthen the relationship in the long-term. However, in saying this, it is important not to alienate clients by continuing to support them in a way that is not helpful for them (Pembroke, 2009). Some professionals would argue that having a basic fondness for your client is essential to the success of therapy (Maroda, 2009). However, Baker (2009; p.58) emphasises the importance of reframing the way we think about this: "The issue is not whether you like someone, but whether you can provide competent service." If the antipathy you feel towards a client cannot be overcome and you feel you can no longer deliver the service that your client needs, it is not a failure to refer them on to another professional.

6. Involving significant others

As Watts and Morgan (1994) highlighted, it can be beneficial to involve an individual's family or a close friend in the therapeutic process. This can be particularly helpful for clients who have difficulties communicating their needs. Their family or friends might be able to help enhance communication and understanding between the practitioner and client by reinterpreting and reframing information in a way that is more accessible for the client (Fidell, 2000). It can be an important learning tool for the practitioner, as they build on the individual's strengths and learn more about what is the most effective communication style for them. This systemic style of working may offer an insight into the client's lived experiences, and can be an effective way of demonstrating the practitioner's desire to understand this experience (Flaskas, 2004). If done in a sensitive and respectful manner, this experience can strengthen the therapeutic relationship, deepen empathy, and shift the perspective of both the practitioner and the client.

Conclusion

As has been discussed, there are a number of factors that can contribute towards the process of malignant alienation. However, by being reflective, proactive and taking preventative steps, we can better manage these negative emotions as they arise. Confronting these strong negative feelings can be a difficult process; however, it is not something that practitioners are expected to go through alone. Work environments that encourage practitioners to debrief and reflect with their colleagues and allow staff to feel more comfortable and supported can consequently have a very positive impact on the outcome of their work.

Exploring feelings of aversion is a worthwhile and rewarding practice. It

encourages us to reframe and challenge some of our own biases and vulnerabilities, and also ensures that we continue to support our clients in the best way possible.

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