



Experiences of Complaints about Counselling, Psychotherapy and Casework: Voicing the Need for Accountability and Care

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Experiences of Complaints about Counselling, Psychotherapy and Casework:
Voicing the Need for Accountability and Care

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Submitted in fulfilment of the requirements of the degree of

Doctor of Philosophy

July 2013

I declare that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or part, for a degree at this or any other institution.

Deborah Sauvage

(31/7 /2013)

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This thesis could not have been achieved without the contribution of the twenty-two participants who gave of their time, energy and trust to talk with me about sensitive matters. My hope is that I can show how much I value their contribution by using it constructively.

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DEDICATION

To Albert, Claire and Luke

In honour of love, endurance and care

Abstract

The original contribution to knowledge that this thesis provides is Australian qualitative data about experiences of complaints regarding the practices of practitioners providing counselling, psychotherapy and casework. At present, only psychologists and psychiatrists providing such ‘talking cures’ are required in Australia to be registered and accountable by law, whereas a range of other occupations such as counsellors, psychotherapists, and social workers may choose whether or not they become a member of, and therefore accountable to, a voluntary professional association. Findings from this research are aimed at increasing knowledge about the dynamics associated with complaints, as well as a range of harmful and problematic practices that lead to complaints.

This research project was designed to address gaps in previous research which tended to focus on harm to clients due to sexual boundary violations as well as on patterns in complaint statistics. Qualitative data which voiced the lived experience needed to be sought and power dynamics needed to be made more visible. Therefore feminist theory and phenomenology were chosen to provide the conceptual framework for the methodology. Qualitative interviews occurred with twenty-two participants who were recruited in three groups: third party complainants; respondent practitioners; and complaint managers. Data across all participant groups was thematically analysed and themes emerged in three areas: impact, power and needs associated with experiences of complaints. Within the cases discussed by participants, there was evidence of significant psychological trauma, barriers to reporting, a lack of ownership or management of power, and systemic failures in providing accountability and care. Findings provided rich data for discussion in terms of implications for legislation and policy, education and public awareness, best practice in preventing and responding to complaints, and areas for further research.

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Acronyms

AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
ACA	Australian Counselling Association
ACWA	Australian Community and Welfare Association
AHMAC	Australian Health Ministers Advisory Council
AHPRA	Australian Health Practitioners Regulation Authority
AIWCW	Australian Institute of Welfare and Community Workers
APS	Australian Psychological Society
COAG	Council of Australian Governments
GSCC	General Social Care Council (United Kingdom)
NASW	National Association of Social Workers (United States)
PACFA	Psychotherapy and Counselling Federation of Australia
RANZCP	Royal Australian and New Zealand College of Psychiatry

Chapter One

Introduction

This research explores the perspectives of Australians who have experienced decisions regarding complaints about the practices of practitioners providing counselling, psychotherapy or casework. It focuses on those in roles of third party complainant, respondent practitioner and complaint manager.

Significance of the Research Problem

When things go wrong with the provision of psychological and human services, this can be a critical, traumatic and life-changing experience for those involved. The practice contexts in which such services are provided are enormously complex, involve clients experiencing significant vulnerability, and practitioners who may or may not be well qualified or well resourced to carry out this work. Difficult, distressing, multi-consequential decisions about what to do and how to respond when something goes wrong and a complaint is made, are lived through by complainants, practitioner respondents and complaint managers. In Australia, such decisions are often made in the absence of effective legislation and regulation systems.

The right to complain about psychological services is important because providers of these services have the potential to harm clients. The right to natural justice if you are complained about as a practitioner is also important. A relatively small amount of international empirical research has been conducted which establishes that clients harmed due to ethical violations by human service practitioners experience acute distress, exacerbation of psychological and personal issues, major life derailment or suicide (Disch & Avery, 2001; Gabriel, 2005; Luepker, 1989; Nachmani & Somer, 2007; Pope & Vasquez, 2007; Schoener, Milgrom, Gonsiorek, Luepker, & Conroe,

1989). In Australia, this is also evidenced by a small amount of case study research by practitioners (Dawson, 1994; Quadrio, 1994), as well as cases presented at a conference regarding professional sexual abuse (Boeckenhauer, Michael, Ormerod, & Wansbrough, 1998), and cases presented in the media (Callinan & Murray, 2001; Callinan, Murray, & Ware, 2000; Cardy, 2009; Egan, 2009a, 2009b). Publicly available tribunal hearing proceedings also provided evidence of harm to clients (Australian Health Practitioners Regulation Authority [AHPRA], 2013a), and there are also some reports published in Australia that practitioner respondents have killed themselves during complaint processes (Callinan & Murray, 2001; Callinan et al., 2000; Middleton, 2004). Respondents have also self-reported to Australian and international researchers and practitioners that there have been serious impacts on their psychological health and career prospects, associated with complaints (Brown, 1999; Celenza, 2008; Celenza & Gabbard, 2003; Hedges, 1999; Schoener et al., 1989).

This research is significant because qualitative research about individual experiences of complaints about psychological services has not occurred in Australia before. It is timely due to a current agenda regarding regulation (Australian Health Ministers Advisory Council [AHMAC], 2013; Schofield, 2008a). This research project can contribute recommendations regarding complaint management systems in Australia based on the experiences of some of those whose lives have been affected.

Motivations

My primary motivation for undertaking this research has been an interest in the development of ethics literacy, as well as concern about the current gaps in regulatory provisions for a range of practitioners providing counselling, psychotherapy and casework. Before undertaking this research I had experiences which resulted in having

my 'ethics eyes opened' (a term I first heard from my principal supervisor). This process of opening up my eyes and more clearly seeing inherent ethical dimensions and power dynamics began when I completed my first dedicated ethics course as part of postgraduate coursework several years prior to the PhD. Through the ethics course I began to engage with ethics at a level I had not previously experienced. To further my journey in gaining a greater understanding of ethics I explored literature about ethics, harm and regulation. I was already attuned to some of the complexity and sensitivity of these matters, and of the limitations of regulatory arrangements, however I realised there was a significant gap in Australian research and literature about these complex topics.

The earliest published literature I could find about a case that had gone wrong was from overseas, in the form of diary excerpts found in an attic about a psychotherapy client's account of her experiences of harmful practice by a prominent psychotherapist in the early 1900s (Speilrein, 2001). During the century since then, there have been a wide range of other accounts and commentary published in books, in the media, and on the internet about cases of harm. These accounts demonstrated what I began to realise were serious and perennial risks inherent in therapeutic relationships. I also became alerted to the depth of complexity involved in assessing 'evidence' of verbal and non-verbal interactions that were inevitably unwitnessed in the privacy of sessions, yet extremely powerful in terms of their psychological impact.

From there I reviewed empirical research and found that there were distinct gaps. Most research had been pre-occupied with sexual boundary violations, focusing on occupational surveys of cohorts of psychologists, psychiatrists and social workers in the United States [US] regarding the self-report of, and knowledge of clients and practitioners involved in violations (Holroyd & Brodsky, 1977; Hutchinson-Mittendorf

& Schroeder, 2004; Strom-Gottfried, 1999; Wincze, Richards, Parsons, & Bailey, 1996) as well as quantitative data about patterns and types of complaints to a range of regulatory bodies (Reamer, 1995; Strom-Gottfried, 1999, 2003). Some Australian and international research established that sexual boundary violations were under-reported (Gallois & Griffin, 1998), that there were structural barriers and injustice in some systemic responses, and that being a victim of professional sexual abuse had deeply traumatic impacts (Boeckenhauer et al., 1998; Disch & Avery, 2001; Quadrio, 1994; Schoener et al., 1989). There was a lack of Australian data, although the little research that had been done in Australia confirmed what was found internationally, regarding the rate of incidence of sexual boundary violations (Wincze et al., 1996). There was also a scarcity of research about cases of harmful practices other than sexual boundary violations, although there was some research in the US about psychotherapy cults and mind control (Singer, Temerlin, & Langone, 1990).

The gaps in previous research signalled a need to focus on qualitative research, and also, to explore the experiences of people who could provide a range of perspectives on decisions regarding complaints.

Definition of terms

This research utilises broad rather than narrow definitions of key terms in order to reflect the breadth of the contexts in which people have experienced decision-making regarding complaints. According to the Oxford Online Dictionary (2013a) a **complaint** is “a statement that something is unsatisfactory or unacceptable, an expression of dissatisfaction, or a statement setting out the reasons for a legal action”. The terms **decision** and **decision-making** are defined by the Oxford Online Dictionary (2013b) as “a conclusion or resolution reached after consideration” and “the action or process of

deciding something or of resolving a question”. The terms complaint, decision and decision-making were used to refer to situations where dissatisfaction existed and where people had been involved with or impacted by decisions in relation to that dissatisfaction. These terms were used because of the need to focus on exploring the lived experience of the *impacts of others decisions* as well as *the process of deciding* in response to situations which involved dissatisfaction with the practices of a practitioner.

The terms **counselling, psychotherapy, and case work** were defined broadly for the purposes of this research. Although there are models which clearly and meaningfully differentiate these activities in theory and practice (Gurman & Messer, 2003), for many people it is difficult to define where counselling, psychotherapy, and casework begin and end. Burnard (1999) sought the views of health-care professionals and others both engaged in counselling or who taught counselling and psychotherapy, and found that respondents offered highly subjective definitions, with common points regarding helping, trust and expertise. Therefore, for the purposes of this research, complaints could be regarding the conduct of a range of qualified or unqualified practitioners who represented themselves in a ‘helping’ role that was perceived as counselling, therapy, or casework which involved interpersonal interaction from a position of expertise and power, and which invoked trust.

The range of **practices** within the broad definition of counselling, psychotherapy and casework included the use of any method, interpersonal micro-skills, intervention, ‘healing’ ideology or paradigm that was *represented to clients* as being in the interests of their wellbeing and personal development. Therefore this definition allowed the inclusion of traditional and non-traditional practices, so long as these were represented to clients that they were offering improvement to their wellbeing. Any service that involved *talking to someone* as a primary way of improving their wellbeing (rather than

making a *physical* intervention like a medical practitioner), or making assessments and referrals, was included in the definition.

When referring to the practices involved in complaints, the terms **problematic, inappropriate, poor, impaired, unethical, harmful, exploitative, abusive or incompetent** are often used. These terms reflect the terminology used in a range of professional literature to describe unacceptable practices of different levels of seriousness.

The term **practitioner** was used as a generic term for any person who provided relevant services in roles that involved a position of expertise and trust, and the provision of a service. Practitioner was a preferred term to ‘professional’, and ‘occupation’ was a preferred term to ‘profession’, because the terms practitioner and occupation addressed any person in a range of occupational roles who practiced with clients, regardless of whether they had professional qualifications or not. This enabled the research to encompass unregistered and registered occupations. The term practitioner was also used because of the need not to identify specific occupations in order to decrease any risk that the cases discussed by participants could be identified, thus breaching confidentiality. A range of other generic terms were used to describe the organisations that were involved in complaint management, rather than specific organisation names.

Research Questions

Three research questions were asked:-

- 1) How do complainants, respondents and third parties describe, reflect on and understand their past experiences of decisions regarding complaints about counselling, psychotherapy or casework?

- 2) What do the perspectives and experiences of complainants, respondents and third parties indicate about dynamics of structural and relational power associated with complaints about counselling, psychotherapy or casework?
- 3) What specific changes need to be made by the industry to effectively address the needs of various parties involved in complaints about counselling, psychotherapy or casework?

Insider research

Robson (2002) defined an insider-researcher as having a direct connection with the research setting. As a social worker researching aspects of an industry that I am a part of, I am an 'insider-researcher'. However I did not have any direct connection with or prior knowledge of any of the cases or matters discussed with me by participants. Instead, my connection with the setting of this research has been that I have experienced 'moral and ethical distress' (Corley, 2002; Strom-Gottfried, 2006) about the risks to clients and the integrity of occupations due to unethical practices, including situations where there has been a lack of effective regulation. Strom-Gottfried (2006) highlighted both the need for, and the barriers to ethical action in response to moral distress. According to Corley (2002), who has written and researched about moral and ethical distress in the field of nursing, ideally, if possible, such distress should be acted on through positive coping strategies such as recognition of the distress, assessment and clarification of concerns, and requests for action by those who hold power. This is opposed to negative coping strategies such as distancing, and escape-avoidance, which are often the understandable response to such situations (Corley, 2002). In a sense, my role as an insider-researcher has enabled me to engage with the task of systematically exploring a very complex context as one way of addressing the moral and ethical

distress that I and many of my colleagues have felt about the lack of effective regulatory responses.

With this motivation in mind, I chose a methodology that did not pre-suppose what I would find out or test a hypothesis, but which was open and exploratory. I did this because it was important not to let the inevitable biases I hold as a result of my insider-researcher position, become a central influence on the findings of the research. I included three participant groups, complainants, respondent practitioners and complaint managers, because it was important that I sourced a range of perspectives rather than focusing on just one. I was aware of my insider-researcher-practitioner position and decided to “bracket off” (Crotty, 1998, p. 79) my own experiences as much as possible, especially in my contact with participants. I did however regularly discuss my own values and experiences and potential influence of these, in supervision throughout the research process. A wealth of new meaning emerged through the research process and whilst I did conduct the research as an insider-researcher, emphasis was placed on basing all findings on what was voiced by participants.

The Structure of the Thesis

After the introductory overview of the motivations, scope, definitions and structure used in the thesis, **Chapter Two** reviews of a range of literature in three categories. The first is a profile of regulatory arrangements within the discourse of ethics and moral philosophy. The second category is harmful practices and the third is complaints. In each category, literature is drawn primarily from countries where services such as counselling, psychotherapy and casework have been provided within industry domains similar to those in Australia. This includes a small amount of translated literature of European origin, as well as literature from the United States of

America [US], Canada, the United Kingdom [UK], and New Zealand. The literature reviewed in Chapter Two is not limited to previous empirical research, and instead takes a tour of a range of publications related to multiple aspects of the context of the research. This includes statistics about the numbers of registered, unregistered and voluntarily self-regulated practitioners, examples of first person narrative from a complainant, and a respondent involved in (separate) incidences of cases of harm, as well as a range of previous empirical research which provides evidence of the impacts of harm. Finally, Chapter Two reviews previous literature about complaints and reveals information about statistics and patterns, as well as case studies and examples of systemic limitations.

An overview and rationale for the research design is presented next in **Chapter Three**, including the conceptual framework. The research is informed by the epistemology of constructionism and the theoretical perspectives of phenomenology and feminism. The choice of both theoretical approaches was made because of concurrent needs to allow exploration of the phenomena that people experienced, and to focus on power. Theories from a range of phenomenologists and a range of feminists are explored in order to grapple with and make explicit the assumptions which informed the research framework. Because of the assumption that it was important to focus on power dynamics, Chapter Three includes a review of theory and models relevant to the analysis of power. This is justified because previous literature did not explicitly focus on the power dynamics associated with complaints and this study is designed to address this gap. The chapter then discusses the reasons why the methodology of qualitative phenomenological research was the most appropriate for such a sensitive and complex research topic. The three research questions are presented before an in-depth discussion of details about the conduct of the study, which involved semi-structured narrative

interviews and thematic data analysis. This includes details about pilot interviews, sampling, participant criteria, recruitment, data collection, and data analysis. Ethical considerations were considerable in this research and this is explored in detail, as well as a discussion of the strategies to achieve trustworthy qualitative research. Finally, Chapter Three discusses the methodological limitations, including those related to recruitment and data analysis.

As the first of three chapters about the findings from the research, **Chapter Four** introduces the three findings chapters, and then presents findings regarding the impacts of complaints. There were six themes regarding impacts. These findings supported and extended what had been found in previous research regarding the traumatic impacts of complaints, costs and barriers to complaints, and also revealed themes about expectations, emotions, and in some cases, learning and growth.

The next chapter, which reports findings about power, is significantly large, and for this reason **Chapter Five** is broken into three sub-sections. These are *cultural power*, *relational power* and *structural power*. These are grouped in one chapter in order to present the forms of power as a whole rather than to artificially separate them. A total of eighteen themes emerged within the three categories of power. The definitions for cultural, relational and structural power primarily emerged from the data and not from previous literature. Whilst it was expected, after reading a broad range of literature relevant to counselling, psychotherapy and social work, that relational and structural power would be present in participant accounts, in the process of data analysis, a very large third category, cultural power, appeared. Because of the paucity of any previous empirical research focusing explicitly on power dynamics associated with complaints, Chapter Five presents a theoretical discussion of power, which draws on the theories about power presented in Chapter Three, the methodology chapter.

The final findings chapter, **Chapter Six**, focuses on eight themes regarding a range of needs associated with decision-making regarding complaints. These themes affirm some of the findings in previous research about what consumers want and need in the aftermath of experiences of medical error. However, the paucity of previous empirical research specifically about the needs of parties to complaints and complaint managers means that these findings address a significant gap in previous research regarding complaints about counselling, psychotherapy and casework.

The conclusions and implications that arise from the research are discussed in the final chapter, **Chapter Seven**. This chapter provides an overview of the key themes of the research which are that there are layers of complex impacts associated with complaints, underestimated power dynamics, and a need for specialist knowledge, accountability and care. Implications and recommendations are then identified for legislation and policy, education and public awareness, best practice, and research.

Chapter Two

Literature Review

Introduction

This chapter provides a review of previous research and literature which informed the research topic, questions and methodology for this study. To date, no research project has been located nationally or internationally which specifically enquired about complainant, respondent and complaint manager experiences of decision-making regarding complaints about counselling, psychotherapy and casework. Over a decade ago O'Sullivan (1999) argued that in general, decision-making in situations of conflict has been under-researched in social work and psychological science, and it appears that this has not changed in recent years.

This research topic relates to many bodies of literature including professional misconduct, impaired practice, boundaries, exploitation, harm, regulation, complaints, ethics, power, and decision making. Despite all of these topics being relevant, it was not feasible within the word length of the thesis to review such a vast range of literature. Therefore specific bodies of literature were focused on for specific reasons. Literature providing a profile of the semi-regulated counselling and therapy industry was chosen because it helped to develop a robust knowledge of the context of the research. This literature informed an appropriate research design including strategies to manage any ethical risks. In addition, literature was also chosen for this review if it focused on harm and complaints. In accordance with a phenomenological stance first-person narratives were included as a means of valuing expressions of the lived experience. In accordance with a feminist stance, an inclusive approach was used to source a wide range of academic and non-academic literature from a diverse range of sources including journal

articles, books, web pages and the media. This was done to avoid privileging academic literature only, and to attempt to value diverse perspectives.

Although it is relevant, one of the bodies of literature that has not been focused on to a great extent is theory and research regarding decision making, or ‘decision research’ (Edwards, 1954). Decision research, as a field of psychology, dates back to the middle of the twentieth century. Classical decision theory (Edwards, 1954) and the rational choice model (Janis & Mann, 1977) are examples of widely cited research that focused on decision-making as an analytical-cognitive process. A new school of thought, called naturalistic decision-making (NDM) (Klein, Orasanu, Calderwood, & Zsombok, 1993) emerged, which is thought to more adequately explain decision-making under difficult conditions such as limited time, uncertainty, high stakes, vague goals, and unstable conditions. Despite the relevance of these conditions in the context of decisions regarding complaints, this study does not construct decision making as an analytical-cognitive process, nor does it explore or test any specific decision making model such as the NDM. Instead, it uses the terms ‘decision’ and ‘decision making’ firstly as a criterion for inclusion in the scope of the research. That is, participants must have in some way, experienced making a decision of some kind, in regard to one or more complaints. The focus beyond that was to explore the lived experience of individuals and their perceptions of the decisions made in the context of complaints. Therefore, this study does not focus on decision making theory, but the lived experience and context surrounding those people making decisions.

The influence of ethics and moral philosophy

This project has as its foundation, an agenda regarding ethics and moral philosophy. Therefore, at every stage of the research, including in the literature review,

ethics needs to be considered. As Rhodes (1991) stated, “Even in the way the questions are posed, one makes assumptions about the proper domain of ethics and its’ limits....a perspective which should be made more explicit” (p. 43). The philosophical and theoretical domains of ethics used in this research are consistent with a Socratic tradition of valuing reflective dialogue and thorough examination of a problematic situation, as well as valuing human rights, the virtues of professions, and feminist ethics of care, as opposed to utilitarian perspectives (Chenoweth & McAuliffe, 2012). One of the key philosophies critically reflected on throughout this thesis, is the ideology of individualism associated with neo-liberalism (Albrecht, 2012). It will be argued that the dominant ideology of individualism is often a source of limitation and problems when attempting to grapple with human needs associated with complaints.

Ethics sits within a paradigm which engages with philosophical discourse regarding structural power, social justice, natural justice and regulation. Natural justice is defined by Swain and Bigby (2009) as “open and clear processes of decision-making, which explicitly identify the evidence, the reasoning and the authority used to reach such a decision... [and which] can be challenged” (p. 339). Natural justice can be provided if there are laws to protect it and procedures that enforce it. Legislative decisions about whether or not rights to natural justice are provided and to whom, are influenced by embedded cultural and socio-political ideology. Regulation of the human service and health industry in Australia sits within a contemporary philosophical debate between classical laissez-faire liberalism which is opposed to government regulation, and social-democratic liberalism which favours some rights to welfare, and some responsibilities of governments to regulate. Freiberg (2011) examined the many approaches and principles embedded into different regulatory approaches such as therapeutic jurisprudence and non adversarial justice. Dworkin (1998) argued for a

deontological approach to rights. He said rights are extremely important moral concerns that require strong protection. He believes human rights should be provided for by law in order to ensure equal dignity and respect for individuals. However, the right of consumers to access complaint avenues about unregistered practitioners has not been provided through legislation in Australia, which presents barriers to accountability regarding the practices of many counsellors and therapists.

A range of literature has explored ethical foundations associated with counselling, psychotherapy and casework. Australian and international texts have been published with the aim of promoting ethical practice (for example, Anderson & Handelsman, 2010; Banks, 2010, 2012; Barker, 2011; Bland, Renouf & Tullgren, 2009; Chenoweth & McAuliffe, 2012; Geldard & Geldard, 2001; Guthiel & Brodsky, 2008; Morrissey & Reddy, 2006; Pope & Vasquez, 2007; Proctor, 2002; Reamer, 1995, 2001; Strom-Gottfried, 2004, 2007). These focus on a range of ethical principles including beneficence and non-maleficence. According to Barker (2011) professional ethics deals with what is good or bad and focuses on the conduct, practices and actions of practitioners. He critically reflected on the assumption within moral philosophy, and particularly within the ideology of individualism, that people have the capacity to actively choose what is right and wrong. He said, "In principle, ethics is only meaningful where people – or groups of people – are self-governing and have the opportunity to make choices free from any coercion" (Barker, 2011, p. 3). His point raises the issue that the legitimate expert power held by any practitioner in a helping role strongly influences clients' capacity for autonomous choice, and the structure of the relationship invokes client compliance. This is why there are extra responsibilities for practitioners regarding their conduct, and why it is within the role of the government to regulate.

Profile of a Semi-regulated Industry in Australia

Professional and occupational regulation. Occupational regulation is a significant feature of the political and economic context for complaints about counselling, psychotherapy and casework. According to Black (2002), “regulation is the promulgation of rules by government accompanied by mechanisms for monitoring and enforcement, usually assumed to be performed through a specialist public agency” (p. 11). Kingsford-Smith (2002) argued that law, power and social control are “adjacent ideas” (p. 38) enmeshed in any definition of regulation. Questions about whether government regulation works, and which regulatory models work best for particular occupations, are broadly relevant to this research context because participant perspectives on regulatory models were sought. However, it is not within the scope of this review to provide a detailed review of literature about professional and occupational regulation to establish whether there is evidence that a particular model of regulation works better than others when applied to occupations which provide counselling, psychotherapy and casework. It is also important to avoid an assumption that regulation in the form of national registration is the only and best solution, and to maintain an open stance on this issue.

Occupational regulation has a range of motivations and impacts. In research about the history and impacts of occupational regulation in the United States, Law and Kim (2005) described a “progressive era” (p. 724) where the government’s role in regulation increased significantly. They found that in the United States between 1900 and 2000 the percentage of the labour force engaged in technical and professional occupations increased from four percent to twenty percent) and by the mid- twentieth century there were more than 1,200 state occupational licensing statutes). In general,

they found that from an economic point of view, occupational licensing was primarily motivated by a professions interest in “creating a monopoly situation to limit competition and raise prices” (Law & Kim, 2005, p.724-725).

There was a trend away from self-regulation in the mid-twentieth century towards centralized government regulation in what Devlin and Heffernan (2007) called a “global tsunami against self-regulation” (p. 23), using the legal profession as one example. In their exploration of the benefits and disadvantages of self-regulation they highlighted autonomy and expertise as the core arguments for self-regulation and a lack of independence and conflict of interest as arguments against. Their concerns about a lack of independence were summed up as follows; “should we allow the fox to guard the chickens...or is it wise to put Dracula in charge of the blood bank?” (Devlin & Heffernan, 2007, p. 28).

Law and Kim’s (2005) analysis suggested a motive for regulation on the part of professionals to address what they called “asymmetric information” where the provider of the service has more knowledge and information about the service and should regulate it in the interests of promoting quality for consumers. In social work literature this asymmetry was, several decades ago, described as a ‘power imbalance’ because clients place trust in the expertise of the practitioner and the practitioner is responsible for acting in the interests of clients (Hasenfeld, 1987). Hasenfeld (1987) claimed that practitioner power was neglected in social work practice theory and that much more research and theory about power was needed. This was already the view of Heller (1985) who had observed at around the same time, that the most striking “oversight” in the literature on psychotherapy was the neglect of power. This historical oversight of the asymmetry of power between practitioners and clients is an important feature of the context in which the decisions about regulation of counselling, psychotherapy and

social work have been made. In Australia, for professions such as medicine and psychology, where the asymmetry is very clear, regulation has been in place for many years, yet in professions where the asymmetry of power between practitioner and client has been historically neglected, mandatory regulation is still not in place.

There is limited literature on the impacts of regulation specific to the professions which provide counselling, psychotherapy, social work and casework. However, Law and Kim's (2005) analysis of regulation data about key professions (focusing on eleven of the seventy-five occupations regulated in the US by the 1950's including health professions such as medical physicians, dentists, nurses etc.) found that increased occupational regulation and licensing reduced mortality rates from illnesses where the quality of physicians was likely to have made a difference; there was not a trend of increased gross or net physician incomes coinciding with increased regulation; there was an increase in costs of malpractice insurance and an increase in malpractice suits because licensing regulations defined practice standards more clearly and thus made it easier for consumers to sue for poor outcomes. They also found that occupations with a large number of practitioners, and those concentrated in urban areas had a greater chance of achieving regulation and licensing). Stricter regulation in some occupations such as medicine was found to have reduced the number of physicians per 1,000 population (Law & Kim, 2005).

In Australia, an important criteria for policy makers when considering mandatory regulation of a profession has been whether it poses significant risk of harm to the public (Council of Australian Governments [COAG], 2009; Cumming, 2008). This is consistent with the report of the Manitoba Law Reform Commission (1994), *Regulating Professions and Occupations*, which stated three factors which should be evaluated when considering the seriousness of a risk of harm: firstly, the likelihood of

its occurrence; secondly, the significance of its consequences on individual victims; and thirdly, the number of people it threatens.

As will be explored in more detail in the section of the literature review on harm, there is a considerable body of local and international evidence of the frequency and severity of harm due to the practices of those providing counselling, psychotherapy and casework. Given that complaints statistics are the primary source of quantitative evidence, there is an inevitable difficulty in measuring the scale of harm in a semi-regulated industry where practitioners may choose not to be accountable to any organization. There may not be formal avenues of complaint about these practitioners which would be represented in published statistics.

In summary, Australian research thus far has not focused on evidence for and against occupational regulation. Available evidence is in the form of complaint statistics in annual reports, and there are significant gaps in this data. It has not been established whether registration of the occupations of psychology and psychiatry has led to increased public safety, because deregistered practitioners may still practice using other occupation titles such as psychoanalyst, psychotherapist or counsellor. Australian research has also not focused on the impacts of voluntary self-regulation by social workers, counsellors and psychotherapists in terms of measuring public safety.

Overview of regulatory provisions in Australia. This research study is situated within the context of semi-regulated industries in which practitioners in a range of occupations provide counselling, psychotherapy, social work, case work and self development services. Semi-regulated means that some occupations are subject to mandatory statutory registration, others are voluntarily self-regulated, and others are not regulated at all. There are a total of 15 health professions in Australia registered with the

AHPRA (AHPRA, 2011). These include medicine and psychology as well as a range of other professions such as nursing, pharmacy etc. However, as stated above, despite a general trend of increased professional and occupational regulation over the past century in countries such as the US, the UK, Canada and New Zealand, counselling, psychotherapy and social work occupations remain unregistered in Australia. Social work, counselling and psychotherapy are self-regulated for those who choose voluntarily to join a professional association such as the Australian Association of Social Workers [AASW], the Australian Counselling Association [ACA] and the Psychotherapy and Counselling Federation of Australia [PACFA], and be bound by their rules. Then there are practitioners in the occupations of counsellor, psychotherapist, psychoanalyst, social worker, self-development counsellor, group facilitator, case worker, youth worker, community worker, support worker and a range of other titles, who are not a member of any professional association, but who also provide services that are received by members of the public as counselling, therapy, case work or self development services.

As mentioned in the introduction to this thesis, it is difficult to arbitrarily define which occupations do and do not provide some form of counselling. The lines defining various services are blurry and some industry discourse confirms this. For example, a training program titled “The Accidental Counsellor” was advertised on the website of the Australian Community Workers Association [ACWA] (ACWA, 2013a). Those advertising this course stated that counselling was often called for in a range of community, welfare and support worker roles, albeit in an ‘accidental’ way, rather than it being a core duty, and that basic training in counselling was important.

Up until recently, legislation in each Australian state has determined different accountabilities for registered practitioners. However, in July 2010, nine health

professions including psychology became regulated by AHPRA as part of a new national registration and accreditation scheme (AHPRA, 2011). Since then another six health professions have also become regulated including for example, Chinese Medicine, Chiropractors, and Podiatry. However, the arrangements for social workers, counsellors, psychotherapists and welfare workers are currently not included in the national registration scheme, as these occupations have never been registered in any Australian state (AHPRA, 2011). This is concerning because trained and untrained counsellors, therapists and social workers can and do represent themselves to the public as providing similar services as registered psychologists, yet these practitioners are not subject to the same accountabilities.

The arrangements regarding social work and human service work are very different to those applicable to other professions. Social work has not been regarded in legislation as a health or health related profession, and does not have an identity of its own in any legislation. For example, the Code of Conduct for Unregistered Practitioners legislated in the Australian state of New South Wales in August 2008, refers to psychotherapy and welfare services, health and health education services, masseurs, naturopaths and acupuncturists, but does not refer directly to social workers (Health Care Complaints Commission New South Wales [HCCC NSW], 2008).

Therefore, in the absence of formal registration, self-regulation models have developed for counsellors, psychotherapists, social workers and welfare workers. The self regulation models for counselling and psychotherapy were examined in detail by Schofield (2008a). Her key findings were that self-regulation in Australia needs to be viewed as a developmental process, that there are a range of models in place for voluntary professional associations at present, and that wider consultation needs to occur in order to establish and agree on the features of a jointly agreed best-practice

model. Schofield's (2008a) study also suggested that previous research has not yet established evidence about how and why particular regulation models work.

It is clear that the regulatory agenda in Australia is changing in response to a range of factors. There appears to be momentum of support within the industry for increased regulation of social work and social care. The AASW has actively pursued registration of social workers since 1968, and reviewed ethics and complaint management and revised by-laws on ethics in 2007, and the code of ethics in 2009/2010 (Chenoweth & McAuliffe, 2012). In 2012 the AASW launched a campaign to seek registration of the profession (AASW, 2013b), the outcome of which is unknown at the time this dissertation was submitted. In 2011, after being unable to seek mandatory registration, the ACA and PACFA formed a private company to provide a single national non-mandatory register of counsellors and psychotherapists, called the Australian Register of Counsellors and Psychotherapists [ARCAP] (ARCAP, 2012). The Australian Institute of Welfare and Community Workers [AIWCW] which was founded in 1969 and subsequently renamed the Australian Community Workers Association [ACWA] in May 2011 has an aspirational code of ethics but no complaint avenues (ACWA, 2013b) and it is not clear whether there is impetus to begin exploring the registration agenda (ACWA, 2013a).

A further regulatory avenue is provided to differing degrees by the health complaint commissions in each Australian State and Territory. Walton, Smith-Merry, Healy and McDonald (2012) recently found that among health complaint commissions in Australia there was considerable variation between jurisdictions in the ways complaint data are defined, collected and recorded. Clients of any health service practitioner can make a complaint to a relevant health commission, usually within one to five years of the incident. The commission will assess the complaint and may decide

to seek a response from the respondent. In the absence of legislation or statutory registration by a board, even if there are concerns about the practitioner, the most a health commission can do is retain the file and possibly use provisions for reporting systemic issues (i.e. multiple serious complaints) regarding a health provider to the Health Minister, who may choose to initiate a parliamentary inquiry. A significant implication of the lack of legislation regarding unregistered providers is that individual client grievances about unregistered providers are unheard and unsanctioned because action can only be taken on systemic issues.

It is important to recognize that registration bodies, voluntary professional associations and health complaint commissions provide only some of the regulatory avenues that are available, and that they only apply to a limited number of practitioners. Complaints about practitioners who provide counselling, psychotherapy and casework may be dealt with in a range of other ways which will be discussed in reference to the literature on complaints, below.

Profile of registered and unregistered practitioners in Australia. While it is possible to clearly define the numbers of registered practitioners such as psychologists and psychiatrists, it is unclear how many practitioners there are in other relevant occupations. There are two reasons for this. Firstly, Australian Bureau of Statistics Census data uses a range of codes of occupations and relies on uncorroborated self-report by members of the public regarding their occupation. Secondly, up to date and precise data about membership of professional associations is not publicly available for all professional associations (such as ACWA and the member associations of PACFA). Nonetheless the following tables provide some of the data from a range of relevant sources. The available figures point to a significant pool of practitioners whose activities are not subject to any formal regulation.

Australian Government Statistics. Statistics from the 2006 and the 2011 Census of Population and Housing (Australian Bureau of Statistics [ABS], 2006, 2011) are provided for comparison of numbers of individuals in a range of occupation who would be considered to provide counselling, psychotherapy and casework services (see Table 1). Two key features are highlighted in the census data. Firstly, the size of the workforce is considerable, and makes up a significant, increasing percentage of the Australian labour force. In 2006 the 84,567 practitioners in seven occupations represented approximately 0.43% of the total number of Australians over 15 who were asked to report their occupation and who adequately described their occupation. In 2011, the number of practitioners in these occupations increased to 106,244, which is 0.49% of occupied Australians (ABS, 2006; 2011). Secondly, in 2006, and 2011, the unregistered occupations of social worker, counsellor, and social health and welfare worker were in much larger numbers (68,927 in 2006 and 85,055 in 2011) than the two currently registered professions, psychiatry and psychology (15,620 in 2006 and 21,189 in 2011). The data suggests a significantly large self-regulated and unregulated pool of practitioners.

Table 1

Overview of Australian Bureau of Statistics Census Data 2006 and 2011 – Self-Report of Occupation

OCCUPATION	AUSTRALIAN BUREAU OF STATISTICS	
	Census of Population and Housing	
	Census 2006 Self Report of Occupation – (Occupation 06 (ANZSCO) (OCC06P)	Census 2011 Self-Report of Occupation - (OCCP [11]- 4 Digit Level)
Psychologists	13,440	18,603
Psychiatrists	2,180	2,586
<i>SUBTOTAL Registered Occupations</i>	<i>15,620</i>	<i>21,189</i>
Social Workers	12,443	16,912
Counsellors	14,652	16,350
Health and Welfare Support Workers	684	776
Welfare Support Workers	40,298	50,205
Social and Welfare Professionals	850	812
Psychotherapists, Psychoanalysts	Occupations not specifically coded in ABS data	
<i>SUBTOTAL Unregistered Occupations</i>	<i>68,927</i>	<i>85,055</i>
TOTAL Registered and Unregistered Occupations	84,547	106,244

Registration data from the Australian Health Practitioners Regulation

Agency. The AHPRA Annual Report indicated that there were 29,142 registered psychologists in 2011(AHPRA, 2011). This is a much larger number than the self-report of occupation from the 2011 Census, which stated the number of psychologists as 18,603 (ABS, 2011). This suggests that more than 10,000 individuals registered and qualified in psychology may not be working in occupations using the title psychologist. While some registered psychologists may report their occupation as psychotherapist, psychoanalyst or counsellor, it is likely that many of the 10,000 psychologists are employed in academic, senior administrative or research positions, rather than in professional psychotherapeutic practice. Since the number of practising psychiatrists was not specified as a category of the general registrations statistics of the 88,293 medical practitioners (AHPRA, 2011), it is not possible to corroborate that data source with Census self-report statistics. However, it is the case that there are 3,500 Fellows of the Royal Australian and New Zealand College of Psychiatrists [RANZCP], which is approximately 1,000 more than was identified through the Census (RANZCP, 2013). It is likely that just as with registered psychologists; many psychiatrists are also employed in academic, senior administrative or research positions, rather than in professional psychotherapeutic practice.

Membership data from voluntary professional associations. Another source of information about the profile of occupations which provide counselling, psychotherapy and casework is the membership of voluntary professional associations. Available membership data for six voluntary professional associations is provided below. This data has significant limitations. For example, some associations do not provide information about membership numbers, and also, it is likely that some individuals may be a member of one or more organizations. For example, a psychologist may be a

member of the Australian Psychological Society [APS], the ACA and PACFA. A social worker may be a member of the AASW, the ACA and PACFA. Each individual could account for three different membership statistics.

Current data about membership of a range of voluntary professional associations demonstrates that it is likely that less than half of practitioners in unregistered occupations choose to be a member of such associations. The AASW reported its membership as “more than 7,000 members nation-wide” (AASW, 2013a), compared to the Census data reporting 16,912 social workers in 2011 (ABS, 2011). The ACA stated that the “ACA is Australia's largest single registration body for Counsellors and Psychotherapists with over 3,000 members” (ACA, 2013a). There are currently 31 member associations of the Psychotherapy and Counselling Federation of Australia (PACFA, 2013). Current data was not available from the PACFA website about the individual memberships of these member associations, nor about the number of practitioners registered on the PACFA register. However, Schofield (2008b) mailed a survey (p. 5) in 2004 to all members (approximately 3,000 total) of the 41 professional associations then affiliated with PACFA. Data about ACA and PACFA memberships makes an approximate total of 6,000 counsellors and psychotherapists, compared with the 16,350 reported in the Census (ABS, 2011).

No information about member numbers of the ACWA was available on their website. In 2009, there was no data on membership numbers available on the AIWCW website. However, the AIWCW (personal communication, March 3, 2009) reported that “in 2008 there were 633 registered members. Over the past 4 years there have been 1,110 different registered members”. Data from the Australian Institute of Health & Welfare [AIHW] (2007a) stated that in 2005-2006, 481,000 people were employed to provide welfare services. These figures point to a very sizeable, unregulated workforce.

Another source of data regarding membership of professional associations has been survey research. Whilst member surveys have not been published about members of the AASW or the ACWA, information about the profile of providers of counselling and therapy in Australia can be sourced from workforce surveys of members of the ACA and PACFA. These two surveys provided descriptive data relating to a combined total of 577 individuals, out of a possible 6,000, who were members of ACA or PACFA (Pelling, 2005; Schofield, 2008b). Despite inducements (free books) and the option to complete the survey online or on paper, only 289 out of 3,000 ACA members returned a survey (Pelling, 2005). The return rate was very similar for Schofield (2008b) with the PACFA survey – 288 out of 3,000. The majority who returned surveys were middle aged women in urban areas. A 9% return rate for each project is very low, and therefore conclusive generalizations cannot be made based on the data (Pelling, 2005; Schofield, 2008b).

However, results point to some concerns regarding the commitment to ethics and the level of training for the members who responded. In the ACA survey, a quarter of respondents stated they did not follow any ethical code or guidelines in their work or did not give a response to this question (Pelling, 2005). Forty-one percent reported receiving their training and qualifications from private providers, forty-one percent from universities, six percent from TAFE, and five percent were self trained or mentored, and the remainder did not indicate their training source (Pelling, 2005). This is very different to the education and training requirements for psychologists where 90% of postgraduate programs in psychology teach ethics and professional practice (Davidson, Garton, & Joyce, 2003).

The PACFA survey found that respondents described their occupations as counsellors (42.4%), psychotherapists (33.3%) and 'Other' (24.3%). Just over half

(51%) were in private practice, 19.7% in a non-government organisation or community agency, 12.4% were in health, and 17% rated their work sector as 'Other'. Interestingly, 82.5% of those who defined their occupation as psychotherapist were in private practice, compared to only 40% of those who defined themselves as counsellor, and 21.4% of 'Other'. It is unknown what 'Other' means, (Schofield, 2008b), and this suggests that the professional identity of those providing services may not be strong.

Pelling (2007) conducted survey research of a sample of advertised Australian counselling psychologists regarding their practice details and self-perceived competence, with a return rate of 62.2%. All were members of the APS. Results again indicated the majority of respondents were middle aged women in urban areas. A small proportion (3%) reported that they did not follow an ethical code and 43.1% indicated burnout was an issue (Pelling, 2007).

These findings establish the lack of uniformity of training levels and commitment to ethics of providers of counselling and psychotherapy. Members of the public are provided with counselling services from some practitioners who have a degree, are committed to an ethical code and are supervised, and some practitioners who do not have any formal training, do not commit to an ethical code, and are not supervised. Valuable comparative data could be sourced if a similar member survey was conducted by the AASW and ACWA of their members. The very low return rate of self-report surveys by counsellors and psychotherapists who are members of ACA and PACFA suggests a lack of practitioner commitment to transparent reporting of their activities. Respondents may have been too busy to return surveys. However it could also indicate an unwillingness to reflect on identity and competence.

Clients of counselling, psychotherapy and case work in Australia.

Despite high rates of psychological distress in Australia, some research has suggested that less than a third of those experiencing such distress seek counselling (Parslow & Jorm, 2000; Schofield & Khan, 2008). Those who do have been found to be tertiary educated individuals, predominantly women, those who are single, separated or divorced, experiencing anxiety or alcohol/substance dependency (Parslow & Jorm, 2000; Schofield & Khan, 2008). Data showed that two thirds of those 17 % of Australians with diagnosed mental health disorders did not use mental health services, and if they did, they saw their GP (Henderson, Andrews, & Hall, 2000).

It is difficult to assess the profile of clients of case work. This work occurs in a variety of government and non-government contexts for which there are a wide range of possible data sources. The AIHW (2007b) reported that in 2003 1.2 million people (6.3% of the population) had a severe or profound core activity limitation, and needed personal care or welfare service support. Therefore a lot of case work may be associated with those who have a disability. In addition, groups who use welfare services are identified in data as people who are unemployed, from a low socio-economic background, homeless, culturally and linguistically diverse, and indigenous (AIHW, 2007c).

On a societal level, there is evidence that there is a negative stigma associated with people who are vulnerable psychologically, in personal crisis, who have mental health issues, and who seek help from the helping professions (Barney, Griffiths, Jorm, & Christensen, 2005; Coverdale, Nairn, & Claasen, 2002; Crisp & Gelder, 2000; Jorm, Christensen, & Griffith, 2006). The pervading stigma, self-stigma, negativity and devaluing of people with mental health issues is likely to impact how complainants and clients are perceived, the services they receive, and the rights they are given.

Lack of consumer understanding of regulation. A further important point about the environment in which counselling and therapy have been provided in Australia, is that there has been a distinct lack of accurate consumer understanding about regulatory arrangements. According to a poll by Roy Morgan Research (n=18,465) commissioned by the AASW, consumers and the general Australian public have major misperceptions of the regulatory requirements of counsellors and qualified therapists, and also, that these generic terms may be used to refer indiscriminately to a wide range of occupations (Craig Hodges Consulting Pty Ltd, 2011).

Of those polled 49% were male and 51% female, with 62% residing in urban areas whilst 38% resided in a rural location. 63% believed that a degree, either at under- or post- graduate level was required to practice as a counsellor or therapist; 14% thought that a Diploma from TAFE or a private college was required. Only 3% indicated there was no need for a tertiary qualification (Craig Hodges Consulting Pty Ltd, 2011). After being asked about the event of a counsellor being found guilty of a serious issue about their behaviour or skills, 91% of respondents believed the counsellor could be struck off or banned from practicing; 80% believed they could be disciplined at work, whilst 78% believed they could be asked to undergo further supervision and training. 87% of respondents believed that it was true that counsellors were required to continue professional training to keep skills up to date, and 7% believed this was not true (Craig Hodges Consulting Pty Ltd, 2011).

It is clear from this research poll that members of the public did not have accurate views about the current regulatory provisions for counsellors and therapists, and are unaware that for many practitioners, there is no formal accountability or power to sanction or ban them from practice. There was also a lack of awareness that counsellors do not require any formal training.

In summary, the information presented in the previous four subsections regarding the profile of the semi-regulated industries in which counselling, psychotherapy and casework are provided, reveals inequity in the registration and accountability status of different occupations. There is a large pool of unregulated practitioners about whom there is very limited information, unclear standards of ethics, supervision and training, and unclear avenues for complaints. Data also suggests that users of these services are likely, for counselling specifically, to be women, and in general, people who are experiencing life crises and vulnerabilities of various kinds and who therefore may be subject to negative stigma. Consumers of services may also not have accurate perceptions of the qualifications and regulatory provisions of service providers.

The literature about regulation and a profile of practitioners and consumers has been reviewed as a means for attempting to grasp the context for this research project, and the next section of this literature review will focus on the basis of complaints – harmful practice.

Harmful and problematic practices

Types of harmful practices. Harm from the actions of practitioners providing counselling, psychotherapy or casework usually forms the basis for complaints. There appears to be contention among legislators in Australia about whether or not the currently unregistered occupations of social work, psychotherapist and counsellor, present a significant risk of harm to members of the public to warrant registration. As stated above, one of the criteria that a profession must meet in order to be registered is “Do the activities of the occupation pose a significant risk of harm to the health and

safety of the public?” (COAG, 2009). The range of literature below provides clear evidence that the answer to this question is yes.

Table 2 presents a list of terminology and language found in literature to describe practices that are abusive, unethical, and associated with harm or no benefit. The list includes annual reports of complaint organizations as well as research and narratives in a wide range of publications. It is apparent that there are many ways that clients can be harmed in an industry which aspires to first, do no harm. In addition, the list also illustrates the complexity of the types of allegations respondents may be required to respond to, and the burden of responsibility for complaint managers when responding to allegations of these types.

Table 2

Types of Harmful Practices by Practitioners of Counselling Psychotherapy and Casework

-
- Illegal activity which harms a client (including assault, paedophilia)
 - Boundary transgressions, violations and abuse of trust including sexual involvement; verbally sexualizing or romanticizing therapy; financial dealings; dual relationships; use of inappropriate touch; personal disclosure issues.
 - Psychological exploitation including cult-like techniques and ‘mind control’, or those involving pseudo-spiritual ideas and ‘magical thinking’ where the therapist imposes a distorted view of reality from an expert position; psychological grooming for dependency and exploitation financially, psychologically, emotionally, spiritually, or sexually; use of expert position to invade clients capacity for boundary setting, to use authority to unreasonably direct clients’ major life decisions.
 - Unclear or non-existent contracting about limits of service or expected outcomes; over servicing or under servicing; failure to provide grievance or restitution procedures.
 - Lack of thorough assessment, effective intervention, or referral
 - Contravention of clients’ rights to confidentiality, poor or inaccurate reporting or note taking.
 - Practitioner impairment, workload stressors, burnout, moral distress
 - Dominance of therapists’ values, beliefs, advice, or method of therapy in a manner that is disempowering or harmful for the client.
 - ‘Empirically’ unproven or questionable methods without a clear evidence base, lack of knowledge of neuroscience, trauma and mental health-specific issues.
 - Problematic approaches to transference and counter transference.
 - Mismanagement of ‘therapeutic alliance ruptures’ and ‘termination’.
 - Distant, cold, unengaged manner, lacking in human quality.
-

A range of literature provides information about how these types of harm occur in the practices of counsellors, psychotherapists and caseworkers. The literature shows that harm can be caused by professional misconduct, client exploitation, poor practice, practitioner impairment, or treatments that are risky for clients or do not lead to improved well being. In a review of international literature regarding professional impairment, the rate of practitioner impairment across health professions was cited at between 5-15% (Wingenfeld-Hammond & Freckleton, 2006). Some literature also suggests that harm can be entirely unintended, and not related to misconduct or impairment (Gartrell, 1998; Gutheil & Brodsky, 2008; Kottler & Carlson, 2003; McAuliffe, 2005a; Pope & Vasquez, 2007). It can result from use of methods that have been deemed suitable by the industry but which do not work in some cases (Lilienfeld, 2007; Roback, 2000). Grunebaum (1986) found that harm was reported by clients who experienced therapies characterized as distant, cold, unengaged, and lacking in 'human quality', or therapies characterized by intense emotional and/or sexual involvement.

When reviewing literature about harm, a range of sources can be used. Each source offers a different focus and builds a broader understanding of the many representations of harm. For example, annual reports for registered professions provide information about complaint types and harmful behaviours in succinct but ambiguous categories, including: - inappropriate conduct; inadequate treatment; boundary issues; fees; inappropriate communication; breach of confidentiality; workplace issues, inadequate report (AHPRA, 2011) While it is difficult to ascertain from such broad descriptors, what happened in these cases of complaint, transcripts of specific complaints can be located on the public pages of the various Tribunal websites.

By comparison however, internet searches about harm from counselling, psychotherapy and casework with a range of relevant search terms produce millions of

'hits' (specific references too many to cite here). These provide access to intimate blogs about sexual abuse by practitioners, confusing feelings for counsellors and difficult decisions about how long to keep paying for more sessions during crises when nothing is getting better, family members concerned about their loved ones receiving treatment from cult-type charismatic therapists, blogs after nervous breakdowns and uncontrollable and debilitating flashbacks to childhood abuse while receiving counselling. One such example is Brittany Morgan (pseudonym) (2013) who wrote:

Then we broke into smaller 'anger areas' where we sat in a circle...But then the man next to me grabbed an oversize bat at the center of the circle and started pounding a big pillow just a couple of feet from where I sat. He was a big man, maybe 6'3", and as he continued pounding, others in the circle shouted out to provoke him... Everyone in the room was screaming, shouting, crying -- so much raw energy that I could feel every heartbeat in my throat... The person in the center [sic] of the circle would get more enraged, more rattled, until often he or she would experience flashbacks -- memories of painful experiences that somehow felt real and present again...The more memories we dredged up, the more praise we got, the more we were 'progressing'. What I didn't know then was that most therapists would never encourage this exhausting pace.

(Morgan [pseudonym], 2013, p. 1)

The internet also provides accounts of discriminatory advice given by counsellors 'treating' those with same sex preferences, and this corresponds to evidence from a recent survey which found that one sixth of therapists in the UK provide treatments which attempt to 'cure' gay sexual identity (Laurance, 2009). There are advocacy websites (The Clinic for Boundary Studies, 2013; Therapy Exploitation Link

Line [TELL], 2013), media articles about cases where social and welfare workers are reported to have failed to act to protect the lives of children or those with disabilities in abusive environments, or were alleged to be aggressive, abusive and punitive to clients. One such media example was a posting which highlighted the significant ethical complexity faced by practitioners in a casework practice setting where there was a failure to prevent abuse of children.

Social workers at the Yorkshire council missed signs that Ian Wathey and Craig Faunch were abusing boys placed in their care between 2003 and 2005. An inquiry report into the case... quotes one member of staff as saying: "The fear of being seen as prejudiced, the risk of talking about the words gay and paedophile together, was too great. There was a pervasive anxiety that, if this view was put forward in writing or verbally, the person putting it forward would be accused of being prejudiced and homophobic".

(Gillen, 2007, p. 1)

These are examples of the complex forces surrounding cases of harm, which highlight the need for research with a methodology that allows for qualitative enquiry into the context for decisions regarding complaints.

A significant contribution to qualitative literature about patient harm in the medical context was made by Berlinger (2005). Her research and discussion focused on the words and actions of individuals, and the policies and practices of institutions, which may offer patients and their families the possibility of forgiving those responsible for harm (Berlinger, 2005). Personal narratives from patients and their families demonstrated the significant impact and complexity of experiences of harm, as well as the religious and ethical dimensions of the aftermath, including conditions for

forgiveness. The depth of complexity in Berlinger's data and analysis suggests that an exploration of the phenomena involved in experiences of harm from counselling and psychotherapeutic relationships is warranted, and will reveal significant complexity as well.

Several books have been published which contain case examples of harmful practices by counsellors and psychotherapists. These books provide a strong critique of the methods and assumptions that many therapies are based on. These include Sands (2000) in her book *Falling for Therapy, Psychotherapy from a Client's Point of View*, where she analysed two contrasting treatments she received from different practitioners and reflected on the harm and help she received from therapy. Other examples of books include *House of Cards: Psychology and Psychotherapy Built on Myth*, by Dawes (1994), and *Manufacturing Victims: What the Psychology Industry is Doing to People*, by Dineen (2001). There is also *'Crazy' Therapies: What are they? Do they work?* by Singer and Lalich (1996) and *Shouldn't I be feeling better by now?: Client views of therapy*, by Bates (2006). House (2003) offered a strong critique of the assumption that therapy is client-centred and used many case examples to argue that it is largely profession-centred and often harmful to clients, in his book *Therapy beyond Modernity: Deconstructing and Transcending Profession Centered Therapy*. There are also accounts of the harmful impacts of false repressed sexual abuse memory 'therapy', such as *Suggestions of Abuse* by Yapko (1994). Elkind (1992) also provided an exploration of cases where both practitioner and client vulnerabilities contributed to treatment breakdown.

All of these books (and others too numerous to include) contain accounts (some de-identified and some identified) of harmful practices and outcomes of counselling,

psychotherapy and casework. For the purposes of this literature review, excerpts from three case examples and the justifications for including these are presented below.

First person narratives about harm. These particular examples of first person narratives have been chosen firstly from the early 1900's and subsequently in recent years, to highlight the long history and perennial risks of harm in counselling and psychotherapy. These examples also highlight some of the unique power dynamics associated with client compliance. The first narrative is from more than one hundred years ago and relates to psychotherapy, as does the second which highlights similar dynamics which occurred in a psychotherapeutic relationship more than a century later. The perspective of a complainant is provided as well as the perspective of what could be described as a 'complaint manager'; someone who was in a position to provide advice regarding the matter. The third narrative is a contemporary account from a respondent practitioner perspective and relates to counselling.

As a client of notable Swiss psychotherapist Carl Jung, Sabina Spielrein began an analysis with Jung in 1904 which developed into an intimate but volatile relationship (Hyde & McGuiness, 1992). Unedited excerpts from Sabina's diary dated 1906/07 (located in an attic decades later and eventually translated and published in the United Kingdom in the *Journal of Analytical Psychology* in 2001) provide a rare opportunity to witness the intensity of a client's distress and insight. In her diary she wrote about Jung:

You finally managed to say to me "a few years ago, I knew a similar woman; she too seemed to me like a goddess, but in the end she turned out to be just a flighty girl".... I cannot allow you to defend yourself by humiliating me...As a matter of fact, my crime would be that of borrowing you from your wife, but after all it is also my man that is being borrowed, and momentarily I do not care

at all! I do not have the least desire to borrow you from your wife!...I am so tired of turning things over and over in my mind continuously...You see... I do not love you now, that is, not in the ideal sense – no, and this state is much more dreadful than death. Nothing matters to me...

(Speilrein, 2001, p. 165)

Although direct writings could not be sourced from Jung regarding Sabina, Sigmund Freud made the following remarks on 7 July 1909 to Jung, in reference to Jung's relationship with Sabina Speilrein:

I myself have never been taken in quite so badly, but I have come very close to it a number of times and had a 'narrow escape'. I believe that...the fact that I came to psychoanalysis a decade later than you has saved me from the same experiences...one comes to master the 'counter transference' which really does arise in one every time, and one learns to shift one's own emotions and place them with expedience.

(Freud, 1909, cited in Eickhoff, 1987, p. 107).

It would be easy to assume that these risks were understandably present in the early years when the 'talking cure' was first being developed but that such a case would be unlikely to occur a century later. Yet in 2005, an account of a similar case was published. The client described herself as having managed to "maintain a responsible and well-functioning persona" for most of her life, but presented to therapy in a vulnerable state having experienced cancer surgery and treatment, suicide of family members, and depression (Anonymous, 2005, p. 670). Eighteen months after this client first saw the psychotherapist, "he announced his need to terminate my analysis because he loved me and wanted me in a personal relationship" (Anonymous, 2005, p. 671). Her

account reveals a shocking depth of complexity of harm, suicidality, nervous breakdown and inability to function, damage to, and loss of her marriage, which she eventually recovered. She described how she slowly became disoriented, “losing her ego capacity to determine fantasy from reality”, and that she experienced acute anxiety and panic attacks when her therapist/partner disclosed her personal details which she had told him in therapy sessions at a dinner party with friends (Anonymous, 2005, p. 676).

Very little has been published where practitioner respondents to ethical complaints reflect on their experiences. The following account was the only first-person narrative from a therapist that I could find in Australian literature. The male practitioner had recently been separated from his wife, when he initiated a sexual relationship with his client. He wrote:

I was ripe for self seduction in relation to counselling the beautiful, apparently vulnerable client who was referred to me. The already weakened boundaries came crashing down as, in an instant I decided upon the course of action I eventually adopted. Notice the highly egocentric nature of the above discussion. It is what happens to people who are experiencing relationship breakdown. A sense of perspective regarding oneself and the universe simply goes out the window. It is a consequence of the highly personal attack on one's soul and sexual self.

(Brown [anonymous], 1999, p. 46).

There are other examples of first person narratives quoted in books and as vignettes in articles and theses, too many to refer to here. Needless to say, it is worth observing that the experience of reading academic research and texts is quite emotionally removed and

passive, compared to reading accounts of lived experience. This supports an argument that research needs to redress this and seek qualitative data.

Sexual Misconduct. Sexual misconduct has been a focus of research for the past four decades. This is because the handling of sexual feelings is an aspect of counselling that is fraught with risks of harm. Researchers in the US such as Pope, Sonne and Holroyd (1993) and Schoener et al. (1989) concluded several decades ago that there is disbelief and denial in the industry about this taboo topic, and that more research is needed. This conclusion was drawn again in a more recent article by Pope, Sonne and Greene (2006).

Examples of ways therapists have exploited or harmed their clients include a range of behaviours other than assault or intercourse, such as nudity, kissing, spanking, and sexual jokes, discussing fantasies or their own sexual practices, suggestive remarks or innuendos (Pope et al., 1993). Some of the cases that went before the California Board of Psychology included a therapist seeing a couple for marital therapy who had intercourse with the wife while the husband sat in the waiting room unsuspecting; other cases involved sexual acts during therapy on victims of previous sexual abuse (Pope et al., 1993).

The two main focuses for researchers have been prevalence of sexual boundary violations and the nature of the resultant harm. In terms of prevalence, a 1977 national survey conducted in the US first established that a total of approximately fifteen percent of psychologists self-reported that they engaged in opposite or same-sex therapist-patient sexual intimacies during therapy, and eight percent had sexual intercourse with patients within three months after terminating therapy (Holroyd & Brodsky, 1977, cited in Pope et al., 1993, p. 3). To place these statistics in the context of the time, it is

sobering to note, for example, that a paper entitled *Erotic contact as a source of emotional learning in psychotherapy* was presented openly at the 1977 Annual meeting of the American Psychological Association in San Francisco (Gross, 1977).

In 1991, half of the respondents to a national US survey of Psychologists (n=1320) reported that they had assessed or treated at least one patient who had been sexually intimate with a previous therapist. These respondents referred to knowledge of a total of 958 patients who had reported to them that they had engaged in sexual intimacies with a previous therapist. When sexual intimacies began during the course of the therapy, harm was reported for 95% of female, and 80% of male patients. When sexual intimacies began only after the termination of therapy, harm was reported for 80% of the female and 86% of the male patients (Pope et al., 1993).

Thirteen years later, again in the US, Hutchinson-Mittendorf and Schroeder (2004) conducted a replication of the psychologist's survey, but instead investigated the attitudes of 144 social workers (out of a sample population of 288) in private practice settings. Over half (54%) of their sample of social workers knew of clients who had been harmed by sexual involvement with other therapists, and ninety-five percent reported the sexual encounters were always harmful to the client (Hutchinson-Mittendorf & Schroeder, 2004).

However, only a quarter reported the exploitative therapist to a licensing board. Almost forty percent of the respondents identified 103 other social workers they believed had initiated sex with between 1 to 4 clients, but only fifteen percent reported these violations to an ethics committee or licensing board (Hutchinson-Mittendorf & Schroeder, 2004). These findings are consistent with earlier research by Sloan, Edmond, Rubin, and Doughty (1998) who analysed 450 responses to a survey of 852 of the 12,

720 licenced social workers in Texas. However, in their sample, they found that only 17% of those surveyed had worked with at least one victim of sexual exploitation by a therapist, but that there was a consistent lack of knowledge of reporting requirements.

The abovementioned studies present findings based on self-report by practitioners over three decades. Because of the small numbers of respondents, these findings cannot be generalized. However, there is a clear similarity in the pattern of findings. Up to fifty percent claimed to know about serious and harmful boundary violations by other therapists, but there has been a very low rate of formal complaint about these practices. The reasons for this need to be further explored through research.

To establish whether trends in survey research from the US were similar to Australia, Wincze et al. (1996) published the findings from a comparative survey of therapist sexual misconduct between an American state, Rhode Island, and an Australian state, Western Australia. Six-hundred and seventy-eight surveys were distributed in Rhode Island with 331 returns (49% return rate). 1057 surveys were distributed in Western Australia with 479 returns (48% return rate) (Wincze et al., 1996). The number of practicing psychologists who reported cases in which patients mentioned sexual involvement with prior therapists was 26% in Rhode Island and 22% in Western Australia (Wincze et al., 1996). Women patients were reported overwhelmingly as the victims of sexual exploitation in both the Rhode Island survey (87%) and the Western Australian survey (90%) (Wincze et al., 1996). The authors compared their results with several other previous US surveys and found very similar results for both the rate of report and the gender of victims (Wincze et al., 1996).

The impact of sexual boundary violations on clients has been researched via surveys and inventories in the US. For example, the findings of a mixed method

research project (n=144) in the US using a combination of surveys, trauma inventories and open ended questions regarding harm experienced due to professional sexual exploitation, established that most victims experienced post-traumatic responses, loss, emotional turmoil, mistrust, depression, relationship difficulties, and difficult complaint procedures (Disch & Avery, 2001). In similar research, Luepker (1999) surveyed 55 participants in a clinic population presenting with problems related to practitioner sexual misconduct. Posttraumatic stress disorder, major depressive disorder, suicidality, use of prescription drugs, concern over use of alcohol and or non-prescription drugs, disrupted relationships, and disruptions in work or earning potential were reportedly increased after the practitioner misconduct.

Pope and Vetter (1991) presented the results of a further US survey study with subsequent treating psychologists regarding the 958 clients who had been sexually involved with a previous therapist. More than 40 percent reported they had experienced incest, other child sex abuse, or rape as an adult prior to sexual involvement with the therapist. Eleven percent required hospitalization, considered to be at least partially due to the sexual involvement with the therapist, 14% percent attempted suicide and 1% committed suicide, and 17% achieved complete recovery from any harmful effects of sexual involvement.

In addition to surveys about prevalence and harm associated with sexual boundary violations, qualitative research involving in-depth interviews with small samples of participants have tended to focus on providing evidence of the dynamics and impacts of harmful practices. For example, Gabriel (2005) researched the intensities and complexities in sexual and non sexual dual relationships for 30 individuals in the UK and found that most dual relationships were experienced by clients and practitioners as harmful, but a few were experienced positively, and this depended partly on the level of

open contracting and discussion about boundaries. Nachmani and Somer (2007) conducted a small-scale qualitative phenomenological project about harm which found that 23 victims of sexual exploitation by therapists in the US experienced “dependency, helplessness and powerlessness, along with feelings of being chosen and achieving control over the therapist... (and) both long and short term harm” (p.1).

Published case studies in a range of international and Australian texts have also established that harmful practices have occurred (Guthiel & Brodsky, 2008; Kottler & Carlson, 2003; Lott, 2000; Morrissey & Reddy, 2006; Pope et al., 1993; Pope & Vasquez, 2007). Schoener et al. (1989) provided a substantial volume of research regarding psychotherapists’ sexual involvement with clients which included surveys of populations of practitioners and small scale qualitative studies including case studies. Quadrio (1992, 1994, 1996) presented case studies of victims of therapist sexual exploitation in Australia. To further confirm the multiple harmful impacts of sexual boundary violations, Ruskin (2011) described the harm he and his psychoanalytic society in Canada experienced when their supervisor was found guilty of boundary violations, and Ross (1995) described the fate of relatives and colleagues after a practitioner violated sexual boundaries in the US. All establish that harm occurs, and that the dynamics of harm can be highly complex.

Psychological manipulation and exploitation. Compared to the large amount of literature about harmful sexual misconduct, there is not a strong presence in academic literature in the social sciences about psychological manipulation, which is another complex type of harm that can result from a counselling or psychotherapeutic relationship. There are many terms that could describe the practices involved in this type of harm, ranging from advice giving, over-servicing, exertion of undue and unwarranted influence, grooming, psychological manipulation, brainwashing, coercion,

thought reform and mind control. Often clients may be experiencing life circumstances of significant vulnerability and reduced capacity for clear thinking and decision making when they become a client. A range of techniques and behaviours similar to those used to promote compliance in cults can be used by practitioners to reduce client's capacity for independent thought even further (Milgram, 1974; Singer et al., 1990).

The phenomenon of what became called 'psychotherapy cults' gained attention from academics in California several decades ago, when they identified similar tactics and strategies of psychological and social influence long studied by social psychologists, social anthropologists and marketing researchers (Hochman, 1984; Singer et al., 1990). This demonstrated that cults are not defined by the content of the ideology but by patterns of influence to which people are vulnerable. A range of processes were found to be just as relevant in non-religious cultic 'psychotherapy' relationships, such as "thought reform" (Lifton, 1961), "brainwashing", (Hunter, 1953), and "coordinated programs of coercive influence and behaviour control" (Ofshe & Singer, 1986). In the 1980s, independent studies of more than twenty-two psychotherapy cults were conducted by Singer, Temerline and Langone in the US and they reported their collated findings in 1990. They found that:

...fifteen were led by professionally trained persons (psychologists, psychiatrists, social workers) who as time went on tended to raise former patients to "therapist" status in the groups. Seven were run by non-professionals (ranging from former clerks to convicted felons)... The patients were primarily middle class to upper middle class Caucasians with some college or advanced degrees. The groups were located in six states.

(Singer et al., 1990, p. 105).

Schwartz and Kaslow (2001), in their review of the developments in cults up until the turn of the century noted that:

Some of the newer cults, termed psychotherapy cults, allege that they enable people to have more power over their lives, to be more productive and to be happier, all goals consistent with mainstream psychotherapy... However their practices frequently violate the ethical standards of the American Psychological Association (APA) and similar professional organizations particularly as they deviate from the ethics code (American Psychological Association, 1992) in the areas of “confidentiality, dual relationships, informed consent, professional competency, dependency and autonomy, financial practices, professional development and separation and termination”.

(Schwartz & Kaslow, 2001, p. 18)

In conclusion, there is a body of academic and non academic literature which established that the practices of counsellors and therapists can be harmful, and complaint-worthy. Harm from psychological manipulation can be extreme, although evidence of this is not easily accessible. The next section of the literature review explores literature specifically about complaints.

Complaints

Harm is often the basis for complaint yet complaints can be interpreted to include dissatisfaction or unhappiness of some kind which may not always constitute harm. Given this broad definition it is worthwhile exploring the various ways complaints about counselling, psychotherapy and casework may be expressed, and also the quantitative and qualitative data published about such complaints in Australia and internationally.

In recent decades there has been an increased focus in literature about the reporting of adverse events in the medical domain (Berlinger, 2005; Berlinger & Wu, 2005; Crone et al., 2006; Iedema, Jorm, Wakefield, Ryan, & Sorenson, 2009; O'Connor, Coates, Yardley, & Wu, 2010; Seys et al., 2012; Willemyns, 2010). This body of literature is significant, and the findings point to themes which may be relevant to, and may parallel, those associated with complaints about counselling practitioners. Nonetheless, literature about medical error is not the primary focus on this literature review because complaints about counselling, psychotherapy and the 'talking cures' are a different category of complaints, distinct from medical error and adverse events.

Pathways for expression of complaints. In Australia there are multiple potential pathways for the reporting of complaints and as stated previously there is considerable inequity in the available formal jurisdictions regarding different occupations and settings. When taking a phenomenological approach it important to map out the range of ways that people may have a lived experience of decisions regarding complaints. It is important not to limit the scope to formal reports of complaints to professional associations or registration bodies because this would not capture the variety of contexts of the lived experience of complaints. Table 3 provides an overview of the various pathways in which complaints may be expressed, reported or unreported, by whom and to whom.

Table 3

Pathways for Expression of Complaints

Who may report complaints?	How may complaints be communicated?	To whom may complaints be expressed?	
Client who directly received service	Verbally	Family members, friends, peers, any member of the public	Voluntary Professional Associations
Family member or other person close to client	In writing – Private journal, or to peers, (via sms, email, letter)	Fellow clients	Registration Authorities
Fellow client who may have observed or been told about problematic practice	Via social media (private or public privacy settings)	Colleagues	Health Complaint Commissions
Colleague of practitioner complained about who may have observed or been told about problematic practice	Via internet blog or website (public or private privacy settings)	Practitioner who provided the service complained about	Other government body e.g. Crime and misconduct commission; Privacy commission; Ombudsman; Human Rights Commission; Anti Discrimination Commission
Other practitioner to whom client or those close to client subsequently reported a complaint about the practitioner	Formally, in writing to organization representative	Colleague and/or acquaintance of practitioner complained about	Parliamentary representatives

Self –report by practitioner	Verbally and/or in writing in meetings or hearings with investigators	Practitioners providing subsequent services to client	Parliamentary enquiries or Royal Commissions
Manager of practitioner complained about	Verbally and/or in writing to coronial inquests	Other worker/s at service where incidents relating to complaint occurred	Media
External supervisor of practitioner complained about	Verbally or in writing as part of conferences	Employers, managers and supervisors (including direct line manager, members of voluntary management committees, boards, Directors)	
Member of Parliament or other government body seeking further action on a complaint or systemic failures		Professional standards units in government organisations	

As shown in Table 3 complaints may be expressed in multiple ways to multiple individuals and organizations. In some cases there would also be decisions not to formally report a complaint; not to discuss it with anyone; or only with peers, family members or friends. There may be informal direct reports to the practitioner only either by a client, someone close to a client, or by a colleague. Such complaints may not be discussed between anyone but the practitioner and the complainant. Complaints may also be reported to front-line managers, team leaders and supervisors about a practitioner who works for them. They may also be reported within large organizations to the professional standards unit or crime and misconduct commission if the practitioner complained about is a public servant. For non-government organizations, complaints may be reported to a voluntary management committee.

A research design that allows a broad perspective on the various ways in which complaints may be expressed allows for the gathering of qualitative data about a range of complaint contexts. If the scope was limited to formal written complaints only, this would not permit exploration of the experiences of those who did not formally report a complaint. These experiences should not be excluded because they may reveal important data about barriers to reporting.

Overview of previous literature about complaints. Data about complaints primarily appears in international research literature in the form of journal articles outlining quantitative data about numbers and broad categories of complaints (Reamer, 1995; Strom-Gottfried, 2003). For example, Brindle (2008) reported that of 49 cases heard about social workers by the General Social Care Council [GSCC] between 2005 and 2008 in the UK, 21 involved allegations of inappropriate sexual relationships. In the US, Strom-Gottfried (2003) analysed 894 ethics complaint cases filed between 1986

and 1997 with the National Association of Social Workers [NASW] and 107 cases were about sexual boundary violations.

Published literature also provided data about the reasons why some complaints did not progress to hearing, and about the timeframes in which complaints were processed. This data highlights the criteria applied by complaint managers regarding which complaints are able to be acted upon by organizations, and also, the efficiency and resourcing of such organizations. For example in Strom-Gottfried's study (2003), a quarter of complaints were not accepted for adjudication because the complaint was not filed within the prescribed time limits. Fifteen percent of cases were also not accepted because if true, "the matter was not seen as an ethical violation" (p.90), "evidence would not have been available to support the complaint" (p.90), the "complaint was poorly drafted" (p.90), the complainant was "not a directly affected party" (p.90), or the respondent was not a member of the NASW. Two percent of cases were mediated, and these took between 64 and 500 days to conclude. The 428 cases that went to hearing remained open for a median of 340 days, with the longest, 3,518 days. The 69 cases where proceedings were withdrawn pre-hearing were open for a median of 272 days (Strom-Gottfried, 2003). Strom-Gottfried (2003) stated there was evidence of a danger of "pre-judging cases without a hearing although this clearly contradicts established procedures" (p. 91).

This raises many concerns. The quarter of complaints not submitted within the deadline indicates 'latency' in reporting these complaints for some reason (Strom-Gottfried, 2003). The 15 percent of pre-judgment of cases within a peer-management model is concerning in case bias was present, as is the very long duration of procedures, and the inability of the association to act on complaints about social workers who were non-members (Strom-Gottfried, 2003). McLaughlin (2010), in his analysis of conduct

hearings about social workers before the General Social Care Council in the UK, strongly critiqued major problems in the procedural rights for social workers, and questioned the basis for judgements and use of power by tribunals.

Other research has established that for those who have experienced sexual violation, the complaint process can be extremely distressing and the waiting times a source of acute secondary trauma (Boeckenhauer et al., 1998; Nachmani & Somer, 2007; Schoener et al., 1989; Quadrio 1994). Strom-Gottfried's (2003) research suggests that NASW complaint avenues have been of potentially great risk to those involved. Without qualitative case study data, it is unknown whether this is the case or not.

Also in the US, Boland-Prom (2009) published the results of a national descriptive study of statistics about cases where social workers were sanctioned by state licensing boards in the US. The study synthesized information and provided data about patterns of complaints (n=874 out of a possible 2282 cases) about certified and licensed social workers sanctioned by state regulatory boards from 1999 to 2004 in twenty-seven of the twenty nine states (Boland-Prom, 2009). The offence data was coded into eight categories in order of rate of incidence. First was dual relationships (noncriminal sexual relationships and nonsexual relationships); second was license-related problems (working with a lapsed license, misrepresentation of license or training, incomplete continuing education units); third was crimes (criminal convictions or admissions); fourth was poor basic practice (maintaining records, confidentiality, problems with reports or court letters, fraudulent or forged client signatures, abandoned client, no informed consent); fifth was below standard care, sixth was irregularities in billing (those not described as theft); seventh was impaired social workers (noncriminal cases with mental health, alcohol, or drug problems are noted) and eighth was supervision below the standards of practice (Boland-Prom, 2009). Boland Prom (2009) also stated

that instead of there being a decrease in recent years in cases of sexual exploitation, “the relative numbers of cases of sexual impropriety have increased dramatically over the decades, a reflection of the growing awareness of the harmfulness of boundary violations and the evolution of the NASW Code of Ethics” (p. 353).

Literature also reveals patterns in the types of complaints and the types of practitioners complained about. For example, in case study research about NASW ethical complaints in the US, Strom-Gottfried (1999) identified a gender pattern in complaints. Even though males were found to be the minority (20%) of social work NASW members, they were the overwhelming majority of respondents to sexual boundary violation complaints. Strom-Gottfried (1999) found that males outnumbered females in this category 71.7% to 28.3%. This trend did not apply however, to general boundary violations. Strom-Gottfried (1999) found that in regard to respondent gender, females were found to have committed general boundary and dual relationship violations in equal or slightly greater numbers than males.

In Australia, Quadrio (1996) addressed gender and culture in her case study research about 40 cases of sexual boundary violations in therapy. She interpreted the findings in light of sexual politics, and was one of the only researchers who directly stated that power needs to be explicitly focused on in order to change cultural norms.

Offenders were chiefly male (90%) and most were senior, well qualified therapists of high status: some were charismatic leaders or teachers. Such a group cannot be dismissed as marginal, deviant, or ill-informed, a much more systemic analysis is necessary to understand how the professions spawn and sometimes protect offenders... It is concluded that the professional culture mirrors fundamental problems of gender relations that inhere in the larger socio-

cultural context where they are expressed in various forms of sexual abuse and violence. A cultural change requires better education on issues of power and sexual politics.

(Quadrio, 1996, p. 124).

Other, recent Australian research provided information about the prevalence, prediction and prevention of psychologist misconduct. When highlighting the need for their research, Grenyer and Lewis (2012) stated that “there is almost no published data, Australian or other, on the prevalence and outcomes of misconduct complaints about psychologists except for summary tables in the annual reports of registrations boards” (p. 68). They found that between July 2003 to June 2007 in the Australian state of New South Wales, there were 248 independent notifications of a range of non-sexual and sexual misconduct against 224 registered psychologists out of a total sample of 9, 489 registered psychologists (Grenyer & Lewis, 2012). This represented a misconduct complaint rate of 2.4%. Mandatory registration for psychologists commenced at different times in different Australian states, ranging from the earliest, Victoria, in 1965, through to the Australian Capital Territory in 1995 (Waring, Hall, & Altmaier, 2008). More research is required to establish evidence of the impacts of registration over this period.

Other significant data revealed by Grenyer and Lewis (2012), was that in addition to complaints about 224 registered psychologists, the New South Wales Board of the Psychology Board of Australia also received sixty-four complaints about non-psychologists, including fifty one who were accused of falsely holding out to be a registered psychologist, and nine complaints about practitioners but not registered psychologists (i.e. social workers, psychiatrists). Complaints about non-psychologists

represented 20.7% of the complaints received by the board over the four year period. This suggests that unregistered professionals do attract complaints. Without jurisdiction it is not possible for them to be heard or sanctioned. There is a need for more research about the barriers to reporting of complaints so that statistics about formally reported complaints are not relied on alone, as a measure of prevalence of harm.

The most striking concern raised from the literature review about complaints is the absence of research about experiences of complaints, and paucity of research about consumer knowledge, perspectives, experiences and needs in general. The importance of researching consumer views, and the difficulties in doing so were reported by Bland, Laragy, Giles, & Scott (2006) when they sought consumer views on social work practice standards. Schofield (2008a), as part of a lengthy report commissioned by the Victorian Department of Human Services about best-practice self-regulation models for psychotherapy and counselling in Australia, reported a lack of consumer knowledge, and the need for more research.

The PACFA [Psychotherapy and Counselling Federation of Australia] office staff report that a consistently high proportion of phone calls over the past 8 years were from the public about self-regulatory issues...(including) how to make a complaint against a therapist...These anecdotal reports...need to be followed up with more systematic research around consumer knowledge, perspectives, experiences and needs.

(Schofield, 2008a, p. 96)

An Australian history of enquiry into systemic failures to address harm. Aside from the limited amount of formal academic research reviewed previously, other published information reveals an Australian history of complaints and inquiry about harm and regulation of health, social care and human services. This history reveals that there have been systemic problems in the provision of effective avenues for complaints and regulation of harmful practices. It is notable that often systemic issues are only revealed in the public domain after serious failings. A range of examples are provided below.

- New South Wales (NSW) Medical tribunal enquiry in 1989-1991 into professional misconduct by psychiatrists and their sexual behaviour with patients (Dawson, 1994). This led to the development by RANZCP in 1992 of the “first ever code of ethics” for Psychiatrists in Australia (Pargiter & Bloch, 1994, p. 188).
- The NSW Chelmsford Royal Commission into Deep Sleep Therapy, 1990 which recommended registration of all mental health workers including social workers and licensing for some, and regarding which the Hon Elaine Nile asked in parliament why criminal behaviour by a number of health professionals was not charged by the Director of Public Prosecutions (Nile & Pickering, 1991).
- Conference proceedings about multiple cases of sexual abuse of clients by various professionals including psychiatrists, doctors, psychologists, social workers, counsellors and clergy, and the problems experienced in seeking redress (Boeckenhauer et al., 1998).
- The Government of the State of New South Wales Royal Commission into the NSW Police Service Final Report (1997, p. 932) found that an unregulated

social worker had been an active paedophile for 20 years and that NSW police had protected paedophiles (Police Integrity Commission, 2009; Simpson, 1998).

- AASW (2004) report about duty of care and the inadequacies of self-regulation.
- Inquiry into Child Protection Services in NSW by Justice Wood 2008 prompted a media release by the AASW calling for a national or state register of workers in these organizations to ensure workers perform their duties professionally and to avoid harm to vulnerable children and families (Lonne, 2008).

The above list provides a few examples of slow, problematic systemic responses and a lack of legislative change. This supports the need for this research project to include stakeholders such as complaint managers to explore their perspectives on how legislative and policy decisions about regulation and complaints are made.

Because complaints may take the form of public interest disclosures or whistleblowing it is also important to briefly appraise relevant literature on this topic. It is stated in some government policies (see example below) that public interest disclosures must be made. However more needs to be understood about what this step might involve in terms of the impacts. One example of legislation, is the following provision in the 2008 Code of Conduct for Unregistered Practitioners (NSW), which instructs health practitioners to report:-

A health practitioner who has serious concerns about the treatment provided to any of his or her clients by another health practitioner *must* [italics added] refer the matter to the Health Complaints Commission.

(HCCC NSW, 2008, p. 1).

The pathways for whistleblowers have often been difficult and multi-consequential, and recent legislative changes designed to protect the privacy of

whistleblowers do not cover members of the public, only selected official public servants and journalists (de Maria, 2009; Mazerolle & Cassematis, 2010). Mansbach and Bachner (2008) highlighted the serious omission in research literature regarding the experiences of whistleblowers in social work who attempt to report systemic issues. The authors found only three studies in international literature about whistle blowing by social workers. Yet advocacy and social justice are key values of the profession (AASW, 2010).

Media reports provide examples that those who speak out about complaints within their industry may face costs and threats to their reputation and employability. This may include being threatened, victimized and ostracised. Such cases appear in the media from time to time, including the case in the UK where Kay Sheldon, a non-executive director of the Care Quality Commission was “subjected to ‘priority monitoring’ and declared a ‘risk’ to the regulator after she had raised concerns that public safety was being compromised by poor leadership and performance” (Lakhani, 2012, p. 1). Doubt was cast upon her mental stability, and “after a short phone conversation and without ever meeting Mrs Sheldon, who has a 26 year history of depression and is an expert in advocacy and patient rights, the doctor described her as possibly suffering from paranoid schizophrenia” (Lakhani, 2012, p. 1).

Another case from Australia highlighting the costs and risks to whistleblowers, has been that of Jo Barber, from Queensland Health’s Ethical Standards Unit whose credibility was questioned in the media by retired judge Richard Chesterman. Mr Chesterman claimed that Ms Barbers “alarming complaints were not supported by evidence” (Helbig, 2012, p. 1). The inconsistency in Mr Chesterman’s position and the motives for questioning Ms Barber’s credibility was a source of confusion, because his own report found that “some disciplinary responses were not a proper response to

serious complaints, citing several cases where the Queensland Board of the Medical Board of Australia failed to report complaints to police or had “extraordinary delays” of up to three years” (Helbig, 2012, p. 1). Jo Barber had “accused the medical board and State Government agencies of failing to protect patients against inept doctors, alleging more than 100 cases of medical malpractice were not properly investigated” (Helbig, 2012, p. 1). More needs to be researched about the experiences of complainants who are whistleblowers and the risks they face when reporting on their peers.

Complaints statistics in annual reports. Annual reports of some registered health professions (see Office of Health Practitioners Registration Boards Queensland, 2009) presented numbers of types of complaint categories without showing how many individual practitioners were complained about. Furthermore, the outcomes for complaints were presented vaguely and separately, so it is not clear what outcome matched what complaint category, or which individual. An exception to this ambiguous style of statistical report of complaints is provided by the Queensland Nursing Council (2008). The Council presents each individual case with information about nature of complaint, date lodged, date heard, sanctions and outcomes. Publicly available tribunal hearings can be read from the internet regarding AHPRA registrants (AHPRA, 2013a). These reveal details of incidents, evidence and the manner of response by tribunal members. The approach by tribunals appears to be legalistic and adversarial.

The annual reports of health complaints commissions are too numerous to review for the purposes of this literature review. However, to give an example of extreme under-resourcing of complaint systems in general and long waiting times, the Health Quality Complaints Commission Queensland [HQCC QLD] (HQCC QLD, 2008) reported the capacity to investigate only 18 complaints that year, yet there were 94 cases in progress awaiting action at the investigation stage. This suggested that the

waiting time for these 94 cases may be very long (possibly several years), which is likely to have implications for all parties. Furthermore, the data about total complaints closed, indicates that the majority of the 1,226 complaints were closed at intake without being assessed (66%), or closed after intake and assessment (89%). Further research is warranted to understand more about, for example, how complainants and respondents involved with the HQCC experienced the 66% of cases which were closed at intake without assessment.

Under-reporting of complaints. There appears to be a trend of under-reporting of complaints about sexual exploitation. In the US, Schoener (1989a, p. 313) speculated that a “miniscule 1-2% of all cases of therapist-client sex are brought to licensure board attention”. In Australia, Gallois and Griffin (1998, p. 88) found that at that time, almost 70% of complaints to the Victorian Health Services Commissioner regarding sexual exploitation by doctors, psychiatrists, psychologists and other unregistered providers were managed informally, without any response being sought from the provider. Only 15% of complaints went to registration boards, and the remaining 15% went to legal action or formal conciliation (Gallois & Griffin, 1998, p. 88). The authors speculated that much more support needs to be given to complainants so they can go forward with formal avenues.

Aside from data about under-reporting of complaints about sexual exploitation, there has been research about the rate of under-reporting of medical complaints. Bismark, Brennan and Paterson (2006) researched the crossover between patients who had suffered an injury from an adverse event in a New Zealand public hospital, and patients from that group who made a complaint to the Health and Disability Commissioner, and found that only one in two hundred chose to make an official complaint. It was found that even in serious cases involving death or disability, only one

in twenty five injured patients complained, with the elderly or socio-economically deprived patients least likely to complain (Bismark et al., 2006). This highlighted that structural issues associated with socio-economic status, and possibly the burden of living with the daily impacts of harm due to adverse events were likely to be barriers to complaint. Evidence from other research related to practitioner reporting of ethical misconduct confirms that there has been a history of under-reporting (Bernard, Murphy, & Little, 1987; Biaggio, Duffy, & Staffelbach, 1998; Gartrell, Herman, Olarte, Feldstein, & Localio, 1987; Wilkins, McGuire, Abbott, & Blau, 1990). There is clearly a need for research which focuses on exploring the lived experience of decisions regarding complaints, to begin to understand what factors may or may not account for under-reporting.

Profiles of practitioners involved in complaints. While there is a paucity in data about practitioners involved in complaints, Roback and colleagues (2007) in the US found evidence of ‘personality pathology’ in some professionals who practiced unethically. Whilst acknowledging limitations regarding the reliability of personality tests, Roback et al. (2007) conducted research about personality and character pathology in health professionals exhibiting different forms of misconduct. Out of 88 physicians tested with two personality inventories, “sexual boundary violators” generated the highest percentage of profiles indicative of character pathology. Forty percent of these were assessed to have severe antisocial character pathology, compared with 5.4% physicians assessed with antisocial character in the “disruptive behaviour” category of misconduct (Roback et al., 2007, p. 316). This was consistent with other clinical findings (Abel & Osborne, 1999), which showed that “physicians involved in sexual misconduct usually show minimal appreciation of the plight of their victims” (p. 232). They also concluded that “when individuals carry out behaviours inconsistent with their

image of themselves...they will attempt to neutralize such negative feelings by developing cognitive distortions, justifications, and rationalizations to legitimize [their] misconduct” (Abel & Osborne, 1999, p. 230).

Bloom, Nadelson and Notman (1999) suggested that at best, approximately half of those professionals charged with sexual misconduct are not amenable to rehabilitation, or at worst, that few, if any perpetrators can be rehabilitated. The reasons given for this are the severe character pathology, lack of motivation to change, and dishonesty. Grant and Alfred (2007) also found that physicians disciplined by boards included a large group of repeat offenders, and more resources are needed for monitoring and discipline because rehabilitative sanctions are not appropriate for this group. As Hare (1998) and Babiak and Hare (2006) pointed out in research which included examples of therapists profiled as psychopaths, individuals may be adept at lying convincingly, speaking with apparent sincerity and without anxiety. Others, such as Celenza (2008) discussed a different group of practitioners, highlighting the vulnerability of one-time offenders, usually “narcissistically needy” or “lovesick” (p. 1), who often show remorse and are highly amenable to rehabilitation. Irons and Schneider (1994) found that sexual addiction was a significant factor in exploitation by health professionals. Reamer (1992) also reported a range of issues associated with impaired social workers.

This research establishes that out of those practitioners who are found to exhibit different forms of misconduct, a significant proportion are considered to have severe antisocial character pathology. Whilst it is unclear how many of these types of individuals there are in the human service industry, the above research has established that they do exist, and a proportion are considered by industry experts not to have prospects for rehabilitation. Further enquiry is warranted about whether complaint and

regulation systems need to have greater powers to enforce effective sanctions in these rare cases.

Types of responses made by respondents to complaints. Very little data is available describing the types of responses made by respondents to complaints, in terms of whether legal representation was sought, whether attempts at mediating client complaints were made, and whether allegations were denied, or apologies and restitution were given. This is an area requiring more formal research. Some data was provided by Gallois and Griffin (1998) from the Health Service Commission of Victoria, Australia, who reported that the responses from health services providers regarding 86 complaints lodged between 1991-1994 about sexualized misconduct were “no response (43%), denial (32%), misunderstanding (20%) and admission/regret (5%)” (p. 89). Other Australian case study research published by Quadrio (1994) presented 8 out of 25 case studies from her work as a forensic psychiatrist working with victims of sexual abuse by professionals and found avoidance, inaction by authorities, collusion by colleagues, cover ups, inaction and victim blaming.

Other examples have shown that the most severe response for therapists who are confronted with such complaints is suicide. A psychiatrist from the Royal Australian and New Zealand College of Psychiatrists [RANZCP], stated:

In the last one and a half decades, multiple members of our College have been deregistered or surrendered their registration in the context of sexual boundary violations. Included have been a number in positions of particular professional prominence: senior psychotherapists, a past member of the College Executive, a previous Editor of the Australian and New Zealand Journal of Psychiatry, and a prior recipient of the Maddison Medal. Jules Masserman, a widely published

psychotherapist who rose to be president of the American Psychiatric Association, was deregistered following the testimony of multiple patients regarding their being raped while under the influence of sodium amytal administered by Dr Masserman. Subsequent to deregistration and settlement of agreed compensation, Dr Masserman shot himself. Suicide is likewise the option taken by one of our ex-fellows alluded to here.

(Middleton, 2004, p. 81).

It is clear that being confronted with these matters can be so painful that some respondents would rather die. Themes around 'survival' and 'life and death' are also reflected in cases in the book *Surviving Complaints Against Counsellors And Psychotherapists: Towards Understanding and Healing* (Casemore, 2001). The case of Dr McGrane, a therapist who murdered the person who lodged a complaint against him to the Health Rights Commission in Queensland in 2002 (cited in Freckleton, 2006), also provides an extreme example of the volatility of responses made in complaint processes.

Other survey research has provided evidence of the impact of professional discipline on practitioners in other health professions for comparison, such as nursing (LaDuke, 2000). A survey explored the experiences of thirty-three nurses in New York State who were disciplined for professional misconduct in 1998. It was noted that over five thousand nurses were at that time disciplined across all states of the USA annually (LaDuke, 2000). The findings of the survey were that many nurses were not able to defend themselves legally, that rank and legal representations were the factors that determined guilt and some took the blame for systems failures (LaDuke, 2000). Disciplinary action usually had more far reaching consequences than simply the nurses'

career. Further research was called for regarding the impacts of complaints, and strategies needed to assist nurses to respond more effectively to disciplinary matters.

An Australian study also provided data confirming that complaints have far reaching consequences for medical practitioners. A cross-sectional study of psychological morbidity in Australian doctors who have and have not experienced a medico-legal matter found that 59% of the 566 general practitioners who responded to the survey reported ever having a medico-legal matter, with 13% having a current medico-legal matter (Nash et al., 2007). Those with a current matter reported increased levels of disability in work social or family life and higher prevalence of psychiatric morbidity (Nash et al., 2007). Those with a history of past medico-legal matters reported increased levels of disability, and male respondents with current or past medico-legal matters drank significantly more alcohol than male respondents with no experience of medico-legal matters (Nash et al., 2007).

Vexatious allegations and false complaints. Systematic research about the means by which false and vexatious complaints have been established to be such by complaint managers, was not found in literature. However, three authors from the US provided anecdotal insight into false complaints. Hedges (1999a) presented his view, after providing expert witness for therapists in court cases, that there is a largely misunderstood phenomenon of what he calls “terrifying transference” (p.2), and that it is a false basis for complaints, usually by what he described as “borderline”, “disturbed” or “rageful” patients (p.2). Gartrell (1998) presented a case where her client stalked her after experiencing ‘erotized transference’. Gartrell reflected that she had not practiced in an unethical manner and did not provoke such a reaction from her client. Schoener et al. (1989) identified a gap in research regarding the power dynamics for complainants and their motives in making allegations and complaints. Because interactions between

counsellor and client occur in the form of private, unrecorded (sometimes noted) communications between worker and client, reliability of self-report of facts by both parties is always an issue. Therefore, in the absence of concrete evidence, decisions about whether a complaint is vexatious or unfounded appear to be unavoidably made on a highly subjective basis. More research into this context for decisions is warranted to explore what standards of evidence should be used, and how natural justice can be provided for by complaint managers.

Some literature reveals there is a negative stigma about perpetrators of sexual exploitation, and this can be very harmful in cases where practitioners are falsely charged with misconduct. Hedges (1999b) expressed outrage at registration boards for findings in favour of unstable complainants. Hedges' believed this occurs because of unfounded prejudice against accused therapists, and a misunderstanding of therapeutic work with disturbed patients. Other cases, such as a participant in McAuliffe's (2000) Australian study of ethical dilemmas faced by social workers, have revealed the devastation and stigma experienced as a result of false allegations of sexual abuse of a client. The allegations were found to be unsubstantiated, yet the experience left a significant impact on the social worker and others involved. It is unknown how prevalent false allegations are, the motivations for clients, and how the system can respond effectively. Celenza (2008) called for a humane and knowledge based approach to those accused.

Conclusion

This literature review focused on three broad topics: regulation, harm and complaints. The first topic, a profile of the semi-regulated industry in which counselling, psychotherapy and casework are provided in Australia, was included in order to develop a robust knowledge of the context of the research, including a profile

of the industry, mainly to inform what the regulatory context is, what is in need of research, and what should inform the criteria for who should be approached as potential participants in the study. The literature on this topic presented a profile of an industry in which there is considerable inequity in consumer rights to seek accountability, as well as inequity in practitioners' responsibilities. It revealed that it is not clear how many unregulated practitioners provide counselling, therapy and casework. There is a need for further research about cases of problematic practice, and how decisions are made about complaints. Given the current semi-regulated environment, it is important to ensure that the scope for this research study includes any practitioner who provides services received by consumers as counselling, psychotherapy and casework, not just registered professions.

The second topic included in the review was harmful practices. The rationale for including this data was to gauge what had not been researched, and also to inform an understanding of the types of harm that may be complained about. The literature review established firstly that there is a significant body of knowledge about the harmfulness of sexual boundary violations. There is a need for more research about a broader range of other harmful practices especially those concerning psychological manipulation and exploitation. Whilst narratives about harmful experiences have been published in books, journals and on the internet, there is a paucity of empirical studies about lived experiences of harmful counselling, therapy or casework, and an absence of published data about the experiences of counselling, psychotherapy and casework practitioners who have been alleged to be responsible for harm. There is a need for more research about how harm impacts on individual capacities to report complaints, respond to them as practitioners, and manage them in complaint management roles.

The third topic for the literature review was complaints, which included mostly quantitative data about the numbers, types, patterns, impacts and responses to complaints. This was included in order to explore what types and rates of reported complaints occur regarding the currently registered professions, and also, what is known or not known about complaints about unregistered occupations. The literature review revealed a distinct inaccessibility of information about who makes complaints, how they make them and where they report them in a semi-regulated industry. The voice of parties to complaints was perhaps the most silent in the literature. This suggests a need for research which provides an opportunity for those with experience regarding complaints in a semi-regulated industry, to voice these experiences. The experiences of those who have been involved in complaints could be used to inform recommendations for legislation, policy and practice in complaint management.

Explicit themes in the literature review focus on inequities in regulation, a lack of consumer knowledge, a lack of clear information about the profile of the unregistered occupations, how harmful sexual misconduct is, and that there have been systemic failures in accountability mechanisms. The most significant, though implicit theme in the literature reviewed in this chapter relates to the use, misuse, abuse and neglect of power, both relationally and structurally. Complex power dynamics occur between practitioners and clients. Power also flows within and between organizations and powerful stakeholders in the context of complaint management. Power is used by legislators who make decisions regarding occupational regulation. Attention to power dynamics appears to be an important avenue for enquiry.

The next chapter explores the methodology, including research questions and research design that was developed in order to seek more information about the experiences of those involved in complaints and the power dynamics surrounding them.

Reading from a wide body of literature has informed an awareness of the potential complexity and distress that complaints may have entailed for complainants and respondents. Careful ethical strategies were put in place for this research project to ensure safety. The next chapter provides an in-depth discussion of the methodology and research design needed to achieve this.

Chapter Three

Methodology

Introduction

As was discussed in the literature review, the research studies already conducted regarding harm and complaints about counselling, psychotherapy and case work were focused on measuring harm, describing the dominant themes in the experience of harm, or quantifying patterns in complaints lodged with various organisations. Non empirical literature provided cases studies, analysis and opinion about complaint and regulatory matters. The review highlighted that there are no studies which explore the lived experience of decision making regarding complaints from a range of perspectives including complainant, respondent and complaint manager.

This chapter outlines my rationale for using a qualitative phenomenological frame to guide the methodology for this study. In it I will specify the sources and types of assumptions, expectations, beliefs and theories which have underpinned various aspects of the methodological framework. I will also explain how I arrived at the three research questions. The conceptual discussion focuses on the epistemology of constructionism; the theoretical perspectives of phenomenology and feminism, in particular Virginia Held's (2005) theory of moral philosophy which she calls the 'ethics of care'; a review of theory and models relevant to an analysis of power; and the methodology of qualitative phenomenological research using Interpretive Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009). I will present details about the method, which involved semi-structured narrative interviews with thematic analysis utilizing NVivo 8 (QSR International Pty Ltd., Version 8, 2008) software. Throughout the chapter, there will be a focus on what constitutes sound,

ethical, qualitative research, and the strategies used in this study to achieve this (Morrow, 2005; Whitemore, Chase, & Mandel, 2001).

Conceptual Framework

It is important to articulate the ways in which philosophies and theories address significant issues inherent within the context of this research. Whilst previous literature provided us with the knowledge that ‘harmful’, ‘incompetent’ or ‘exploitative’, ‘complaint worthy’ practice, and peoples decision making experiences in relation to it exists, what are the epistemological assumptions about how we know it exists? If this research study seeks to find out more about it, how can and should, this new knowledge be produced?

If harm, complaints and decision making do exist, do they exist only in human consciousness, in people’s perception of it? Or does harm also exist in a world independent of human consciousness? Is it an entity which exists when laws, rules and codes are found to have been broken and it can be thus measured by those who observe this? Is it real and measurable simply when people describe their experience of it? Is harm objectively real, even when one or more of the parties involved, do not subjectively perceive it to have occurred? And regardless of how it exists, how should researchers seek knowledge about what should be done about it? These are complex questions. There is a need for research which grapples with the intense subjectivities and perceptions associated with complaints.

Therefore this research context presents important concerns which need to be addressed by the theories that constitute the conceptual framework. Ideally, one theoretical paradigm would neatly address such concerns. However, Danermark, Ekstrom, Jakobsen and Karlsson (2002) offered the view that in order to effectively

address social science research contexts, researchers need not be limited by dualism and polarization of theoretical positions. Therefore, a range of specific theoretical approaches can be applied. Any congruence and incongruence can be carefully addressed. This has been described as a “both-and” approach, rather than an “either-or” approach (Danermark et al., 2002, p. 2). Given these complexities, in order to arrive at an appropriate research design, the first tensions to be addressed are ontological and epistemological.

Ontology. There is debate among social scientists regarding whether the ontology of realism fits with the epistemology of constructivism. According to Crotty (1998) ontology is the “study of being” (p. 10). It is concerned with the nature of existence and the structure of reality. The essential ontological question is: - is the world really there regardless of whether human beings are conscious of it? Realism answers this question by asserting the ontological notion that realities do exist outside the mind. In other words, as Crotty (1998) states, “the world is real, but it becomes a world of meaning only when meaning-making beings make sense of it” (p. 10).

If we accept this definition of the ontology of realism, it can be argued that it is consistent with the premises of this research. This study assumes harmful human behaviour exists and is real, and therefore part of the focus is to seek to find out what recommendations can be made to prevent this. Yet the main focus of the study is to seek the multiple, subjective lived experiences of complaints about such events. In other words, real events and behaviours have occurred in the physical world, such as words spoken and heard, and actions performed and witnessed, but these only become meaningful once people subjectively experience them. Smith et al. (2009) summed this up clearly, when they stated that, “we are concerned with examining subjective experience, but that is always the experience of ‘something’” (p. 33). It appears to make

sense that subjectivity and realism can sit alongside one another. People subjectively experience something real.

It is useful to extend the discussion of the ontology of realism to briefly consider critical realism, which emerged from the writings of British philosopher Roy Bhaskar and others (Archer, Bhaskar, Collier, Lawson, & Norrie, 1998). According to Danermark (2002), “critical realism claims that it is possible to gain knowledge of actually existing structures and generative supportive mechanisms, albeit not in terms of a mirror image” (p. 10). In other words, structures and mechanisms do exist beyond the subjective consciousness of them, and these have power to cause impacts, but this reality cannot be measured by science with the precision of a replication (or mirror image) of that reality. Danermark (2002) stated that “One property of reality is that it is not transparent. It has powers and mechanisms which we cannot observe but which we can experience indirectly by their ability to cause – to make things happen in the world” (p. 20).

It is assumed that powers, structures and mechanisms cause things to happen in the worlds in which complaints about alleged harm have occurred. It is important that this study focuses on the dynamics and impacts of these mechanisms. In summary, according to Archer et al., (1998), “critical realism claims to be able to combine and reconcile ontological realism, epistemological relativism, and judgemental rationality” (p. xi). These ideas from critical realism are relevant to this study and offer a foundation upon which to explore structural and relational power, and recommendations for systemic improvements.

However, it must be noted that many social scientists have claimed that a constructionist epistemology is not compatible with the ontology of realism. For

example, Burr (1995) presented seven features of social constructivism, as follows:- anti-essentialism; anti-realism; historical and cultural specificity of knowledge; language as a precondition for thought; language as a form of social action; a focus on interaction and social practices; and a focus on processes (p. 4-5). It would appear that the anti-realism Burr associates with constructivism would be incongruent with the ontology of critical realism discussed above. Similarly, Rodwell (1998) stated that “for constructivists there is no reality until reality is perceived” (p. 27).

Guba and Lincoln (2005) and Morris (2006) emphasised that constructivism assumes a purely subjective reality and is not used to measure a reality that is separate from the observer. Morris defines the task of a constructivist researcher in regard to ‘reality’. She said, “The observer discovers this reality in partnership with participants in that reality and data is gathered by means of a hermeneutic dialectic from which a joint construction of a reality, unique to time and place, evolves” (Morris, 2006, p. xviii). The emphasis on a jointly constructed reality that is unique to time and space defies the premise that reality exists outside of human consciousness.

Despite these contentions, Crotty (1998) asserted that “realism in ontology and constructionism in epistemology turn out to be quite compatible” (p. 11). He staked this claim primarily by arguing that realism has been confused with objectivism. He said the ontology of realism should not be confused with objectivism, which is an epistemological notion asserting that meaning exists in objects independently of any consciousness (Crotty, 1998, p. 10). Realism’s main premise is that reality does exist outside the human mind which is quite a different emphasis compared with objectivism, which sees meaning as independent of consciousness.

Despite the debate about whether constructivism can be consistent with either a realist or anti-realist ontology, I argue that the research context of this study, notably people's perceptions and subjective experiences, is more congruent with an ontology that privileges subjective experience rather than focusing on realities that exist outside human consciousness. Therefore, the ontological stance for this study is primarily anti-realist, consistent with a constructionist epistemology.

Epistemology. Epistemology was described by Maynard (1994) as being “concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate” (p. 10). According to Crotty (1998) epistemologies can be broadly categorised into objectivism, subjectivism, and constructionism.

Objectivism purports that an objective meaning exists separate from subjective human consciousness. Truth about the reality of a situation is knowable and can be found out through scientific research. Within objectivism exists positivism (assurance of unambiguous and accurate knowledge of the world) and post-positivism (which embraces the ‘uncertainty principle’ and the alteration of the object through being observed, which calls into question positivist science’s claims to certitude and objectivity) (Crotty, 1998).

Subjectivism posits that meaning does not come out of interplay between subject and object but is imposed on the object by the subject. It is associated with structuralist, post-structuralist and post-modernist forms of thought. It relies heavily on anti-realist ontology, in that meaning does not exist aside from human consciousness, and has nothing to do with an interaction with an objective reality (Crotty, 1998).

Constructionism rejects the objectivist and subjectivist view of the world and proposes that truth or meaning comes into existence in and out of our engagement with the realities of this world, and that both object and subject contribute to the construction of meaning (Crotty, 1998; Morris, 2006). As stated previously, this fits with a ‘both-and’ approach, rather than an ‘either-or’ approach. A constructionist epistemology fits with an enquiry into experiences of complaints because it allows for the interplay between objective events and subjective perceptions associated with incidents and decisions.

Phenomenology. Phenomenology was chosen for the research design because it is a paradigm which is congruent with the epistemology of constructionism and principles associated with the hermeneutic dialectic (Crotty, 1998; Morris, 2006). It is important to avoid a simplistic misrepresentation of the breadth and depth of phenomenology. It is a philosophical tradition that has been attributed to four key philosophers: Edmund Husserl (German mathematician, 1859-1938), Martin Heidegger (Husserl’s student, also a German philosopher, 1889-1976), Maurice Merleau-Ponty (French philosopher strongly influenced by Karl Marx, Husserl and Heidegger, 1908-1961) and Jean-Paul Satre (French existentialist philosopher, author and political activist, 1905-1980). An overview of the key ideas of these four philosophers provides an orientation to some of the phenomenological assumptions underpinning the approach taken to the methodology for this study.

Husserl was critical of science’s privileged knowledge claims and broke with the positivist orientation of science and philosophy in the late 1800s. According to Smith et al., (2009), Husserl hoped that phenomenology could “lay firm conceptual foundations for a different and more authentic science” (p. 15). One of the key ideas from Husserl was that of ‘eidetic reduction’, which aims to get at the ‘essence’ of the experience of a

particular phenomenon. Husserl was also primarily concerned with individual psychological processes, such as perception, awareness and consciousness (Smith et al., 2009). Husserl's 'eidetic reduction' allows the researcher to seek from participants the essence of their experience, the most basic components of it, what they perceived and lived with at the time, and what they perceive and live with now as a result of complaints. Eidetic reduction takes the research beyond a descriptive summary of events; it distils a core sense of what these experiences were about.

Heidegger however, offered an emphasis on the 'person in context', and the phenomenological concept of 'intersubjectivity'. The term 'intersubjectivity' refers to "the shared, overlapping and relational nature of our engagement with the world" (Smith et al., 2009, p. 17). It is important that in this study, the focus is broader than just individual psychological processes, and considers the person in context.

Merleau Ponty focused on the way in which one's perception of the other always comes from our own embodied perspective, in that we see other's actions with a different significance because we can never ultimately experience the other's experience. Along with Heidegger, Merleau Ponty "emphasised the situated and interpretive quality of our knowledge about the world" (Smith et al., 2009, p. 18). He underlined the inevitability of interpretation when we attempt to perceive or know the world. This is relevant to this study not only in appraising the perspectives of the research participants, but also in being transparent about the interpretations I make as a researcher and my basis for them.

One of Satre's significant contributions to existential phenomenology was to emphasize that existence comes before essence (Satre, 1946). This is congruent with the 'anti-essential' premise of constructionism (Burr, 1995), in that meaning is not a fixed

essential reality, but consciousness and meaning-making is an active, developmental, ongoing, process of becoming. This is an important point when considering the findings of this study. This study does not uncover fixed essential truths, but instead reflects the active process of participant's consciousness of their experiences of the phenomena of complaints, at a momentary point in time. According to van Manen (1990), "reflection on lived experience is always recollective; it is reflection on experience that is already passed or lived through" (p. 9-10).

Now that the original articulators of phenomenology and some of their key ideas have been briefly introduced, we can turn to the specific application of phenomenology to research. In contemporary times, phenomenology is a term that has been applied in many different contexts as a philosophy, paradigm, approach, theory and method. According to Patton (2002), varying forms of phenomenology are complex, in that transcendental, existential and hermeneutic phenomenology, offer different nuances of focus. Regardless of these different nuances, phenomenological approaches share a common focus on exploring how humans make sense of experience. Patton (2002) stated that this requires capturing and describing how people experience a phenomenon, including "how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others" (p. 104). This is exactly the expectation that has informed the research design and research questions in this study. The research questions enquire about how participants perceived their experience of decision making about complaints, and how they described it, felt about it, judged it, remembered it, made sense of it and talked about it with me as the researcher.

Hermeneutic phenomenology, using the Interpretive Phenomenological Approach (IPA) (Smith et al., 2009), was chosen because it offered a rigorous qualitative research methodology. It provided structured guidance on how the researcher

should 'read', 'interpret', and present the data. IPA involves interpretation through a process of analytic induction. Analytic induction is a method for attempting to derive theoretical explanations from a set of cases (Denzin & Lincoln, 2011). It is an iterative process, which requires the researcher to reflect on and modify his or her thinking in light of the next piece of evidence assessed (Smith et al., 2009). In order to manage bias and dominance of the researchers own assumptions in the inductive analyses, it can be assumed that qualitative researchers must be able to know and articulate their preconceptions up front, in order to separate, or at least delineate them clearly, within the interpretative process. Smith et al. (2009) reflected on the work of Gadamer and Heidegger, and argued that the process of discovering researcher preconceptions is highly complex, dynamic, non-linear and multifaceted, as follows: "Rather than putting one's preconceptions up front before doing interpretation, one may only really get to know what the preconceptions are once the interpretation is underway" (p. 26). Based on the literature review, I did have preconceptions that the impacts, power dynamics and needs associated with complaints would be revealed in the research interviews. However, in terms of the themes that were revealed in these categories, these were arrived by using iterative process of analytic induction.

In summary, phenomenology was the primary influence on the qualitative research design in that the questions and method focused on firstly, how humans made sense of their lived experience (van Manen, 1990); secondly, on describing how people experienced a phenomenon, including how they perceived it, described it, felt about it, judged it, remembered it, made sense of it, and talked about it (Patton, 2002), and thirdly, on interpretations using an iterative process of analytic induction (Smith et al., 2009).

Feminist theory. The final theoretical approach informing the research design was feminist theory. Feminism informed the research on multiple levels including methods, ethics and data analysis. As with any theoretical approach, there are a multitude of ideas and perspectives within this paradigm. This has been called the ‘varieties of feminist thinking’ by Tong (1995) and the ‘many feminisms’ by Crotty (1998). Tong (1995) presented seven types of feminist thought including liberal, Marxist, radical, psychoanalytic, socialist, existentialist, or postmodern. I am aware that I hold many of the assumptions associated with welfare egalitarianism, associated with a non-classical liberal feminist stance (Tong, 1995). Welfare or egalitarian liberalism focuses on social justice rather than civil liberties and calls for state intervention in the cause of equity (Tong, 1995). This is highly consistent with the values embedded into the AASW Code of Ethics (AASW, 2010) for social workers in Australia, to which I subscribe.

However, the feminist moral philosopher Virginia Held (2005) highlighted the need for an ‘ethics of care’ of which justice is one part. She stated that “care and its related considerations are the wider framework, or network, within which room should be made for the liberal individualism that has contributed so much to our understanding of justice and well-being” (Held, 2005, p. 88). She also stated that,

Care seems the most basic moral value... Without care... there would be no persons to respect and no families to improve... Within a network of caring, we can and should demand justice, but justice should not push care to the margins, imagining justice's political embodiment as the model of morality, which is what has been done (Held, 2005, p. 71-72).

This research study was concerned with both justice and care, and therefore feminist theories about both were relevant. However a critique of the political embodiment of justice was not the focus. Nor was a critical theoretical enquiry embedded with assumptions about injustice and oppression. The primary focus was a phenomenological enquiry about people's lived experience, power dynamics, and what they thought was needed within contexts of complaints and complex decision making. This research context seemed to warrant a centrality of Held's (2005) feminist approach to moral philosophy, to guide not only the methodology but the analysis of data as well. This research needed a theoretical focus which allowed exploration of what care, (and a lack of care), meant on multiple levels; morally, politically, ethically, in professional practice, and in relational interactions of various kinds.

Another way that feminism informed this research is because it focused on power, and in particular personal or relational dimensions of power. The feminist slogan 'the personal is political' (Hanisch, 1969) was relevant to an exploration of power in the context of counselling and therapy. Interestingly the slogan was the title of a memo published in a pamphlet in New York in which Carol Hanisch provided a radical feminist critique of the political assumptions embedded in the ideology of 'therapy' (Hanisch, 1969).

As a feminist researcher, Jenkins (2007) stated that one of her key preoccupations has been "making visible" issues of "power" and "positionality" (p. 83). As a social worker, researcher and practitioner I share this preoccupation. The second research question for the study has been influenced by this, in that it attempted to 'highlight' or make visible elements of participant experiences that related to power.

This raises the question of why a feminist or critical frame was not chosen instead of phenomenology, as the main approach to this research. Grossman and colleagues (1997) discussed some of the key features, practices and problems associated with feminist research. They firstly stated their bias towards an inclusive stance; that is to focus on what includes a study under the umbrella of diverse feminist philosophy, theory and method, rather than what excluded it. They argued that it is the ‘approach’ rather than the ‘topic’ that determines whether the research work is feminist or not. However, they also explored whether research is feminist if it included specific key attributes. These attributes included whether it challenges traditional or devaluing views of women; it uses methods of inquiry that provide alternative views of women’s lives; it looks at women within the meaningful contexts of their lives; it values a collaborative stance with participants; it considers sex and gender contrasts in context and within explicit theoretical frameworks; it explores alternatives that empower women and minorities; and it contains implications for social change (Grossman et al., 1997).

The reason that the primary theoretical frame for this study is phenomenological and not feminist is because the topic for this study did not primarily explore issues of gender and the lives of women. It had a broader focus on lived experience of men and women, and did not ask research questions about specific, pre-assumed patterns of oppression of women. However, in the literature review and in the data, power and gender were clearly represented as important themes. The studies on complaint statistics and case studies provided evidence of gendered patterns and dynamics, with men being the majority of respondents to complaints about sexual boundary violations, and women being the majority of victims of reported violations (Quadrio, 1996; Schoener et al., 1989; Strom-Gottfried, 1999, 2003). There are also gender patterns in the occupations which provide counselling, psychotherapy and casework, and also within client groups

(Pelling, 2005; Schofield & Khan, 2008). Gender also impacts relational dynamics within therapeutic and other relationships. Therefore, there was a need to pay attention to gender; hence the use of a feminist lens as part of the conceptual framework.

The other main feminist influence on the research design was that this study adopted principles from the ethics of feminist research (Grossman et al., 1997; Held, 2005; Tong, 1998). Simpson (2007) highlighted the importance of doing research in ethically sensitive domains, and of considering and managing the impacts.

Considering how research will impact upon the individuals and communities encountered is vital in creating any credible or indeed morally defensible, research programme. Whilst at times the ethical conundrums may appear un-navigable, the risk of shying away from whole areas and communities of research is to risk silencing often the most vulnerable and the least visible.

(Simpson, 2007, p. 157)

Complaints are an example of such an ethically sensitive topic, one which has not been well-researched.

Catherine Stimpson of Rutgers University confirmed that there are many streams of feminism in which “both men and women can be feminists”, including Held’s feminist moral philosophy (Stimpson, cited in Held, 1993, p. viii). Sara Delamont (cited in Carter & Delamont, 1996) supported this view and rejected the position of universalisation of position towards any category of gender. Powell (cited in Carter & Delamont, 1996) stated that both ‘feminist’ and ‘masculinist’ methodological influences include non-homogenous, rapidly emerging and divergent positions and streams and cannot be generalised. However he identified some of the problematic assumptions associated with ‘masculinist’ approaches to research methodology,

including that the 'good' researcher needs to be "semi-robotic, emotionless, although not so much that he is incapable of establishing for purely pragmatic and instrumental purposes...rapport" (Powell, cited in Carter & Delamont, 1996, p. 3). Powell asserted the inevitability of emotion in research, and for the need for more transparent discussion about it.

I support the critique of what Powell called 'masculinist' or 'traditional' research methodological approaches and I was deliberately not 'robotic' in interviews. However, at the same time I remained calm and took care not to dominate the emotional space between myself and participants. I experienced what I would call a duty of care to carefully set aside researcher 'neutrality' at times, and to use specific skills from a therapeutic approach. I attended to the emotions expressed by participants using interpersonal micro-skills such as reflection of feelings, and also statements of validation and care.

For example, in one interview by phone, the participant's voice became choked with emotion, and sounded teary. After the participant had disclosed some very sensitive and upsetting information associated with her experience of a complaint, I made several long statements of validation, and told her that I heard the depth of her concern for her family members. I then calmly said, "My heart goes out to you". I heard the participant take a large intake of breath, and was then very choked up. She then thanked me several times for saying that, for understanding and said it meant so much to her. I asked if she needed to have a break or get a drink of water, and she said, "No no this is good, it is helping, thank you". It appeared that a deeper level of validation of her emotions and sense of safety occurred due to my disclosure of my own emotions.

A qualitative researcher, Maurice Punch (1986) summed up how pivotal ‘access and acceptance’ is, as well as emotions and interpersonal skills, in the relationship between researcher and researched. He said, “Entry and departure, distrust and confidence, elation and despondency, commitment and betrayal, friendship and desertion are as fundamental here as are academic discussions on the techniques of observation...analysing the data and writing...” (Punch, 1986, p. 13). Punch (1986) also identified emotions such as “deep feelings of obligations to the researched” (p.73). When presenting excerpts from interviews in the thesis I found it very challenging to reduce the number and length of excerpts, because of what I realised were deep feelings of obligation to participants.

Power theories. Because the second research question of this study focused specifically on power, it was important to explore which theories and models about power would be used in the analysis and interpretation of the data. It was also important to make my assumptions about power clear. Therefore this section briefly reviews a range of theoretical approaches to power. It addresses phenomenological and feminist approaches to power because these are the two main theoretical approaches which form the conceptual framework for this research. Other approaches from theorists not categorised as feminists will also be explored because they offer concepts that are relevant.

As stated previously, feminism attempts to make power more visible (Jenkins, 2007). And yet within feminism there are many different paradigms in which power is explained and understood. Allen (2011) called on feminists to “spend more time explicitly discussing and defending their conceptions of power that up until now have been implicit in their work” (p. 17), and then went on to categorise feminist approaches to power into three broad definitions. The first is ‘power as a resource’, or something

that should be distributed more equally (Allen, 2011), which she said represents liberal feminist approaches. The second is ‘power as domination’ (Allen, 2011), which she said represents phenomenological feminist, radical feminist, socialist feminist, post structural feminist, analytic feminist and intersectional understandings. The third definition is ‘power as empowerment’ (Allen, 2011) which argues against what can be perceived as a ‘masculinist’ conception of power as a form of domination, and sees power as the capacity to transform and empower oneself and others (Held, 1993). In the research context for this study, all three of these broad conceptions of power are relevant. For practitioners, clients, complainants, complaint managers and regulators, power can be a resource, and can dominate or empower.

One example of feminist theory focusing on power as domination was from feminist phenomenologist Simone de Beauvoir (1974), in her book *The Second Sex*. De Beauvoir considered how women are situated in terms of power in social, cultural, historic and economic contexts. She argued that ‘transcendence’ versus ‘immanence’ is the essential tension relevant to an analysis of power. She conceived that ‘immanence’ is the historic domain ascribed to women, where women’s existence has been oppressed in any attempts at transcendence, and forced to exist in a passive way, being defined in relation to men and the masculine. She argued that men’s existence is associated with the domain of ‘transcendence’. ‘Transcendence’ in this context means to be active, defining, productive and powerful. Women’s existence has been oppressed through cultural, historical and economic forces, to the point that they are the ‘other’ in relation to the male ‘subject’ (de Beauvoir, 1974).

De Beauvoir offered an incisive gender analysis of inter-subjective power. However, as stated previously, the feminist approach for this research was one which did not apply universal categories to women and men, nor focus on gender *per se*.

Therefore, despite the use of a phenomenological methodology, a feminist phenomenological approach to power was not the most conceptually relevant approach for this research. Nonetheless, the concepts of transcendence and immanence, as well as the inter-subjective oppression of those who are ‘other’ in relation to the ‘subject’, are relevant, and will be discussed in the findings chapters on power.

Another relevant feminist theorist who has written about power is the feminist moral philosopher Virginia Held. As mentioned previously, Held’s (2005) moral philosophy influenced the way ethical considerations were approached in the research design. However, her philosophical theory also underpinned the analysis of power in the findings of this study. In essence, the analysis of the findings of this study required theory that focused on tensions between care and justice, rather than utilitarianism, deontology, or teleological ethical dimensions. This is because this study has a focus on the lived experience of human beings and their human needs within an industry explicitly premised on an ethos of care. Held’s (1993) moral philosophy importantly challenges the ‘masculinist’ notion of power as the “ability to cause others to submit to one’s will” (p. 136). She enabled an analysis of power to move beyond domination into positive forms of power. She stated that “the capacity to give birth and to nurture and empower could be the basis for new and more humanly promising conceptions than the ones that now prevail of power - empowerment, and growth” (Held, 1993, p. 137). The analysis of findings will focus on participant narratives describing empowerment and growth, as well as the factors which present barriers to this.

The eminent feminist US psychiatrist Dr Jean Baker-Miller (1976) also developed the premise of power as ‘empowerment’, within what she called ‘relational-cultural theory’ as explained in her influential book, *Toward a New Psychology of Women*. The theory holds that isolation is one of the most damaging human experiences

and is best treated by reconnecting with, and getting support from other people. Dr. Baker-Miller (1976) proposed that social competition helped provoke psychological illness and that the therapist's role was to foster an atmosphere of empathy and acceptance for the patient, even at the cost of the therapist's neutrality. These concepts are consistent with the feminist ethics of care approach. In the chapter on power, this is discussed in relation to isolation and a lack of support for parties to complaints, as well as social competition in the form of an adversarial culture in which many complaints are responded to.

The power to produce knowledge, and the assumptions embedded in the production of knowledge is a form of power, namely epistemological power. The tensions between epistemologies and theories within epistemologies highlight that all knowledge production is theory laden. The dynamics of epistemological power have been a pre-occupation for feminists such as Harding (2004), who has written extensively about "feminist standpoint theory". Historically, feminist standpoint theory derived many principles from Hegel and Marx, such as rejecting the liberal assumption that social and historical factors are irrelevant to the production of knowledge (Harding, 2004). Feminist standpoint theory offers both descriptive and causal analyses of experience, power, epistemology, and the effects of power relationships on the production of knowledge (Harding, 2004). These concepts were methodologically useful in the data analysis stage of the research, and informed interpretation of data on power. Feminist standpoint theory was also used to explore and make recommendations about how the knowledge produced by this study interacts with the societal structures in the contexts surrounding complaints.

There are limitations within any conceptual approach to power, including feminist approaches, and it is important that these be addressed. The limitations in some

feminists' portrayal of 'positive' uses of power such as care, nurturing, and empowerment were critiqued strongly by Wartenberg (1990), to the point where he said they are not recognized by some social theorists. Wartenberg (1990) pointed out that 'situated' power relationships and the ideological norms associated with social acceptability may be the ultimate theory which explains empowerment of others. He questions whether transformative power can be recognized as a theory, or something else. It is not within the scope of this thesis to prove or disprove Wartenberg's claim. It is clear however, that tensions exist between theorists about what constitutes 'theory' and which forms of power can be measured, detected or interpreted as applying to specific situations and relationships.

There are a range of other authors who have not been categorized as feminist theorists who have offered more narrowly defined models or typologies of power. These have been summarized below because they are useful in the analysis of power dynamics within the vast and often intangible dimensions of cultural, relational, systemic and institutional power, and the structural power that flows within all of these. Many of these typologies and definitions are congruent with, deepen or extend the wide ranging feminist conceptualisations of power as discussed previously (see Allen, 2011). I include some of them here because they offer specific, relevant typologies of power that are useful in the analysis of power in relation to the second research question for this study.

For example, the prominent US lawyer and academic Wesley Hohfeld (Hohfeld & Cook, 1919), defined power quite narrowly as the ability to unilaterally alter rights. Rights are a powerful resource that can be allocated. Denial of rights can mean domination. Protection of, and the ability to exercise rights can mean empowerment. He said that rights and duty are correlative concepts, and that one should not exist

without the other. Embedded within any 'rights' perspective on power is moral or normative ethics which define what constitutes which rights should and should not be allocated. This view of power as the ability to alter rights, and that rights and duties should be correlated is particularly relevant in the context of this research. At present, the 'accountability rights and duties' allocated to practitioners in different occupations are inequitable, especially for unregistered professions.

Social psychologists John French and Bertram Raven (1959) proposed five bases of 'interpersonal influence' and 'social power'. This included '*coercive power*' and the application of negative influences such as the ability to withhold reward, threaten or carry out threats, and instil fear of loss; '*reward power*' where the power wielder is able to confer valued rewards and benefits; '*expert power*' where skills and expertise are used to help others understand a situation, suggest solutions and use evidence-based or respected judgement; and '*referent power*' is the ability to administer to another a sense of personal acceptance or personal approval, where a person becomes a 'role model' and their charisma and interpersonal skills build loyalty to themselves and their ideas; and finally, '*legitimate power*' which is derived from a person's allocated, authorised position or duties (French & Raven, 1959). All five of these bases of interpersonal and social power were apparent in participant narratives and will be explored in later chapters.

Another theorist, Steven Lukes (1974) discussed "three dimensions of power" (p. 15-24). He said one dimensional power is decision-making exercised by formal institutions which could be measured by the outcomes of decisions. Two dimensional power is one dimensional decision-making power, plus agenda setting, and described the techniques used to achieve two dimensional forms of influence include inducement, persuasion, authority, coercion and direct force. Three dimensional power includes

aspects of decision-making, agenda setting plus the ability to shape preferences via values, norms and ideology. This view of power assumes that all social interaction involves power because ideas operate behind all language and action. This model is useful because it highlights the different dimensions which can impact on agency or capacity to exert influence. Participants in this study were impacted by all three of Lukes' (1974) dimensions of power, including the decisions by formal institutions, the agendas set by legislators and within the socio-political culture surrounding various occupations and industries, as well as the power of ideas, such as norms, values, and various 'healing ideologies' or methods purported by different practitioners.

At around the same time as Steven Lukes' ideas were published, the humanist, existentialist psychologist Rollo May (1972) offered his typology of five kinds of power. This included two 'negative' forms of power (exploitative and manipulative), one that can be 'positive' or 'negative' (competitive), and two that can be 'positive' (nutrient and integrative). According to May (1972), exploitative power is 'used on another' and is the most destructive form of power where the aggressor allows the victim no options in the exchange. Manipulative power is 'used over another' and refers to person's unequal in their power and resources, where the person with more power acts in their own interests to influence the others behaviour. Manipulative power is common in unfair interpersonal interactions that sometimes occur in power imbalanced relationships such as parent-child, teacher-student, therapist-client, Competitive power is 'used against another' which can be negative when one person gains only if another loses, but can also be positive if both parties gain constructive stimulation through the competition. Nutrient power is 'used for another' when an individual is concerned with the welfare of other people and use their power to advance and comfort others. Nutrient power is common in functional parent-child, friendship and intimate relationships.

Integrative power is 'used with another' and is the most constructive use of power. It is beyond nutrient power and is performed with the person instead of merely for the person – it inspires purpose and growth.

May's (1972) typology of power provides concepts within which to interpret the various power dynamics referred to by participants in this study. Furthermore, his definition of anxiety as "the apprehension cued off by a threat to some value which the individual holds essential to his existence as a self" (May, 1950, p. 72) is relevant also. It is relevant because it places the 'self' as the primary domain where threat and loss (or gain) of something of value can occur. This concept is important in this study because power dynamics had a significant impact on the intangible domain of the 'self'. Indeed the primary site of the impacts of power described in this study was the 'self'.

A final and much more recent theorist who has proposed a contemporary typology of power was Alvin Toffler (1991) who offered a critique of power at the 'edge of the 21st century'. His view was that there were three main kinds of power: violence, wealth and knowledge (Toffler, 1991). Two of these, wealth and knowledge were visible as phenomena referred to in participant narratives.

The above review of a range of theoretical approaches and typologies of power has demonstrated that definitions and conceptualisations of power are varying and contested. The analysis of power in this research study will refer to a range of theories and models in the process of interpretation of the major and minor themes that emerged about power. Discussion will focus on the different forms, types and flows of power dynamics. The aim will be to highlight, interpret and analyse the explicit and implicit references to power in the descriptions of their experiences provided by participants. It is not the aim to conclusively measure or determine the sources of power according to

one theoretical model. Whilst feminism offered a range of theoretical approaches to power, and these guided the ethical dimensions of the research design as well as providing moral theory regarding the ethics of care, and theory about epistemological power and empowerment, a range of non-feminist theorists and authors provided specific typologies of power that are relevant to the analysis of phenomena described in participant narratives.

Research Questions

The above conceptual framework influenced the development of the following primary research questions. Secondary questions used to structure the interviews are listed in Appendix A. Three research questions were used:-

- 4) How do complainants, respondents and third parties describe, reflect on and understand their past experiences of decisions regarding complaints about counselling, psychotherapy or casework?
- 5) What do the perspectives and experiences of complainants, respondents and third parties indicate about dynamics of structural and relational power associated with complaints about counselling, psychotherapy or casework?
- 6) What specific changes need to be made by the industry to effectively address the needs of various parties involved in complaints about counselling, psychotherapy or casework?

Conduct of the Study

Pilot interviews. As part of the preliminary stage of the conduct of the study, a series of questions were drafted to provide the format for semi-structured interview questions. These were then trialled in pilot interviews. Pilot interviews occurred with three people (colleagues) to test the interview questions and the ethical viability of

interviews from the complainant, respondent and third party perspective. Pilot interviews, of approximately two hours (complainant), one hour (respondent) and one and a half hours (complaint manager), occurred using the proposed interview questions to guide the interview.

The colleagues who participated in the pilot interviews were willing to use de-identified real examples from their own experience of complaints. This was particularly useful in the trial of the interview process, because it prompted discussion of ethical issues such as the impact of potential identification of complaints to me as an interviewer. I noted several issues after each interview. Firstly, in each interview, significant emotions, including hurt, distress, frustration, anger, regret and fear were expressed when recalling and discussing sensitive matters. In the complainant interview, the participant cried at various stages of the interview, even when the incidents discussed had occurred more than three years prior. I found that I needed to adopt an empathic stance and attend to the emotions as they arose. Secondly, the feedback from the respondent interview was that my colleague had chosen a minor complaint matter because of a concern about a risk to reputation if they disclosed a more serious complaint they had received about their practice. Thirdly, the complaint manager interview enhanced my awareness of how important it was to explain exactly how I would report on and de-identify cases discussed. There was considerable apprehension for colleagues in ensuring they spoke in a de-identifying manner.

The result of the pilot interviews was that they confirmed the importance of the informed consent process and also that as the researcher I took steps to ensure the interviews were emotionally safe for participants. I would need to attend to emotions and safety, including clear explanations of de-identification strategies. One of the participants in the pilot interview highlighted the need to self-select which complaint

matters they felt comfortable talking about, and this provided a rationale for keeping the criteria for complaint matters broad and inclusive of a range of matters. No changes to the interview questions or process were deemed necessary. Even when intense emotion had been felt by the participants, feedback about the responses I made to this during pilot interviews were positive.

Sampling. There is not a known finite population of those in Australia who have had experiences in relation to complaints about the practices of a counsellor, psychotherapist or case worker. Therefore a non-representative sampling method was used (Denzin & Lincoln, 2011). Because this was exploratory research within the context of a semi-regulated industry, the decision was made not to apply a specific sampling frame of, for example, those who had experienced complaints managed within a specific registered profession such as psychology, or psychiatry, or within a specific time period. The risk of identifying individuals would have increased had such a sampling frame been imposed, due to the fact that names and proceedings of tribunal hearings for these professions can be accessed by any member of the public.

Due to the sensitive nature of the topic, and the unknown level of interest or response, a careful, staged recruitment process was used. Participants were sourced through 'purposive' and 'snowball' sampling methods (Denzin & Lincoln, 2011). A list of possible agencies and professional colleagues was made, to whom I sent an email with information about the study, requesting them to pass on details of the study to anyone they thought may be interested.

Participant criteria. Three groups of participants were sought for the study (complainants; respondent practitioners; complaint managers) and 7-10 participants

were sought in each group, subject to review as the project unfolded. Participants were required to be aged over 18 years and capable of informed consent.

The first group was complainants, and though all attempts were made to recruit client complainants, only third party complainants (TPC) were willing and able to be recruited. The sampling criteria for the complainant group included clients who had directly received a service; partners, family, or friends of clients; members of the public; counsellors or therapists who had concerns about the practices of a past counsellor or therapist of one of their clients which led them to report, or consider reporting a complaint; colleagues; supervisors; and supervisees. The rationale for inclusion of such a broad range of complainant perspectives was based on the work of Schoener et al. (1989), and Strom-Gottfried (1999) in her analysis of complaints made to boards and professional associations in the US. This clearly showed that complaints have been made by people in any of the above roles, and not just by clients who had directly received a service.

Attempts were made to recruit client complainants who had directly received a service. However, all attempts to recruit client participants revealed difficulties which will be discussed below in the section about recruitment. At the end of the recruitment and interview process, it was found that only the third party complainant perspective was represented in the complainant group, and the name of this group was changed from complainant, to third party complainant.

The second group of participants was respondent practitioners (RP), which included any practitioner in Australia who had provided counselling, psychotherapy or case work about whom a complaint was made, either directly to them by the complainant or a person close to the complainant, informally or formally within an

organisation, or to an external body. The rationale for inclusion was that by including a range of standpoints, greater depth, richness and reliability in the qualitative data would result.

The third group of participants was complaint managers (CM). The criteria included any person in Australia who had had a paid or voluntary role which involved managing, providing information or services to parties to complaints, on behalf of an organisation. The complaints had to be about practitioners who had provided counselling, psychotherapy or casework. This included complaint enquiry officers, managers and supervisors; members of informal hearing panels as well as formal statutory bodies responsible for hearings; investigators; advocates; and legislators. The rationale for inclusion of these complaint manager perspectives was that they added a third standpoint, which contributed to the reliability of the research in a manner similar to 'triangulation'. If the study was limited to complainant and respondent perspectives, this would have overlooked key stakeholders who held positions of structural power in relation to parties to complaints. Their perspective on phenomena they experienced and observed in complaint contexts was valuable, especially given that they were likely to have had significant experience regarding decision making across multiple complaints.

The criteria for the complaint scenarios to be discussed by participants was that these needed to relate to one or more of the following:- serious matters of illegal activity, professional abuse, exploitation and practices in breach of professional boundaries or ethical codes, which resulted in harm to the client; use of ineffective methods which did not result in satisfactory or expected outcomes for client; practitioner impairment (physical or mental health, drug or alcohol, burn out or personal crisis) which impacted negatively on the client; breaches of ethical codes, including confidentiality, human rights and discrimination; lack of clear contracting about the

service to be provided; and any other matter, including those that may be seen as relatively 'minor' in severity by the party concerned. These criteria were informed by the literature about harm and complaints which specified the range of categories of complaints. The criteria was broad to enable inclusion of a wide range of different types of complaints, and make the process of recruitment easier in light of the perceived difficulties in accessing participants. The limitation of such a broad criteria of complaints was that the experiences researched could not be used to provide specific data about specific types of complaints, not about specific organisations or types of complaint hearing systems or methods.

The two compulsory criteria regarding content of complaint were that firstly, the complaint must have been about the services of a person representing themselves in the roles of counsellor, psychotherapist, therapist, caseworker or providing counselling, psychotherapy, psychological services, self-development, therapy or case work. If a 'pastoral care worker' or 'self development course provider' offered counselling, psychotherapy or casework activities as part of their represented services, this would be acceptable to include in the research.

Another criterion that applied to complaint situations was that the complainant in all cases had to have had sufficient concerns or intent to seriously *consider* reporting it, or report it. If a complainant had concerns about a practitioners practice but it never entered their mind to actually report it, this would not constitute a sufficient level of concern, and would not be appropriate for the study. The reason for this is that the study needed to focus on decision making regarding complaints, and if there was no thought given to a complaint, despite concerns, there would be insufficient relevance for the study. In most cases the matters discussed had been reported to someone. In one case,

despite significant contemplation about whether or not to report, the matter was not formally reported as the complainant was aware of many barriers to doing so.

Other criteria included that the complaint may have been about a person with no training or professional qualifications, or with qualifications including psychology, social work, psychiatry, nursing, human services, welfare, or education (for example school counsellors etc). The complaint may have been about registered psychologists or psychiatrists who were mandatorily registered with a registration board, as well as practitioners who voluntarily chose to be a member of a range of professional associations, or practitioners who chose not to be a member of a professional association. Therefore regulated, self-regulated and unregulated professions were included.

The complaint may have been about practitioners who worked for a government or non-government organization or in private practice. Participants may not have told anyone, or told others, either informally or formally about the complaint/s. There was no restriction on the timeframe for when the incident/s occurred, or the length of time over which decision making occurred. The timeframe for complaint matters was kept broad also for the reason that it was anticipated that recruiting sufficient participants may have been difficult, and a broader criteria would reduce barriers to participation.

When potential participants first contacted me expressing interest in participating in the study, I asked them whether they were comfortable with and preferred either face to face and/or email communication; and if they had access to a computer. Eighteen participants preferred face to face and/or email, and four participants were more comfortable with a phone interview. Murthy (2008) suggested that the reliance on computer based data collection methods meant that certain groups

may be disadvantaged on the basis of class, race, gender and literacy. Therefore alternate data collection methods of face to face and phone interviews were included.

Recruitment. Recruitment occurred purposively using a snowball method (Denzin & Lincoln, 2011) through targeted agencies and professional networks one at a time, with a scripted approach and distribution of a flyer (see Appendix B). A combination of phone calls and email was used to make contact and provide the flyer to recruitment contacts. Responses were received from each contact before the next step in recruitment via another agency or individual occurred. I did not request to be informed of who recruitment contacts disseminated the information to. At no point did any of the recruitment contacts inform me in an identifying manner about who they had distributed the material to, and not all confirmed whether or not they had passed the flyer onto others.

The rationale for selection of recruitment contacts was that they may have had knowledge of potential participants to whom the research could be advertised. The names of recruitment sources could not be included in this thesis as this would have potentially compromised anonymity of participants referred by these recruitment sources. Forty sources were approached within nine months. In all but one case, recruitment sources informally (rather than formally) distributed the research flyer to an undisclosed number of individuals and organisations in their networks.

In one case, a large organisation with jurisdiction for registered, and to a lesser extent non-registered practitioners, agreed to formally mail out information about the research to targeted individuals (respondents and complainants) on their database which yielded a 6.25% response rate (one individual) of participation. This organisation stated that because of the sensitivity of complaints about sexual boundary violations they

would not send the research flyer to those involved in such cases. Therefore they had sent the flyer to a total of sixteen (16) complainant/respondent pairs (a total of thirty-two (32) individuals), regarding complaints about services related to counselling, psychotherapy and casework which did not relate to sexual boundary violations.

It became clear that although recruitment contacts had distributed information about the research to clients who had directly received a problematic service, none of the individuals who made contact and agreed to be interviewed in the 'complainant group' were clients. It was reported in four instances by those who had attempted to pass information onto clients they knew of who had been involved in complaint matters, that the feedback had been that the client feared that the potential trauma of participation was too risky for them to proceed. Another example of feedback was from a recruitment source who had forwarded the research flyer to a colleague who had been involved in a sexual boundary violation with a client of a mental health service. The recruitment source stated that the potential respondent assessed they were still too traumatised by the experience, despite it being several years ago, to be able to speak about it. It appears that the level of psychological injury associated with complaint matters can be a significant barrier to participation in research.

Two potential participants who heard about the research after seeing a flyer from colleagues expressed a willingness to participate in the research. However, they were currently working within large government organisations and this presented an unforeseen barrier to recruitment. Complex ethics approval applications needed to be submitted to regional ethics committees before the research flyer could be responded to by workers in this organisation, and the organisation had the right not to permit workers to participate in the study. The two individuals who had been interested in participating after hearing about the study through informal channels made contact with me at a late

stage in the recruitment process, when only one or two further participants were required, and a deadline for completion of data gathering was imminent. Therefore the decision was made after discussion with supervisors, not to enter into what was likely to have been a three to six month long ethics approval process for more than one region of a large government organisation in order to facilitate participation for these participants. This has meant that the respondent practitioners who participated were not currently working within a government department, but were in private practice or working for a non-government organisation that did not require ethics approval for participation in research.

There was feedback also from some potential participants that as part of the process of the hearing of their complaint, they had agreed in writing that they would keep the proceedings of their hearings confidential and were concerned that research participation would breach this even by identifying themselves to the researcher, even without naming others involved in the complaint. It is interesting that such confidentiality agreements can contribute to the silencing of what are important and valuable experiences, ones which can be a rich source of learning and development for others in the industry.

The interviews were carried out in stages as participants were located, before moving on to recruiting and interviewing the next participant. Recruitment stopped after the interview with the twenty-second participant because of the significant amount and complexity of data that was generated from each interview. Transcription and data analysis had begun concurrent to the recruitment and interviewing stage, and it was assessed in conjunction with supervisors, that when the original target number of between 21 and 30 participants was achieved, there was no need to recruit further.

Data Collection

Overview of participants. There were twenty-two participants. As can be seen on Table 4 these included ten males and twelve females. Six were from the third party complainant perspective, five from the respondent practitioner perspective and eleven from the complaint manager perspective. All participants were invited to choose a pseudonym they wished to be used as a means of de-identifying but labelling their contributions.

Table 4

Overview of the Three Participant Groups by Participant Gender and Pseudonym

	Third Party Complainant	Respondent Practitioner	Complaint Manager	TOTAL
Male	Bruce Mark	Henry Joe Simon	Justin Alexander John Tran Zac	10
Female	Jen Mary Sarah Zoe	Sally Veronica	Annie Jessica Joan Lisa Saskia Stephanie	12
TOTAL (male:female)	6 (2:4)	5 (3:2)	11 (4:7)	22

To protect confidentiality and anonymity, demographic information about participants was not sought. However, the majority (all but four) of the participants were over 40 years of age. Participants were interviewed from four of the eight Australian States and Territories, and from a range of professions, occupations and organisation types. As shown in Table 5 participants in each group had different roles in relation to the complaints they discussed. Complaints were reported, or responded to, in different ways by each participant, to different organisations, and were about practitioners in a range of different practice settings and occupations.

Table 5

Overview of Context of Complaint Matters Discussed by Participants in Three Groups

Participant groups	Role/s in relation to complaint/s	Number of specific matters discussed	How reported?	Practice settings and occupation of persons complained about
Third Party Complainant N = 6	Person close to client = 4 Colleague to practitioner complained about = 2	1 matter = 6	Not formally reported = 1 Formally reported to manager = 1 Formally reported but no regulatory jurisdiction = 4	- Non government organisation - Government organisation - Private practice - Counsellor - Psychotherapist - Therapist - Self development counsellor - Social worker
Respondent Practitioner N = 5	Practitioner complained about = 5 Other roles discussed in relation to complaints about others = supervisor of other practitioners, colleague, manager of service = 5	1 matter only as Respondent Practitioner = 4 More than one matter/different complainants as Respondent Practitioner = 1 Number of other complaint cases discussed by participant from perspective <i>other than</i> as respondent = 12	Informal written complaint from colleague = 1 Formal written complaint/s to Board/Professional Association/ Government Body = 4 Same complainant lodging multiple complaints to different organisations = 3	All private practice - Counsellor (2) - Psychologist - Social worker - Psychotherapist

Complaint Manager N= 11	Voluntary management committee member, intake officer, panel member (voluntary and paid positions in a range of organisations), board member, executive officer, manager government organisation, complaint investigator, advocate, manager community organisation, consumer support facilitator.	Total matters referred to = 50 (including brief reference to some matters, and in depth discussion of others)	To boards, complaint commissions, misconduct commissions, ombudsman, government departments, non- government organisations, voluntary management committees, voluntary professional associations, government enquiries.	- Case worker - Child protection officer - Counsellor - Family therapist - Group facilitator - Relationship counsellor - Pastoral counsellor - Psychoanalyst - Psychiatrist - Psychologist - Psychotherapist - Self development counsellor - Social worker - Team Leader - Therapist - Youth Worker
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The complaint matters that participants' discussed included matters that had been dealt with in four of the eight Australian States and Territories by:- statutory boards; ethics panel's and committees of voluntary professional associations; health complaints and privacy commissions; managers, voluntary management committees and professional standards boards and committees of small and large non-government organisations (NGOs); managers and professional standards committees within government departments; ombudsman offices; misconduct commissions; the offices of parliamentary ministers; police; and courts.

Each of the third party complainants discussed only one complaint they had been involved in. Three of the six third party complainants discussed their experience of complaints about the same individual practitioner. These three participants were in contact with one another and had heard off the first participant I interviewed that the interview was a constructive experience. It was decided that when the subsequent two participants approached me requesting to participate in the study, that this was appropriate. Each of their experiences was unique in terms of their lived experience, and they met the criteria for the study.

Participants in the respondent practitioner and complaint manager groups discussed more than one complaint they had observed or been involved in. All of the participants in the respondent practitioner group discussed experiences of being a respondent to one or more complaints, as well as other experiences of being in a complaint manager role regarding other complaints. This appeared to suggest that practitioners who have been in the industry for any length of time will respond to complaints in many contexts, including complaints about other practitioners' practice.

The complaint manager roles ranged from senior executives and hearing panel members in government and non-government organisations, to investigators, advocates, enquiry or intake officers. Some complaint managers reflected on informal roles they had had in a range of organisations managing complaints, as well as formal roles on hearing panels.

The matters discussed in interviews ranged from current matters or matters within the past few years to matters they had made decisions about in the 20 years prior. A summary of the cases and perspectives discussed by each participant is provided at the beginning of the impact chapter. Participation in the research relied on self-report of facts and retrospective reflections on lived experience. There was no requirement of any objective corroborating evidence of events. However, any material evidence, including documentation of complaint and responses made by others in the decision making process was valuable. Six of the eleven participants from the third party complainant and respondent practitioner groups read information from formal complaint documents during their interviews. When they read from documents they were asked not to state names or identifying information about any other parties named in those documents.

Method used. A phenomenological method of data collection was chosen because of the limitations of other methods such as the Critical Incident Technique (CIT) (Byrne, 2001; Flanagan, 1954). As Byrne (2001) stated, one of the limitations of CIT in a previous study was found to be that “participants’ descriptions and embedded meanings emerged from a combination of experiences rather than from a single or clearly demarcated incident” (p. 2). In this research project, complaints involved multiple critical incidents. In these incidents, objective, real events did occur and were witnessed by those involved. Yet the objective facts of these were not identifiable or measurable by observational research methods. Only the subjective experience could be

examined through reflective dialogue to find out the manner in which the subject experienced the incident/s and had constructed meaning since the incident/s occurred.

In-depth semi-structured qualitative interviews used 15 questions as a guide for each interview (see Appendix A). Participants were given the option of Email-Facilitated Reflective Dialogue/s (McAuliffe, 2003) via a secure internet connection or face to face interview. Email Facilitated Reflective Dialogue had been used successfully in other ethically sensitive research (Egan, Chenoweth, & McAuliffe, 2006; McAuliffe, 2003; McCoyd, 2006) and was therefore provided as one option for participation should participants prefer it instead of a face-to-face interview. One participant specifically requested a telephone interview and a variance to the ethical protocol approved by the Griffith University Ethics Committee enabled this to occur. Telephone interview was then chosen by three subsequent participants for ease of scheduling a time for the interview without requiring travel to meet. The interviews were completed in one session in twenty cases, with two cases requiring a follow up interview due to lack of time in the first session. In the two cases where there were two interviews these were conducted within a one week period to reduce any risk of re-traumatisation through repeated opening up and retelling of potentially distressing material.

The sequence of contact with participants was as follows. First, there was contact by phone after initial recruitment through the purposive/snowball method. Communication then occurred by email and phone to establish whether the participant would prefer face to face only, email only, or a combination. Table 6 shows the method of interview used with each of the twenty two participants.

Table 6

Method/Location of Data Collection

Method/Location	No.	Participant Group
Email only	1	Third Party Complainant (1)
Email plus phone	1	Third Party Complainant (1)
Phone only	3	Third Party Complainant (2) Respondent Practitioner (1)
Face to face		
- meeting room at public library	1	Third Party Complainant (1)
- coffee shop nominated by participant	1	Complaint Manager (1)
- private offices of participants	14	Respondent Practitioner (4) Complaint Manager (10)
- home visit	1	Third Party Complainant (1)
TOTAL	22	

One email interview occurred. One interview commenced as email dialogue but at the participants request, changed to phone. The reason given was that it was difficult to get back into the flow of thought repeatedly when opening up each email with the next series of questions, and it was better to just talk about it in one session. The main reason participants gave for preferring face to face was that email took too much time, whereas face to face was completed with a time commitment of only a couple of hours meeting. Four interviews occurred over the phone (including the one that began by email and then concluded by phone). Seventeen face to face interviews occurred, including at a public library meeting room (1), a private area of a coffee shop nominated by the participant (1), and in participants' private offices (14). No interviews occurred in the researchers' workplace and the researcher travelled interstate many times to

conduct interviews. One interview occurred in a participant's home upon their specific request. Arrangements were made for a colleague to attend this home visit with me in accordance with safety protocols. The reason for the interview at home was that the participant felt they would be more comfortable in familiar surroundings discussing sensitive information and preferred not to have to travel from home. The colleague who attended this research interview with me signed a confidentiality agreement. The participant consented to this arrangement before the interview.

All face to face and telephone interviews were tape recorded and transcribed in full by the researcher. Hardcopy and electronic files were stored securely in a locked cabinet and password protected laptop. As showed in Appendix C, a total of 319,577 words of transcript data were collected. Transcripts ranged from 8,868 (John CM) to 20,203 words (Alexander CM), with an average transcript length of 14,526 words. The majority of data (48%) was from the eleven complaint managers, with 28% from the six third party complainants, and 24% from the five respondent practitioners. Individual transcripts were of different lengths partly because of differences in the amount of time the participant had for the interview. In interviews with complaint managers John, Tran and Zac there was only a one and a half hour timeslot available in the participant's schedule and this tended to mean responses were more succinct in order to cover all questions. Although it was important to attempt to achieve a balance in the amount of data contributed by each participant in the findings chapters, this was not possible because there were differences in the amount of data obtained from each participant.

Data analysis. Semi-structured narrative interviews and manual thematic analysis according to the Interpretative Phenomenological Analysis (IPA) method were used for data analysis as set out by Smith et al. (2009). The first step involved "reading and re-reading" each participants reflective narrative from a stance of being open and

not imposing any theoretical explanatory model up on it (Smith et al., 2009, p. 82). Reading and re-reading occurred through listening to audio-recordings and then transcribing each interview. The second step was “initial noting” (Smith et al., 2009, p. 83). This involved printing out each transcript and manually writing notes identifying core descriptions in participant narratives. According to Smith et al. (2009)

This is likely to describe the things which matter to them (key objects of concern such as relationships, processes, places, events, values and principles) and the meaning of those things for the participant (what those relationships, processes, places etc. are like for the participant (p. 83).

Initial noting highlighted what Smith et al. (2009) called “linguistic comments” (p. 88), noting participant language and phrases, which were then interpreted through what Smith et al. (2009) called “conceptual comments” (p. 88). One example was where a participant said they ‘went skinny as a rake’ and were not sleeping in the aftermath of a complaint. This linguistic phrase was highlighted with a highlighter pen then interpreted through conceptual comments about whether this could be interpreted as a mental health symptom of acute anxiety, post traumatic stress or depression as one of the impacts of the circumstances surrounding the complaint.

NVivo 8 (QSR International Pty Ltd., Version 8, 2008) software was then used to assist the efficiency of analysis. Each transcript was uploaded into NVivo 8, and segments referring to similar meanings were highlighted and categorised into what are called ‘nodes’ within NVivo 8. This produced one hundred and fifteen ‘tree nodes’, made up of a total of many hundreds of specific ‘child nodes’. The ‘tree nodes’ were then categorised under the umbrella of a smaller number of broader categories which were then identified as the major and minor themes and exceptions.

Interpretation and analysis took place through an eidectic (extraordinarily detailed and vivid), inductive (providing reasons which support conclusions) process (Smith et al., 2009). Several steps suggested by Smith et al. (2009) occurred next, including “developing emergent themes” (p. 91), “searching for connection across emergent themes” (p. 92), “looking for patterns across cases” (p. 101), and “identifying recurrent themes” (p. 107). Different levels of interpretation were used to identify the themes explicitly referred to by participants, and also interpreting evidence for implicit themes not directly referred to. As will be discussed below in the section about strategies to ensure reliability of qualitative research, the assistance of colleagues was used to compare and confirm the evidence for, and reasons why specific themes were interpreted from the data.

The next step was to move from thematic structures situated in each participant narrative to an overall thematic structure, which summed up sets of different types of phenomena. Themes were structured in accordance with the three research questions. These were then presented as themes.

Ethical considerations

Consent. Detailed consent procedures were carried out to ensure that participants had full information about the research and likely impact on them. Participant information sheets and consent forms (see Appendix D) were utilized as part of the informed consent process. Participants were asked when completing the consent form, if they wanted the opportunity to review their contribution after it had been made, and to re-consent to the intended use of the information; that is to see the excerpts to be used in the thesis and verify accuracy and satisfaction with the level of de-identification. Two participants preferred to do this and were provided with the findings chapters,

including the excerpts from their interview, prior to submission of the dissertation. One re-confirmed her consent.

The other apologetically withdrew consent for excerpts to be published. When withdrawing consent for the publication of excerpts, this participant stated that “Due to changes within organisational contexts it no longer felt safe to speak frankly and openly about the issues, in particular the fear of misinterpretation and misunderstanding of the comments made has been heightened, as has a fear of recrimination for open, honest disclosure”. This lack of safety, even when contributing to a de-identified research project, underlined the barriers to transparent exploration of sensitive matters. This participant’s interview made a very significant contribution to the data used to arrive at many of the themes. Feedback from this participant was that he appreciated the “sensitivity and cautious approach” I took as a researcher in response to his concerns.

Benefits and risks of the research. It was assumed that this research may involve benefits and risks to participants, and that it was important to plan strategies to manage risks. This dilemma had been faced by other researchers such as Disch (2001b), who included a follow-up debriefing questionnaire designed to gather data about respondent’s experiences of her research process. Results of the follow-up survey showed that nearly all respondents found the study to be both helpful and difficult. Disch (2001) concluded that “The fact that research on trauma is likely to be painful or upsetting even when it is helpful to respondents underscores the importance of making potential risks of participation very clear” (p. 221). Therefore, participants in this research project were advised that psychological and emotional distress was likely to impact on their capacity to function as a result of being asked to revisit and discuss unpleasant, distressing, disempowering or traumatic past experiences.

This research study was proposed on the assumption that the potential risks to participants would be outweighed by the potential benefits. If the research did not go ahead, there would be no risk to participants, yet there would also be no opportunity for members of the public to have input into changes to a problematic situation. Although the benefits of participation were not empirically measured, feedback on the interviews indicated that there were benefits from reflection on their decision making, and for some, catharsis and release of pain. Based on the feedback from some participants (mostly third party complainants and respondent practitioners) it appeared that interviews resulted in some integration of difficult or fragmented past experiences and/or steps towards closure. Of further benefit to participants was a sense of being able to influence constructive changes. A few complaint managers gave feedback that they had not had the opportunity to spend time reflecting on their role in regard to complaints and that it was beneficial in recognising their skills.

Management of impacts on participants. The ethical risks associated with this methodology were potentially considerable for some participants given the sensitivity and psychological distress associated with complaint matters and also the risks of being identified. Protocols to address these were contained in the ethics application which was approved after full review by the Griffith University Human Research Ethics Committee (HSV/17/09/HREC).

In order to manage risks there were participation criteria which specifically applied to group 1 (third party complainants) and group 2 (respondent practitioners). The incidents and experiences associated with the complaint must have been sufficiently in the past to allow for reflection in hindsight with sufficient safety. Each participant was provided with an information sheet which stated the potential distress that participation may involve. Participants were asked to self-assess whether they had

enough resources to enter the research with sufficient safety. This was also assessed in a preliminary interview. The way this was done included asking potential participants if they had identified support (family, friends, and therapeutic support if needed) to manage the inherent risks of psychological and emotional distress due to participation in the research, what their plan would be to access this support should they need it after the interview, and practical commitments of time, accessibility for interviews.

Because participants in group one had, or knew of someone close to them who had a problematic experience of counselling, it was not assumed that referral to counselling would be a suitable means of ensuring adequate support through the research process. Instead, individualized plans for support and safety were discussed prior to participation, based on each participant's situation.

In no case were there concerns regarding the reported health of a participant and there was no need to apply the protocol of asking for the name of a support person who the participant agreed could be contacted should the researcher have concerns about the need for support due to the impacts of the research. Instead, where there was distress during the interview, the researcher attended to this at the time, and also made follow up calls the day after, and in one case, again, three days after the interview to check wellbeing. The follow up was appreciated and the interview was described as an intense but very positive experience.

Participants were prepared for questions which asked them to describe and reflect on their experiences of complaints in detail. They needed to assess whether they felt safe enough in communicating with the researcher after the preliminary interview, and to raise any concerns prior to participation. They were assured that participation could be stopped at any point, and all transcripts would be returned to them if requested

up until a specified stage of data analysis and write up. No participant stopped any interview and all communicated that they were positive about the interview process.

Participants agreed in writing that they would not disclose any identifying information (name, location, and organisation) about the counsellor, therapist or caseworker who was the subject of their complaint or in any way that identified individuals involved in the complaint process. In interviews, participants were asked to use pseudonyms in discussions of relevant parties. In the written information provided at the outset it was stated that disclosures remained confidential between researcher and participant unless there was considered to be an immediate risk and duty of care. In this case the matter would have had to be discussed with research supervisors in light of relevant ethical codes of the AASW and the APS, and legislation. An outcome of such discussions, had they been required, may have been to refer the participant to report the matter urgently. In two cases there were disclosures which indicated ongoing severe risks to the wellbeing of clients but it was clear that all avenues of reporting had been exhausted and relevant authorities were fully and currently aware of these risks. Evidence was provided of this by participants including letters sent to relevant authorities. Therefore there was no duty of care to act further.

As part of informed consent protocols, participants agreed that they may receive written information provided by the researcher about their options for complaint avenues should participation in the research prompt them to want to take further action. Unless subpoenaed to do so, as a researcher I could not provide any reports about the content of research interviews to any subsequent investigators who somehow became aware of the interview. None of the participant interviews involved the need to provide information about complaint avenues because either the complaint had already been through complaint avenues, or there was no jurisdiction to report the complaint within.

Management of impacts on researcher. In all interviews the impact on the researcher was managed effectively in accordance with pre-planned strategies. These included safety protocols such as reporting in by phone to my supervisor immediately before and after each interview, and advising of my location; ensuring a colleague was present at the one requested home visit interview. My principal supervisor ensured that appropriate debriefing occurred soon after all research interviews. Whilst there were no problematic emotional impacts felt after interviews, the opportunity to debrief was beneficial and important to ensure that the interview experience was integrated and processed. The main impact on me as a researcher was associated with a general sense of moral distress about harm to clients, and the integrity of professions, and also a general sense of wanting to include much more context, detail, and lengthy excerpts in the dissertation, in order to reflect the complexity of people's experiences. Supervisors reminded me of my task and role as researcher which assisted me to manage these impacts.

Strategies to Achieve Trustworthy Qualitative Research

The validity and reliability criteria for this research project were informed by Bowen (2008), Guba and Lincoln (2005), Morse and colleagues (2002), and Whitemore et al. (2001). Guba and Lincoln (2005) stated that trustworthiness in qualitative research is ensured through strategies designed to achieve credibility, transferability, dependability and confirmability. In summary, the trustworthiness of this research was ensured through application of the following six measures outlined by Bowen (2008, see p. 148-149).

The first was "triangulation" (Bowen, 2008). The inclusion of three perspectives (third party complainant, respondent practitioner, complaint manager) provided richer

data regarding the phenomena associated with complaints, than a one-sided sample. It was particularly valuable in data analysis to see confirmation from multiple perspectives that specific themes were perceived as relevant, and to explore the differences and nuances in each perspective. This use of triangulation was particularly relevant to the context of experiences regarding complaints, where there was potential for polarisation of perspectives.

The second strategy was “member checks” (Bowen, 2008). Because the interviews were audio recorded and transcribed, rather than the interviewer relying on note taking or observations, the accuracy of contributions was able to be assured and checked if the participant wished to do so. As part of consent procedures, participants were asked if they did, or did not wish to see the excerpts of their contribution before these were published in the thesis to ensure that these were accurate and also that these were sufficiently de-identified, as was discussed above. A final strategy which partially served the purpose of ‘member checking’ was that there was an opportunity for participants to check and verify the overall findings and thematic interpretations after they received a participant report of findings. No participants reported disagreement with these themes and findings after receiving the report.

The third strategy aimed at increasing trustworthiness of the research was “inter-rater reliability” (Bowen, 2008). Three sessions occurred over a period of eight months involving myself and five other qualitative researchers in order to establish inter-rater reliability of coding and data analysis. Inter-rater reliability involved the use of a panel of individuals who met to independently code data, then compared and discussed their interpretations. ‘Coding panel’ sessions for this research study involved, at different times, my three supervisors, a colleague who had done qualitative research using a phenomenological methodology, and a fellow PhD student who had knowledge of the

study. The first session involved two supervisors and I reading a de-identified transcript and noting thematic comments, then comparing these. There was a very high level of congruence. Whenever there was a difference in the terms used by each member of the coding panel, this was discussed and through consensus, the final name of the code was decided and recorded. The second session involved the same process but with two different researchers and two different transcripts, and again congruence was very high and differences were resolved through consensus agreement on the term that best described the code. The third session involved me and a fellow PhD student coding a print out of sets of data I had coded into themes from interview transcripts using NVivo 8 (QSR International Pty Ltd., Version 8, 2008). This was an extensive process, and some discrepancies were identified regarding the categories. We discussed the basis for the interpretations made and arrived at some changes. One of the main outcomes of this final coding panel session was the differentiation of different categories of power in the presentation of themes about power. These were cultural power, relational power and structural power.

The fourth strategy used was “negative case analysis” (Bowen, 2008). Cases and participant narratives were re-examined to see which individuals and sections of specific narratives contradicted dominant thematic interpretations. These exceptions were made explicit and included as either a minor theme or exception in the presentation of findings.

The fifth strategy was an “audit trail”. Each step in the research process was noted in a research journal, showing evidence that it had been carried out in accordance with planned methodology, and that the links between information in transcripts and emergent themes and analysis were clearly justified.

The sixth and final strategy aimed at ensuring trustworthiness of the qualitative findings of this study was to ensure what has been termed “thick descriptions” (Bowen, 2008). Thick descriptions means that data should be used in a manner which showed participants’ attitudes and experiences were at the heart of all data sourced and presented. One of the reasons the thesis includes so many raw excerpts from participant narratives is because of the need to reveal “thick descriptions” and to show the reader that each theme was generated from what was expressed by participants. Although lengthy in places, participant narratives occupy the majority of each findings chapter, in order to meet the objective of presenting a rich portrait of people and their experiences.

These six strategies ensured that the research methodology was effective in producing reliable findings. The overall strengths and limitations in the findings will be discussed in the final chapter of the thesis.

Conclusion

The methodology chapter has presented the conceptual framework for the study, including the ontology of realism, the epistemology of constructionism, as well as theoretical perspectives from phenomenology, feminism and a range of theorists who have written about power. Feminism and theories about power have also been conceptually explored in the methodology because they will be used to interpret the data and themes relevant to the research question about power. Interpretative Phenomenological Analysis (Smith et al., 2009) and feminism informed the research method and strategies to ensure ethical research.

The rationale has been provided for three research questions, the conduct of the study, data collection and analysis using NVivo 8 (QSR International Pty Ltd., Version 8, 2008). Ethical considerations have been described in-depth, as well as the steps taken

to maximise the validity and reliability of qualitative findings of this research.

Limitations in the research design have been acknowledged.

Overall, the methodology chapter provided evidence that the conceptual framework and research design was robust enough to enable the conduct of an effective qualitative research project. The research process was sufficiently well-designed to provide participant safety despite inherent risks, and enabled the collection of rich, vivid, detailed data. Analysis and interpretation of this data produced major and minor themes, and exceptions. These have been categorised into findings about firstly, the impacts of complaints; secondly, cultural, relational and structural power dynamics surrounding complaints; and thirdly, the needs of those involved in complaints. These themes are presented and explored in the next three findings chapters.

Chapter Four

Impacts of Complaints

Introduction to the Findings Chapters

This chapter is the first of three findings chapters. Chapters Four, Five and Six begin with definitions of the terms used to describe each chapter. In accordance with a phenomenological approach, rather than using previous literature to define ‘impact’, ‘cultural, relational, and structural power’, and ‘needs’, I arrived at definitions for these terms after immersing myself in and interpreting data from participant narratives. Also in accordance with a phenomenological and feminist approach, the direct voice of participants is central to the findings, and therefore excerpts from participant narratives are presented throughout the next three chapters, as well as my discussion of each theme in relation to literature.

Efforts were made to present a balance of contribution from participants across the three findings chapters, and overall, approximately half of excerpts are from complaint managers, with a quarter each from third party complainants and respondent practitioners. It is noted where very few participants discussed a particular theme.

In order to get a sense of the types of matters and the contexts for decision making, a summary of the complaints discussed by each participant is provided below. Some participants discussed complaints from more than one perspective, for example, some respondent practitioners (RP) had also been a complaint manager (CM), and this is indicated. The summaries are intended to be referred back to, where necessary, throughout the findings chapters, to orient the reader to the context of each participant interview.

Complaint Matters Discussed by Participants

Third Party Complainants (TPC)

Jen TPC#1

Jen discussed her concerns about a colleague's inappropriate boundaries and poor practice with young clients. She did not report her concerns formally. She did not have direct evidence, as sessions occurred in private behind the closed door of her colleagues' office. Yet she observed body language which raised concerns for her, including the practitioner emerging from the office putting his arm around the shoulders of young male clients, and also, the practitioner approaching certain clients in what she sensed was an imposing yet intimate way, discussing their private information with them in interactions in front of others in the organisation. She also heard reports from clients about what she considered unhelpful advice-giving by the practitioner, rather than proficient counselling services, including religious advice that God would solve their problems. The problems faced by clients seeing the counsellor included mental health and self-harm, bullying, partner violence, financial, accommodation and family relationships, and warranted skilled counselling interventions.

Bruce TPC#2

Bruce discussed serious concerns about a professional colleague's casework practices involving vulnerable young clients with histories of severe childhood trauma in a residential care setting. The colleague was in a role with higher status above Bruce and other workers. Bruce was concerned about this colleagues' negligent practices, including:- giving a massage with moisturiser (shirt off) to a young boy with a history of severe sexual abuse and past incidents of him being a perpetrator of abuse on siblings and then reacting punitively when he had an erection and acted out sexually;

inappropriate religious advice being used as an 'intervention' when clients acted out sexually e.g. being told to 'go to church to meet Christian girls'; inaccurate case notes and inappropriate hand over protocols; frequent gift giving to clients to attempt to buy affection; favouritism and unfair punishment, including eviction from residential care; the colleague becoming emotional and complaining about how she was being treated by clients rather than actively managing team responses to serious behaviour challenges amongst client. There were multiple incidents over a six month period, including one incident which resulted in a client becoming physically uncontrollable. Bruce eventually reported his complaints at an exit interview and these were well received by his manager, who had not been aware of these practices.

Mark TPC#3

Mark discussed a complaint about the death of a family member who received services provided by unqualified practitioners in private practice who were providing self development services. Originally the matter was defined as suicide, yet eventually when another organisation enquired about it, the services were found to have caused a fatal psychosis and death of his family member. Because the practitioners were working in an occupation not required to be registered, there was no jurisdiction for accountability, sanctions, or requirements for supervision or monitoring.

Zoe TPC#4

One of Zoe's family members had been a client of an unqualified therapist and had become involved in a coercive psychotherapy group. The therapist used mind control and group brainwashing techniques to convince members to sever relationships with their family members, to spend special occasions and holidays with the therapist, to believe they had been sexually assaulted by family members, and eventually, that they

themselves were sexual predators who had assaulted others. Physical assault also occurred within the group. She attempted to make a complaint to more than four organisations, with no success as the practitioner was unregistered.

Sarah TPC#5

Sarah discussed her experiences after finding out that a family member had been the victim of mind control, hypnosis and false repressed memory 'therapy'. The 'therapy' led to false allegations against family members of sexual assault. The 'therapy' had been provided by an unqualified therapist in private practice. Eventually Sarah's family member stopped receiving services from this practitioner and retracted the allegations of sexual abuse and engaged in a process of repairing damaged family relationships. Sarah has attempted through numerous avenues to seek accountability for the practitioner. She discussed numerous complaints she made to a range of organisations. In the absence of jurisdiction over an unregistered practitioner, the matter remained unheard.

Mary TPC#6

Mary discussed her attempts to seek jurisdiction for a complaint about a case involving the services provided to two of her adult children by an unqualified practitioner in private practice. Mary described the cost to her, her spouse and other family members, as a result of the severing of contact by her children, and the loss of contact with her grandchildren. She said contact was severed due to the influence of a practitioner who used hypnosis, mind control techniques and false repressed memory 'therapy' to instil false allegations of physically and sexually violent abuse. She said the allegations of such abuse were investigated and dismissed by police, and no one who knew her children at the age the alleged abuse occurred reported any injuries whatsoever. Because

the practitioner is in an occupation not required to be registered there was no jurisdiction for the complaint.

Respondent Practitioners (RP)

Simon RP#1

Simon is an unqualified practitioner in private practice. He received a complaint from a former client who wished to have copies of file notes (needed for a court process) from sessions ten years prior, in which she disclosed sexual abuse. Simon had received advice that records only needed to be kept for seven years and did not have any files to give the client.

Henry RP#2

Henry discussed several complaints made by a former client against him, which he described as a vexatious complaint to several organisations over a period of a decade. Whilst he had technically breached his client's confidentiality, he had done so in a report provided to a party to court proceedings and the report provided very limited information. He said that while it could be regarded as technically a breach, it did not breach the spirit and intent of the rules. He also described the impact he felt when the complainant publicly informed others that he was unethical and incompetent, damaging his reputation. Yet he was not able, due to confidentiality, to rectify that situation by publicly or privately stating fuller circumstances to those who approached him. He could not explain the details of the complaints, nor that some of the complaints made over a ten year period, were not upheld.

Veronica RP#3 + CM

Veronica discussed a range of complaints, including those made formally to various organisations by one particular client alleging she had misrepresented her occupation. It

was a difficult complaint to respond to as she had not been responsible for the inaccurate occupation title ascribed to her by a third party who had quoted something she said. Another complaint was made by a member of the public to a different organisation, about her role in writing a report when she had a conflict of interest due to a personal relationship with the subject of the report. This latter complaint was admitted by Veronica and upheld, and was a source of regret and learning for Veronica. Veronica also discussed her own experience of wanting to, but refraining from making complaints about colleagues and those she was training, including about inappropriate sexualised standards of dress. She also discussed complaints made to her by her clients about previous interactions with other practitioners, including unwelcome reciting of bible verses as a method of grief counselling.

Sally RP#4 + CM

Sally was a respondent to a complaint her client made indirectly about her, to a medical practitioner who had referred the client to Sally. The referring medical practitioner then reported the complaint to Sally, stating that the client was too afraid to make the complaint directly to her. The client had felt she had been harmed due to Sally not acknowledging the psychologically abusive dynamics in her marriage. In her responses to the complaint Sally had acknowledged certain errors, both to the referring medical practitioner, and the client, and had decided to continue to work with the client. She felt afraid of how things would go if the client ever made a formal complaint after Sally had already acknowledged harm. Sally also discussed her role as a complaint manager supporting and providing information to supervisees who had complaints made about them in various large organisations.

Joe RP#5 + CM

Years ago, Joe had been in a very difficult period of his life due to a separation with his spouse. During this time he had seen a couple for marital therapy and then after the couple separated, had formed a sexual relationship with the wife, his former client. He was then pursued over a long period of time in a civil court lawsuit by his former client, the ex-husband, as well as by a regulation body. Joe acknowledged he did not have sufficient knowledge of ethics prior to the boundary violation, and his legal representatives identified that the rules governing former clients were not clear. Joe felt shocked and betrayed by the clinical and punitive manner in which the organisation hearing the complaint dealt with the matter. He also discussed other matters reported to him in his practice over the years, regarding boundary violations by other practitioners.

Complaint Managers (CM)

Justin CM#1

Justin discussed his experience responding to complaints in multiple roles over decades in a range of government and non-government organisations. Whilst Justin originally consented to have de-identified excerpts from his interview published, he then reconsidered and withdrew consent for the publication of excerpts from his interview. Therefore Justin's voice does not appear, even though it made a very significant contribution to the data. Justin's concerns about the impacts of his participation in the research underlined the sensitivity and risks involved for a complaint manager voicing his experiences.

Jessica CM#2

Jessica worked in a complaint manager role in an administrative capacity, and also in other roles as a line manager. For confidentiality reasons she did not refer to the details

of specific cases, but discussed her observations of parties to complaints, and a range of responses made, including cases where there was no jurisdiction for the matter.

John CM#3

John had decades of experience, including in a very senior role managing a complaint organisation. He referred to numerous complaints, including sexual boundary violations, practitioner impairment, misunderstanding of service provided, confidentiality and record keeping, inaccurate medico-legal reports, and a complaint from client displaying multiple personalities, stating symptoms were worse after treatment.

Stephanie CM#4

Stephanie discussed several different complaints she had responded to in a range of roles within a range of government and non government organisations, including hearing, investigating, and mediating complaints. Complaints ranged from boundary violations to matters involving the death, abuse, or injury of clients. She also discussed a lack of follow up in casework services which resulted in negative impacts on clients, and matters involving a lack of management of risk in a group work program, which resulted in a complaint from a client who alleged unfair exclusion from the program.

Lisa CM#5 + TPC

Lisa discussed a range of roles in different government and non government organisations in which she had investigated, heard and managed a range of different complaints formally reported to her. There was a complaint about inaccurate and incompetent medico-legal reports, conflict of interest with friends providing supervision and reports, and about practitioner impairment due to mental health issues. She also discussed her experience of being pressured by her employer to be a whistleblower, and

to lodge a complaint about one of her colleagues' unethical practices. The complaint could not be investigated without Lisa providing complex evidence which could easily be refuted by the practitioner. Clients were not aware the practices were unethical and regarded the practitioner favourably.

Joan CM#6

Joan had decades of experience managing government and non government services, including an organisation which provided advocacy services. She discussed cases including where a client was groomed to feel love for a practitioner through the intimacy of psychotherapy sessions, who met her in motel room and administered drugs then raped her; creation of dependence and over-servicing and the use of healing ideologies and methods that required significant time and financial commitments by clients; sexual and physical assault of clients by caseworkers in institutions; smoking marijuana and supplying alcohol to clients who were minors; fraud, including lack of accountability for paid hours of work; attending work drunk or on drugs; giving private phone numbers and meeting clients after work hours.

Annie CM#7

Annie had been in a role as advocate for complainants over several years. She discussed cases of physical and sexual abuse by caseworkers in institutions, as well as caseworkers in government and non government organisations who failed to act on reports of assaults on clients by carers, as well as sexualised boundary violations by counsellors and psychotherapists.

Saskia CM#8

Saskia's experience was extensive as a line manager, supervisor, and in roles investigating and hearing complaints. She discussed matters of breaches of

confidentiality; sexualised therapeutic relationships and sexual boundary violations; practitioner impairment; lack of accountability for work practices and paid hours; incompetent supervision practices; and complaints about child protection interventions.

Zac CM#9

Zac discussed his role providing information to the general public regarding the dynamics, and some specific cases of alleged harmful outcomes due to the practices of practitioners providing counselling and psychotherapy, especially as part of group programs. He reflected on his observations of the cases reported to him by members of the public, as well as the risks to him in making information publicly available.

Alexander CM#10

Alexander has extensive experience managing formal complaints as well as a separate role providing therapeutic support and supervision to practitioners. He discussed matters regarding grooming of clients, sexual boundary violations, and practitioner impairment.

Tran CM#11

Tran had decades of experience responding to complaints about a registered occupation, both as a complaint manager and a separate role providing therapeutic support and supervision. He discussed matters involving boundaries, the harmful impact of practitioner's narcissism, and what he called 'theory abuse', where a particular modality was used in a way which dominated the client.

Themes – Impacts of Complaints

Participant narratives provided evidence that complaints about counselling, psychotherapy and casework services have a significant impact on all involved. For the purposes of this chapter, 'impact' is defined as the effects, preoccupations, force, or impression on people from the incidents leading to the complaint and the complaint

process itself. Impacts are the implications and states of being that people experience and are left with due to their involvement in complaint matters.

Each complaint is as unique as a human fingerprint and therefore the impacts of complaints cannot be easily generalised. A fuller understanding of the impacts of each complaint could only be gained through thorough exploration of multiple perspectives from multiple individuals involved, in order to, metaphorically speaking, trace the unique contours of each fingerprint. Within the scope of this study, it was only possible to seek the perspectives of each participant on the matters they had been involved in. Therefore the findings in this chapter convey the most salient themes about the impacts described by individual participants regarding their own lived experience, and also their perceptions of the impacts on others.

A general theme noted in the data regarding impact was that complainants and respondents felt the impacts to a much more significant and pervasive extent than complaint managers. Complaint managers did feel impacts but to much less extent. Their observations of the impacts on parties to complaints have been included in the thematic analysis. The nuances and differences in perceptions of impact across the three groups of participants will be apparent in the participant narratives throughout this chapter, but the main aim of analysis was to identify phenomena regarding impact across all three participant groups.

The first theme is that complaints about counselling, psychotherapy and casework have a complex impact on people's capacity to manage expectations of all other parties involved. *Expectation management* involved a preoccupation with constant re-evaluation of what is presumed, reasonable or possible. The second theme is that complaints often involve multiple *costs, risks, barriers and burdens* which impact on

decision making. These costs include risks of negative impacts on health, wellbeing, relationships, income and capacity to function, as well as a significant cost in time and energy spent on complaints by all parties. The third theme is that many of the circumstances associated with complaint cases and the complaint processes themselves involve such substantial and lasting distress that the impact could be described as ‘layering’ of psychological injuries and traumas for complainants and/or respondents. *‘Layers’ of psychological trauma* was reported by most (though not all) complainants and respondents. Whilst trauma was not experienced directly by the complaint managers, trauma was observed by complaint managers as one of the main impacts experienced by parties to complaints. The fourth theme is that complaints invoke *intense emotions* which are often difficult to attend to. The fifth theme regarding impact was a sense of *futility and fatalism* which accompanied many parties to complaints at different stages of their decision making process. Futility meant a sense of uselessness in achieving the required purpose, and fatalism meant a sense of having no control and therefore no point. The sixth theme provided an exception which contrasted with the other five themes. This was that some participants reported that they experienced *learning and growth* as a result of their decision making experiences regarding complaints.

Complex expectation management. This theme explores the way that complaints affected people’s capacity to manage their expectations of others, and of complaint mechanisms. The descriptions of the types of expectations that needed to be managed defy generalisation. However, an analysis of participant narratives suggested that the main factors associated with difficulties in managing expectations included:-

- Distressed states of crisis, vulnerability, shock and confusion

- ‘Assumed’ expectations of others – e.g. trustworthiness, skill, fairness, and justice
- Unclear, contentious and/or non-existent ‘evidence base’ for practice standards as a measure for expectations
- Lack of awareness of, information about and/or jurisdiction from regulatory bodies
- Lack of clarity and predictability in standards of factual evidence and investigatory/hearing practices for complaints
- Polarisation of expectations and/or ‘taking sides’
- Need for skilled support to actively establish and manage expectations

Expectation management had a significant impact because it pre-occupied time, energy, and thoughts of all parties. This process of expectation management was complex and difficult because it often occurred in contexts of crisis, strong emotions, trauma and various mental health symptoms. This made it hard to think, and hard to find the words to express what had happened and what was needed or expected. There was also a sense of ‘assumed expectations’, that practitioners and their practices were automatically trustworthy just by virtue of their occupation title, and there was a sense of assumed expectations of care, understanding, support and justice from complaint processes. There was also a sense of intense complexity in grasping, explaining and managing expectations because people’s ‘minds’ were in what can be described as a uniquely confronted state. Words like ‘mind games’ or ‘mind bender’ were used to describe this mentally confronted state where it was hard to establish and manage thoughts and expectations, as shown in following participant narratives.

As a complaint manager, Annie reflected on the difference between medical and non-medical complaints. She underlined the extra complexities in expectations regarding complaints about 'intangible' counselling, therapy and casework.

So with the medical complaint it is something tangible...But if someone wanted to make a complaint about a counsellor, like, where is your evidence there?

People use different practices, they have different philosophies. Boundaries are different with everybody. It isn't as tangible. It is your word against theirs really.

In a complaint against a counsellor how do you prove that damage was done?

How do you show what was there before the counselling service and measure the damage done afterwards? (Annie CM#7)

Bruce was a third party complainant who had serious concerns about a colleague's practices with vulnerable young people who were living in residential care, such as favouritism, giving religious advice, massaging a client with a history of severe sexual abuse and then reacting punitively when he reacted sexually to the massage. Bruce reflected that although he registered shock when witnessing these actions, practitioners often do not consciously think about practice standards or what to expect from their colleagues, especially those in a superior position. This impacted on his decision making regarding the validity of his concerns and who to report his complaints to.

Most workers, even 'experienced' ones, likely have very little understanding of what is normal or acceptable or is reasonable to expect from [colleagues].

(Bruce TPC#2)

Zac, a complaint manager, commented that mind control and dependence in exploitative therapist-client relationships meant that clients became unsure about what to expect from a practitioner.

With your guru making all the decisions for you, you begin not to practice your own critical thinking in deciding what you will do with this or that. It's the brain or mental equivalent of a muscle that is not being used - it just wastes away. It's kind of still there but it's a lot harder to think. (Zac CM#9)

Henry (RP#2), as a respondent to a vexatious complaint, explained that the circumstances surrounding the complaint had to be understood in depth, and that 'commonsense' expectations could not be applied when attempting to work out what to do about the situation. Whilst he had technically breached his client's confidentiality, he had done so in a report provided to a party to court proceedings and the report provided very limited information. He said that while it could be regarded as technically a breach, it did not breach the spirit and intent of the rules. He also described the impact he felt when the complainant publicly informed others that he was unethical and incompetent, damaging his reputation. Yet he was not able, due to confidentiality, to rectify that situation by publicly or privately stating fuller circumstances to those who approached him. He could not explain the details of the complaints, nor that some of the complaints made over a ten year period, were not upheld. He used the terminology 'mind games' and 'mind bender', and said it was extremely difficult to be clear about what to expect regarding his own redress for the potential damage to his reputation.

Jessica, in her role as a complaint manager, also reinforced the theme of not feeling clear about what to expect or how to progress.

It felt really unclear and it was new territory for all of us. And I think we all struggled and felt impacted by that. (Jessica CM#2)

Jen also highlighted that there may be assumed expectations of practitioners in the helping professions. She realised that in hindsight her own expectation was that counsellors were automatically trustworthy and did not need to be monitored. She also reflected on the expectations of young clients of different cultural backgrounds dealing with a powerful adult in a counselling role.

The fact that they got that job means they've been signalled as a person of high esteem... In the clients' cultures, an older male will often be well dressed, well spoken, sort of strict in manner; will automatically have power over anyone in the room, top of the food chain. (Jen TPC#1)

As complaint managers, Justin (CM#1) and John (CM#3) said that it was very important to be clear about what to expect regarding the steps involved in an effective hearing process. Some of the pitfalls in expectations are to pre-judge too early due to the emotion and distress, and forget to step back at a distance and consider both sides. John confirmed the need for complaint managers to be clear about the expectations of their role, and that this was necessary in order to manage risks of over-identification with parties to complaints. He highlighted his perception of the different approaches of different professions and the influence on expectations regarding complaints.

...what I find is that health professionals are the worst people to judge themselves because first they identify with the respondents too much so they will dismiss things too easily. And in the sexual boundary ones or the obvious misconduct they go over the top the other way, and they say that's outrageous and they get all huffy about the professions reputation so their judgement gets

unbalanced. But we are just professional complaint handlers, that's what we do, and we don't get that confusion of roles...We had a mixture of staff and we had some social workers and they had a tendency to get more captured by the complainants and to sympathise with them more. (John CM#3)

John also explained the difficulties of being what he called 'captured by the complainant', and the consequences of keeping files open for a long period due to a lack of clarity around what can be done. This led to unrealistic expectations for complainants which caused enormous distress.

Because their [complainants] expectations would be all wrong and they would get confused and when they don't get an outcome... I saw the aftermath of it, is what happens when you don't do that with people up front, you keep building files, and because you have given them [the complainant] to understand that certain things would happen then you can't not do it and you can't tell them no because you have been promising for some cases two or three years. And I would see these files ... the investigators couldn't bring themselves to terminate so they just keep making more and more inquiries with practitioners or others, and the complainant becomes a basket case because the file is open for three or four years with no decision. And what has happened is that the investigator got captured by the complainant. (John CM#3)

Lisa, another complaint manager, reinforced the theme that there may be an expectation perceived by those involved in hearing complaints to be 'neutral'. This required some effort and was motivated by the need to meet expectations for a fair decision making process.

Because you feel sorry for both parties and we wanted to tell them 'I'm feeling for you', and you wanted to insert empathy and kind words and you wanted to really make them feel that you understand. But then you had to be neutral for both parties. Because if you gave one party too much airspace then you would worry that the other party is going to say you were biased. So I found that process quite difficult. (Lisa CM#5)

Justin explained that parties to complaints asked for 'out of the ordinary things' which prompted those managing the complaint to revisit what could be considered reasonable expectations.

Zoe, as a third party complainant, talked about the way those close to her gave her support in trying to manage her expectations in relation to the complaint. One of the expectations she had to manage was whether or not she could expect to be able to 'fix' or change the lack of accountability for unregistered practitioners.

He [partner] said 'you know, look, I value you for what you're doing and I appreciate why you're doing it but you need to know that you can't, you are not going to be able to fix everything' And I remember looking at him and going, 'yes I can' ... And I said 'look I promise I won't let it destroy me or us'. And he said 'that's all I want you to do. You do what you have to do, but when you reach a limit, that's it'. And he said if it starts to impact on... (daughter) and I, and he said I am going to tell you. And I went, 'okay I want you to'. (Zoe TPC#4)

Joan, as a very experienced complaint manager over many decades, reflected on the dynamics that can strongly influence and distort a client's expectations of what is reasonable. She observed that clients became enmeshed in a situation where they were developing more and more idealistic, distorted expectations of a practitioner and their

practice methods, often with powerful pseudo-spiritual components associated with a specific purported healing ideology and method. For clients who were disillusioned with the mode of service provided by mainstream 'maintenance' psychiatrists and psychologists, alternative modes of therapy promised much. Joan said clients were trapped between two 'realities' and it became impossible for them to develop realistic expectations of what would help them with their mental health needs.

It had ceased being helpful but they felt indebted to the [practitioner]. Rather than saying good bye and that you value what you have learned from it and how do you now take that back into your real life. If that did happen then you know suddenly they'd start getting on with their partners a bit more because this separating people from their support network is something that was really obvious with that group of women and men who were into [model of practice]. Because they just committed their whole lives to it. They did those weekends and it cost them a fortune and most of them didn't have that much money to throw around. And then some flipped into the psychiatry world and then ended up with maintenance psychologists and psychiatrists and all of that... It's sort of like people were trapped between this highly personalised and intimate, almost spiritual reality, and then this really harsh reality where they don't even talk to you - like the psychiatrists who just make the diagnosis and give you a pill. So people were really trapped between those two realities... (Joan CM#6)

Alexander summed up his observation of the difficulties clients face when managing their expectations of practitioners. He said that the more vulnerable a person is, the less likely they will tune into the signs that they are being abused. He says that it is crucial for people who seek counselling services to have an outside influence to help them establish reasonable expectations.

The less need they are in for counselling, the quicker the light bulb turns on that this counsellor has an agenda, and the agenda's not necessarily in the interests of the client... Those sort of people tune in very quickly. Unfortunately we have complaints, and I've received a recent one, this is a practitioner who has been counselling them for two years, and it's taken them to, it's taken something in their personal life to give them some sort of strength, to actually reflect on what's happening, to realise that they've been abused in one shape or form or another, whether that be financial, physical, whatever...or it takes an outside influence to make them aware. (Alexander CM#10)

In summary, the phenomenon described as 'complex expectation management' appeared in many participant narratives. Interpretation of the narratives established that one of the main conscious or unconscious pre-occupations during complaints, was expectations of self, others, and systems. The phenomenon of complex expectation management was associated with experiences of vulnerability and mental health symptoms, and a lack of accessible information and reference points to guide decision making. Expectations were powerfully influenced by the charismatic power of practitioners and ideologies associated with particular 'methods' of 'healing', to the point where it was perceived that it was impossible for some clients in some situations to 'think for themselves'. The 'mental muscle' which provided the capacity to critically reflect on the service they were receiving was not working. There appeared to be a need for processing of information regarding complaints with someone skilled, and for support from others in working out what to do and what to expect.

The phenomenon of difficulty managing expectations appeared also for respondents in situations which needed considerable explanations of details in order for

people to appreciate their responses to complex allegations and incidents. It was not clear what to expect when seeking redress for the impact of vexatious complaints.

For complaint managers, the phenomenon of difficulty managing expectations appeared to be a process of constantly managing new information and the emotional impacts of it, of hearing and responding, and for some, being conscious of the aim of not ‘getting captured’ by a complaint, and not over-identifying with parties to complaints. The lenses or paradigms through which decision makers filtered their perceptions of complaint matters and parties to complaints, (such as defining parties as victims and perpetrators according to models of exploitation and abuse of power) appeared to have a powerful impact on expectations and decisions.

Expectation management also occurred in an industry context of evolving and/or contentious, or non-existent evidence-based practice standards. There was also a lack of jurisdiction, inaccessible regulatory bodies and lack of support resources, as will be discussed in later chapters about power and needs. Participants from all three groups described phenomena where expectations were complex, intangible, unpredictable and unclear rather than straightforward, concrete, stable and clear.

While this study found that complex expectation management is one of the key impacts experienced by those grappling with decisions about complaints, it was not possible to find previous empirical research specifically about expectations of complaints about counselling, therapy and casework. In a book about how to ‘survive’ complaints about counselling and psychotherapy, Jones (cited in Casemore, 2001) said that from the beginning of any helping relationship, the practitioner and the client bring uncertainty, and that when managing and responding to complaints there is a need for “acceptance of uncertainty” (p. 131). Material made available by the Prevention of

Professional Abuse Network [POPAN] is largely aimed at assisting consumers to manage their expectations, to identify warning signs, and to enter into any relationship as a service recipient with clear, conscious expectations of how to identify risks (POPAN, 1998). Other professional literature such as codes of ethics, also underline the importance of contracting regarding expectations (AASW, 2010; ACA, 2013b; APS, 2007). Therefore, the finding of this research that the phenomenon of complex expectation management was a key impact in complaint contexts is consistent with broader industry assumptions that careful management of expectations is important.

Costs, risks, burdens and barriers. The second theme regarding impact is that parties to complaints experienced many costs, risks, barriers and burdens which impacted on decision making. These costs can be summarised in the following categories:-

- Time, energy and stress pre-occupied with complaint
- Loss of wellbeing and capacity to function – including trauma symptoms
- Death due to fatal psychosis and suicide
- Loss and damage to relationships – loved ones and colleagues
- Loss of privacy, distress at exposure of private information
- Threats to reputation, employability, organisation's funding
- Financial costs – legal fees, complaint procedural costs, loss of income
- Reporting of complaints was prevented by compromised wellbeing, existing burdens, and perceived further costs of reporting – also burden of anxiety and guilt from non-reporting
- Ongoing burden of damage to sense of 'self'

As stated in the previous theme, the process of intense expectation management was costly in terms of time and energy taken up in cognitively and emotionally processing expectations, whether consciously or unconsciously. Furthermore, as will be discussed below, trauma and re-traumatisation was one of the most significant burdens on daily wellbeing. There were also other costs financially, and in the form of damage to family and other relationship systems on a large scale. Whistleblowers and advocates faced ostracism professionally, and received personal threats in some cases. One of the most important themes was that in some cases discussed in participant narratives, the perceived costs of reporting a complaint were so significant that participants did not report complaints. The preoccupation with, and impact of costs meant that some complainants did not formally lodge a complaint, or ceased pursuing a complaint for fear of the costs and risks to them or others. This left them with another form of burden – anxiety and guilt about the consequences of not reporting.

Mary was a third party complainant in a case involving the services provided to two of her adult children by an unqualified therapist in private practice. Mary describes the cost to her, her spouse and other family members, as a result of the severing of contact by her children, and the loss of contact with her grandchildren. She said contact was severed due to the influence of a practitioner who used hypnosis, mind control techniques and false repressed memory ‘therapy’. Mary’s situation shows that there can be a significant, large scale systemic impact and cost to families as a result of exploitative and abusive practices by a therapist. There were also significant financial costs as well in lawyer fees to attempt to reinstate visiting rights with grandchildren.

We weren’t allowed to see the kids. But we tried to go through a mediation with her, and with the pair of them, but [daughter], we didn’t hear anything from her... So we went to a lawyer then... a thousand dollars later and two letters

later, we, oh we had to see the kids in a park, out in the open, and they weren't allowed to be out of his sight, I can't remember the exact criteria she put down, and my husband said this is rot, we're not going to adhere to this. So he wrote a letter to her, and he said 'how would you feel if these accusations were levelled at you?' So we promptly got a letter... and that if we wrote a letter again, it had to be through the lawyer or the letter would be put in the bin or something to that effect anyhow. So we were still on square one. (Mary TPC#6)

Another third party complainant, Mark, also described his perceptions of the costs and barriers faced by some of his wife's family members in the process of having a complaint heard and investigated. The cost they feared was that their loved one's personal intimate information was going to be publicly exposed as part of the hearing process, when it was only ever intended to be discussed within the confidentiality of the therapeutic relationship.

They didn't participate. They didn't go to the [hearing]. They wrote to the [complaint organisation] and made me sign a letter too, that they wanted it to stop... But they did [hear the matter] anyway, thank God. They didn't want the public spotlight... Because people seek [counselling/therapy services] because they have got a few little scars... it was written on pieces of paper that she submitted to the [practitioner], because they ask you to write down what are the issues in your life, and all of that became public. (Mark TPC#3)

Both Annie and Justin, who are complaint managers, discussed cases where those involved had mental health symptoms which affected their participation in complaint procedures. For example Annie (CM#7), observed costs faced by one particular complainant, whose mental health symptoms of agoraphobia were a

significant problem. Justin (CM#1) had repeatedly observed respondents who had been experiencing severe mental health symptoms in the lead up to complaint hearings.

Bruce, a third party complainant, weighed up several potential costs and impacts in his decision about whether or not to make a complaint about unethical and negligent practices of a colleague. Although Bruce was angry about these practices and the harm to clients, he realised in hindsight that he had feared complex impacts and costs if he reported matters formally and had to then deal with a breakdown in his workplace relationships. When he eventually decided to leave the job, he felt he had 'nothing to lose' and then made the formal complaint to a manager at his exit interview.

... even if [colleague] cut my hours down I had more [work] offered than I could poke a stick at... I really only made the complaint as I was extremely bitter, frustrated, angry and about to get on a plane to fly to the other side of the globe. I had nothing to lose. (Bruce TPC#2)

Lisa discussed her experience of being pressured by her employer to be a whistleblower, and to lodge a complaint about one of her colleagues' unethical practices. The complaint could not be investigated without Lisa providing complex evidence which could easily be refuted by the practitioner. Clients were not aware the practices were unethical and regarded the practitioner favourably. Lisa felt there were costs and risks either way she went with her decision. If she did complain, she faced risks to herself. If she did not complain, she felt responsible for the impact on clients.

Where my level of discomfort lies is the perceived pressure from the [organisation] to pursue this and my ethical responsibility as a [practitioner] to pursue that. Even though as an individual I've made the decision that the cost is too high and the [organisation] basically said they are not going to do it without

me. So it would have to be me taking it on. Like I said, my assessment is that the cost is not worth it. But then having an organisation place responsibility on me, in terms of my ethical responsibility for future clients - that's hard. (Lisa CM#4)

This theme of complaints being costly, full of barriers, difficult to surmount, hard, burdensome, involving costs no matter what you did, was also experienced by Zoe. Although she pursued a complaint with numerous organisations, including politicians, she arrived at a point where the personal cost overwhelmed her. Then she was left with the guilt that she should have been able to do more.

I said 'I can't do it [name of family member]. It is just too horrible. It is just too hard. I can't'. And she just looked at me and she understood. And I didn't feel like I'd let her down or [other family member] down in any way. But I had just reached that point... And it was so hard, I kind of felt guilty afterwards. (Zoe TPC#4)

Jen had faced a decision about whether to report her concerns about a colleague in a counselling role. She clearly weighed up costs and impacts when assessing her course of action.

Fundamentally, in that situation that wasn't the highest risk of clients being molested in the office. But what I saw was much more subtle and still powerful – some sexually creepy guy with lots of power issues imposing himself in a powerful role with young vulnerable clients... I remember [colleague in a higher position] saying she chose her battle and he was one of them. And that was really obvious to me that I wasn't going to choose him. I could only handle so much and that's why I didn't choose him. (Jen TPC#1)

Veronica is a practitioner who has observed that clients tend to bear the cost of problematic practices themselves and use coping strategies rather than complain. She also said that part of the problem is a lack of information about practice standards and accountability measures.

So I have had clients...and the one that stands out to me had just had her three-year-old drown, and she found someone in the phone book who said they were a grief counsellor and through the whole session, about every 10 minutes, read a bible verse to her. And her response was not to say anything to the counsellor, but not going back there and coming to see someone else... I think clients, the public needs to know when things are not kosher, or when things are amiss, that the answer is not to just 'not go back'. (Veronica RP#3)

Joe, a respondent practitioner responding to a complaint about an intimate relationship he formed with an ex-client, described the potential cost he faced of losing his job and career as a result of the complaint against him.

But very aware that in that process I was potentially losing my career, losing control, or potentially losing control of my life as expressed as a professional person. (Joe RP#5)

Zac, a complaint manager, faced significant threats and impacts including legal challenges from a practitioner when information about harmful impacts of their practices had been published. Zac had adopted strategies of assessing public interest, and when he should publish, and also took on an undercover role in order to protect his own welfare.

...the cone of silence. It is very much undercover. It is not something for cowards as I learned when we had the legal grief with [practitioner]... our legal

guy explained that there are issues here and you can be held accountable for what is being published and this is what has happened to other people etcetera. And you do have this moment and you sort of go, 'oh do I really want to be doing this?' ... and then you go, 'well damned if I am going to be a coward' ... You've got to be ready to pay a potential price and count the cost and be prepared to pay it. (Zac CM#9)

Joan also described the risk she, and the complaint advocacy organisation she worked for, faced when high profile practitioners who were being complained about attempted to gain enough political influence to shut down the complaint advocacy service. Joan said she also got threatening phone calls from practitioners as well. She said it was important that this be revealed, as she thought most people would not realise how risky and potentially costly it is to become involved in challenging those in power.

I had the [person representing organisation complained about] write to [high profile political leader] asking to de-fund us. (Joan TP#6)

Joan also described the professional costs including practitioners who were ostracised and passed over for promotions and key positions after they took on the role of whistleblower or advocate for those making complaints in child protection or health.

I think the culture has changed a little bit now but I'd hate to be anyone whistleblowing on a child protection person or someone in the health department. There was a really strong advocate at the [organisation] and she's been ostracised over the years and she can never get a job. She is a brilliant advocate. (Joan CM#6)

It is clear that complaints involve a range of significant impacts in the form of costs, risks, barriers and burdens which make it difficult to pursue and sustain the complaint process. The impact of these barriers, costs and risks may mean that some

complaints are not formally reported. Under-reporting of complaints has been evident in previous literature. For example, literature from several decades ago (including Bernard et al., 1987; Gartrell et al., 1987; Hutchinson-Mittendorf & Schroeder, 2004; Wilkins et al., 1990) regarding psychologists', psychiatrists' and social workers' awareness of boundary violations by colleagues found that compared to the rate of awareness of incidence, the rate of report of ethical misconduct was infrequent. Biaggio et al. (1998) referred to "obstacles", "forces" and "barriers" which prevented reporting, including "ties of loyalty to colleagues and institutions", "fear of negative repercussions and personal costs", and "insufficient understanding of, or information about the ethical guidelines or the conduct in question" (p. 275). The findings of this study confirm cases recently reported in the media in the UK (Lakhani, 2012) and in Australia (Helbig, 2012), that those who speak out about complaints within their industry may face costs and threats to their reputation and employability.

Another serious cost associated with complaints and the incidents that led to them is the cost of human life as a result of death due to fatal psychosis and suicide. There is evidence of the cost to human life in previous literature. For example, Australian psychiatrist Warwick Middleton has reported on the suicides of prominent practitioners after being found guilty of sexual misconduct (Middleton, 2004). In regard to the death of clients, it was found by New South Wales Deputy State Coroner, Malcolm McPherson that the death of a client of a self-development course conducted by unqualified counsellors, was caused by a fatal psychosis triggered by practices used as part of the course (Coroners Court of New South Wales, 2009). Other evidence that death can result from harmful practices and the resultant complaint procedures includes reports of suicide of complainants and respondents to complaints. For example, Pope and Vetter (1991) presented the results of a US survey study which outlined the

characteristics (reported by subsequent treating psychologists) regarding 958 clients who had been sexually involved with a previous therapist. Fourteen percent attempted suicide and one percent committed suicide (Pope & Vetter 1991).

A local Australian case example of the cost and risk to human life for those involved in complaints was the tragic suicide of a client who had repeatedly been disbelieved when attempting to report sexual abuse by his counsellor. The counsellor also suicided himself when he was eventually charged with sexual abuse of clients at Brisbane Grammar School and St Pauls Anglican College (Callinan et al., 2000; Callinan & Murray, 2001).

Such published cases suggest that the costs, risks, barriers and burdens reported by participants in this study are phenomena that have existed and continue to exist in related fields. There appears to be a strong link between costs, risks, barriers and burdens, and the decision not to report complaints.

Layers of psychological trauma. Participants described a range of traumatic impacts involved with complaint matters. Depending on their role as third party complainant, respondent practitioner, or complaint manager, they may have experienced the traumatic impacts themselves, and/or observed these impacts on others. Even though the complainants in this study were not direct clients of services, the impacts they experienced and observed others experiencing (including clients and others close to clients), were still described as traumatic in most cases. This is a significant finding which underlines the scale of impact on persons other than just the client who directly received the service.

Traumatic impacts resulted from incidents leading to the complaint and any aspect of the decision making and hearing process regarding the complaint. There was a

strong theme of ‘layers’ of trauma, where there had been crisis, stress or traumas of various types that led a client to receive help from a practitioner in the first place, and then there was added trauma on top of the original stress if they considered seeking redress for a complaint. Respondents also described being traumatised, or experiencing added trauma in the complaint process.

In arriving at a definition for this theme it was important to grapple with terminology and definitions. The term ‘traumatised’ was commonly used by participants and therefore this term was chosen to describe this theme. However it is important to highlight the unique context and idiographic nature of each complaint discussed by participants, and not to lapse into generalising. Not all complaints involved trauma, and the trauma was different in every case. In order to clarify our understanding of the impact of complaints it is necessary to deconstruct the meanings ascribed to ‘trauma’, ‘traumatic’, ‘traumatised’, and ‘re-traumatised’. These terms appeared to be used by some participants to convey meanings which parallel aspects of the symptomatology of clinical disorders such as acute stress disorder (ASD) and post traumatic stress disorder (PTSD). Trauma appeared as a phenomenon in multiple layers which had profound and complex impacts on people. In each layer of trauma, there had been harm or threat to psychological safety involving helplessness and fear, and then various forms of what could be interpreted and categorised as hyper-arousal, re-experiencing and avoidance. Yet, it was also clear that the meanings ascribed to ‘trauma’ by participants went far beyond ASD and PTSD, as their descriptions revealed a range of ‘traumatic’ short and long term impacts. These impacts and symptoms were highly complex, multi-faceted, and involved acute and ongoing injuries psychologically, and also to relational systems (damage, severing and altering of pre-existing relationship systems).

The following narratives provide descriptions of traumatic experiences in participants' own terminology, and also their observations of the trauma experienced by others. They describe aspects of the lived experience which demonstrate a range of impacts under the theme 'layers of psychological trauma'.

Alexander, a complaint manager and practitioner, summarised some of the traumatic impacts in complaint matters he has dealt with. His terminology demonstrated the scale of trauma experienced by complainants.

We've had complainants who've obviously been financially disadvantaged by the [practitioner], that's a deep concern. We've had people who are obviously close to being suicidal, if not suicidal, because [practitioners] have leveraged their position as a [practitioner] to have an affair, or to enter into a relationship with a partner of a client for the wrong reasons. That's soul destroying. A couple go to counselling then suddenly one of them goes home to find the [practitioner] having an affair with the other one, and they went to the [practitioner] for this trust, to help fix their relationship... Not only that, there's nothing we can do for the peripheral, for the children, other members of the family; it has a significant domino impact. (Alexander CM#10)

Alexander also highlighted the role of trauma in the background of some practitioners as a contributing factor to their dysfunction as a practitioner. He said there needs to be an avenue for providing therapeutic help in such cases.

... a lot of these people have been traumatised one way or another, we know that trauma is the catalyst in a lot of these things. They need help, and unfortunately that's the problem, we can't mandate help. (Alexander CM#10)

Henry's perception was that the past complex trauma experienced by one of his clients, and the borderline personality traits she displayed, were factors in the vexatious complaints she made about him. He said that complaint bodies need to be able to understand these potential motivations and dynamics, and to be aware that repeated and vexatious complaints can be misused and distorted as a form of perpetration of abuse. He referred to a theoretical model to try to explain the dynamics involved when his client had been a 'victim' of trauma in the past, but 'flipped' into being the 'perpetrator'.

When people talk about victim rescuer perpetrator, that's Carpman. Carpman's research was in alcoholic families and what most people don't realise is that he talks about two people doing the dance but you will switch roles. There is often a flip. So [client] claims to be the victim in this, but the process now is that she becomes the perpetrator and I become the victim. (Henry RP#2)

Bruce described the lack of capacity his colleague had to deal with the level of trauma that her clients had experienced. This suggests that anyone working in psychological or social care services needs to be equipped to work safely and effectively in managing the impacts of past trauma on clients.

Smooth seas don't make good sailors. [Practitioner] had nowhere near enough life experience to be suited for that job. She had worked as a [volunteer in a community group] and likely got on very well with the sort of 'good Christian girls' she was trying to get [client] to connect with... but as for working with kids who were suffering from such crazy amounts of trauma as I described to you earlier, she was way out of her league... It was also a great example to me of how good people can do bad things even though they mean well. It doesn't

make them bad people but I don't find their actions any less excusable. (Bruce TPC#2)

Joan, as a complaint manager, used the term 'trauma' to describe the impact she and others witnessed on multiple women who had been sexually exploited by a registered practitioner. She said that there was a powerful and traumatic impact on complaint managers after they had seen the trauma firsthand. They could then more fully comprehend the importance of public awareness, reporting and the need for jurisdiction for all complaints.

I know the [complaint management organisation] wanted to be more public about their reporting so that would encourage people to come forward, mainly because they saw firsthand the trauma. They had a really hard case with those women that had the one offender, and they really saw the consequences. (Joan CM#6)

Sarah described the impact she felt as a third party complainant after finding out that a family member had been the victim of mind control, hypnosis and false repressed memory 'therapy'. Sarah described symptoms of post traumatic stress such as 'total shock' and uncontrollable crying, and that it was very hard to control herself when attempting to seek help.

That night I think I was probably just in total shock, (pause), and the next day I just cried all day. I got straight on the phone to try and find out what we could do about it. And it was very hard to control myself on the phone. Nobody wanted to know about it. They would talk to [family member], but they would not talk to me because I was not the victim. [Family member] was the victim.

(Sarah TPC#5)

Another complainant, Mark, became emotional and unable to speak during the research interview when he began to describe his shock and grief since his wife's death due to a fatal psychosis. He also described his desperate need to try to understand what happened through any means available to him. Mark also explained that some other family members' needed to cut off from the pain in order to 'keep going'. This description suggests ongoing post-traumatic responses such as avoidance of potential triggers, years after her death.

Her poor [family members]... it is too painful for them to even think about. It is just too traumatic and painful so they just shut it away and get on with their lives, and... (Voice is emotional)... They don't go there... And if they do they just cry. (Pause). (Mark TPC#3)

Mark (TPC#3) also described how some other family members were able to search for avenues for complaint and information in the early period after his wife's death. He said he was so distressed he was unable to do that at that time, and without their support he would never have been able to seek a fuller investigation of the circumstances of his wife's death. Zoe's experience as a third party complainant also shows the impact of trauma on her ability and the ability of other family members to manage a complaint. Zoe's experience highlights the harrowing impact including feeling physically nauseous, crying uncontrollably, and also needing to avoid and manage triggers in order to function.

The first time I decided I needed to give up on the whole process was the very first time my [family member] had spoken to me about the allegations. Because we were talking, well, he was talking. And I was doing everything the counsellor we spoke to had said, which was if he talks just let him talk to

validate, don't question, just let him talk. But that just became so harrowing to listen to, listening to him on that other end of that phone, just his heartbreaking sobbing, and knowing that he two thousand percent believes that this is what happened to him... And I was kind of thinking, I was in my bedroom and I had, I think I told you I had these textbooks all of this information on all this stuff that I was like, 'right I am going to know everything and I'm going to be able to get through this'. And I remember looking at all the stuff on the bedside table, and I started to cry and I just looked at it and I went 'it doesn't matter how much I know, or whatever I do, it is not going to change the fact that this is what he believes. (Pause). It doesn't matter what information I have armed myself with about regressive therapy, about [Practitioner], about hypnotism about anything. Every bit of information I have got, he has got 10 answers for it'. And that's when I stopped and I thought 'my god', and I hung up the phone from my [family member] and I walked out into the dining room and just burst into tears and stood there and sobbed. I felt so nauseous from what I'd heard that I just wanted to puke. And I just stood there and sobbed. And my husband was just standing there holding me while I sobbed. And the next morning I got up and I went, 'all that stuff in the bedroom on the bedside table, get rid of it'. (Zoe TPC#4)

One of Zoe's other family members had also attended some sessions with this therapist, but was too traumatised to go through the process of making a complaint. Zoe's description again highlights the added trauma when a system does not respond effectively, especially when a complainant is already traumatised and 'not up to it'. In the absence of registration the complaint organisation could only request a voluntary mediation with the therapist which was inappropriate in the circumstances.

I know that [family member] tried to ring them back and I said to her 'look, this process has to be done through you. You need to call them and you need to go through the process so when you feel up to it you need to call them' and I think she did a couple of weeks later... And again it was like, too hard. And she said 'I can't, it's just too hard'. It's not that she wasn't physically up to it; she just didn't because the process was too difficult to even bother with because they still said the same thing that it was the mediation process and it had to be mutual with him. And we said 'well how was that even going to work?' ...and it's like this system is letting us down again because the process of just, we'll take the call, fob them off, get rid of them as quick as possible, doesn't allow them to get the information that they really kind of need to follow up. I got the whole, 'oh yes your complaint has been registered thank you'. And ... I am thinking okay is there more to it? And I go, 'and?' And she says 'well that's it'. 'What do you mean that's it?!' Like, [voice becomes quiet and choked with emotion] I was excused. (Zoe TPC#4)

Mary described the acute stress she and other close family members experienced when one of her adult children became involved in seeing an unregistered therapist firstly for sessions, and then participating in regular live-in group psychotherapy retreats. This led to a palpable change over time in the level of contact her daughter had with her parents, her family, and also eventually led to separation from her husband, and a sudden move to another town with her children. Meanwhile the therapist had become highly enmeshed in her life. Eventually the daughter also made extreme allegations that she had been a victim of multiple violent sexual assaults by her parents, which was a source of acute distress. Mary described the hurtful impact and some of the

physiological symptoms of PTSD that she, her spouse and her daughter's spouse experienced.

Well, we've both hurt together. And he [spouse] went, he went as skinny as a rake. Initially I lost weight. This is when our [daughter], she rang us up... She obviously wasn't very happy and was going to all these [group sessions with practitioner], and [practitioner] obviously said to [daughter] 'oh, go to these [sessions]'... and then next thing we know, actually it was [date], she rang up, she said, 'I'm going to [another town], mum. I'm taking the [children], [husband]'s not coming.' She didn't even come here and say goodbye. Yeah, and we could see how much it was hurting [daughter's husband] too, because the poor bugger, he was, he went like a scarecrow too. (Mary TPC#6)

Jen described the potential traumatic impact, and being 'freaked out totally' if she ever saw the practitioner again.

And I would really prefer it if I never ever saw him again... if I saw him on the street he would freak me out totally, have a huge effect on me. (Jen TPC#1)

Joe's account as a respondent practitioner shows the 'layering' of distress in his life throughout the period of the complaint. He had been in a very difficult period of his life prior to the complaint, due to a separation with his spouse at the time he had become involved with a former client in an intimate relationship. He was then pursued over a long period of time in a civil court lawsuit by the ex-husband of the ex-client he had a relationship with, and felt betrayed by the clinical and punitive manner in which his profession dealt with the matter. Whilst he did not describe himself as suicidal, nor use the term 'traumatised', he was depressed, fearful and angry, and years later needed to avoid opening the files about the complaint.

Because a lot of this also, initially, had occurred during a very difficult period of my life and incidentally was re-occurring at another difficult point in my life, I found myself contemplating whether I really wanted to remain a [practitioner] whatever the outcome was. At its extreme I could understand, although I wasn't suicidal, I can understand why some people would do some crazy things and act it out, and commit suicide...And if it was not for the fact that I did receive some legal assistance, that was more fortuitous than by design, and that I did have a good bevy of friends and supporters, I am not sure I would have survived that in the same way. It certainly made me feel depressed and fearful. (Long pause)... I think I was certainly reactively depressed. And just running on, (pause), autopilot, I suppose...even preparing for this [research interview] I looked at these four volumes. These lever arch files, four of them of all that history and, um, (pause) I thought, no, I don't want to go through all of this stuff in any great detail. (Joe RP#5)

Although Joe did not describe these reactions as symptoms of trauma, it could be that the sense of being on 'autopilot' could have been a form of dissociation, and the avoidance of contents of those files could have been because the contents represent potential triggers for distress which needed to be avoided. This suggests that Joe's experiences may have impacted him with varying post-traumatic symptoms.

John (CM#3), a complaint manager, used the term 'basket case' to describe the impact on complainants when it took three or four years with no decision on a complaint. 'Basket case' implies significant traumatic distress, largely as a result of iatrogenic failures in the systems managing complaints. Annie, in her role as a complaint manager providing advocacy support to complainants, described trauma as one of the reasons complainants did not continue with complaint processes. She cites

the lack of confidence in the system and the fear of being re-traumatised in the complaint process.

Because of a lot of the trauma and dysfunction in people's lives they come with the best intentions but things can happen in their personal lives, some of them are transient, some of them are homeless, some of them are living with addictions, so all of that impacts on their ability to actually continue. The other big one is that it re-traumatizes people. So some of them will drop out. They'll come and get information, they realise 'oh god I will have to live through this again and tell it to people' so they choose not to do it. (Annie CM#7)

Stephanie, in her role as a complaint manager, had an experience where a practitioner-respondent refused to be interviewed on the basis of being too traumatised.

She refused to be interviewed on the basis that she was too traumatised and stressed out because of the investigation that I was carrying out... So she mounted this defence as to why she would not speak to me... (Stephanie CM#4)

Jessica's account as a complaint manager also confirms that respondents are sometimes too traumatised to participate in an investigation or hearing. She described a case where a respondent practitioner was so traumatised they were hospitalised.

...with one matter, a few days before hearing the [practitioner] was hospitalised. And we took that really seriously, offered the opportunity to postpone the hearing if that was needed, asked for medical certificates to see if they were ok to go ahead. (Jessica CM#2)

Henry was a respondent to a vexatious complainant which traumatised him to varying degrees over a long period. Henry was asked to describe the impact on him.

A dark place. A place where you are trapped and scared and where there is not a lot of light coming through. Claustrophobic. Torturous place. (Henry RP#2)

Veronica's statement also reinforces the theme that the incidents leading to complaints leave people traumatised, and that there is a perception that redressing it in a legal context will add to the trauma and make things worse.

There has been a trauma happen to you but dealing with it in a legal context is actually going to be more traumatic, some way or another. [Pause]. You are best to try and... deal with it without that other stuff because dealing with it, or redressing it will actually just make it worse for you. (Veronica RP#3)

It was clear from Mark's account, that the trauma of the complaint process was 'layered' upon the primary trauma which was the death of his family member. He described the pervasive impact on him of traumatic grief, and that this was the biggest impact compared to the lesser impact of the injustice that there was no jurisdiction to seek accountability.

I have to say, it has been big, but it is not really the biggest thing in my life. It is more, I suppose, just the loneliness of losing that very special person in my life. That is what I live with. I don't sit around thinking of the injustice or what other poor souls who have done or will [receive the same services that harmed his wife] have been through. I don't sit around obsessing over that... Sure I contemplate it from time to time, particularly when it was all being investigated... And it is a trifle, compared to the grief... Just missing her. (long pause). (Mark TPC#6)

In summary, trauma was referred to in a broad range of ways by participants and clinical definitions of 'trauma' in mental health literature did not appear to capture the

dimensions of trauma that participants referred to. Therefore it is worthwhile appraising these definitions in order to highlight the limitations of current definitions.

Some clinical definitions for trauma refer to symptoms of post traumatic stress (Australian Centre for Posttraumatic Mental Health [ACPMH], 2007). These definitions require that symptoms must have been in response to a 'traumatic event', as specified in a publication from the Australian Centre for Posttraumatic Mental Health.

ASD and PTSD are a set of reactions that can develop in people who have experienced or witnessed a traumatic event. Traumatic events involve life threatening situations or serious injury that lead to feelings of intense fear, helplessness or horror. They include physical or sexual assault, natural disaster, war or a serious accident. For ASD and PTSD the definition of traumatic events does not include other stressful and life changing situations such as being retrenched, getting divorced or the death of an ill family member.

(ACPMH, 2007, p. 3)

This definition implies that 'traumatic events' involve threat to physical integrity or safety, and do not include events that pose a threat to psychological integrity or to relational integrity. This presents difficulty when attempting to convey threat and injury to identity, relationships, social and work systems that arise in complaint cases.

Furthermore, when limiting the definition of 'traumatic events' to those involving physical threat, it may reinforce the possible misconception that incompetent or unethical counselling, psychotherapy, case work or self development services could not involve circumstances resulting in physical injury or death. Certainly, these services cause harm in a very different manner to the way surgical or physiological procedures do. And yet, the cases discussed in this study show that methods used by counsellors,

therapists, and case workers, the power associated with a 'helping' or professional role, and the iatrogenic risks of complaint processes themselves can result in severe psychological injury, and subsequent physical injury or death.

In some cases these injuries warrant being described as the psychological equivalent of 'critical' physical injury and in some cases permanent disability or impairment, in that impacts were so severe and pervasive that they damaged integral aspects of people's capacity to function. These severe, complex and ongoing traumas are not easily measurable in concrete or physical terms, but did involve severe impacts on mental health, destruction of relationships, and major life derailment.

Furthermore, in some cases discussed in this research, death or physiological injury resulted from incidents which occurred during states of acute psychological injury. One example of psychological injury which led to death was when a client died due to jumping from a building during a fatal psychosis induced by regression activities (involving screaming and beating pillows) in a self development course. Other examples of physical injury were suicide attempts of clients and family members due to psychological injury after 'false repressed memory therapy', and physical assault among members of a coercive psychotherapy group. Also, psychological injury usually has a somatic or physical dimension such as physical symptoms, effects on respiration, blood pressure, sleep and appetite patterns, and gastrointestinal organs, associated with panic and dread.

In the process of arriving at the theme 'layers of psychological trauma' it was noted that participants' descriptions did relate to some of the symptoms of post traumatic stress specified in the International Classification of Diseases ICD-10 (World Health Organisation [WHO], 1992), and the Diagnostic and Statistical Manual of

Mental Disorders DSM-IV (American Psychiatric Association, 2000). The criteria in the ICD-10 (WHO, 1992) include symptom clusters associated with re-experiencing (intrusive replaying of memories invoking intense emotional and somatic reactions), avoidance (avoiding thoughts, activities, people, places, detaching, dissociation), and hyper-arousal (sleeping difficulties, irritability, lack of concentration, hyper-alert for danger). Many of the statements from participants indicated they had experienced these symptoms or observed others experiencing them.

Other descriptions revealed much more complicated traumatic impacts beyond clinical definitions for ASD and PTSD. Although it is not listed in the DSM-IV, Herman (1992) described “complex PTSD” which is thought to arise from severe, prolonged and repeated trauma, almost always of an interpersonal nature. Pelcovitz and colleagues (1997) described this as a “disorder of extreme stress, not otherwise specified” or DESNOS. According to Briere and Scott (2006) and Briere and Spinnazzola (2005) the relational and identity disturbance experienced under complex PTSD or DESNOS includes the tendency to be involved in chaotic and frequently maladaptive relationships, to have difficulty negotiating interpersonal boundaries, and reduced awareness of one’s entitlements and needs in the presence of compelling others.

Many clients of counselling, psychotherapy and casework present with a need for treatment and therapeutic support around the range of issues that led them to be a client. This may include a need to address the impacts of crisis, and relational or interpersonal trauma. For many, these existing traumatic interpersonal experiences mean they are also at risk of having a reduced awareness of their own needs, and difficulty negotiating boundaries in the presence of a practitioner in a legitimised position of power. Intersecting ‘trauma dynamics’ are relevant when attempting to understand the multifaceted impacts of complaint matters. This ‘layering’ of the impacts

of psychological and interpersonal trauma appears to be a hallmark of complaints about counselling, psychotherapy and casework.

The evidence of layering of trauma from participant narratives in this study is consistent with the findings from previous research. For example, Pope and Vetter (1991) presented the results of a US survey study which outlined the characteristics (reported by subsequent treating psychologists) regarding 958 clients who had been sexually involved with a previous therapist. More than 40 percent had experienced incest, other child sex abuse, or rape as an adult prior to sexual involvement with the therapist (Pope & Vetter, 1991). This finding suggests that previous, or ‘primary trauma’ exists for clients, prior to the trauma of sexual exploitation by a practitioner. Disch and Avery’s (2001) research also established that clients who had been victims of sexual boundary violations experienced post traumatic stress.

There is evidence in literature also, that there are far-reaching traumatic impacts on colleagues in the professional community surrounding respondents to complaints, as well as previous clients of those found guilty of misconduct. This adds to the ‘layers’ of trauma. For example, Ruskin (2011) published an article specifically about the impacts on his professional group in Canada after sexual misconduct by a senior trainer and supervisor in their professional community. He uses the terminology “traumatic” to describe the impacts, as well as the many costs to clients, colleagues and himself as a past supervisee of the practitioner complained about. Similarly, Ross (1995) wrote about the fate of relatives and colleagues in the traumatic aftermath of boundary violations.

In summary, it is clear that parties to complaints experience a range of traumatic impacts, including symptoms of PTSD, due to the incidents leading to complaints, and in the process of attempting to have complaints heard and acted upon.

Intense Emotions. Alongside the symptoms of trauma, and the other costs and risks, complaint matters also impacted on people by invoking a range of complex emotions. These included feeling fearful, hurt, shattered, broken, angry, frustrated, powerless, personally attacked, defensive, devalued, disgusted, sickened, disoriented, anxious, conflicted, distanced, and numb or blunted in emotional reactions. Emotions were represented as preoccupying, unstable and difficult to attend to. In many cases emotions were related to symptoms of trauma responses. Somatic and physical aspects of emotions were often described, including the impact of emotions on capacity to function.

Jessica described the impact as a complaint manager when she first hears or reads a complaint matter. She said she often feels instant alarm, ‘raw emotion’ and reaction to ‘people’s pain’.

One complaint we have at the moment - reading the material it is instantly alarming, with concern for the clients safety and their emotional wellbeing.

Like, that’s... raw emotion and reaction to people's pain. (Jessica CM#2)

This is reinforced by Annie, another complaint manager, who described a wide range of emotions she has felt in reaction to her role managing complaint matters, including taking statements, attending hearings, and also seeing the reactions of parties to complaints to the outcomes of hearings.

Horror, sadness, anger, frustration, pride, relief, apprehension, hesitancy, elation.
(Annie CM#7)

One of the key emotions described by complainants and respondents was fear. Mary described the intense fear she felt, and that the client (her family member) and other family members felt. She said that fear of the practitioner meant clients and those close to clients wanted to run away to protect themselves. This fear meant it was extremely difficult to make a complaint and risk further interaction or confrontation with the practitioner. There was also a need to focus on daily survival in the aftermath of the destruction to wellbeing and family relationships. Ex-clients and family members had attempted to form a support network, and Mary's comments provide her observations of the fear she and others felt. .

I guess just like me, [client] wants to run. And I think that's something that [practitioner] does, he makes them all scared. As one woman told me, her friend was running scared. So he does, he scares them. (Mary C#6)

Stephanie also observed a complainants' fear. She had been in a role as a complaint manager managing a complaint made by a young client to a voluntary management committee of a community organisation. She perceived that the fear associated with the complaint was metaphorically like the fear associated with an out of control situation, like a 'runaway train'.

For her, I think she was really scared. And I think it got bigger than Ben Hur for her. I think she just wanted to say something and she did. But then it was a bit like a runaway train then. Once you started it, it couldn't stop... if I was to put myself in her shoes at 16... I would be pretty freaked out. (Stephanie CM#4)

Joe, as a respondent to a complaint, commented that the whole situation involved a lot of fear.

I certainly experienced a lot of fear. But a lot of people who were coming after me, they had all sorts of fears about things. (Joe RP#5)

In her responses to a complaint, Sally had acknowledged certain errors and had decided to continue to work with the client. She felt afraid of how things would go if the client ever made a formal complaint after Sally had already acknowledged harm.

I'm scared now. Because some of the things that I am aware of, that in being therapeutic and agreeing with her that I have harmed her... is that if that went to a formal complaint, you know, she could quite rightly say that [Sally] agreed with me that she was doing me harm. (Sally RP#4)

Veronica also described her fear when she faced a hearing panel as a respondent to a complaint.

The one time I had to appear before the [hearing panel at [organisation]] I was terrified. I was just terrified. I was terrified because it wasn't a serious complaint, but it was a complaint that was completely justified based on something really really dumb and stupid that I did. (Veronica RP#3)

Alexander, as a complaint manager, expressed anger as his main emotion in response to the lack of regulation of the industry.

We do get a fair few complaints but generally the non-members. Non-registered [practitioners] far outweigh the registered. And that really p's me off to be honest. (Alexander CM#10)

Bruce, as a complainant, also felt angry, bitter, frustrated and powerless to prevent harm to a client due to a colleagues' ineptitude.

So in short, I see the harm resulting from neglect that arises from ineptitude and people, co-ordinators, managers not prioritising certain issues as they do not understand how important they really are. This makes me angry, bitter and frustrated as I see it happening but feel powerless to intervene as I'm casual and those involved don't necessarily value my opinion as we see the situation through different eyes. (Bruce TPC#2)

Sarah, also a complainant, experienced frustration when there was no jurisdiction to hear her complaint about an unregistered therapist.

It is very frustrating. To go round and round and round in these circles. And I can see why people would just not bother. (Sarah TPC#5)

Zoe also felt frustrated, devalued, and distressed when nothing was done about her complaint.

Well I fully expected them to do nothing with it because that was the tone. It was like 'yeah, got it, noted, piss off'. 'Hey cool, thanks for that'. As I said, I would just hang up the phone after every phone call getting more frustrated and more angry and just completely over it. (Zoe TPC#4)

Powerlessness was another emotion reported by participants. When trying to decide what to do about her concerns about a colleague counsellor, Jen was aware that she did not have enough 'evidence' and did not feel she could ask clients directly without them having approached her.

I had nothing to report, that was the other thing. What can you do, go to your boss and say this guy creeps me out? How can you deal with that? I mean I couldn't go to the [clients] and say 'does that guy feel you up when you are in

his room?' Why would I do that? I am not the policeman. I am the [colleague]. So you know, it was a really awkward situation to be in and a lot of the time, when I saw him with the [clients] and particularly when he had any physical contact with them, I became hyper aware of it as well, because I was policing my reaction to it as well. (Jen TPC#1)

Veronica also felt powerless as a practitioner who responded to a complaint. A former client had published grievances on the internet about Veronica, accusing her of a lack of expertise and for falsely representing her expertise. Veronica also said that the powerlessness and injustice led to a sense of wanting revenge.

I felt so powerless. Like it was the feeling of powerlessness that was just overwhelming. I could not believe that I had, that there was at that moment not one thing I could do to stop this going around the globe. And I suppose I did catastrophize it a bit in my mind. You know, and had visions of 50 million people in the world reading about me. (Laughs)... But I guess it was the powerlessness. And it was the powerlessness about the fact that I could not defend myself. And that she had this right, apparently, to put that out there and make those, what I felt were, I don't know, insulting at least, defamatory at worst. And that really pissed me off. So I was powerless and then I got really angry. And then fairly quickly I became a bit vengeful. (Veronica RP#3)

Another emotion frequently referred to was a sense of feeling conflicted and ambivalent. Zoe revisited this emotion often when she tried to advocate for legislative change and registration of all practitioners.

I have days where I just look at it and I go 'why? What difference is it going to make? It is not going to bring [family member client of practitioner] back'. And

then I come to the conclusion that the only thing that I can achieve is others not actually having to go through this process. (Zoe TPC#4)

Jen also felt conflicted between the part of her that knew her concerns were legitimate, and the part of her that also knew she did not have enough evidence to voice her concerns and/or prove a complaint.

So for me, the way I felt about it, conflicted most of the time, not able to really seriously voice my true opinion ever, genuinely. And the problem was that I had not much evidence, really, apart from my feelings and observations of what I saw as certain predatory behavioural patterns in him. (Jen TPC#1)

Another emotion frequently discussed in relation to respondents in particular, was the feeling of being personally attacked. Veronica commented that usually the relationship between practitioner and client is fair and decent. Yet when a client made a vexatious complaint, it was particularly affronting, not easy to brush off, and taken as a personal attack.

It's all fair decent good stuff. You do your job. They do their job. And it is lovely. It is why I do it. It's part of why I do it. And so when someone comes in and kind of dirties that I am not very mature about it or evolved or whatever I'm supposed to be... I do take things quite personally. (Veronica RP#3)

Stephanie, in her role as a complaint manager hearing a complaint, observed that a practitioner took the complaint personally, instead of thinking about it as her work, not her, being complained about.

I think when the complaint came in one of the [practitioners] that was actually targeted, for want of a better word, she was the main person that was

complained about, she really took it personally. Which I can understand to some degree. But, you know you have also got to try to put it into a professional perspective of, okay, let's try and separate the person, and the wounding that occurs from that level of complaint, but also to be professional well. I suppose, I, (pause), her response made me question how emotionally involved she was with this [client]. (Stephanie CM#4)

Henry's experience as a respondent to a vexatious complaint highlights the intense challenge of attending to emotions and trying to be methodical in response to a complaint.

And the hardest bit I think is how do you actually respond to things methodically, accurately, without all the emotion, when you are in an emotional dishwasher? (Henry RP#2)

Jessica described the distress she experienced as a complaint manager, including being the brunt of aggression from those who disagreed with the outcome of a complaint.

Tears yes. Probably twice in the last eighteen months. Where I have been that distressed by something... not at the point of hearing a story. It is often towards the end I find, of the process, the build up, and I have realised the impact that that has had on me...often the most distressing part of it for me is taking on the feedback, sometimes really aggressive feedback from [practitioners]. The respondents have had some really hard aggressive things to say sometimes, like, screaming at me on the phone saying 'how can you sleep at night how can you live with yourself being involved with this evil process'. (Jessica CM# 2)

Jessica also discussed the anxiety she always felt when calling a practitioner to advise them a complaint had been received about them.

My immediate reaction was anxiety... to have to ring this person and tell them this complaint had been received... I take on a lot of anxiety about how hard it must be to get that phone call from me out of the blue... So I take that really seriously and it impacts every time to make those calls. (Jessica CM#2)

Justin commented on the isolation that complaint officers can experience in dealing with highly significant and emotional exchanges with parties to complaints. He also said that whilst there is considerable emotional impact, one organisation he worked within phoned parties to complaints as well as communicating in writing. Although this had more emotional impact for those managing complaints, it was intended to humanise the process. Justin also described the complex mix of emotions he felt when managing complaints. This mixture included sadness, combined with concern, shock, disillusionment and anger.

Emotional blunting or distancing was also a part of the impact for those involved in complaints. For example Bruce felt that he and his team needed to distance from emotions in order to avoid hurting or undermining his colleague whose practices he complained about.

We still had to work with [practitioner] and didn't want to hurt her feelings nor undermine her. (Bruce TPC#2)

Jen referred to the way that people stopped reacting, became emotionally 'numb' and 'adjusted' to problematic behaviour of a counsellor in her workplace.

Things that happened with his behaviour around clients would become 'wallpaper', because you get used to that behaviour. You expect it, you guard from it and you kind of adjust. (Jen TPC#1)

It is clear from participant narratives that one of the most significant impacts associated with complaints is that they are highly emotional matters. These emotions are complex and need to be attended to and managed. Emotions were experienced internally and acted upon externally in different ways by different individuals. Participant narratives showed that emotions were experienced most strongly by complainants and respondents. However, complaint managers were also impacted by a range of emotions, especially those who had direct contact with parties to complaints.

The finding that complaints invoke intense emotions is consistent with a range of published narratives, and a small amount of previous empirical research. For example, a qualitative research study about 30 general medical practitioners' experiences of patients' complaints in the United Kingdom found that in various stages of complaints, intense emotions were predominant.

The first stage described being out of control, feelings of shock and panic, and a sense of indignation towards patients generally. The second stage described the many conflicts generated by the complaint: emotional conflicts such as feelings of anger, depression and even suicide.

(Jain & Ogden, 1999, p. 1596).

Other examples include the experiences published in the UK about complaints. These were written by a client complainant in a book about surviving complaints against counsellors and psychotherapists (Casemore, 2001). In each account, a range of intense emotions were described. Intense emotions were also described in the transcripts of conference presentations made by victims of sexual exploitation by professionals (Boeckenhauer et al., 1998); in an anonymous account written by a psychologist who was the respondent to a complaint about a sexual relationship he formed with a client

(Brown, 1999); and in another anonymous account of sexual exploitation written by a client of a senior psychotherapist who had an esteemed role in a psychoanalytic society (Anonymous, 2005).

Futility and fatalism. A final major theme regarding impact was that participants described being left with a sense of futility and fatalism primarily due to evidence issues, power dynamics and systemic gaps. Many participants said that complaints within the systems they dealt with were futile in achieving useful outcomes. Many participants were also left with a sense of fatalism; that nothing was going to change for the better; that due to the complexities of these types of complaints, the standards of evidence, and lack of political will to bring in effective regulation, the system would not be improved. There are several nuances in the sense of futility and fatalism experienced by participants, including a lack of power and jurisdiction; systemic failures; dysfunction and a lack of care by those managing complaints; difficulty providing evidence of unwitnessed interactions; crippling legal fees; and penalties that did not address the causes of the problematic practice. A range of participant narratives are included below to illustrate these nuances.

Lisa, as a complaint manager, described a sense of futility in a situation where she and others hearing a complaint had no power over the organisation that employed the respondent practitioner. This meant that the client's desired outcome, that an inaccurate report be removed from their file, could not be enforced.

This client, when we asked them 'what would you like the outcome to be?', one of the things they wanted was that [incorrect information] be removed from their file. And of course we had to tell them we don't have the power over that and that they would need to take that up with the [employing organisation]. Which is

really quite sad because I think at some point people get really fatigued by going through the process... for them to then go and try to challenge an [organisation] and potentially make things worse, that's hard for them. (Lisa CM#5)

Lisa went on to explain that when an organisation has no capacity to enforce a range of outcomes to complaints, it makes the whole process futile, or a 'waste of time'.

There is no way they can check that she has learned from this. She effectively got away with her behaviour. Yes you are breached, but no penalty so what's the worth of that. What a waste of everybody's time! (Lisa CM#5)

Alexander (CM#10) used the metaphor 'left hanging' to describe what happens to people who have a complaint about an unregulated practitioner for which there is no jurisdiction. This was reinforced by Zoe (TPC#4), who said the organisation she complained to could only offer a voluntary mediation with the practitioner, which was not only inappropriate but futile because the practitioner totally believed in what he was doing and had no willingness to consider complaints. She also said that the complaint was fobbed off. It led to an impact of a sense of fatalism – 'too difficult to even bother'.

Annie, in her role as an advocate, described a sense of futility in the way complaints were investigated, as well as iatrogenic harm that occurred due to systemic failures and inappropriate standards of evidence.

We would send in a complaint and get a letter of response saying 'well they are going to send an investigator'... So an investigator comes who is usually an ex federal policeman or someone like that. So they come and investigate the complaint and, like, there is nothing to go on, because there is no 'evidence'.

There is no abuse written in the files. Very often there is no file...so, it is like,

‘well, what you investigating here?’ ...So many of the [complainants] are on the back foot, and feeling very powerless. (Annie CM#7)

When Henry grappled with his experience of a client who pursued complaints about him over a ten year period, he described anger at the futility of the system.

I guess I am more angry that the system backs them [the complainant] and becomes complicit with a disordered person at my expense... I have got the system siding with that complicity and very little redress other than a letter at the end which says you are cleared, but now I can't go public with that because it has her name on it [and would breach confidentiality]. (Henry RP#2)

Jen described a sense of futility due to the dysfunction within the organisation and inability to manage conflict and complaints.

And his boss, I didn't trust her very much. I found her a pretty dysfunctional administrator, and that was reflected in the way she dealt with our staff stuff generally. (Jen TPC#1)

There was also a sense of fatalism for Jen in that ‘nothing happened’ even after the organisation had been through a ‘whole procedure’ regarding an issue with her colleagues’ conduct.

I remember them going through a whole procedure and nothing happened at the end of it which also spoke volumes about how the [organisation] handled conflict. (Jen TPC#1)

Joe, as a respondent to a complaint, said that the outcomes seemed futile or ‘a nonsense’ because they didn't relate to the events that had taken place.

There was no outcome that I saw related clearly to the events that had taken place. It all just seemed to be a bit of nonsense. Or cruel. (Joe RP#5)

Joan described the futility in the outcome for women who complained about sexual boundary violations by a registered practitioner. Once de-registered, the practitioner was able to move from direct practice to another lucrative role, yet the complainants were crippled by legal fees, making the complaint process futile and a source of further harmful impact.

The [practitioner] was deregistered as a [practitioner] and then went on to set up the business side of [field of practice] and set up a [large business]... And all of those women were just left with that. Some of those women didn't get good legal advice. The people that were processing their complaints through the civil court and following on from [complaint organisation], well some of those women ended up without a cent left by the time they paid legal fees. (Joan CM#6)

Joan summed up the sense of shock she felt when observing how badly the system failed in so many complaint cases.

The more you get involved, listening to the impact then you know it just does seem like it's a really unjust response... Because the subtleties of how the professionals get away with it are quite subtle. And the average person would think 'are you kidding? This is shocking'. (Joan CM#6)

Joan summed up a sense of futility and fatalism in the following statement.

I think the systemic issues have really made me think 'what the hell are we doing?' I've been in the [field of practice] sector for 30 years and you think 'sometimes I'm advocating for things when it actually can do more harm than

good. What are we actually advocating for and what will it do to the people who have to go through the complaints system when nothing or very little is done for them?'... They [the complaints] are like little tornadoes, I think. They just come in, and it whirls up, and then it goes. Nothing systemic is looked at. There is no analysis of them. There is no public reporting. It is still that you keep it a secret. (Joan CM#6)

Zoe was unequivocal in her perception that the lack of care and ignorance of how harm can occur meant that complaint was futile.

Ignorance. Lack of funds. Care factor. Probably zero care-factor. They just don't get it. And I don't think it would matter unless it had happened to them. (Zoe TPC#4)

Stephanie had a role as an investigator, and found that the ineffectiveness of the system for managing complaints became a major barrier to doing anything constructive. The futility of the situation became clear to her and she decided to 'get out'.

For me it became a real question around, 'how effective am I as a worker within this environment?' So for me it was time to get out. (Pause). I suppose there are lots of issues within organisations...really hard to prove, really hard to investigate, really hard to do anything! (Stephanie TP#4)

Stephanie also described the sense of fatalism and futility that occurs for complainants when it takes so long for their complaint to be acted on.

Whereas I have had others which have been kicking around for a year, and by that stage really, they don't even believe that it is going to get investigated and even if it is going to get investigated, it has happened 12 months ago. People are

not going to remember stuff now, it is 12 months. You needed it to be back then.
(Stephanie CM#4)

Mark described his recommendations that all practitioners need to be registered, trained and monitored. He also expressed a fatalistic sense that even after a case as serious as the one involving the death of his wife, he thought the recommendations may be soon 'forgotten' by the government.

We made recommendations that people should be qualified, say, like a psychologist, minimum standards, and part of an accredited body. How quickly that is adopted by the government I don't know. I suspect it may be forgotten. I don't know. I hope not. (Mark TPC#3)

Lisa expressed fatalism because no matter how much regulation is put in place it will always be difficult to fix the problems with standards of evidence in these complaints.

And even regulation, and even making this process less complicated is not necessarily going to fix those kind of issues. This is because of the privacy of the interactions...(Lisa CM#5)

For more than half of participants, a sense of futility and fatalism had a significant impact on the experience of decision making, and on the meaning made after involvement in complaint processes. This indicates a need for closer inspection of the gaps in current systems which may contribute to this sense of futility. This also indicates a need for support for parties to complaints to more effectively address their needs.

The theme of futility and fatalism is consistent with some previous research about health complaints. For example, a survey (n=983) householders in eight

communities of rural Victoria found that “the most common reason why rural residents don’t make formal complaints when they are dissatisfied with their care is that they believe it is futile to do so. Over half of those who had complained reported that their complaint produced no change” (Jones et al., 2006, p. 322).

It is important also to closely inspect those participant experiences which provided exceptions to the theme of futility and fatalism (and exceptions to all of the above mentioned themes), to see what aspects of complaint matters were associated with ‘constructive’ impacts. These exceptions will be explored in the next minor theme which presents narratives describing impacts of complaints such as learning and growth.

Learning and growth. One of the minor themes which presented as an exception to the other themes was about learning, healing and growth from complaints processes. Learning included gaining knowledge, skills or wisdom, and growth included the changes and developments that occurred within individuals and organisations. Often learning and growth were one of many impacts, and existed alongside, or in hindsight after, the impacts of expectation management, costs and burdens, trauma, and intense emotions.

For example, Justin explained his experience as a manager initiating change. He described the initial costs in terms of people having hostile perceptions of him, and then the sense of ‘reward’, after the development, improvement and growth.

Sally, a respondent practitioner, decided to work differently after a complaint and felt a sense of being challenged, learning a lot, developing skills and being very thoughtful and intentional in her practice.

I guess this case has been one of the more challenging and it has really (pause), maybe I have rested on my laurels for a while. I have worked really hard with

them and I have been really thoughtful about what I am going to do in each session. So I think I have continued because it is an opportunity for me to develop my skills further and be more reflective in my practice... there has been gain for me as well, professionally. (Sally RP#4)

Mark, as a complainant, described one moment of acknowledgement that he received from a person indirectly involved in running a service which had provided a harmful service to his family member. He described the constructive impact on him of a genuine apology.

It [apology] wasn't from the [practitioner] but it was from the [manager]. Still, it meant a lot. (Mark TPC#3)

Annie reflected on the added dimensions she has gained in life due to observing the vulnerabilities of parties to complaints, and that she did not treat them as 'other'.

We are all vulnerable, so you can always see a part of yourself and I think that is the connection that you can make with the person (Annie CM#7)

Annie found that the work as an advocate did not cause a sense of burn out or stress, but was rewarding and gave her life a source of meaning.

People have asked me similar questions about, particularly about the vicarious traumatisation and 'do you ever get burnt out/'and I have to say 'no', and they look at me with disbelief... And when I left this work I actually missed it. Yeah, because I was getting a lot out of it myself. These people were teaching me a lot about humanity, and life, and myself. So it was reciprocal. (Annie CM#7)

Bruce also reflected how positive it was to learn so much through his experience of a complaint about his colleagues' practices.

On positive notes I have learned no end of lessons from staff and the [clients] about different ways of dealing with tricky situations and how character failings can lead to disputes... But yeah, it's one of the great things about the job and inasmuch as I had a bad experience with [colleague], I did learn heaps about it, both about me and how I handle such situations and about how others act and react as well. (Bruce TPC#2)

Henry also referred to powerful lessons he learned about the risks that can be involved in working with clients who demonstrated destructive traits. It seems that he learned self-protection, or defensive practice strategies.

I guess the application of the lessons is that if I have a couple come in and one is borderline or particularly cluster B borderline, I become very good at escalating it so that they leave, very quickly... I had another case that I got a bit burnt with but not to this degree. I made a decision that if I sense that, I am going to accelerate it quickly. (Henry RP#2)

Learning and growth, including moments of validation or healing did occur as some of the many, multi faceted impacts experienced throughout complaints. Often the learning and growth was hard won, and the only constructive by-product of otherwise unwanted, painful and difficult experiences.

Learning as an impact of complaints was also found to be a minor theme in a qualitative study done in the UK about GP's experiences of complaints. The study found that "a small minority described the complaint as a learning experience", with the majority of participants experiencing reactions such as "practicing defensively" and "planning to leave general practice", and describing how they "became immune to complaints" (Jain & Ogden, 1999, p. 1596). This is consistent with the finding of this

study, that learning and growth was an exceptional, minor impact, compared with the other major themes regarding impact.

Conclusion

In summary, the themes represented in participant narratives in this chapter show that parties to complaints and complaint managers have lived through and observed complex impacts on themselves and others. These include the impacts of complex expectation management, costs, burdens and barriers, layers of psychological trauma, intense emotions, a sense of futility and fatalism, and in some exceptional cases, learning and growth.

It is important to recognise that the complainants interviewed in this study were not the direct clients themselves, but were third party complainants such as those close to clients, and colleagues. Their perspective on impacts would be moderated somewhat by virtue of the fact that they were not the actual clients who received the service directly by the practitioner. Yet still, the impacts were so severe, even on third party complainants, that they warranted being described as trauma. The impacts on respondent practitioners were also so severe that they were described as traumatic. There was evidence of fear and helplessness for parties to complaints which underlines that complaint matters are often a unique source of psychological trauma, invoking the full spectrum of PTSD symptoms. The impacts on complaint managers were different and much less severe, however participant narratives showed that complaint managers were impacted by observing trauma in parties to complaints, and experienced a range of intense emotions, including shock, anger and frustration, and futility and fatalism in the face of systemic gaps and failures.

The cases and incidents described in this study provide Australian qualitative research evidence of harm from practices carried out by those in a range of regulated, semi-regulated, and unregulated occupations. In short, it has been reported by participants in this study that severe harm and injury has resulted from the actions of providers of psychological and social care services. Participants reported their observations that the practices of some practitioners led to death, physical injury and psychological injury. This included fatal psychosis, suicide, rape and assault; as well as severe psychological injuries which in some cases were life threatening or severely harmful to clients and those close to clients, including suicidality, hospitalisation due to acute mental ill-health, PTSD, depression, acute anxiety, loss of relationships, loss of rights to adopt or care for children, loss of supported housing, life derailment, temporary and ongoing loss of capacity to work and function, and financial losses. Participant reports also show that practitioners who have received complaints about their practices have experienced life threatening states, including suicidality and hospitalisation due to mental ill health, as well as depression, acute anxiety, PTSD, life derailment, temporary or ongoing impacts on capacity to work and function, and financial losses. The findings also reveal how complex the costs, risks, barriers and burdens are in relation to complaints. All of these costs provide reasons why complaints are unreported, and underreported.

One of the gaps in previous research about the impact of complaints that this study has addressed, has been the lack of research about complaints about non-sexual boundary violations. This study found that severe harm results from a range of practices other than sexual misconduct. There needs to be more research on the impacts of ‘mind control’; psychological manipulation; hypnosis; false repressed sexual abuse memory ‘therapy’; regression and emotional release activities; breaches of confidentiality;

inaccurate medico-legal reports; over-servicing, dependency and financial exploitation; non-sexual boundary violations such as socializing and spending special occasions together; cases where a particular healing theory, ideology or method is purported as the answer to a clients problems with harmful effects; inappropriate religious or other advice; favoritism and punishment through control of access to services; poor quality risk assessments and irregular follow up in child protection and other situations of duty of care. There also needs to be more focus and research on the power dynamics that invoke trust and compliance, which is then used by practitioners to create opportunities to physically and sexually assault clients (for example, clients in social care settings). This study reveals there is a largely un-researched, untold story of many powerful ways that the helping professions can harm clients and those close to clients.

There are also aspects of the impact of complaints that the findings of this study did not address. Because it is a phenomenological study, it sought data about the human costs of complaints. It did not find out about the financial cost involved in managing, hearing and sanctioning complaints. Because of the need to de-identify cases, and the inclusion of perspectives on complaints about a range of registered and unregistered occupations over the past two decades, this research did not produce information about the impacts experienced within different complaint organisations or due to specific complaint protocols at any specific point in time.

Impact is only part of the story about experiences of complaints. Power, in the form of cultural power, relational power and structural power will be explored further in the next chapter.

Chapter Five

Power and Complaints

Introduction

Power is differentiated from impact, in that the findings regarding impact described the effects, preoccupations or impressions on people as a result of experiences associated with complaints and the incidents that led to them. The findings related to power however, refer to sources of agency including the provision and use of resources; the influence of customary practices, ideologies, and norms; the methods used to exert influence and control; the capacity to define how others are viewed and treated; and the ability of roles and institutions to determine the rights of others and procedural events.

The findings in this chapter relate to the second research question which specifically asked about power. The chapter on power is the largest and most complex findings chapter and for this reason has been broken down into three sub-categories. These sub-categories relate to three main forms of power: cultural; relational; and structural power. The sub-themes relating to each of these categories of power are explored in detail with reference to participant narratives.

In accordance with the feminist conceptual framework the intent in this chapter is to make power more visible, and to detect it even when it was not explicitly referred to by participants (Jenkins, 2007). The interpretations which follow the excerpts from participant interviews link themes with theories and typologies of power presented earlier in the methodology chapter. Empirical research literature is discussed to a much lesser extent in this chapter, because of the lack of previous research focusing explicitly on power as it relates to complaints. Therefore this chapter provides much more conceptual analysis than other findings chapters.

Themes - Cultural Power

This first section of the power chapter contains sub-themes regarding cultural power. Cultural power was a significant implicit form of power represented in participant narratives. Cultural power refers to the influence of norms, values, customary practices, ideologies and paradigms in the cultures in which complaints were managed. Participant narratives revealed that these forms of cultural power were dominant influences shaping experiences and decisions about complaints. Culture included the micro-cultures within organisations, the industry cultures within counselling, psychotherapy, psychology, psychiatry, social work and ‘self-development’, as well as the broader Australian political and social culture. Often participants did not explicitly discuss norms, values, customary practices and paradigms as forms of power, but these were revealed implicitly. The majority of participant narratives described incidents and perspectives which revealed themes of dysfunctional rather than functional cultures surrounding complaints.

The themes regarding cultural power are not presented in a hierarchical order of the most dominant to the least dominant, and this aligns with a feminist approach. Instead, the themes follow time, beginning with descriptions of historical changes and inherited dysfunctional elements of culture, through to observations about the present, and concluding with narratives about functional aspects of culture for future complaint management. The major themes and one minor theme which presented an exception to the major themes are as follows:

- a historical lack of robust accountability
- un-owned power
- inadequate ethics literacy
- avoidant and adversarial approaches

- dehumanisation and disempowerment
- examples of constructive cultures

When interpreting themes regarding cultural power there is a risk of overstating the conclusiveness of findings or over-generalising. Participant narratives provided perceptions and observations from the unique standpoints held by each individual. It is not intended that the following themes would characterise the culture within every organisation or sector, or regarding all complaints. The themes in this section of the power chapter interpret the way that cultural norms and ideologies were represented by participants.

A historical lack of robust accountability. If cultural power is defined as the influence of norms, values, customary practices and paradigms, it can be assumed that historical origins of these norms and accepted practices are an important source of information. History provides information about how power has been used in the past, and how this influences the way things are done in the present. The main phenomenon that participants discussed regarding the past was a historical lack of robust accountability. For example, there have been historical norms that supervision was not a requirement (at least for unregistered occupations); that adherence to a code of ethics or code of conduct was not required; that there was insufficient clarity of purpose and skill in complaint handling; and natural justice had often not been applied. It should be noted that the theme of a historical lack of robust accountability was discussed mostly by complaint managers because they had knowledge of the history of systems, whereas complainants and respondents did not tend to focus on this.

Alexander is a practitioner who has had a role managing complaints about an unregistered profession. He reflected on historical developments in accountability infrastructure during the period of his career.

When I first started practice we didn't have supervision, we didn't have professional bodies. Oh they were around, [organisation] was around but nobody joined. And we didn't practice by a code of conduct, we were totally non-accountable. We felt we were accountable to ourselves, and I think most of us had a strong sense of moral obligation, you know, community justice, those sorts of things, but we weren't accountable to anybody if we buggered up. (Alexander CM#10)

Justin, also an experienced practitioner commented that in some organisations there had been a hidden history of significant problems in the way complaints had been managed. He also described a lack of clarity about how to make a complaint, and a lack of information for complainants and respondents.

John is a non-practitioner who has a role managing complaints about registered professions. His account suggested that an insufficient skill-base for complaint handlers is not just a historical problem, but one he has grappled with recently, and which applies to registered health professions. He discussed the need for specialist skills and a clear identity and role. He said there are pitfalls, which can result in a lack of robust accountability when practitioners manage complaints about their own professions.

A big issue we questioned when I first started was 'oh well you are not health professionals how can you deliver this service?' And what I find is that health professionals are the worst people to judge themselves because first they identify with the respondents too much so they will dismiss things too easily. And in the

sexual boundary ones or the obvious misconduct they go over the top the other way, and they say that's outrageous and they get all huffy about the professions' reputation so their judgement gets unbalanced. But we just, we are professional complaint handlers. That's what we do and we don't get that confusion of roles. (John CM#3)

One of the pitfalls he observed is that some complaint handlers get what he described as 'captured' by the complainant. He suggested that sympathy could become the focus rather than accountability.

We had a mixture of staff and we had some [practitioners] and they had a tendency to get more captured by the complainants and to sympathise with them more. The complainants would love them up until the point it came to make the decision and then they would bring forward a proposal and you would go through it and there's no evidence, no basis and then you would have to deal with the complainant who says well your investigator promised me this guy would be struck off, this sort of stuff. It is a real pitfall. (John CM#3)

Lisa's perception as a complaint manager was also that when in a role as an 'enforcer of a code' you cannot 'think' like a practitioner. She too had had experiences in a culture where the focus has not been on 'enforcing' robust accountability.

So that to me is a concern and I say this over and over and over. We are thinking too much like [practitioners]. And we're not thinking as enforcers of a code [of conduct or ethics]. (Lisa CM#4)

The evolution of historical change from the past to the present was discussed by Tran. Tran is an experienced practitioner in a registered profession who has also had a long term role managing complaints. He emphasised the way that accountability for specific

types of harmful practice are focused on more than others at different times. This has meant gaps in accountability for practices that were not yet clearly acknowledged as harmful.

Of the research conducted 10, 15 years ago, and thinking about what is ethical and not ethical...there was a big emphasis on...therapists getting sexually involved with clients... that is no longer the case... These days it's much more about the kinds of services which people expect, what they get, and I think there's a new area which hasn't been written about, actually they're two new areas. One is the notion of therapists or supervisors who are highly narcissistic, and the potential impact that has upon supervisees or patients, but it's not an area that's terribly well explored. And then [inaudible] has recently written on theory abuse, and what is it when we have our own theory, whatever that is, and we impose it on patients without really listening and so on. (Tran CM#11)

The general sense from participant narratives was that the cultures around ethics and complaints in the helping professions have been characterised by historical changes from the past to the present. In terms of ethics and accountability, the past has been perceived as dysfunctional rather than functional, and even in registered professions, some participants perceived that there have been ineffective responses made due to a lack of clarity and expertise in managing complaints, and conflicts of interest when professionals manage complaints about their own.

Lukes (1974) theory of three dimensions of power can be used to analyse the theme of a historical lack of robust accountability. Two dimensional power involves the capacity to set agendas (Lukes, 1974) and appeared to be an inherent form of power operating within the cultures surrounding complaints. Alongside it, Lukes three

dimensional power (Lukes, 1974), the ability to shape preferences via values, norms and ideology was also relevant. According to Alexander, Joan, Justin, Jessica, Saskia, Stephanie, Zac, Tran, Jen, Mark, Mary, Sarah, and Zoe, it appeared the need for more robust accountability mechanisms for unregistered occupations had to be clearly placed on the agenda in order for these to be developed. It is only in recent years that some professional associations have begun to act on an agenda to require members to commit to codes of conduct and ethics, and that ethics complaints procedures have been more robust. Recent campaigns seeking registration by social workers (Healy, 2012) indicate that value has been placed on robust accountability. Luke's two dimensional power, 'agenda setting', is now being used to keep registration on the agenda. Only time will tell if 'agenda-setting' with politicians eventuates in the use of what Lukes (1974) defined as one dimensional power, which is decision-making power exercised by formal institutions (i.e. legislators and government regulatory agencies).

Regarding registered professions, the perspectives of some participants such as John and Tran suggested that there has been clear, conscious agenda to address sexual misconduct, but that other forms of harmful practice were yet to be clearly understood and made accountable, and it was perceived that there have been problems associated with health professionals assuring accountability for their peers.

Un-owned power. The next theme relevant to cultural power was that power in counselling, therapy and casework services was perceived as un-owned. Un-owned power was interpreted as a theme because some participants described power that was unacknowledged, denied, and minimised rather than owned and actively managed. They referred to power which manifested in unspoken taboos. Taboos existed where certain matters were not spoken about, openly addressed or managed. Un-owned power was

described explicitly and implicitly in multiple ways, as evidenced in the following participant narratives.

The vast inequity in the standards of accountability between registered and non-registered occupations, between government and non-government sectors, and between employees and those self-employed in private practice, demonstrates that there has been a lack of ownership on the part of legislators, to manage the power held by these occupations. In other words, it has become customary in Australia for legislators to remain uninvolved in regulating the power held by these occupations. These occupations have been left to self-regulate if they wished. Alexander, a practitioner who has been in a role as a third party managing complaints about an unregulated occupation, clearly stated that the absence of legislation ensuring mandatory accountability for all practitioners is a major problem. Without legislation, there is no capacity to address complaints, or to monitor and manage the power held by practitioners who choose not to be a voluntary member of any professional association.

That's probably about 85% of our problem is that we don't have any jurisdiction. Um, as I say, we get far more complaints about non-members than we do members, by far, we probably get ten to one, um, complaints about [practitioners] who are not ours. (Alexander CM#10)

One of the other implications of the lack of registration is an inability to 'own' and manage impairment. In the absence of a regulatory framework there is no way to support practitioners who are in need of confidential, safe, support which may empower them to address impairment.

Alexander also described the dysfunctional way he has observed complaints being managed within small voluntary professional associations which do not have any

complaint structures in place whatsoever, or where complaints are not addressed in an effective manner within the weak mechanisms that do exist. According to Alexander, having no complaints mechanism or a weak mechanism, is a clear sign that these voluntary associations are not motivated by the need to own and manage the power held by members. He suggested this may be influenced by a culture of 'bias' towards protecting their own.

...a lot of those [practitioners] actually are voluntary members with [other organizations] but they're small, with very little standards, with no complaints mechanisms of any sort, or complaints mechanisms are so weak, but also they're more interested in keeping members so they don't apply the complaints mechanisms, they don't follow it on, it's the money and the members they need. So the systems are biased, a bit like the boys' club. (Alexander CM#10)

Joan, a practitioner who has had many roles managing complaints about a range of registered and unregistered practitioners, stated her current knowledge of serious boundary violations that were not being addressed effectively. She gave an example of the Corrections sector which she felt posed significant risks, and where complex power dynamics were not appropriately understood or acknowledged, and were therefore not owned or well managed.

I still don't think there's enough emphasis on it. I think and I know off the record of at least in the last four or five years of having 15 to 20 conversations with women in professions, half of them in [organisation]. There's just no training whatsoever... I think [large government organisation] as a system needs to bloody take responsibility for the role they put young women in with controlling men. So when I listen to those women and the whole thing of saying 'well

you've got the power' [as a practitioner], isn't necessarily true. There's a whole male power that goes on with prisoners and those guys on probation. And I mean it's like a little secret. (Joan CM#6)

Joe, a practitioner in a registered profession, also described issues with sexual boundaries in the prison sector.

I was involved in work in prisons with some junior [practitioners] who got into all sorts of trouble. (Joe RP#5)

Saskia, a practitioner who has had experience in multiple roles as a complaint manager in complaint management within workplaces and regulatory organisations, reflected that her values regarding professional boundaries were not always shared by others, and that a lack of ownership of the power of boundaries is a problem in the industry.

I have very strong values around professional boundaries and that it is never okay to engage in a sexual relationship with your client. And that comes from a history of working in sexual abuse. And having done a lot of sexual abuse training and seeing, I guess, how naive some professionals are about their obligation to act responsibly. My view I guess is that it is a bit of a copout that they are so naive. They are not actually that naive but it is a presentation they might make in order to defend the indefensible. (Saskia CM#8)

Tran also commented that regardless of the evolution in the culture of attitudes and regulatory provisions, practitioners will 'justify all kinds of things' as a way of not owning their power or responsibility.

I think the rules are also necessary because people will justify all kinds of things. And practitioners are not all that good by and large and there's research to support this, at evaluating their own performance, which is not a good thing. There's some, supposedly there's some research that says 90% of [practitioners] place themselves in the top 10% of effectiveness, and it's like driving, we're not good at self-assessing, we always inflate. (Tran CM#11)

Joan highlighted the complexity of the discourse about power and that 'client choice' can be constructed in a way which disowns professional power. She said that the use of terms like empowerment and self-determination can cause confusion.

...we talk about empowering clients. And I think there is a lot of confusion in the discourse. I think things like 'its people's choice', 'client's choice' all the time, 'self-determination'. Whereas I would say 'well I am sorry it's not self determination, it's their choice within a set of conditions'. So if a client says I want to have sex with you and you feel inclined, it's not a case of them to choose to be self determining. (Joan CM#6)

Joan referred to cases where employers had not stated clearly to inductees that it is misconduct to have sex with their clients, and that this taboo topic is often not spoken about in the welfare and community sector. This contributed to the lack of awareness and ownership of professional power.

Veronica described her experience of her own reluctance to speak up about an issue relevant to professional boundaries. She had been in a training role, and despite concerns about the style of dress of two of the trainees, she found it very uncomfortable to own and act on her power to provide feedback and address the issue of standard of dress.

This is a bit of a taboo subject in the industry as well. There are two [practitioners] I'm aware of...Both are very, very attractive young women and who dressed like they are going nightclubbing. And when I watch her doing a counselling session I cannot go past her cleavage. And there was a male trainer that I was doing the assessment with and we both commented on it and I said 'I bags that you tell her'. And he said 'I'm not telling her or saying anything!'... I mean I had two years with that [practitioner] and I never told her. (Veronica RP#3)

Another form of disowning power discussed by Justin was that some practitioners do not take complaints or accountability seriously, and he discussed examples of reactions by respondents which indicated this. Mark, a complainant, also said that the practitioners providing services had trouble admitting that their services can be powerful.

...but they don't even admit it is powerful. Only one or two people under oath came forward and said yes it was powerful when they were cross-examined. 'Is it a powerful experience?' 'Well, um,' and then they were not answering the question so the barrister said, 'If people are crying is it not powerful?' 'Well then yes I suppose it is then'. You know? Finally they admit that it is powerful stuff, that powerful emotions are being released. You know, they, no one from the [service] told the court that people punch pillows and scream. (Mark TPC#3)

Mark went on to say that not only did the practitioners involved not admit the power of the service provided, they were also secretive and wanted to hide the details of what activities and services were actually provided. His account suggests that perhaps the power of the activities used was not really understood by the practitioners involved.

But also, there appeared to be a lack of commitment to the expected values of transparency and openness that he assumed would be associated with anyone in a helping role.

And I asked... I demanded to know what they had done to [client] ... Like the hour by hour... And she was so reluctant to, you know, because it is all a bit of a cult thing... I finally got out of her. It was like pulling a tooth out, that it was some sort of regression involved. I said 'Was it hypnosis?' and she said 'No, it was more like some sort of meditation'. (Mark TPC#3)

Mark pointed out the futility of suing or 'going after' practitioners when he clearly believes they did not intend harm. This implies that he does not believe they abused power they knew they had, it was more the case that they did not take ownership of something they didn't fully understand. While Mark was very clear that while no harm was intended, he was very aware of the state of denial that practitioners were in when they would not accept responsibility for how powerful and destructive their practices could be.

... I don't really want to go after these people. (Pause). Because they didn't mean to do it. But at the same time I don't know why they are so damn sure they weren't responsible for it, at the same time....Denial. 'It couldn't be us. We don't harm people!' (Mark TPC#3)

Joan also observed a distinct lack of attention to how power is used. She explicitly stated some of the assumptions about power that she believes are embedded into the culture of the non-medical and community sectors. One of the assumptions is that non-government practitioners don't have power, or that their power will

automatically be used well. Also, it is a common assumption that women will automatically use power better than men.

In comparison to the medical model or the institutional model we don't have the same type of discourse about power. You see that in women's organisations where there are no men yet therefore there is no attention to who uses power, and how power is used. So it is that ideology that somehow we don't have power, or that we automatically use power well because we are not in government or in a hierarchy or a hierarchical profession. I think that is a culture that can be very dangerous. It is not reciprocal; we are not putting the same standards of accountability on practitioners like we are on the institutions or the government. (Joan CM#6)

In summary, participants referred to a range of ways that a lack of ownership of power has manifested in cultures surrounding complaints. This theme can be analysed in light of theories about power – especially theories about the influence of ideological norms. Joan used the word ‘ideology’ (see excerpt above) to describe the form of power she saw operating in the industry she worked in. Language is used in the industry to describe clients as ‘self-determining’ and capable of ‘autonomous choice’, which can then be used to position the client as being responsible for exercising agency and choice when regarding sexual relations with a practitioner, or for consenting to receive services that were damaging. This could be critiqued as an example of ideology transmitted through language. According to Freedom (2003) “ideology permitted...itself to be represented as if they [sic] were truth-claims that possessed universal, rational validity” (p. 6). The claim that a client is, or can be, self-determining is not universally or rationally valid, yet it is commonly stated. It is a claim that is contradicted by the legitimized expert position held by practitioners, and the fact that this expert position

invites client compliance. Furthermore, it is a claim that is contradicted by the realities of client vulnerability, crisis, and impaired capacity for decision-making. It is also contradicted by the complex structural disadvantages impacting on clients, as well as the fact that many clients are involuntary, subject to practitioner assessments, reports and recommendations within powerful systems. The language of client self-determination can be seen as having political and ideological dimensions which misrepresent important realities.

Mark highlighted another manifestation of a lack of ownership of power, in that he said he observed practitioners denying that their services were ‘powerful’ and believing that if they were powerful, they were not powerful in any way that could cause ‘harm’. This implied there was an irrational, but strongly held belief that some forms of power can be guaranteed to only ever produce good in the counselling industry.

Wartenberg (1990) placed great emphasis on ideological norms as a form of power, and believed that individuals develop situated power depending on the ideological norms that surround them. Freedom (2003) emphasised the ubiquity of ideology, and said that “we produce, disseminate, and consume ideologies all of our lives, whether we are aware of it or not” (p. 1). He acknowledged Marx and Engels as having had a strong influence on our understanding of ideology, and that they were responsible for the claim that ideology was politically motivated, imposed by the ruling class to serve their interests, and that often ideas and realities were obscured to in order to reproduce de-humanising social relations under capitalism (Freedom, 2003). Freedom also highlighted that ideology was seen by Marx and Engels as often being disseminated unconsciously.

...ideology was disseminated by those who specialised in the mental activity of sublimation: priests offering ‘salvation’ were an early example of that ‘emancipation’ from the real world. ...dissemination could be an act of deliberate manipulation, but it could also, especially for Engels – be an unconscious, or self-deceptive process.

(Freedon, 2003, p. 5).

It could be argued, according to the theory that power is ideological, class-based, and often unconsciously and self-deceptively reproduced, that cultural norms of a lack of ownership of power, and the historical lack of robust accountability, have served the ‘ruling classes’ in several ways. This may not have been the conscious intent of those involved. One interpretation is that the ruling class (in the form of those holding power in government) have preferred not to have to fund expensive regulatory infrastructure, especially when the users of services are often perceived as marginalised, unlikely to exercise political or economic influence, or significant voting power. The reproduction of the ideology that counselling, psychotherapy and casework, and the unregistered occupations that provide it, are not powerful or harmful enough to warrant registration, would therefore be in their financial and political interests.

The interests of the ruling class could also be interpreted as a motivation for why only psychiatry and psychology are registered providers of counselling and therapy. Perhaps the professions most allied to the dominant ‘medical’, ‘clinical’, ‘scientific’, and ‘business’ models of service delivery such as psychiatrists and psychologists are more closely aligned with the norms of the ruling classes. According to this interpretation, it would be in the interests of the dominant ruling class to reproduce the ideology that unregistered occupations are not powerful enough to warrant registration

because this would preserve psychiatry and psychology's share of, and status within, the counselling and therapy market.

A final analysis of ideological power as a form of cultural power applies to those who do not take ownership of their own power within unregistered occupations (such as those practitioners observed by Mark). Practitioners may believe and 'reproduce' the ideology that they do not hold the power to harm, for self-serving means: to protect their income; to reduce the requirement to spend personal resources on getting qualifications or developing knowledge and an evidence-base for the services they provide.

If, as Joan says, ideological power has been operating in the cultures surrounding complaints, it is important to acknowledge this as an important form of power that has led to the lack of ownership of power and lack of robust accountability. These manifestations of ideological power have significant implications which will be discussed further in the concluding chapter of the thesis.

Inadequate ethics literacy. The term 'ethics literacy' was used by one of the participants, Jessica, and when reading her transcript during coding, the term stood out as the most appropriate word to define a phenomenon that appeared as a theme across many participant narratives. Inadequate ethics literacy referred to a lack of knowledge and skill in comprehending and applying ethics. After data analysis I searched for previous literature about 'ethics literacy'. Whilst I could not find the term 'ethics literacy' defined clearly in scholarly work within the psychological sciences, it had been referred to publications within a diverse range of disciplines. For example, 'ethics literacy' was defined within business ethics as having specific 'components' such as: dealing with ethical issues that arise from positions of power; shaping the ethical

climate of an organisation; concepts and frameworks for ethical decision making; knowledge of the different ethical issues likely to be faced in an area of work; and knowledge of relevant codes of ethics (Barsh & Lisewski, 2008). In a text about 'communication ethics literacy' it was referred to "a pragmatic alternative to prescriptive telling about 'the right' and 'the wrong'" (Arnett, Harden-Fritz, & Bell, 2009, p. 2). Arnett et al. (2009) also stated that the "doing" of ethics requires one to have the necessary ethics literacy to ask, "What is the good we seek to protect and promote?" (p. 3). This emphasised the need to be able to speak a language that would allow dialogue about and comprehension of, intent to promote good.

Another related term 'mental health literacy', was defined by Jorm and colleagues (1997) as "knowledge and beliefs about mental disorders which aid in their recognition, management or prevention" (p. 182). Again, the idea that there are components to literacy was conveyed: "Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking" (Jorm et al., 1997, p. 182).

Therefore, ethics literacy is defined here as the knowledge, beliefs and information required to recognise, comprehend and dialogue about ethical dimensions in a given context, in order to examine and inform positions about which actions will promote good. Examples were described where consumers of counselling, therapy, casework and self development services had inadequate ethics literacy, as well as some practitioners. Inadequate ethics literacy was also described as applying to some managers, supervisors, complaint handlers and organisations.

Bruce is a practitioner who did not have formal qualifications but who worked for an organisation in the community sector. He made a complaint to his manager at an exit interview, about his colleagues' incompetent and negligent casework and counselling. He described a sense of naivety, lack of experience and makeshift responses to highly complex practice situations with vulnerable young people.

We were all very green. I was the most experienced worker at that stage by about 6 months with most other workers having only worked there for 6-9 months at the very most. We were all just making it up as we went along. (Bruce TPC#2)

Saskia also stated that even when there were procedures of accountability, practitioners often did their work without ethical awareness or conscious attempts to measure what they do and how they do it.

I think that even when professions have some procedures of accountability, members are largely unaware of them. People politely go about doing what they think they have been qualified to do with little consideration of the consequences of their actions... not thinking that their code of ethics could be one yardstick to measure what they do and how they do it. (Saskia CM#8)

Veronica, an experienced practitioner in an unregistered profession also described a sense that practitioners do their work without giving much thought to ethics, or the potential for a complaint.

I think there is something about an attitude, and I suppose lots of us, and I have it as well, of, that will never happen to me. That would never happen to me. Like if I give someone a hug they would never complain. You know what I mean? There is that sort of attitude. (Veronica RP#3)

Tran spoke about ethics as something marginalised and compartmentalised, and not at the core of practitioner identity.

I think this is the problem, we often think of ethics as something that occurs in classes on ethics, and so we have a unit for six months, and people attend thirteen workshops and so on... but the point is, I think it should be part of people's supervision, and part of who we are in terms of what does it mean to be an ethical person. (Tran CM#11)

Lisa also discussed a disadvantage of the fact that complaints are surrounded by confidentiality and secrecy in order to protect the identities and privacy of those involved. One of the implications is that this compartmentalises and restricts the learning and increased ethics literacy from cases where things went badly wrong. She went on to say that there needs to be a way of publishing de-identified summaries of the types of cases managed by self-regulatory bodies, with an emphasis on learning from other's mistakes.

...there has been occasion where I have been involved with other [practitioners] where I wanted to draw on that experience, and I had to be very careful and cover-up where I got that knowledge or what I was really talking about. So in a way that's really restrictive because of the huge learning experience and you can't actually share that learning. (Lisa CM#5)

Joe is a practitioner from a registered profession who responded to a formal complaint about an intimate relationship he formed with an ex-client at a time when this was not clearly defined as an ethical breach in the code of his profession. He stated his concerns that ethics was not taught to him sufficiently and that he had to 'get it along the way'.

...understanding about what constitutes professional behaviour and professional ethics. I think that's certainly nothing that was really taught even at Masters level. So, none of my training informed that. I had to get it along the way. (Joe RP#5)

Joan also referred to the lack of contemporary emphasis on ethics training regarding sexual boundaries. She suggested that parts of the community and not for profit sector were yet to develop the same culture and standards regarding sexual boundaries as the clinical professions, and that there is resistance to this.

And I can't remember the last time I saw a professional development session on it... even on transference. In the old days people would sort of talk about it in that way and everyone in our sector would say 'no no no that's too clinical and medical'. But we need to find some way to talk about it. (Joan CM#6)

Saskia also reflected on an interaction she had with a respondent to a complaint which demonstrated ignorance of contemporary ethical standards. Saskia had assumed that the values broadly held by her profession would be understood and upheld by all practitioners.

I asked this person (respondent practitioner) didn't they think that a counsellor had an obligation to, a greater obligation than a person in the general public, to behave in a more appropriate manner. And he was equivocal about that. And I was taken aback... He thought that it depended on the circumstances about whether boundaries needed to be maintained. And whether clients and workers should have relationships depended on the length of time that that's been out of that relationship.... They kind of, didn't demonstrate any real understanding of the counselling relationship or a professional relationship. No understanding of

transference. No understanding of boundaries. No understanding of respect. No understanding of the code of ethics and what it requires of people. And I was absolutely gobsmacked at their, at what I think, was profound ignorance.

Ignorant and dangerous professionals; I don't know how better to say it. (Saskia CM#8)

Veronica said that clients are often not aware of the ethical standards regarding boundaries. This reinforced the theme that inadequate ethics literacy applies to clients as well as some practitioners.

...men have an hour of time with a pleasant woman who is animated and interested and interesting and so forth, how bloody appealing and lovely that is for some men. So that's why I would never hug a male client. I have had men ask me out for coffee and I have even had one man who said 'maybe when we are all done with this, we could catch up for a drink sometime?' And I said 'look, that's not what can happen. Once we have been in a counselling relationship that's where it stays'. (Veronica RP#3)

Participants also described specific areas of inadequate ethics literacy, including a lack of knowledge of what occupation titles mean, and a lack of knowledge about the absence of registration for many occupations. Justin said that it was often only at the point where things went wrong that the client found out about regulation.

Sarah, a complainant about an unregistered therapist, supported this view that many complainants have no idea where to go with their complaint.

You know, where do I start what do I do? ...and nobody that I have spoken to so far can actually suggest where to next. They have got these suggestions. Go to [organisation]. Well I went to them and they can't help with this! (Sarah TPC#5)

Stephanie, an experienced practitioner who has been in a range of roles as a third party responding to numerous complex complaints, confirmed cases of tokenistic complaint mechanisms and lack of substantial ethics literacy on the part of organisations. She described an organisation which simply stated that there was a right to make a complaint. However, no information was available to the public or to consumers regarding complaint protocols, and there was no framework within the organisation giving guidelines about how to respond to complaints.

No. Not at all. All it said was that you basically have a right to make a complaint. And that if you want to do so you need to do so in writing to the [manager]. And that was pretty much it. (Stephanie CM#4)

She went on to express her concerns about the impact on a complainant of launching into an unpredictable complaint process, without any clear information or ethics literacy about protocols, or what might to expect.

I am wondering whether the young person was ever really informed about what would happen if she made the complaint. If you do this, this is potentially what could happen. And I don't think that conversation occurred prior to the complaint being written. (Stephanie CM#4)

Zoe, as a third party complainant, said that not only did she lack information and knowledge herself, but the people she approached for help with her complaint also had very little knowledge and were naïve and uninformed about how harm can occur.

Like the [organisation representative] from the [organisation], he was stunned. I talked to him for nearly 2 hours and he was just stunned. He is like, I've worked in this area for 20 odd years, and he said I have never ever come across anything like this before... And he's a professional. So how do you expect a layperson to

understand it? Somebody with no exposure and no understanding of the process or the damage that can be done! (Zoe TPC#4)

Sally, who was interviewed primarily as a respondent to a complaint about her own practice, had also been in the role of a complaint manager. In that role, she had supervised another practitioner who made a complaint about colleagues' negligent practice and lack of duty of care with suicidal young people. She reflected on the lack of ethics literacy she had as a supervisor regarding how a complaint would be dealt with within the organisation her supervisee worked for. When asked if she knew enough about the organisations complaint protocols she replied, "No. No way!".(Sally RP#4)

Jessica, in her role as a complaint handler, said that ethics literacy was lower than she thought.

...some of the questions that people ask, the frequent questions that are coming up are ones that we possibly had an impression that people would have known that, or had an understanding of those issues. So possibly the ethics literacy is lower than we thought. (Jessica CM#2)

Alexander reflected on his role as a trainer, and that he was 'astounded' at the lack of ethics literacy.

I think there's a lot of ignorance out there. I teach ethics as part of workshops I run, and I always get astounded by the amount of [practitioners] who have no idea about note-taking, and when it comes to ethics, the rights of the client, confidentiality, those sort of things, but I think that comes back to the education system within [field of practice], I think it's very poor, there are a lot of holes in it, a lot of inconsistencies in it. (Alexander CM#10)

In summary, it was the perception of many participants that it was the norm for many consumers, practitioners and organisations, for there to be a generalised lack of ethics literacy in the cultures surrounding complaints. This theme reveals a lack of knowledge and information. It portrays a culture in which something is not attended to that should be; something is not provided that ought to be. It implies that there has been a failure in someone's responsibility to ensure this knowledge and information is available.

The theme of a 'lack of ethics literacy' can be analysed in light of ideas about how knowledge is produced, or 'epistemological' power. It is relevant to use the ideas of feminists such as Harding (2004) who focused on the effects of power relationships on the production of knowledge. Harding (2004) drew principles from Marx, such as a rejection of the liberal assumption that social, historical and ideological factors are irrelevant to the production of knowledge. This perspective suggests that the reasons for a lack of knowledge, or a lack of provision of information, would be political and ideological. In the time since the 'talking cures' of psychotherapy and counselling were formalised in westernised cultures, and the models of practice entailed in 'casework' were developed, this evolution would have involved the dominance of the interests of certain stakeholders who held the power to determine which knowledge was produced, how it was disseminated, and to whom. Stakeholders included the theorists, educators, researchers, legislators, regulators, managers, researchers and practitioners. The mechanics of how a lack of ethics literacy evolved in the contexts described by participants would be highly complex, but suggest a lack of focus and attention to ethical dimensions by those in positions where they could produce and disseminate this knowledge. One example of literature confirming a lack of focus and attention to ethical guidelines was the workforce profile survey conducted by Pelling (2005) which found

that a quarter of counsellors who responded to the survey stated they did not follow an ethical code.

Another example of the way in which knowledge production relies on the interests of researchers is that it was only due to the efforts of researchers and advocates in the late 1980s and 1990s that a body of evidence was formed regarding the harmful effects of practitioner sexual boundary violations (Boeckenhauer et al., 1998; Pope et al., 1993; Schoener et al., 1989; Quadrio, 1994). Prior to this, harm from boundary violations occurred, but knowledge of it was not actively sought nor disseminated.

Another example of the power to disseminate information, is where an organisation, such as the one discussed by Stephanie (above) did not provide detailed information to clients about the organisations' complaint protocols. It could be argued that this knowledge and information was not well attended to because it was not primarily in the interests of the stakeholder to provide it. As stated in the analysis of ideological power in relation to the previous theme of a lack of ownership of power, often individuals and organisations do not consciously act in their own interests; it can be an unconscious process. Whether knowledge is produced and provided with conscious intent or not, it seems that 'epistemological power' is one of the forms of power dynamics relevant to the evolution of cultural norms in the contexts surrounding complaints.

Avoidant and adversarial approaches. Participant narratives tended to describe either avoidant or adversarial approaches to complaints. Avoidance involved norms of not acting on complaints, not reporting at appropriate levels, concealment or hiding of complaints or misconduct, minimizing or sanitising, and breaching but not sanctioning or addressing root causes. Adversarial approaches involved a culture of

blaming and punishing rather than inquiring, learning and restoring. In an adversarial approach, legal provisions and roles were often relied on to 'fight' allegations.

Avoidant approaches will be presented first. For example, some participant descriptions revealed a subtle but powerful norm which resulted in the avoidance of dealing with complaints. This norm was that reporting of complaints to management, regulatory boards or professional associations was not considered. This may have been due to a lack of ethics literacy, a lack awareness of protocols around reporting of complaints, and fears about the likely costs and potential pitfalls of a formal complaint process. The end result was that many complaints did not come to the attention of those with the power to regulate or address the causes of the complaint. This is an important finding of this research, that many complaints are not reported formally for many reasons.

Stephanie, who managed a complaint in her role as a Management Committee Member, discussed a culture of not telling managers about complaints. Had the client not found out that she had a right to make a formal complaint to the management committee, the committee would never have found out. This would have meant that management would not have looked more closely at some unethical practices that had become the norm in the agency.

It wasn't until the formal complaint came in that the management committee were told. And then I just said 'what you doing?' And the more that I became involved, the more concerned I became, and alarmed in relation to stuff that was happening around personal boundaries. The practice was just not appropriate for access to private home phone numbers, therapist's phone numbers. Getting called out in crisis and going out at midnight to see young people. 'No, no, no no

no no! What are you doing?' And I don't think the management committee were aware of that stuff. (Stephanie CM#4)

Stephanie reflected in hindsight, that even though some of the practitioners complained about were registered professionals, it was never part of anyone's awareness that a complaint should be made to a board or professional association.

Look I don't think that it was ever sort of mentioned. I don't think any of the workers were concerned. (Stephanie CM#4)

Bruce, a complainant about an unregulated professional, did not have knowledge of regulation protocols, nor of any grievance procedures or practice standards applicable within his organisation. Instead of making a complaint, he decided to leave the organisation and only expressed his concerns at an exit interview. Bruce also said that he and his colleagues discussed their grievances and complaints about their colleague, but did this behind her back and not with managers. He said this may have been influenced by an assumption that management knew already but was not going to act, but also by norms of not wanting to hurt people, not wanting to make the organisation look bad, and not dobbing or breaking cabinet solidarity.

We were a very sociable bunch and met up most Sundays at the pub to drink, debrief and unwind. We often discussed our displeasure at how the [workplace] was functioning and how [practitioner] was not. We knew it was a bad situation but felt we had no-one to talk to as we either a) assumed management knew or b) didn't want to go over the top of [practitioner]. It's all part of the 'cabinet solidarity' that reinforces the group. (Bruce TPC#2)

Avoidance of confronting practitioners about complaints was also described by Saskia. She said that not only are people unaware of complaint processes, they tend to

avoid using them, and instead she said “consumers vote with their feet, they don't go back to the practitioner, and they complain about them with their families or whoever” (Saskia CM#8)

Bruce described a form of passive-aggressive avoidance of dealing with the issues he had with the conduct of a colleague. He also avoided ‘fighting about it’ by deciding to leave the organisation rather than make a complaint.

The fact was that I thought she was a vain and foolish person with a level of good intentions that were matched only by her incompetence. I clashed with her (albeit in a passive-aggressive silent disliking between the two of us) and therefore no longer work in that [workplace]. (Bruce TPC#2)

Justin also said that in general, there is resistance in the broader Australian culture to ‘dobbing people in’, and reporting is avoided.

Stephanie highlighted another powerful form of a culture of avoidance in organisations. In some cases, practitioners were investigated and found negligent after complaints, and recommendations were made regarding sanctions or supervision, but the organisation did not act on these, and simply ‘moved staff around’.

There were times where we actually recommended people to be removed or sacked just because of the level of damage that they had caused. Often it wouldn't happen though. We had no way of enforcing that. We could just, put it out there and hope that they take it on board but often they did not... Nine times out of ten, particularly with some of the larger ones, it was the same people that we were investigating. They just got moved around. (Stephanie CM#4)

Stephanie then gave her view on why some organisations avoided their responsibilities in this way.

I could be really cynical. I just don't think they have enough staff to be tossing out staff. Some of these people that we would be investigating have ten years plus with the [organisation]. So they are on the ground and they are committed to working, but I don't think the agency is making the best decisions. (Stephanie CM#4)

In addition to a lack of resources, Stephanie also referred to a culture of giving practitioners the 'benefit of the doubt' as a form of avoidance.

Often people say well let's give them the benefit of the doubt. Well, I have just written the report and there is evidence to suggest that their decision-making is not good. And I suppose for me I always take the view that if that report was leaked and put on the front page of the paper how do you reckon you'd fare in actually keeping this person and promoting them? Because that's often what happened. (Stephanie CM#4)

Joan reinforced that there are norms which minimise and avoid acceptance of responsibility.

'Oh it was just a human mistake', and that 'he was such a good practitioner in other ways', if they are the charismatic good ones. Everyone wants to justify it somehow instead of stating the responsibility for the behaviour. (Joan CM#6)

Tran also said that those in teaching roles find it difficult to report because of a norm of 'seeing the best in others', which is similar to giving people the 'benefit of the doubt'. This norm however, may be motivated by a need to avoid conflict.

I think [practitioners] find it very difficult to report, by and large, because [practitioners] have a culture of being supportive to our [peers and supervisees] and seeing the best in them...but things go on which should not go on... I think one should, one should raise issues where one has concerns. That said, I think absolutely that we need to first raise it with the person concerned... And probably the barrier is that people find it really difficult to deal with conflict. (Tran CM#11)

Sally also referred to an avoidance or 'covering up' of problematic practice by practitioners themselves, but highlighted different reasons for this. She said that covering up occurs because it is not safe for practitioners to openly admit their mistakes.

And in [organisation in specific field of practice] particularly, mistakes are made and they are made often. But it is covered up or it's, covered up is not the right word. It's not safe to say, 'I didn't do that', 'you are right I didn't follow up for various reasons'. It is not safe for those [practitioners] to openly acknowledge where they went wrong... They are more likely to be highly defensive and pathologise the client and I can't see that being useful for anyone. (Sally R#4)

Joan said that in other industries there is a culture where faulty services or products are withdrawn from sale. She suggested that part of the reluctance and avoidance of this in her industry is due to sensitivity to the impact on an individual practitioners' life. She also said that some of the norms of the industry are inappropriate and end up protecting offenders.

Imagine if the manufacturing industry didn't recall cars that had had bad brakes or mechanical faults? I don't know why we have to hide it in our industry. I don't know why people feel the need to think that it is so sensitive that you are going

to wreck a colleague's life, when that person has already done that through their own actions. (Joan CM#6)

Justin also discussed his experience that some employers in organisations avoided dealing with complaints by creating pressure for practitioners to resign. This is another form of avoidance which means that misconduct and poor practice does not come to the attention of regulators, and allows the practitioner to move on to another place of work.

The next series of participant narratives refer to a norm of an adversarial culture surrounding complaints. An adversarial approach involves investigating 'breaches' and 'failures', punishment for failure, blaming, taking sides, using arbitrary and legalistic standards of evidence, cross examination, defending and surviving rather than communicating openly in a relatively safe, supportive environment. An adversarial culture was perceived as leaving little room for transparency, acceptance of responsibility and problem solving.

Findings regarding adversarial power dynamics will be presented in more detail in the findings about relational and structural power. This particular theme about cultural power briefly focuses on participants' perceptions that an adversarial approach was customary as a norm for the paradigm in which complaints about counselling, therapy and casework were dealt with.

For example, Joe commented that the adversarial manner in which a complaint about him was processed by a registration body forced him to fight back with equally legalistic and adversarial strategies. Yet what he wanted was to be able to show his humanity, to learn and change.

And the [regulatory organisation]...one would think that there would be enough smarts there to realise this is an incredibly stressful time. And that if there is to be anything akin to a win-win outcome, even if it be that a [organisational response] was to occur, that some learning and appropriate change take place, this was not the way to do it. My experience was that if anything, it has potential to drive people underground, become highly legalistic and to go to rules of evidence or whatever technical aspects, and not deal with it or put a human face on this whole process. There was never any chance for me to do that. Never!

(Joe RP#6)

Tran observed that a culture of 'notification of breach' within a punitive framework is unhelpful and stifles reflection and the potential for open acceptance of responsibility. He said that a safe, supportive and confidential service which helps practitioners make sense of complaints needs to be set up and resourced.

I've actually been in that role of supporting someone against whom a complaint has been made...in terms of trauma and meaning making and so on. I think firstly such people need to be able to gain some kind of support to make sense of what might appear to them to actually really not make sense. And to be able to do that within an environment that is not part of any kind of process that is seen as potentially punitive, because any kind of notification type process there are potential consequences that is seen, rightly or wrongly, as a potentially punitive process. (Tran CM#11)

Alexander also said that many cases would be nipped in the bud if the conditions were right at the start of complaints, for practitioners to reflect, admit any responsibility and apologise.

...the majority of cases that they hear could have been nipped in the bud at the very beginning if somebody just said, 'sorry'. If somebody had admitted responsibility, and said, 'look, I did that, I didn't mean it, but I accept responsibility, and I'm really sorry that it hurt you'... People, most, the average Australian, is quite happy with that. It's only when they don't get it, people defend poor actions, then people get upset and want blood. But that's a process that people build up to. At the very beginning, most people are just happy to say, 'well, you know if you just acknowledge what you did and then say sorry, I'm happy. That's all I need'... People just don't understand how powerful saying sorry is. As long as you're sincere. (Alexander CM#10)

Sally also reflected on the need for processes that allowed people to admit they were wrong, without feeling they were going to be 'done over' if they did.

I wonder what kind of process would allow people in our field to acknowledge that they are wrong in what they have done; in a way that they are safe, and builds and adds to the profession rather than taking away. So I wonder what kind of process would allow that. It is the same in supervision if it allows you to say I did a really terrible job and it was a really bad job and I need to work this through. Without feeling like you are going to be done over if you acknowledge it. (Sally RP#4)

Lisa expressed her frustration that in the unregistered professions there is no power or resources to do more than 'breach' a practitioner and slap them on the wrist. She said that breaching only, without the capacity for follow up, allows the practitioner to get away with what they had done, without any framework put in place to provide the level of professional development and monitoring required. This suggests the

adversarial or punitive approach is tokenistic and does not address the root causes or problems.

There is no professional development or monitoring required. There is no way they can check that she has learned from this... 'Yes you are breached, but no penalty', so what's the worth of that? What a waste of everybody's time because that person is not going to learn from their experience. 'Oops slap on the wrist! Naughty! Don't do that again'. But not giving them the way to learn not to do that again. (Lisa CM#4)

Stephanie said that the reaction of respondents to complaints sometimes depended on how much trouble they thought they were in. In an adversarial culture, if there was a threat that there could be severe sanctions for their actions, she found that some respondents used all strategies available to them to protect themselves. This included making complaints about the investigation and hearing process.

It depends how much trouble they thought they were in... I have had a couple that have been completely hostile. And have made complaints about me and my process. (Stephanie CM#4)

In summary, themes of avoidant or adversarial cultural norms surrounding complaints were referred to in many ways. It could be argued that cultural norms of avoidance of conflict, or an adversarial approach to dispute resolution, have developed partly due to the influence of the historical origins of our cultural understandings of how conflicts should be dealt with. According to Stacey and Lavarch (1999) post-invasion Australia inherited 'adversarialism' as a fundamental underpinning of civil litigation and this has informed cultural norms about how disputes should be dealt with. They also said that the cultural foundation of the adversarial system is individualism or "the

pursuit of individual rights” (Stacy & Lavarch, 1999, p. xii). This is another example of ‘ideological power’ informing the paradigms within which we think and act (Freedon, 2003). Even when these paradigms do not serve the desired purpose, we are influenced by their inherited legacy. Stacy and Lavarch (1999) also offered a critique of a process whereby a mix of reality and perception has shaped what they called “folklore” regarding approaches to justice, which can, and needs to be challenged in the interest of real reform. They said that, “The first perception to be challenged... is that Australia has a pure adversarial system. It is generally agreed that this is not the case” (Stacy & Lavarch, 1999, p. xi). They described “interventionist” approaches by judges and policy makers designed to attend to the needs of justice systems and society as a whole rather than an unfettered adversarial approach which champions the desires of individual litigants only (Stacy & Lavarch, 1999, p. xi).

Sampford, Blencowe and Condlin (1999) pointed to the use of Alternative Dispute Resolution (ADR) strategies in various sectors of the justice system, which also challenges the ‘folklore’ that Australia is a purely adversarial system. Again, according to an analysis of ideological power, there would be certain interests being served by each particular model or approach. Stacy and Lavarch (1999) suggested that the ideology motivating the use of ADR strategies is “economic rationalism”, or the need for governments to find ways to reduce the overwhelming costs of administering an adversarial system, especially when judicial and tribunal administration costs are the responsibility of the government.

In terms of cultural power, it appears that a generalisation can be made that in most contexts in which participants experienced complaints, there were influential cultural norms of avoidance or adversarialism, instead of enquiry, restorative or other approaches. The influence of the ideology of individualism, and a focus on individual

rights and individual responsibility, as well as what could be described as individuals using defences or survival strategies rather than proactively and openly engaging in addressing and managing disputes, appears to be a dominant paradigm influencing these cultural norms. Yet, as will be discussed later in chapter six, it appears that many participants said that different approaches are needed instead of avoidance and adversarialism.

Dehumanisation and disempowerment. The themes of dehumanisation and disempowerment of parties to complaints were described by some participants. These terms describe phenomenon that are experienced or observed on an intangible level. Phenomenological interpretation allowed these to be made more visible. Dehumanisation was interpreted as a theme in descriptions where systems did not make room for, did not acknowledge, validate, or support the human needs of parties to complaints. Dehumanisation was interpreted as the phenomenon present when people expressed perceptions, observations, and experiences where they were treated as objects without human feelings or a need for their human dignity to be understood and respected. Dehumanisation also involved systems attending to administrative functions in delivering outcomes to complaints, but not attending to the needs of the humans involved. Disempowerment was described in a variety of ways, mostly implicitly. Disempowerment was interpreted when participants described dynamics where disrespectful or unfair preconceptions or stigma were imposed and rights of various kinds were denied.

For example, Bruce, when reflecting on his work in a setting where numerous interactions with the child protection system occurred, openly stated that he had witnessed a disempowering approach to ‘difficult’ clients to the point where they were ignored if they had a complaint.

The harder the clients are to deal with, the worse the red tape, which frustrates them more and makes them harder to deal with. This also leads to a culture of 'I can ignore you because you have no power'. (Bruce TPC#2)

Sally also referred to the use of labels for 'difficult' clients, and that labels can have significant power to construct and define people in a disempowering manner.

It's like when practitioners say things like 'oh I am not getting anywhere with that client because they are resistant'. And I will always ask, 'when you say resistant what do you mean? That the therapy isn't going anywhere? The therapy includes you. Where are you being resistant to engaging with a very challenging behaviour? Maybe you are not using the right tools?' So just saying that one is borderline or they're resistant or whatever is a defence used by our profession. And quite rightly because you can easily get burned. (Sally RP#4)

Justin described how a process of interpretation occurs in reading complaint statements. He said that depending on your pre-conceptions of clients, you may assess a matter as valid or invalid for proceeding to a hearing or investigation. He said there had been a culture in the past in some organisations he worked in, of not believing clients, and taking a long time to assess, all of which was disempowering. Justin also said that people often pathologized anyone who wished to express a complaint or dissatisfaction in general. Using mental health diagnoses as labels could be part of the process of disempowerment.

Joan said that even when clients expressed their needs and recommendations to complaint organisations, they could be disempowered by not being listened to.

What victims always say is that they want more public education about it. But that's never taken up anywhere. The [organisations'] view was if we do too

much of that we will get more complaints. And we said 'that's the idea!!'
(Laughs). They say 'we don't want to fund it because we'll have everybody
complaining to us'. (Joan CM#6)

Joe, as a respondent to a complaint, also felt pathologized, disempowered and
dehumanised when he felt he was characterised as a 'predatory scheming person'. He
felt betrayed by his own profession in the process, and that his profession had betrayed
its own values in the dehumanizing way the complaint was managed.

...I felt betrayed in some sense by my own profession. I wasn't, and nobody
actually really said, except for this lawyer, that I was a predatory scheming
person... But nonetheless I was treated, I felt like I was treated like that... And
it is just crap...It attacked my sense of fairness and justice. But it also was
something that I did not expect to come from my own profession. I just naively
thought my own profession was somehow different and that we are different in
the way that we deal with human beings and it didn't prove to be the case. (Joe
RP#6)

Jessica said that in her role managing complaints in a regulatory organisation,
the organisation had faced accusations that they disempowered complainants by looking
after practitioners.

...that's often an accusation that people will say that we are just here to cover up
for our own and look after our own. So possibly that is a perception that some
might have at the start of the process. (Jessica CM#2)

Yet the paradox was that Jessica also received feedback from practitioners that they felt
disempowered and that the organisation did not do enough to protect them.

That is certainly feedback I have had from [practitioners] that we don't do enough as a profession to protect them from these complaints. (Jessica CM#2)

Stephanie had observed that in general, complaints were forced into a bureaucratic structure that was not designed for these types of complaints, and that this was experienced as dehumanising, making a bad situation worse.

The complaints process that you have now is an administrative process that deals with administration. It does not deal with the human component of complaints. It just doesn't. It makes it worse. (Stephanie CM#4)

Stephanie discussed the protocols in a large bureaucratic organisation regarding complaint processing. Her account highlights the mismatch between bureaucratic protocols and the human needs of parties to complaints.

I don't know whether that particular process is really good. Because often the complaint information that is received is put through a filter system and pops out with terms of reference. Even though these people are providing a piece of themselves on a page, it meets a certain criteria to a required response... So when we start an investigation, we go back and interview the complainants and when you do that, you go 'Oh wow!, your complaint is not actually about this stuff that I've got here. Your complaint is actually about *this* stuff'. It is difficult because you have to tell the complainant that what I am actually charged to do is something completely different, so what I now need to do is go back to the powers that be and say well it is really about this and can I get that added to the terms of reference... Which frustrates people...the actual forcing it into a framework that just isn't really designed for it. (Stephanie CM#4)

Mark, as a complainant, reinforced the theme that in his experience pain and human needs were largely ignored. He said it was very important that anyone managing or hearing complaints focuses on attending to the personal dimensions of suffering.

Ignoring your pain, ignoring you... it is so damaging. (Mark TPC#3)

Saskia also observed a respondent to a complaint misusing professional knowledge to pathologize a client and condemn her as unreliable in a complaint hearing, which was very dehumanizing.

...it was interesting that the witness felt he was in a position to make all sorts of statements and claims and at one point, began to say 'this is not going to do this young woman', in front of the young woman, 'any good at all this process. She's troubled' and he talked about her in the third person. 'She's troubled, she won't get any benefit at all from this process'... So objectified and distanced himself from her. (Saskia CM#8).

Zac, in his role as a provider of information to consumers, has heard from complainants that in the absence of jurisdiction for complaints about unregistered practitioners, the only source of power they can access is by going to the media. The use of the media may be an attempt to influence public awareness, to humanise the personal stories of those who are harmed through counselling, psychotherapy or casework, and to attempt to bring about change.

About the most effective way at the moment is through the media and TV stations to tell the human story. (Zac CM#11)

The participant perspectives included in the theme of disempowerment and dehumanisation can be interpreted as demonstrating cultures in which power was

perceived as a resource (Allen, 2011). When this resource was not used appropriately by those who held it the result was often disempowerment. This is congruent with Held's (1993) conception that power is the capacity to transform and empower oneself and others, and also disempower oneself and others. It was notable in many of the participant narratives that those involved in complaints expressed what they felt needed to happen, or how resources needed to be used to empower instead of disempower. This certainly characterised power as a resource, something that could be used well, or badly.

In terms of the theme of dehumanisation, concepts drawn from the theoretical approach to power articulated by feminist phenomenologist Simone de Beauvoir (1974) are relevant. Although de Beauvoir applied her analysis to gender oppression only, the concepts of how individuals and groups become situated as the 'other' in relation to the 'subject' can explain the process of dehumanisation as a form of oppression in the contexts of complaints. The use of labels and pathologizing as a means to ignore, minimise or deny the human rights and needs of parties to complaints is a powerful example of 'othering'. In de Beauvoir's (1974) conceptualisation those who hold the power are able to be active in defining and producing meaning, which forces others to exist in a passive way, simply by virtue of the fact of how they have been defined in relation to dominant values and ideas. According to de Beauvoir (1974), the dominant values maintained through cultural, historical and economic forces are 'masculine'. 'Masculinist' cultural norms have broadly been described as a lack of value on emotions and the personal spheres of lived experience in relation to the rational and functional public spheres of existence (Allen, 2011). This may explain the dynamics of power involved in experiences of clinical, blunt, dehumanising experiences of complaints.

Examples of constructive cultures. To conclude the themes about cultural power, we now turn to a theme which presented exceptions to the abovementioned

themes. The main exceptions regarding culture were revealed in participant narratives which provided examples of constructive and functional cultural norms which created conditions for accountability, care and learning.

For example Tran said that he knew of a case where a client reported a complaint about a past service they had received from another practitioner, to a current practitioner. Instead of normalising bad practice or avoiding the complaint, it was respectfully reported.

The practitioner was respectful, they said, “I had a client who reported such and such with another practitioner. I have discussed it with the practitioner, and I feel compelled to report it, I don’t know what happened.” And to me that’s somebody saying, ‘ok this is an important issue’. Somebody saying something...they’ve exercised their duty of care. (Tran CM#11)

Stephanie also discussed cases where an organisation dealt with complaints in a timely manner in order to attend to urgent human needs.

Certainly one [organisation] that deals fairly quickly on some matters, not on all, certainly any serious matters... they will deal with it within 24 hours. As soon as it comes in, and it warrants an investigation they will be on it... the investigation is started within 24 hours. It is a quick response. (Stephanie CM#4)

Stephanie also described instances where some respondents to complaints in [organisation] were very open to the investigation and open to learning.

So some respondents were really open to the process. Particularly ones from the [organisation]. They saw it as learning. And this would usually be around

[practice method]. So they would be really open to what is happening and trying to engage with that. (Stephanie CM#4)

The theme of learning from complaints was also confirmed by Bruce. He said that his manager responded to his complaints in his exit interview very well. He felt cared about, listened to and respected, and learning and constructive change resulted.

...the organisation learned a lot from our situation and things have changed (mainly for the good I might add) considerably since then. (Bruce TPC#2)

Justin made a number of significant contributions to this theme. He said that change in dysfunctional aspects of culture can occur, and can be successful, given certain conditions. He said that the reward does come for those who are prepared to put in the consistent effort to increase ethics literacy and practice standards.

The examples of constructive, functional and 'good enough' responses to complaints described in this final minor theme broadly correspond to the deficiencies raised in the main themes regarding cultural power. That is, to improve the situation of a historical lack of accountability, low ethics literacy, and un-owned power, there needs to be careful management of power on multiple levels. Furthermore, effort needs to be put into creating a culture of safety to enquire into mistakes rather than immediately adopt an avoidant or adversarial approach.

The types of power interpreted to be operating as part of cultural power were 'agenda setting' and 'the ability to shape preferences through values, norms and ideology' (Lukes, 1974); 'ideological power' (Freedon, 2003; Wartenberg, 1990); 'epistemological power' (Harding, 2004); power as a misused 'resource' (Allen, 2011; Held, 1993); and power as oppression through 'othering' (de Beauvoir, 1974).

These forms of power were influential because they had become embedded into the customs and accepted practices surrounding complaints. Cultural power however, only tells one part, although a large part, of the story about power dynamics surrounding complaints. Another part of the story is represented through descriptions of relational power dynamics as presented in the next category of themes about power.

Themes – Relational Power

This section of the power chapter contains sub-themes regarding relational power. The definition for this theme was arrived at after coding and analysing the data. Relational power refers to dynamics embedded in the interpersonal communication between parties to complaints and complaint managers. Participant narratives revealed that interpersonal communication dynamics and relational resources significantly influenced the incidents which led to complaints and in the management of complaint matters. This category of findings refers to the power of interpersonal behaviour and communication to give some people more agency or influence than others in relationships. Relational power is not only generated and exercised through interpersonal behaviour and communication, it is also generated through people's access to and use of a set of interpersonal and relational resources. These resources include a persons' capacity to exercise interpersonal and communication skills, their past and present sense of trust, safety and wellbeing when relating with others, their capacity to define boundaries and to know ones needs and to assert these in various contexts.

Participant narratives indicated that the use of specific interpersonal behaviours such as grooming, psychological manipulation, 'mind control', aggression, stonewalling and use of others' sensitive personal information were very powerful in various contexts. Relational power dynamics were also evidenced in the level of trust or

mistrust, and cooperation or conflict between and among people. Relational power was also exercised in the manner in which conflict was communicated and acted upon.

Relational power is differentiated from cultural power in that it does not focus on broad paradigms of beliefs, norms, customs and accepted practices within organisations, groups and societies. Relational power is also differentiated from structural power in that it does not focus on the power assigned to and exercised by institutions or roles. However it is assumed that cultural and structural power is embedded within, and flows through relational exchanges. The four major themes relating to relational power were:-

- Psychological manipulation and ‘grooming’ behaviours
- Relational strategies used to survive conflict and threat
- Being heard, modes of communication
- Relational support

Psychological manipulation and ‘grooming’ behaviours. Participants described relational dynamics in which the trust placed in practitioners was used to generate psychological power over clients. The term ‘grooming’ was used by some participants, and is described by the Child and Adolescent Sexual Assault Counselling Incorporation [CASAC] as:

... actions a person deliberately uses to try to befriend and make an emotional connection with a person so they can hurt them. Grooming is a way of getting someone ready for abuse and involves tricks... used to manipulate their victim, the victim’s family or community over time. Sometimes it is hard to see when someone is being groomed until after they have been abused, because some grooming behaviour looks like ‘normal’ caring and nice behaviour.

(CASAC, 2012, p. 1)

Four strategies are used in grooming, all of which are aimed at maintaining control, including building trust through favouritism or making the victim feel special; a process of desensitisation to activities that are not in the victims interests; isolation and secrecy, including threats of consequence if the secret is broken; and maintaining the message that the victim consented or is responsible (CASAC, 2012, p. 2).

Psychological power includes the ability to influence the cognitions and behaviours of the client. In the context of a relationship of trust, specific practitioner behaviours could be used to groom, condition, instil beliefs, unduly influence or coerce vulnerable clients to behave in a compliant manner that met the interests of the practitioner not the client. The reason this theme has been included under the category of relational (embedded in interpersonal behaviours) rather than structural (embedded in roles and institutions) power is because often the method of conditioning relied on the interpersonal behaviours and nature of the attachment to the practitioner. However, the role of a practitioner and the structural power generated by it, cannot be artificially separated from the influence of relational power.

Clients were vulnerable to having their beliefs manipulated because they were often in a position of needing to address problems, crises and distress of varying kinds, including mental health, past or present abuse, grief or loss, and/or relationship issues. In this context practitioners were able to influence clients to believe that compliance with the beliefs and views of the practitioner, and ongoing contact with them, could provide solutions and healing. It was also apparent that some participant narratives described specific strategies of 'mind control' associated with cults and cultic relationship dynamics. These strategies were used by practitioners to manipulate client's

thoughts and behaviour, and to encourage them to sever existing relationships and invest more time and money in contact with the practitioner.

Therefore this first subtheme regarding relational power contains descriptions of a range of dynamics associated with psychological coercion and client compliance. This includes grooming; undue influence; invasion of psychological, relational and sexual boundaries; manipulation; 'mind control' and 'thought reform'. Whilst grooming and breaches of boundaries were the terminology used by participants to describe relational power dynamics, 'mind control' and 'thought reform' were not explicitly labelled as such. In the interpretation of the data, these terms have been chosen to best describe the complex process whereby a person in a position of power and trust (practitioner) is able to use their relational status to influence the 'mind' and 'thoughts' of clients in such a powerful manner that clients were not aware they had been brainwashed and were being exploited.

Cult-like relationship dynamics were identified in observations by Alexander. He said even when there is evidence to suggest that a practitioner is not competent such as deregistration, some practitioners have a cult following of clients who are still highly influenced by them and in need of the relationship with them.

I think a bad [practitioner] who's counselling to meet their own agendas is so close to being a cult, I find it hard to separate the two actually, because they're usually charismatic, and their clients can be clients for years before something happens and suddenly the light bulb goes on. Or sometimes the light bulb doesn't, and we've had clients, we've had counsellors who've had complaints made against them who still have a significant following, and it's only been a few who've broken away, seen the light and made the complaint, and these

counsellors have been deregistered but they still have a following of people who go and see them. (Alexander CM#10).

Alexander also described an example of a practitioner who groomed a client to form an intimate relationship two years after sessions ceased.

[Practitioners] can groom clients to form relationships... we actually had one – of a [practitioner] who waited the two years, according to the [organisations] code of conduct you're not allowed to have a relationship of any kind, whether it be emotional, physical or whatever, with a client until a minimum of two years after the last session. We had a [practitioner] who waited the two years before having a relationship. The problem was, and the reason why he was de-registered, was because he had been grooming the client whilst he was practising, to form a relationship...and as soon as the two years were up, she left her husband and went with the [practitioner]... It was still ongoing because he was using his skills and the knowledge that he had gained through counselling this woman as leverage to maintain the relationship. (Alexander CM#10)

Joan also commented about a grooming or mind control strategy of separating people from their existing support and relational networks in order to isolate the person and maximise the influence of the practitioner, and their worldview.

Separating people from their support network is something that was really, really obvious with that group of women and men who were into [method of practice]. Because I mean they just committed their whole lives to it. They did those weekends and it cost them a fortune and most of them didn't have that much money to throw around. And then some slipped into the psychiatry world and then ended up with maintenance psychologists and psychiatrists and all of

that. It's sort of like people were trapped between this highly personalised and intimate, almost spiritual reality [of method of practice], and then this really harsh reality [of clinical mental health treatment] where they don't even talk to you. Like the psychiatrists who just make the diagnosis and give you a pill. So people were really trapped between those two realities (Joan CM#6)

Joan referred to a recent conversation she had which highlighted the complex psychological manipulation that occurs in the context of relationships with violent aggressors, and that much more needs to be understood about how it impacts women in particular. She seemed to refer to complex interpersonal power dynamics called the 'Stockholm Syndrome' whereby victims form strong attachments to aggressors or abusers.

I know about five women [practitioners] who are in relationships with ex-clients. One recently rang me in a situation where it's domestic violence. 'Well hello he was on probation for a serious violence offence'. But you know they fall into this 'we can rescue him' syndrome. It is really that 'Stockholm Syndrome' of the good woman rescuing the bad man. (Joan CM#6)

Jen said that the practitioner who she suspected was sexualising relationships with young male clients conveyed an image of being an upright, trustworthy, moral person. She saw this as part of his grooming strategy. Yet she had serious concerns about him using power and control to abuse clients.

It was the unnatural interest in young male clients; I reacted to power and control, not sexual preference...And associations with God, Christianity and justifications, basically, his behaviour was a kind of grooming. In his office

there were pictures of his [child] and [spouse]. For all intents and purposes he was an extremely well groomed, dapper, straight, older gentleman. (Jen TPC#1)

Mary's account could be described as 'mind control' or 'thought reform' as a powerful form of psychological coercion by an unregulated therapist. The therapist had a particular world view in which he believed memories of abuse were unconsciously repressed and contained in the cells of the body, and he used techniques involving meditation, hypnosis, massage and counselling to 'release' them. Mary observed alarming behaviour changes in her children after they had had extensive contact with the therapist over several years.

... [daughter] wouldn't let us inside, she screamed at us through a door, and she said she could 'see' these things that had happened, and I said to her, '[name of daughter], nothing happened'... we went around to see if we could talk to [other daughter], she did the same thing, and her eyes were like saucers, she was, like she was mad. (Mary TPC#6)

Mary said that she originally used to babysit for her daughter so that her daughter could attend sessions with the therapist, never imagining that such horrific harm could eventually result from seeing a therapist.

The first few retreats that she went to, she said to me, 'mum, when you come out of them, your mind's all over the place'. And that didn't sit with me very well. (Mary TPC#6)

Mary tried to comprehend what exactly had the power to manipulate her daughters so severely.

...that's what they said, a lot of people look for somewhere to belong, and this guy [practitioner], he's smoother than butter, and he's just taken her along on the ride and got into her head. Oh one time we were there, she was meditating, and she got up to say, 'see you later' to us, and her eyes were absolutely miles away...and then she said she wants to be like [practitioner], and she wants to help people. And that's his theory, that he's helping people. (Mary TPC#6)

In addition to observations of grooming, undue influence and breaches of relational boundaries, there were also descriptions of specific interpersonal behaviours aimed at wielding or generating power in response to conflict, or to avoid complaints. These will be discussed in the next sub-theme.

Relational strategies used to survive conflict. Participants described a range of behavioural and interpersonal responses to conflict, including avoidant, defensive and aggressive responses, use of powerful allies and counter complaints against those who have complained.

Jen described what happened when a colleague attempted to make a complaint against the practitioner that Jen also had serious concerns about. The practitioner used his resources and networks within the organisation to block the complaint with a counter complaint.

As far as I know there was no staff member complaint made against him, except one woman who found his aggression so difficult to work with...she was questioning his practice. And he came down against her; he went straight to the [organisation] and blocked her. And by doing that, he then made it really hard for anyone to care. We all just sort of went, right, I am stepping right back from that... I don't want him complaining about me. (Jen TPC#1)

Jen also commented on the way that the practitioner had gathered a lot of personal information about his colleagues, mainly during the early stages of meeting him during conversations in the tea room. She said he had a knack of being able to ask probing questions and to provoke personal disclosures that in hindsight felt uncomfortable. She was afraid that if threatened by any complaint, he may twist personal information about staff and misuse it if anyone ever challenged him.

He also knew things about every staff member. He had stuff, not stuff, but you know, enough to twist it the way you wanted to. (Jen TPC#1)

Sally described her observations when she was in the role of a complaint manager, of the defensiveness of a practitioner in response to a serious complaint about counselling and casework with children. She also described the use of an alliance with the manager to pathologize, discredit and victimize the complainant.

The files showed she [respondent practitioner] was driving children to places without parental permission. She was keeping kids in her rooms like detention and wasn't doing anything therapeutic with them. One child had become increasingly suicidal and had attempted and she had not written it in her notes anywhere. So there were some errors that existed and it seems to me that the temp had adopted a highly defensive position and didn't feel safe enough to acknowledge that she had made mistakes and then began to use tools to victimise the person who attempted to bring this to others attention. So forming alliances with the [manager]. There was a counter complaint and they were beginning to pathologize her that she had [mental health condition] and wasn't coping. And naturally she did become increasingly fearful and anxious. (Sally RP#4)

Stephanie described the use of stonewalling by some managers as a means of wielding power in response to a client's complaint. She said clients were not able to access information about grievance protocols and if they had not been resourceful enough to seek out an external complaint body, the matter would not have been investigated.

...they complained to the manager repeatedly and got stone walled. So they got jack of it and went to the [external organisation] and that's how the investigation came about. (Stephanie CM#4)

Stephanie went on to describe a conflict of interest and an alliance and personal relationship between a manager and the respondent practitioners.

...once we started looking at the picture down there where that office was there were certainly some issues around the manager and her personal relationship with those [practitioners]. So there was an interpersonal thing going on there that was clouding professional judgement. (Stephanie CM#4)

Justin described how some respondents approached him in his role as a complaint manager and attempted to share their 'real' perceptions of the complainant in secret. This could be perceived as an attempt at collusion and to build an alliance with the complaint managers, rather than express the issues pertinent to the case in a professional, respectful manner in hearings, which would provide a right of reply for the complainants.

Simon, an unqualified practitioner in an unregulated profession, stated his opinion of the client who had made a complaint about him. His interpretations appear to support Justin's experience that some respondents describe complainants in an unprofessional manner in an attempt to discredit them. The client had made a complaint

because Simon was not able to provide case notes of sessions in which she had disclosed childhood sexual assault. Simon said he had, in accordance with accepted guidelines, kept the notes for seven years then destroyed them. However, the client was not aware of these guidelines, and wanted the case notes as they were relevant for court proceedings ten years later. Simon's descriptions suggest he thought the client lied about the sexual abuse, falsely blamed her father, 'would screw anyone' and was mounting the court action to attempt to seek a payout, and that he thought it was appropriate to describe her this way.

...just like this [client/complainant]... she was out, she was out to get a government grant if she couldn't fix someone for it in the courts, she wanted to get a government grant for her sexual experiences. And it wasn't like that! She was a bloody thief! And she'd screw anyone..., but she couldn't and I knew that. People are like that, this is, there was something on TV last night, how surely some people don't live with criminal thoughts, you better believe that they do, there are entire criminal families that live and think like that. And sometimes we get them coming to therapists. (Simon RP#1)

In addition to the relational power embedded in responses to conflict, power was also embedded in different modes of communication, as will be explored in the next sub-theme.

'Being heard' and modes of communication. This sub-theme reveals that a sense of 'being heard', 'having a voice' and 'feeling safe' in complaint matters was strongly influenced by the modes of communication regarding complaints. Modes of communication include over the phone, face to face in a range of locations and physical spaces, and in writing. Modes of communication also included the tone, manner and

context of verbal and non verbal communications.

Some participants described how powerful it was when parties to complaints spoke directly and face to face about their experiences. Annie said that it was important in her role as an advocate in interviews with complainants, to speak face to face, and for her to write notes, rather than ask them to present her with a written impact statement.

Almost always people don't come to me with any written stuff. A couple have, but the majority don't. So it was a lot of face-to-face talking and I would actually write down their experiences in the process. (Annie CM#7)

Annie also said that hearing a person's experiences face to face was powerful due to the ability to witness emotions and sense the 'truth' (or otherwise) of what they were saying. She also described the way that the mode of communication, and a sense giving voice to experiences, being heard, and feeling safe enough to do so, was an outcome in itself.

Meeting people face-to-face, you can see and hear the truth of the impact it has had on their life. I mean people tell their own story and it is very powerful... No-one who has not been abused could talk about it the way that they do. (Annie CM#7)

Joe's experience as a respondent indicated that even though he wanted to be able to talk to members of the organisation hearing the complaint, he was not permitted to do so and had to answer questions in writing. The rigidity of the requirement to respond in writing was for Joe, a cold, blunt and disempowering process, not aligned at all with the values of his profession.

...there were legal people there. And they gave me notice either then or shortly after that, that I had to answer certain questions... But it was in writing, I could not deliver them personally as well. (Joe RP#5)

Justin said that when people have to listen, to hear things said by another person, they are impacted. He said that sometimes it facilitates powerful outcomes such as reflection and acknowledgement. Justin also made the point that face to face hearings are appropriate for some groups of practitioners and complainants but not others. This was echoed by Alexander. Alexander said that face to face communication between parties to complaints is very powerful. He emphasised the need to protect parties from this, because there is the potential for harm and inequity in the communication process.

With our complaints mechanism both parties actually don't come face to face... that is to protect the complainant, and to protect the [practitioner]. Because what we'd end up with is what we see in our legal system now, is whoever's the most articulate wins the day. So that comes back to education, privilege, and a whole heap of things which doesn't bring equity into it. (Alexander CM#10)

Saskia, in her role hearing a complaint, observed a respondent practitioner's verbal and non-verbal behaviours during a hearing, and in a teleconference. She considered these to be very powerful and disrespectful towards the complainant, and could have intimidated her.

I understand that people, they are in an adversarial situation... But I had an expectation that the [practitioner] would at least be respectful. He sat with his back to, although they were sitting on the same side of the panel, he had his shoulder raised towards the other party. His non-verbal communication was really very powerful. And on the teleconference he declined to even

acknowledge the other party to the complaint at all. It was made clear that this person was on the line and said 'hello', he just didn't respond. He made some comment that 'I know that they're there'. And so there was a whole lot of kind of immature behaviour that went with, I guess this high level of anxiety, about what the outcome potentially was going to be. (Saskia CM#8)

Stephanie described the efforts made by complaint managers on a voluntary management committee to make the hearing process as safe and constructive as possible, given the power imbalance faced by a teenage client.

We had to do some work around the [practitioners] being there. There were two meetings. One where I wanted, and others, wanted to meet the young person and have a chat with them. And, I suppose for me, I really wanted to make sure she was okay with the process. And the reason for that was she was 15 or 16. And she was going to be in a room with six other adults, that all had a whole lot of power, and she had nothing. So I really wanted to talk to her about how we could make that more safe for her and what we were going to do if she felt like she couldn't actually talk in that forum. So we spent some time with her and we got her a support worker in... And then we also got the [practitioners] in separately as well and we just talked about maintaining control at all times and just tried to manage it tightly. It was a really hard afternoon. (Stephanie CM#4)

Annie described how powerful the mode of communication was for complainants. She said it was important that parties to complaints have an advocate, someone to talk to who knows the process and can also assist them in communicating their complaint, rather than relying on written information only.

...they needed someone to talk to, to explain the process. [Organisations] might send out some written information about this process but you needed to talk it through with somebody so that you fully understand what it means... And some people don't have the writing skills to write a professional letter about complex and traumatic stuff. (Annie CM#7)

Saskia described clients who were able to demonstrate powerful interpersonal skills in the process of lodging their complaint about decisions by practitioners regarding their child. This showed how much power was gained through strong interpersonal and communication skills.

It was a difficult practice situation for all involved because of the level of animosity and vehemence around it and partly because of the intellect and intelligence, and status and position of the family. They were not, you know, often statutory departments work with people who are marginalised for a whole lot of reasons about poverty and not having access to resources. This was a family that had access to many resources, were well educated, highly intelligent, articulate and powerful. And they used that. They used that... And that's not unreasonable. It put a lot of pressure on everybody in the situation. (Saskia CM#8)

Annie said that the people who manage complaints need to have particular interpersonal and relational qualities which enable parties to complaints to trust them, to be heard, and that their expectations can be managed carefully.

I think it is the people they employ to be in that position that is really important. So the [organisation] do it really well because they have got women with expertise who sit in, who handle complaints and are sitting in on face-to-face

meetings that we go to... compassionate, wonderful listeners... Interpersonal skills, highly developed! (Annie CM#7)

Jen also described her decision making process in working out who she might talk to for support and guidance about her complaint.

The first thing I would have done is gone to him and said this [practitioner] has overstepped this boundary, and I also trusted this person more than any other female member of staff. I found the women would trivialise really big problems and would step back away from responsibility, like from what I call civic responsibility. This guy... was across ethical practice, had the capacity to articulate things very simply, directly and powerfully. (Jen TPC#1)

Alexander described how, during the intake stage he takes a particular stance relationally – by not judging, by listening, and by extending support to the client by assisting them to understand the procedures. It could be described as a person-centred stance.

When I'm listening to a member of the public making a complaint or discussing an issue they have with a [practitioner], I never at any stage consider the [practitioner]. Because the [practitioner's] not part of it, that's something to consider afterwards ...they [complainants] don't understand our [policy document], to them it's a document that overwhelms them... people are just happy to have someone listen and spend time explaining things... like they're getting somewhere. (Alexander CM#10)

In summary, participant excerpts referred to the need to create relational safety through specific strategies and modes of interpersonal communication. In the lived

experience, significant power resided in specific modes of communication. The tone, content, interpersonal micro-skills and intent of the communicator have the power to further add to the suffering, or ameliorate it. The ethics underpinning the purposeful attention to modes of communication could be described as Held's (1993) 'ethics of care'. Participant excerpts suggest that in dispute resolution it is possible to apply modes of communication in a way in which both justice and care are equally important.

The type of power that best describes the use of careful, sensitive, person-centred and effective communication in complaint matters could best be described as Rollo May's (1972) 'nutrient power' which is 'used for another' to advance their welfare. Furthermore, May's (1972) 'integrative power' is 'used with another', when complaint managers succeed at working in an empowering way with parties to complaints to actively listen, equip parties with information, and to be respectful of their needs as they progress through the complaint process. The use of nutrient and integrative power can maximise the likelihood that complaint processes have restorative by-products of feeling heard, and of learning and improvement.

Relational support from family, friends, supervisors. There were many descriptions of the need for parties to complaints, as well as complaint managers, to find safe, supportive relationship where they were listened to and validated. Support was a significant and powerful resource which empowered people and helped them function through complaints.

Alexander described the need to be heard and to get support from his spouse.

That's tough because of confidentiality. To be totally honest, I get a lot of support from my [spouse] ...she has a fairly good understanding, but obviously

there's nothing I say that would identify anybody. She's a very good sounding board for me. (Alexander CM#10)

Alexander also valued the opportunity to talk things through with a supervisor and colleagues.

...obviously my supervisor... I talk a lot with the people in [colleagues role], after cases, obviously, not during them about the processes. We both debrief off each other... And so after each complaint we pull it all apart, and say, 'could it have been handled better, does the [document] need changing, does it need simplifying or expanding or whatever'. (Alexander CM#10)

Sarah described how much support was generated by forming support groups of victims of harmful practice, including an ex-client group, as well as a group of those close to ex-clients.

We have sort of formed a group, actually two groups, the exes who were in with [practitioner] and [ex-client] sort of looks after all of that side and I look after the families. All the families they get in touch with me and we keep in touch. (Sarah TPC#5)

Sarah also said some ex-clients and family members find that a support group suits them but others do not want to be reminded of the situation, are overwhelmed and need all their resources to survive the impact, and therefore are not able to participate.

Participants described how powerful it was to have an opportunity to be heard by others. This was a form of support which enabled them to talk through and reflect on issues throughout the decision making process.

You are in a very vulnerable position when you decide to enter a complaint process. In that state of vulnerability I think you just need someone there to talk to, someone maybe to give another opinion and just to be beside you to say ‘well, you know, yes that was tough having to retell all of that’. And just to know that you are not doing this on your own. That there is someone there to lean on when you need to lean on them, whether that is a good friend, whether that be an advocate, a professional advocate, or a family member. But I think that if someone rings up and makes an enquiry about a complaint I usually ask people if they have got support people. ‘Have you got family who know you are doing this that can support you?’ It is really important that they had somebody to fall back on. (Annie CM#7)

The phenomenon of relational support was a powerful form of care (Held, 1993), and nutrient power in action (May, 1972). It was also a powerful antidote to what May (1950) described as the anxiety that is felt when there is a “threat to some value which the individual holds essential to his[/her] existence as a self” (p. 72). Support is what appears to help maintain a functional ‘self’ in the lived experience of complaints. Based on feminist psychiatrist Baker-Miller’s (1976) theory that isolation is one of the most damaging and oppressive human experiences, support is essential for human empowerment.

This concludes the themes relevant to phenomena of relational power and the power of specific interpersonal behaviours to influence others and to impact people’s lived experience. These themes illustrate the complexity of influence of certain behaviours in specific contexts. Spoken words and non-verbal actions can be powerfully constructive and destructive when used by a person in a position of trust and power. It is clear from participant narratives that people’s verbal and non verbal communication and

interpersonal behaviours can induce compliance and disempowerment, and the converse, care and empowerment. The power of these interpersonal behaviours is embedded within and magnified by layers of cultural and structural power surrounding the interaction. Therefore relational power cannot be artificially separated from cultural and structural power.

The next section of this chapter on power focuses on structural power. It presents the key themes relating to legitimised roles of authority, laws and policies, institutional and systemic sources of power.

Themes – Structural Power

This section of the power chapter contains sub-themes regarding structural power. Structural power exists in roles, institutions, laws and procedures, and is influenced by gender, race, age, political, socio-economic and educational status. Structural power imbalances between the roles of client and practitioner, and between parties to complaints and board/panel members or investigators, amplify the impact of previously discussed cultural and relational power dynamics.

Complex structural barriers for complainants had considerable influence on their decision making and experience of complaints. These structural barriers existed because of the vulnerabilities and risks associated with being in the role of client in relation to the legitimised authority, expertise and professional role of the practitioner. The major themes regarding structural power are: -

- Problematic management, supervision and resources
- Problematic legal roles and protocols
- Disempowerment associated with client role
- Untimely responses to complaints and isolation of parties to complaints

- Narrow focus for assessment and gate keeping
- Status credibility and networks
- Conflicts of interest
- Strategies to address structural power imbalances

Problematic management, supervision and resources. Problems with the use of power in the roles of management and supervision, as well as a lack of allocation of appropriate resources, were described by all six of the third party complainants and three quarters of complaint managers. It was also referred to by respondent practitioners Sally and Joe, but not by Simon, Henry or Veronica. This suggests that complainants and complaint managers were much more focused on management, supervision and resource issues than some of the respondent practitioners, all of whom were in private practice, were.

This theme has been categorised as a form of explicitly structural power because it describes perspectives on the way those in legitimised positions of power and authority within systems used that power. According to French and Raven (1959) “legitimate power” is derived from a person’s allocated, authorised position or duties. When these roles and duties are not performed in accordance with appropriate standards, this is a misuse of legitimised power.

Saskia, a third party involved in managing a complaint, referred to a case where a long-term friend of the respondent was his supervisor. Management within the organisation paying for the supervision had not enquired about any potential conflict of interest due to this friendship.

So there was a really weird blurring of boundaries in that relationship. The person was being paid by the government authority as a supervisor, because they

had approved having a supervisor for their [practitioner]. But they hadn't particularly inquired, I don't think, about the background or the prior relationship or whether there was any conflict of interest in a supervisory relationship.

(Saskia CM#8)

Lisa also described a complaint case she had managed where the supervisory role was problematic.

She was an old-fashioned practitioner and had the same supervisor her whole career. I just don't think the supervisor was skilled ...because either she didn't discuss cases in depth or have supervision often enough... there was no education or accountability in that particular supervision relationship. (Lisa CM#5)

Stephanie discussed the problems that can occur when practitioners are also managers reporting on service outcomes. When she had a role investigating a complaint, she interviewed a range of workers and looked more closely at the evidence. She found a very different picture to that suggested by outcome statistics.

He was just in a remote area and was saying that he was doing a good job and producing some numbers that were suggesting that he was doing a good job. But the actual level of evidence that would support that was not there... He had two new [practitioners] working under him that were completely snowed and not functioning well. (Stephanie CM#4)

Bruce's account of his experience as a complainant described dynamics that can occur when managers, supervisors and leaders within organisations do not function. He highlighted the pivotal impact that a lack of management had within his organisation. He also highlighted that some practitioners are naïve, inexperienced, have an

underdeveloped sense of practice standards, and face many barriers which stop them from challenging or critiquing managers and supervisors.

In one [workplace] in particular the [practitioner – management role] was so disorganised that appointments were always missed, basic needs were not met and chaos reigned supreme... She was not suited to working in that environment. That is entirely my opinion though and I know other people work happily under her... (Bruce TPC#2)

Bruce went on to say that a culture of 'cabinet solidarity' is very powerful. It means that the chain of command will not be broken, even when management is inappropriate. He says that this is how people survive in dysfunctional environments.

The fact is that relationships and 'cabinet solidarity' are so key to functioning in such a dysfunctional environment... I have only seen a handful of [workplaces] where staff are happy with co-ordinators let alone upper management but they would not break the chain of command. (Bruce TPC#2)

Like Bruce, Stephanie gave her perceptions about how a culture developed where staff did not address practices that they were not comfortable with, such as giving out their home phone numbers to clients and being on call 24 hours.

In that agency, there were workers who clearly were not comfortable with that but were actually doing that because that's what they thought was required of them by the agency. And obviously for whatever reason didn't feel comfortable enough to say I don't feel this is appropriate. So, yes, that was interesting in that when I spoke to staff, it was like 'well I don't want to be doing this stuff!' And I said 'well, why are you doing it then?' (Stephanie CM#4)

Bruce talked about a 'managerial black hole', where a new practitioner-manager had not received enough support from her managers either, and the impacts of this were fed down the line to the staff and the clients.

Another important aspect of this was that we were functioning in somewhat of a managerial black-hole. [Practitioner] was likely not receiving enough support for her in her new role and this led to us not receiving the support we so badly needed...I've encountered other instances of what I consider to be malpractice through ignorance or lack of understanding of what [practitioners] are meant to be doing. (Bruce TPC#2)

Joan also discussed concerns that poor decisions from the top feed down to end users. The culture in which bureaucratic managers make decisions in funding authorities has an impact on the end-product delivered to consumers. She gave an example, that funding is at such a low rate for community organisations providing sexual abuse and trauma counselling, that the needs of clients cannot be addressed safely.

I would say that the [government department] shouldn't be funding this unless organisations can pay what it really costs to have someone qualified enough for it. So if we want to have staff members doing this work we need to be paying \$80,000 or \$90,000 because that's the level of skill we need to do it. Because that's the level of trauma and need that people are entering with. With practitioners base-funded to do the counselling, it is just more harmful than good. They'll never attract skilled practitioners. (Joan CM#6)

Stephanie also made observations about the time and resource pressures faced by caseworkers in crisis settings. She said that even when there are resources such as

managers and supervisors to assist with the work, everyone is so time poor, that access to these resources is impaired.

For me it was also tricky because you have got these workers that are working in crisis and they are all crisis workers. It is not about having the luxury of time to plan or to think about what they were doing, and they have lots of structure there to support them but they don't have the time to even access it. (Stephanie CM#4)

She also reflected that even when negligence is caused by a lack of resources or a dysfunctional working environment, the sanctions for complaints fall on individual practitioners who lose their jobs.

At times I have found it quite difficult where I would be recommending the termination of somebody when I'm thinking, maybe if they actually had some space, time, and mentoring, they would not be a bad practitioner. But if left in this environment, in this context without effective management and supervision, their decisions are not good. (Stephanie CM#4)

Justin also described a lack of resources and gave several examples relevant to this theme, which he preferred were not published.

In summary, the theme of problematic management, supervision and a lack of resources demonstrates that in the contexts surrounding complaints there have been problems with the use of structural power embedded in legitimized roles and institutions.

Problematic legal roles and protocols. One of the most significant structural power issues discussed by many participants was the power of a legal role and protocols within complaint processes. Legal roles mean the involvement of, consultation with and representation by solicitors and barristers. Legal protocols are encompassed within

legislation, the legislature (including parliamentary and administrative), and the protocols that exist within courts. Legal protocols also refer to the pervasive influence of the judicial 'system' and 'paradigm' on the way that non-judiciary hearing bodies and complaint managers make decisions about standards of evidence, rights to justice and representation. There was a strong link between financial status and capacity to access legal roles.

According to Alexander, involvement of legal roles had significant capacity to influence the structure of complaint proceedings in a manner that was seen to exacerbate the power imbalance.

When you start bringing legal representation into the process, it then becomes very much like our legal processes now. Who can afford the best legal advisor? Now, a [practitioner] has access to professional indemnity insurance...up to \$10 000 worth of legal representation... what happens when you have a legal service is we become expert at defending ourselves, and the public have no expertise whatsoever in laying a complaint. (Alexander CM#10)

Several of the respondent practitioners including Henry, Joe and Veronica confirmed that they sought out and relied on legal representation when a complaint was made about them. Veronica stated that one of her first responses to the complaint was to contact her lawyer.

So I contacted a solicitor who I have had over many years now, had a good professional association with. She is a very senior solicitor at a huge law firm. (Veronica RP#3)

Joe reflected on how he was grateful for his legal support as a respondent to a complaint. He was also circumspect about how the legal role was used as part of

playing the game according to how the game should be played, which did not necessarily address the substance of the matter.

I have a lot of gratitude for the legal, [long pause], [laughs], I don't know how far to go here. [Long pause]. I think in the process I saw the difference between the game and the substance. (Joe RP#6)

Access to legal representation is not so straightforward for many clients. Mary reported difficulties in seeking legal representation, and a lack of knowledge about who may have expertise in this area of law. She said that in the absence of registration, and because there are no other avenues for the hearing of her complaint about an unregistered practitioner, her only recourse was civil action. This had been suggested by a group of other complainants who wished to seek redress about the same practitioner. However Mary highlighted the lack of financial resources.

... talked about a court action. That will cost money, and as I said, we're in the [low socio-economic region], and who's got 40 grand to put a court case through? (Mary TPC#6)

Annie also described the need felt by some complainants to attempt to access legal support to have their matter heard. She said that in rare cases, the use of pro bono legal representation made this possible.

We sourced out some lawyers who were able to do pro bono work because that was the only way that people could afford it. So there are a couple of sympathetic lawyers that will do that but you also had to be sure that the case will be relatively successful... (Annie CM#7)

Joan reinforced how pivotal and yet costly legal representation for complainants was.

Some of those women didn't get good legal advice. The people that were processing their complaints through the civil court and following on from [complaint organisation], well some of those women ended up without a cent left by the time they paid legal fees. (Joan CM#6)

Joan also highlighted the impact of structural power embedded in the way consent was defined in laws and statutes. In some constituencies criminal codes did not make it clear that the power held by practitioners in fiduciary relationships meant clients are not in a position to give consent to sex. This gap in the law created a source of confusion in which lawyers could use a legal argument, claiming that clients consented to sexual relationships and that practitioners were not liable. Joan said this needed to be addressed.

So we advocated for a fiduciary relationship to be inserted into the criminal code so that the confusion about consent could be dropped. (Joan CM#6)

An overly legalistic process was described by some respondents as dehumanising and a blunt method of examining the context of the complaint. Joe (RP#5) described a gap between his expectations of how his profession may deal with an initial meeting regarding a complaint, and how it actually was dealt with. He said he walked into the initial meeting alone, and was completely unprepared to find several lawyers there

But the way it progressed immediately to that legal kind of mode concerns me. So any subsequent meetings I had a barrister with me. Thank goodness he was actually working pro bono for me. Because I had been done in financially at that stage. (Joe RP#5)

Another respondent, Henry, was dubious about the use of what he called ‘legal and technical lenses not a human lens’ in order to assess complaints, yet he found that legal representation was a necessary part of making an effective response to complaints. Henry explained that in the process of receiving a series of complaints over many years from one client, through various organisations, he concluded that this client was a vexatious complainant. He decided to use all legal avenues to fight back.

Yes I had a certain amount of time to write a response and I bounced off some legal guys... So then we went and wrote a letter with a solicitor which actually had 19 points and three pages responding to the Act. (Henry RP#2)

Henry also highlighted how necessary legal representation was, yet also highlighted the barriers to accessing it to attempt to seek some redress when his ex-client defamed him on the internet.

I have no re-dress to this woman apart from civil law. At huge cost. (Henry RP#2)

Joe also explained a complex situation where his ex-client, who had access to legal resources, used a range of methods to threaten a civil suit against Joe over many years. Eventually the matter was heard and dismissed, but after significant legal cost.

...each year, he would continue to send legal stuff to me and keep the thing alive. And he was able to absorb those legal costs. But it was costing me a lot of money. After about 10 years of this I spoke to my solicitors, we engaged a barrister and it was basically ‘bring it on’. That case was subsequently heard and the judge dismissed it and awarded costs to me. Which is a strange sort of victory, because in round terms I had spent around \$70,000 in that period and got \$28,000 back. (Joe RP#5)

Justin described a concern that decision making about the various protocols offered to parties to attempt to resolve a complaint may be dominated by fear of, and a wish to avoid, the costs and complexities of legal proceedings. He suggested that mediation proceedings can be motivated by agendas such as brokering a payout to avoid a fuller legal hearing. This highlights the procedural power that exists in the manner in which organisations deal with complaints. Annie also echoed the theme of the use of lawyers and mediators by organisations in order to avoid or ‘get out of’ unwanted consequences of a complaint, and to avoid financial sanctions.

Sometimes they will employ a lawyer to attend these meetings. So immediately there is an imbalance in power. So they sort of turn it into a semi-legal process when it is not, and they create an imbalance. Other times they employ a mediator, or so-called mediator. My experience with those mediators is that while they appear not to be biased, they are. They are not there for the best outcome for the [complainant]; they are there for the best outcome for the [practitioner]. (Annie CM#7)

Zac had been a third party who had provided information to complainants wishing to seek redress for their complaints about an organisation providing counselling and self development programs. Zac expressed his opinion about why this organisation had a history of taking legal action for defamation against anyone who spoke out against their services. In the absence of regulation of these services, aggrieved clients felt they had no redress to report their concerns apart from the media and public domain. Yet this placed them at considerable risk of costly legal consequences for defamation.

[Organisation] are very litigious. In a way they have to be because they have got a lot to hide and there is not too much to them in the end. (Zac CM#9)

Legal involvement in complaint matters was clearly one of the most significant forms of structural power. The socio-economic status of clients and practitioners had a strong influence on capacity to utilise legal roles and protocols. The type of power that can be interpreted as applying to legal forms of structural power is what Hohfeld and Cook (1919) defined almost one hundred years ago as the ability to unilaterally alter rights. Rights are powerful resources that can be allocated and advocated for within structures of society. Legal rights are provided by governments through legislation, and also by legal representatives who are paid to know and represent individuals' legal rights. Only those with enough 'wealth', as a form of power (Toffler, 1991) were able to access legal representation. Therefore there was considerable inequity in access to this form of structural power.

Disempowerment associated with client role. Whilst no direct clients were part of the complainant group, a few participants, mainly complaint managers, made observations about how disempowering it was for clients in complaint matters due to being in the role of client. As discussed in the previous chapter on impact, one of the biggest barriers to reporting complaints was the risk of being re-traumatised in the process of the complaint being heard. Structurally, clients, simply because of being in the client role, were in a disempowered position in relation to the practitioner and those in roles of managing and hearing complaints. This was mainly because in the process of investigation, clients were given no choice but to endure the scrutiny and exposure of their personal circumstances. This scrutiny, and the findings or judgements about whether they were believed or credible, had the potential to destabilise their capacity to function. The risks and structural power imbalances faced by clients were exacerbated when legalistic forms of cross-examination were involved.

For example, complaint manager John explained that some boundary violation matters did not progress because the complainant could not face being re-traumatised.

Often the real difficulty, and it is a similar thing that women experience in sexual assault cases, that to go through and relive the experience and be cross examined in that sort of forum is very very uncomfortable. And brings it all back and to be attacked and challenged. And some things fail to proceed for that reason because people don't want to go through that whole experience. (John CM#3)

Stephanie described how a teenage client appeared to be fearful that the organisation would not respond appropriately to her complaint. Some of the barriers this complainant faced were that she was experiencing complex and difficult personal circumstances which led her to be a client of the service in the first place. Another factor which highlights the complexity and scale of the relational and structural context surrounding complaints was that there was pressure on this complainant from other clients of the service who were ostracising her. They were saying she was a troublemaker who had ruined everything because she wrote a complaint.

... I don't think the young person actually believed that it was going to be responded to. In that first conversation she was really concerned about the trouble she had caused. Because she had heard back from other [clients] that the whole organisation was up in arms because you have written that complaint. 'What have you done you have ruined everything'. (Stephanie CM#4)

Like Stephanie, Annie also highlighted that clients she has worked with have had a similar lack of confidence in the systems' capacity to respond effectively to

a complaint. Annie described the reasons why complaint matters would not progress beyond the initial enquiry stage.

... lack of confidence in the system. Confidentiality issues... Personal circumstances... they come with the best intentions but things can happen in their personal lives, some of them are transient, some of them are homeless, some of them are living with addictions. All of that impacts on their ability to actually continue with the complaint. The other big one is that it re-traumatises people. (Annie CM#7)

Lisa, as a complaint manager, reinforced the theme of disempowerment because of the client role. She discussed the barriers that a couple seeking adoption faced when contemplating whether or not to complain.

...because they are desperate, these families that want to adopt children, they are not going to take an [organisation] on. They are going to roll over and do exactly what they are told, because it is so hard to adopt, and it is so hard to be approved. And that [organisation][is] getting away with it... I think that as a [practitioner], to decide whether a family can adopt a baby or not, you have an incredible amount of power over that couple, deciding whether they are going to be blessed with a child or not. (Lisa CM#5)

The forms of power relevant to the phenomenon of disempowerment due to client-hood included French and Raven's (1959) 'coercive power' which involved the ability to withhold rewards, carry out threats and instil fear of loss, and 'reward power' where the power wielder is able to confer valued rewards and benefits. In a counselling or therapy situation, the client is in the position of need, and the power resides within the actions of the practitioner to confer or withdraw a range of benefits to the client. In a

complaint situation, the client is also in the position of need, and power resides in the actions of complaint managers who are in a position to instil fear of loss, as well as conferring or withdrawing a range of benefits. Simply because of how they are situated structurally, clients are disadvantaged and disempowered. This means that special strategies need to be put in place to assist them in using complaint systems.

Untimely responses and isolation of parties to complaints. Participant narratives provided evidence that in many systems the norm was to not respond to complaints in a timely manner. This was not always the case, and in some cases the response was timely as will be discussed. Furthermore, some organisations managing complaints did not appear to be proactive in contacting parties to complaints regarding progress and left parties isolated, uninformed or ‘waiting alone in the dark’. The timeliness of response was one of the forms of structural power which resided with those in legitimized roles authorised to manage complaints. Untimely responses, and leaving people uninformed about progress on the complaint, had considerable negative impact on parties to complaints. Participant descriptions suggest it was a major contributor to added ‘layers of trauma’, and was a source of and iatrogenic system-induced harm.

According to Mark, the complaint process he was involved in took a long time and he was left isolated and uninformed of progress.

I was left in the dark. I used to ring up the [organisation] every few months to find out when it might come up. And yet it seemed to take forever. It took three and a half years. And four until the final outcome. So yes, it is a long time. And that is regrettable that it does take such a long time because you want closure

and you want answers... And I had to call them [for updates on progress]. (Mark TPC#3)

John, a complaint manager, also referred to cases which were open for several years with no decision.

And I would see these files and you go back through and you see... the investigators couldn't bring themselves to terminate so they just keep making more and more inquiries with practitioners or others, and the complainant becomes a basket case because the file is open for three or four years with no decision. (John CM#3)

Annie said it was wonderful when a timely response to complaints was made by the respondents complained to, but that this often did not occur.

Some of them are very timely and respond really quickly which is wonderful...Other [respondents] you have to ring them over and over again asking for a response or what's happening with this? ...the ones that are with the [organisation] have been waiting for many years now. (Annie CM#7)

Stephanie also confirmed that the systems she has worked within as a complaint manager and investigator were not timely.

It is not timely at all. People wait....12 months before the complaint is even started. I have certainly walked into a room and gone 'Oh blah blah I am starting this investigation' and they say 'well I lodged that complaint 12 months ago'.

And you are behind the eight ball before you even start. (Stephanie CM#4)

The form of power that is being misused when complaint organisations did not progress in a timely manner nor regularly inform the client, is Luke's (1974) 'one dimensional

power' exercised by decision makers in formal institutions holding 'legitimized power' (French & Raven, 1959). This misuse of power could also be considered, in some cases, as a form of 'exploitative power' where the oppressor allows the victim no options in response to their actions. Exploitation of the vulnerability and powerlessness of complainants and respondents who depend on the complaint organisation for outcomes that significantly impact their wellbeing, may not be intended, and is likely to be due to a lack of resources. However, it does exacerbate the suffering of parties to complaints and amounts to a form of iatrogenic systemic harm.

Narrow focus for assessment and gate keeping. Organisations hearing complaints held considerable legitimised structural power to gate-keep complaints, and to decide if, what and when resources would be allocated to them. If this power was not managed well, this represented risk, potential cost and disempowerment to parties to complaints.

For example, Mark described the power of representatives of an organisation to assess and define why his [family member] had died after attending a self development course conducted by unqualified practitioners. Representatives of that organisation had significant power to be a gatekeeper for how the death was responded to.

What happened was that I was asked to go to the [organisation] and give a statement. Virtually the next day I think. And the [organisation representative] said that he believed that it was suicide. And myself and her [family members] said 'no no no, it was not suicide'. It was something more than that because she would never have taken her life. Had she been in a normal state of mind, but this was something different and more than that. We didn't get very far with the [organisation]. (Mark TPC#3)

The gatekeeper role held by organisations also applied to decisions about how matters were heard, and who was permitted to be involved in hearings. Annie described a situation where a complaint organisation did not allow a support person for a complainant.

And it all comes back to the power imbalance in that meeting... He was a very vulnerable man with mental health issues and he was not allowed to have a support person there. And who makes those decisions? The powerful [respondent's employer organisation]. What right have they got to make that decision about who comes to support him at the meeting? (Annie CM#7)

Annie also discussed a lack of predictability and consistency in the protocols used to manage complaints in different branches of large organisations. The power to change processes had a significant disempowering impact on complainants.

And they change processes depending on what the complaint is. So sometimes they will bring in a legal person, and it is not meant to be a legal process. (Annie CM#7)

In some cases a lack of consistency and unclear protocols for the assessment of complaints was problematic and resulted in confusion of expectations and a sense of injustice for parties to complaints. Whilst the range of different types of complaints require that complaint managers need to exercise discretion and gate keeping about the way different complaints should be managed, it was important that the principles and reasons for assessment decisions be clear and fair. It was seen as a misuse of power in some cases where the assessment and gate keeping decisions appeared inconsistent and poorly based.

Status, credibility and networks. This theme considers a quite different form of power, quite separate to the procedural power of gatekeepers with complaint systems. This theme presents a form of structural power held by those in people's networks who were in positions of status, credibility and influence within political and societal structures. When parties to complaints had connections with individuals in positions of power, credibility and status, they were able to utilise that power to gain agency. These positions or roles of power included those within workplaces, within collegial and professional networks, and within political networks. When parties to complaints were validated and supported, or conversely, devalued and unsupported, by individuals in these high status roles, there were powerful dynamics of influence and leverage. This could be considered to be the use of what French and Raven (1959) called 'referent power', or the ability to administer to another a sense of personal acceptance or approval, and to use charisma and interpersonal skills and connections in a convincing manner.

Mark explained that in order to have the matter of his wife's death more fully assessed, he and his family needed to rely on connections and networks with those in reputable positions of significant political and professional power, to leverage sufficient influence to have the matter assessed further by another organisation. These connections were available to his extended family members by virtue of their professional networks. This highlighted how important it can be to have 'credible', well networked people embedded in positions of structural power, to advocate for matters to be thoroughly investigated.

...but [family member's] employer was the [high status professional position]...
And [another family member], she worked in the [high status organisation]. So we can thank, I guess, who we knew, for having the [representative of another

organisation's] eye put over the case, and that it was the subject of an [organisation] investigation. Otherwise it would have been written off by the [organisation] as a suicide and never seen the light of day. As I understand it this has happened to quite a few other people. (Mark TPC#3)

Simon also commented from the position of respondent to a complaint, about the power of influential connections and money.

You see, not everyone has a load of money, has a load of power behind them, has influential families who can get them out of these strife's. (Simon RP#1)

Joan said that high status manager of a large organisation which held responsibility to manage complaints regarding the serious misconduct of several of its employees had attempted to shut down any source of advocacy and information for complainants.

I had the [manager of organisation employing respondents] write to [high profile political figure] asking to de-fund us. So you get that sort of thing. (Joan CMP#6)

After receiving a complaint about her work via another professional on behalf of a mutual client, Sally reflected on the structural power imbalance associated with the status and credibility of different professions.

And I thought yeah, he is a [practitioner] so must be much wiser than me and I am just a mere [practitioner]. So clearly he is right and I must bow down and do what he said... And I do think there is definite professional disempowerment. (Sally RP#4)

Alexander also described his perception of the different levels of political access available to different professions. This reinforces Sally's comments about a professional pecking order.

And a perfect example is the [political figure]. Three years we've been trying to get a meeting with [political figure] and [political figure] won't meet with us. If I was a [leader] of the [registered profession], I'd probably get a meeting with [political figure] tomorrow, I'd just have to ring and ask. (Alexander CM#10)

Status and credibility were also a source of structural disempowerment for those with mental health issues. John described the way that the stigma of mental health issues can be used to attack a complainant's credibility. When powerful professional expert witnesses were brought in to either validate or devalue a client's credibility, this seemed to sway the outcome powerfully.

...it is probably one of the most difficult issues we deal with. Particularly with people with mental illness, they can be well at times and not well at others... And we took one just recently to the [hearing body]... and in that case the woman was seeing a [practitioner] for a variety of issues but she did have a bit of a history or background of mental health issues. That was used against her by the respondent in a big way to attack her credibility. We took that to the [hearing body] and we won. Even though they went to the extent where they produced a witness, a psychiatrist who said, 'oh, well people with borderline personality disorders often make up stories about sex', the [hearing body] rejected that. So it is not a bar, you don't sort of automatically disbelieve someone like that. It depends on all the circumstances... even though a person may have a history of

mental illness it doesn't necessarily mean that, as this defence tried to argue, that they have no credibility at all. (John CM#3)

Clearly the use of networks and contacts with people in high status influential roles had considerable influence on complaint processes and this is an example of the use of 'referent power' within the power structures surrounding complaints (French & Raven, 1959).

Conflicts of interest. Some participants reported that organisations did not have effective procedures in place to govern the use of structural power assigned to specific legitimised roles of authority. One significant issue was when line managers were the ones in the role of assessing and hearing complaints about staff members with whom they had a prior relationship, rather than a more neutral person or external organisation having this role. In some cases this led to a conflict of interest, in that the person making decisions about complaint processes and outcomes had vested interests in the process and outcomes. At times it was perceived that roles were misused to enhance the interests of individuals and to protect organisations.

For example, according to Sally, one of her supervisees was victimised because she expressed dissatisfaction with the way her manager had dealt with a complaint about a colleague's practice. As an external supervisor, Sally felt she did not have enough knowledge about how this organisation would proceed with a complaint about a counsellor. She became very concerned about how much power the manager had to make a counter complaint about the colleague who complained.

My understanding is that initially it is supposed to be attempted to be dealt with at the [immediate organisation] level with the [manager position]. But from my understanding they didn't have any kind of external mediators or anything like

that. The [manager] did the mediation. And she was unhappy with the outcome and that seemed to make her more a problem to the [manager]. Because he decided no action should be taken so everyone should be happy. So there wasn't any learning. Nothing happened. So she took it to the next level and I am not sure exactly how it happened but there were a lot of meetings in front of [broader organisation] and writing and responding. And having a code of conduct and to my knowledge she is now defending herself, about 'was she being vindictive'... 'Is she acting in a vexatious manner?' So it has become about something completely different. What she wanted to have happen was that the temp who had the issues and problems with her practice be addressed. (Sally RP#4)

Stephanie described a matter where she was in the role of investigating a serious complaint as an external investigator. One of the staff members responsible for the decisions which led to the death of a child, refused to answer questions, and made a counter complaint to his manager about the investigator. Stephanie's account highlights that there can clearly be a risk of conflict of interest in complaint matters due to managers having pre-existing relationships with their staff.

...it was a child death review, and the [manager of practitioners involved] in question had done nothing. He had walked into a role which he had been promoted into quite quickly, into a role in a remote area and had done nothing. No supervision whatsoever... But anyway, he refused to answer my questions. And I said 'okay, you don't have to answer my questions, I don't mind. I will just put in my report that you have not answered the questions'... So he complained to the [organisation representative] that I was overbearing and that I was pushy and that I was unprofessional and all of this stuff. Now mind you, I had two

colleagues next to me because child death reviews were always done in, usually pairs or if it was an indigenous child, there was an indigenous rep, and it was on voice recording. So, he had contacts at a high level and his old [manager] must have taken on board what this [practitioner] had said so there was a high level meeting where the report was tabled and discussions are made at a [high level] of the [organisation]. That report was tabled in this meeting and the [manager] queried the credibility and the validity of the report based on my involvement. (Stephanie CM#4)

The conflicts of interest when ‘in-house’ management of complaints occurred by line managers and supervisors was an issue in the way structural power was used in some complaints. This suggests that impartiality and independence, or at least attention to and transparency about the protocols in place to manage any conflicts of interest were important. Such strategies to address power imbalances in complaint matters will be discussed next, in the final theme of this chapter.

Strategies to address structural power imbalances. Alexander, Stephanie, Justin, Jessica and Annie described the policies and protocols put in place to attempt to address structural power imbalances in the way complaints are heard. These descriptions imply that power imbalances and risks of misuse of power are inevitable, and therefore need to be carefully paid attention to. Also implicit in this theme was a sense that it was not always possible to attend to power effectively, and that the benchmark was to try to strive for a ‘good enough’ attempt to address power. This revealed a gap between ‘ideal’ and ‘real’ capacities regarding management of the significant complexities associated with power dynamics.

There were inherent tensions between the need to manage power ‘on behalf of’ those who were considered less powerful and vulnerable due to their status within systems, relationships and structures, and the need to apply ‘impartial’ and ‘equal’ procedural rights to all parties, regardless of how ‘vulnerable’ they were. Often, the evaluations of what strategies to use were made according to personal and professional values, principles and opinions. There appeared to be considerable use of practice and experiential wisdom by those who had been involved in managing complaints, and who had learned from situations where things appeared to work or not work. Opinions did not appear to be explicitly based upon a body of evidence-based guidance about best practice in complaint management, nor any consensus about best practice within the industry.

For example, some organisations attempted to manage power by having rules about the membership of hearing panels, aimed at equalising the structural power imbalance between the practitioners hearing complaints, and the practitioner complained about. Alexander described the reasoning behind decisions about who sat on hearing panels in his organisation.

[Hearing panel members] are seconded to the complaints committee... how they work that out is we generally try to make sure it's peers hearing complaints about peers... and there's also one member of the public seconded to the committee to make sure that the complainant's perspective is understood....
(Alexander CM#10).

Stephanie described the way voluntary management committee members who managed a small non government organisation were seconded in to form a complaint hearing panel. Because those managing the complaint perceived that there was a need to

avoid any conflict of interest in hearing a complaint about their own staff member, strategies were put in place to try to ensure each party had dedicated support.

...the admin and myself met with her [complainant] and then we decided that it would be a group process and that it needed to be not only me from the management committee but someone else. Because if I was going to be the staff representative I needed to make sure that the staff could get someone else from the management committee meeting to deal with the management committee stuff. And the administrator was going to be there and two workers had to be there so it was pretty top-heavy. So then the young woman managed to arrange a support worker from another agency, who she felt comfortable with, to come along and be with her and be an advocate if that was required. (Stephanie CM#4)

In terms of power theories, the abovementioned examples of attention to the needs of parties to complaints and attempts to structure hearings in a manner intended to address power imbalances could be seen as the use of power as “empowerment” (Held, 1993). According to Held (1993), when power is used to empower it is thoughtfully applied for the express purpose of transforming and empowering oneself and others in a particular context. Furthermore, there appeared to be an underlying use of what Hohfeld and Cook (1919) narrowly defined as the ability to alter rights. This power was used in constructive approaches to complaint management to protect rights, and to create an environment where people could more effectively exercise the rights they had.

Participants described a range of steps taken to attempt to create fairer and more empowering responses to complaints. These included setting up preliminary meetings with parties to complaints to explain complaint protocols and to assess how they were

feeling and what their needs were. It also included using a certain amount of flexibility in structuring the numbers and types of people present in hearing processes, and the place where the hearing was held, in a way that was appropriate to different types of complaints and power imbalances between parties to complaints. The intent behind having professional peers on hearing panels for complaints was intended to provide a depth of understanding and empathy for the challenges faced by a practitioner of that level of experience and training, and to emphasise the need for a developmental approach. The inclusion of support people for each party was an important measure to attempt to address the power imbalance. Furthermore, it was also considered appropriate by some complaint managers that investigation and hearing of complaints occurred by an independent body which specialised in complaint management, and that this helped to remove risks of perceptions and fears of bias for complainants.

Whenever power is used to protect or deny rights, those applying this power are reliant on a deontological ethical paradigm, where certain rules and duties are considered morally or normatively 'right', and therefore have the power to inform decisions. Perhaps the real power then, lies in the normative assumptions that inform views about what are right and wrong ways to manage complaints. Cultural norms inform decisions made by legislators and complaint managers about what rights should be protected for parties to complaints, how the hearing process is conducted and what is communicated by whom. This demonstrates that structural power embedded within roles and institutions holding decision making power, stems from cultural power. The rules and normative standards informing such decisions stem from cultural ideologies, which was where this chapter on power began. Perhaps the question raised in the themes relevant to structural power, is "What ideologies, norms and customary practices

should be best applied by those in positions of structural power responding to complaints?”

Conclusion

This chapter has provided thematic findings regarding three categories of power – cultural, relational, and structural. In data analysis the intent was to make power visible rather than remaining invisible and implicit. Power was revealed as phenomena that existed on multiple levels. A range of power theories were used to interpret the types of power operating within contexts surrounding complaints. These included Lukes’ two dimensional power, the capacity to set agendas; and Lukes’ three dimensional power, the ability to shape preferences via values, norms and ideology (Lukes, 1974). Individuals developed situated power depending on the ideological norms that surrounded them (Wartenberg, 1990). Ideological power was also transmitted through language (Freedon, 2003). The various norms informing the use of power could be interpreted as serving the interests of the most powerful ruling classes or interests in Australian society and the cultures surrounding complaints (Freedon, 2003). Furthermore, the ideology of individualism may be the powerhouse driving the individual adversarial approach to disputes. Epistemological power, or the power to produce knowledge was also evident, and the reasons for a lack of knowledge, or a lack of provision of information in the contexts of complaints, would be political and ideological (Harding, 2004). Feminist phenomenologist Simone de Beauvoir’s (1974) analysis of power informed interpretations of how individuals and groups become situated as the ‘other’ in relation to the ‘subject’, which can explain the process of dehumanisation, which was experienced by some as disempowering and oppressive in the contexts of complaints. Power was also a resource (Allen, 2011), a form of empowerment and transformation (Held, 1993), and a right that could be altered by a

person or institution in a position of structural power (Hohfeld & Cook, 1919). It was also evident in some participant narratives that there were positive forms of power such as nutrient power, and integrative power (May, 1972). This was especially in rare cases where there was learning, growth, and support through complaints. French and Raven's (1959) reward power, expert power, referent power and legitimate power were also revealed as part of various power dynamics associated with complaints.

The most significant form of power was interpreted to be cultural power, in which norms, ideologies, customary practices and paradigms had a major influence on what happened with complaints. A historical lack of robust accountability for unregistered occupations has provided a norm for the Australian community. This fed from and into a paradigm that these occupations were not viewed as powerful, that any power held could not be used in a harmful way, and that therefore, there is a lack of ownership and management of power. A problematic cycle is reinforced when legislators require occupations to prove they are harmful in order to become registered, yet norms exist that these occupations are not powerful, and in the absence of registration a lack of jurisdiction for complaints means it is difficult to capture quantified evidence of harm.

Other themes regarding cultural power included a culture of inadequate ethics literacy for the broader Australian community regarding the qualifications and accountability of a range of occupations. Inadequate ethics literacy was also a theme perceived as existing in the industry to varying degrees for practitioners and complaint managers as well. A culturally inherited adversarial approach to disputes was shown to have significant limitations for parties to complaints and they often felt dehumanised and disempowered within systems. A norm of avoidance of dealing with complaints was common, rather than a transparent, problem solving approach in which it was 'safe

to say' when something had gone wrong. Nonetheless, a few participant narratives revealed a range of constructive and empowering cultures in which complaints were managed which demonstrated that it is possible for cultural norms to be used in an empowering manner within specific complaint responses.

In terms of relational power, there were highly complex examples of psychological manipulation and grooming. Psychological manipulation, mind control and thought reform could be regarded as the misuse of the same forms of power associated with cognitive restructuring that is often used for 'good' in therapeutic work. Much more research needs to be done to understand more clearly the processes and types of power used in psychological manipulation and grooming, and how to protect clients from these.

It was also clear that a range of relational strategies were used primarily for the purpose of 'surviving' complaints. This mainly involved the use of personal information to paint a person in a light that was perceived as boosting one's power and credibility in the eyes of someone in a position of power within the complaint context. Counter complaints were used in this way, to position the person making the complaint in a negative light. Relational strategies also involved relying on alliances and pre-existing networks to protect oneself and de-rail others' attempts to seek accountability. Vexatious complaints revealed a form of power that was likened to the relational oppression used by a perpetrator of abuse. Denial and stonewalling were also powerful relational strategies to defend against the threat posed by complaints. These forms of power needs to be factored in and addressed when complaint managers assess how to proceed with complaints.

Significant power to dominate or empower were evident when people felt heard or not heard within complaints. Modes of verbal and non-verbal communication, and the types of information provided had enormous significance. This is one of the most constructive findings regarding relational power. This suggests that one of the most purposeful ways to reduce iatrogenic harm associated with the delivery of complaint services is to use modes of communication and apply interpersonal skills in a way that is most needed by parties to complaints. Relational support was similarly described as a significant source of empowerment.

In terms of structural power, there were indications that institutional and systemic mechanisms were not functioning sufficiently enough. There were perceptions that problematic management, supervision and resources contributed not only to incidents that led to complaints, but unhelpful responses to complaints as well. The role of client was perceived to be uniquely disempowered by a range of structural forces, including stigma, and the issues that brought them into client-hood in the first place. There were also problems associated with untimely responses to complaints and a narrow focus for assessment and gate keeping of complaints, and these were perceived to present profound structural obstacles and impacts for parties to complaints. The final form of structural power was that of credibility associated with access to the status of certain roles in the community, which could be used as leverage to influence the pathways and outcomes of complaints. There were also some examples of specific strategies used to manage structural power, with particular attention to the use of legitimised power to apply complaint protocols intended to ameliorate power imbalances between parties to complaints and complaint managers.

The findings regarding power were complex, rich and of great depth and breadth. The themes provided a wealth of information which can be used to inform

awareness of the types of power operating in complaint contexts, and how to attend most effectively to these. An understanding of power dynamics can be used to inform an understanding of the needs associated with complaints. The major themes regarding needs associated with complaints will be presented in the next and final findings chapter.

Chapter Six

Needs Associated with Complaints

Introduction

Participant narratives provided perspectives on needs associated with complaints. Needs are defined as essentials that cannot be done without. Needs are also defined in the context of this research as things that sustain people, systems and cultures with the aim of improving functioning in contexts of harm, failure and/or conflict. Often needs were paradoxically identified in descriptions of situations where needs were not met. Therefore descriptions of unmet needs are included in this chapter as a means for illustrating the converse, needs. It is important also to note that this research does not evaluate what is needed to improve the effectiveness of specific complaint managers or organisations. Instead this chapter identifies major and minor themes and exceptions regarding needs on a range of levels. It is intended to inform a holistic approach to improving the conditions in which complaints are addressed by any individual, group, organisation, or culture.

As stated previously, participants described the circumstances of each complaint case as if describing the unique contours of a fingerprint. Just as no two humans are the same, no two complaints are the same. When participants were asked what is needed for effective complaint management many stated that it was hard to pin this down in generalised terms and that needs are likely to be somewhat different in each case. Nonetheless, several themes emerged, as listed below. In brackets are words which have been interpreted to describe the core phenomena captured in each theme.

- Legislated jurisdiction (Protection, Accountability and Equity)
- Increased ethics literacy (Information and Awareness)

- Specialist knowledge, roles and resources for complaint management
(Enfranchisement)
- Interpersonal champions and sources of sanctuary (Care and Support)
- Dedication to a humanized and holistic approach (Person Centredness)
- Neutrality and impartiality (Fairness)
- Constructive by-products of complaints – reflection, restoration, learning
(Growth)

Themes – Needs Associated with Complaints

Legislated jurisdiction. All participants except Simon and Bruce said there needs to be effective and equitable legislation to protect the public and ensure accountability for all practitioners, not just the currently registered occupations of psychologist and psychiatrist. Simon and Bruce expressed concerns about the risks of regulation which will be discussed below as exceptions to this theme.

Legislated jurisdiction would require comprehensive laws to be put in place to ensure an equitable pathway for accountability for all practitioners providing counselling, psychotherapy, casework and self development programs. The current situation in Australia where legislated jurisdiction either does not exist at all or is vastly different for registered compared to unregistered occupations was seen as highly problematic. The fact that an unregulated environment exists where many practitioners practice however they wish was seen by participants as in need of urgent change. It has been interpreted that the core needs associated with the call for legislated jurisdiction are the phenomena of ‘protection’, ‘accountability’ and ‘equity’.

As a complaint manager with decades of experience managing the intake of complaints about an unregistered occupation, Alexander clearly stated that legislated jurisdiction is needed.

That's probably about 85% of our problem is that we don't have any jurisdiction. We get far more complaints about non-members than we do members, by far, we probably get ten to one, um, complaints about [practitioners] who are not ours (Alexander CM#10)

Lisa commented on the need for regulation to address the complete lack of accountability for private practitioners.

I mean, without regulation, anyone can set up private practice in their back room. And no one can touch them if they're not a member of the [organisation] and even if they are a member, they can just resign and still practice anyhow. (Lisa CM#5)

Sarah's experiences as a third-party complainant reveal the multiple attempts she made to seek jurisdiction for her complaint about an unqualified, unregistered therapist in private practice. Legislation and jurisdiction applicable to all practitioners is necessary to avoid the intensely frustrating, disempowering and futile situation she described.

I'll just read this letter from the [complaint management organisation]. 'Thank you for your complaint which was received [date]... Unfortunately your concerns regarding [practitioner] are outside our jurisdiction. The [complaint management organisation] does not have any power over these types of therapists however if the [practitioner] is claiming qualifications as a [practitioner type] he does not have they may be able to take action'. That says

the [complaint management organisation]. Now the next letter I get. Ahh, the same sort of thing. “If you wish, you could write to the [organisation]”. So, I wrote to him and he passed it on to the [organisation]. I wrote to the [organisation] and he has passed it on to the [organisation]. The [organisation] says ‘this is outside my jurisdiction blah blah blah blah’. Whose bloody jurisdiction is it? (Sarah TPC#5)

Justin said there is a need for legislation to ensure there is sufficient power and specialist resources to manage and respond to impairment and repeat offenders. Jessica, also a complaint manager, said there are considerable inequities in the legislative powers regarding registered occupations versus unregistered occupations. She gave the example that there was a need for legislation which enforced suspension of practice while a serious complaint was heard.

This particular case has raised gaps for us... Do we have any right to ask or contract with [practitioners] to not practice in a certain setting for a period of time until a complaint is resolved. (Jessica CM#2)

Other literature and discourse confirms that it has been perceived that there has been a need for legislated jurisdiction for some time. For example, the AASW has recently conducted a campaign to seek registration for the profession of social work (AASW, 2013b) and has also campaigned unsuccessfully for this in the past (AASW, 2004). Recently the Australian Health Ministers Advisory Council [AHMAC] sought submissions in response to a discussion paper entitled “Options for the regulation of unregistered health practitioners” (AHMAC, 2011). Despite exploration of options, as yet, legislated jurisdiction is not in place to assure equitable avenues for accountability across occupations.

It should be noted that an exception to the theme that legislated jurisdiction was needed was presented by two participants (Bruce TPC#2 and Simon RP#1). They said that legislation and further regulation was undesirable because it was fraught with disadvantages and risks of creating more 'bureaucratic red tape'. They also felt that too much regulation may limit the variety of modalities offered in the industry and that it was an unnecessary use of precious resources in an already under-resourced industry. Nonetheless, these two participants agreed that there needed to be some form of recourse for consumers.

Part of the problem that has led to a lack of action in the area of legislation for mandatory regulation is a lack of understanding or ethics literacy regarding the problems with the current semi-regulated system. The next theme further explores the need for increased ethics literacy.

Increased ethics literacy. The theme of a need for increased ethics literacy included a need for public awareness about qualifications and regulation arrangements, about how to assess and seek quality therapeutic services, about risks and ethical standards, and about what to do with any complaints or concerns. This theme also included a need for increased ethics literacy for practitioners, those managing and supervising practitioners, and those managing complaints.

Jessica said she often dealt with situations as a complaint manager where it was obvious there were misconceptions about regulatory provisions. People were often shocked when they found out there was no clear jurisdiction for complaints about those who chose not to be a member of a voluntary professional association.

There is often shock and anger and from complainants as well as from other [practitioners]. There seems to even be misinformation with [practitioners] who

think that we could at least investigate a complaint against another [practitioner] regardless of their membership of the [organisation]. So I think that's a big one, people's understanding of registration or not and what we can and can't do.

(Jessica CM#2)

Alexander described a need for public education to address problems associated with an 'unjustifiable belief' or child-like trust placed in counsellors and other helping professionals. He also described 'ignorance' about the current lack of regulation.

With the public with [practitioners], they have an unjustifiable belief, or a...[pause] it's like a child's trust, they have the word [practitioner] on the door, then I will go and I will spew my entire emotional and personal life to this person, with the belief that this person is there to help. And it's ignorance. We shouldn't trust doctors to be gatekeepers for mental health, and we shouldn't trust that someone calling themselves a [practitioner] is not there to manipulate and abuse us. We should have a healthy cynicism in the sense that we should question, and we should do our research. We should find out 'are these people accountable? Do they have the appropriate training?' (Alexander CM#10)

Zoe spoke about the need for public education. She also said there needs to be a safety net to protect members of the public from being abused by a therapist when they are already, understandably, vulnerable.

There are so many vulnerable people out there and there is no real education, there is no safety net for them. And these people are struggling enough as it is. They don't need shit like [practitioners] in their head. (Zoe C#4)

Joan said there is a need for more open discussion, education and training for professionals as well.

Good education so that everyone knows that this is what is expected. People need to know what supports are available in their role in their profession and if they are feeling attracted what they do about it. Those things need to be more openly discussed professionally, and through supervision. (Joan TP#6)

Tran also gave an example of a gap in ethics literacy regarding how to practice ethically when a client indicates affection for their practitioner.

I can think of a situation that has happened very recently in my work as a supervisor, a [practitioner] came in and says, 'I saw a patient A, the patient has indicated his or her affection for me, what do I need to do?' And there is almost a knee-jerk response I think, we need to protect the therapist, that's fine, and what does that mean? Does that mean ending therapy and telling the patient to go somewhere else? If you really think deeply about these things, what would be worse than ending therapy when something emerges which is really part of the dynamic within the relationship and something that needs to be dealt with ethically. And I'm not sure that we provide enough opportunities for trainees to reflect on those kinds of issues and to understand dynamics and deal with them accordingly. (Tran CM#11)

Joan said that licensing approaches to regulation such as suitability cards would not be enough to address the issues surrounding complaints. She said security and qualification checks did not go far enough to create the appropriate conditions needed in the industry to prevent and address complaints. A 'culture of safety' was required as part of ethics literacy in the industry.

Well I think it is about educating people about how to create a culture of safety more than having cards to rely on. (Joan TP#6)

Alexander suggested a public education campaign involving all relevant professions is needed.

...a proper awareness campaign, I think that would be definitely in the public's interest...to educate the public on the difference between the disciplines, what each one has to offer, how you go about getting them, but also accountability, and training and standards. (Alexander CM#10)

In summary, participants' comments indicated a perceived need for a range of strategies to improve ethics literacy for consumers and practitioners. This perception that is supported by the survey by Roy Morgan Research (Craig Hodges Consulting Pty Ltd, 2012) confirmed that consumers and the general Australian public have major misperceptions of the regulatory requirements of counselors and qualified therapists. Furthermore, workforce surveys of counsellors and psychotherapists (Pelling, 2005; Schofield, 2008b) pointed to some concerns regarding the commitment to ethics and the level of training for the practitioners who responded. These findings cannot be generalised across all of the occupations who provide counselling and therapy, but they do suggest there is an issue with ethics literacy for unregistered occupations.

Specialist knowledge, roles and resources for complaint management. In addition to increased ethics literacy, participant narratives indicated a need for specialist knowledge about how harm can occur, about the dynamics that can be involved in complaint matters and about how complaints should be managed. There was a need for those they consulted regarding complaints to respond in such a way that demonstrated an awareness of harmful practices, and also the skills to manage highly emotionally sensitive complex matters involving a range of human needs. Also included in this

theme was the need for specialist, distinct roles and resources for complaint management.

For example, Mark summed up the need for specialist knowledge for anyone dealing with these types of complaints because they involve unique dynamics.

Well it is unique because you are getting damaged when you are actually seeking help from somebody. You are seeking to improve your life not undo it.

(Mark TPC#3)

Mary's experience demonstrated how important it is that complaint managers have comprehensive specialist knowledge about how harm can and does occur.

I really think it's just like it's too hard. It's something, as I said, that a lot of people don't fully understand and I really don't think they want to go there.

(TPC#6)

Sarah also spoke about a lack of knowledge, describing it as a 'dark spot'.

Because nobody really knew anything about it. Or maybe they knew, but they didn't want to do anything about it because it was too, um, it is a dark spot. They go is it or isn't it, does it happen or doesn't it? (Sarah TPC#5)

Justin confirmed that in the past he has observed that some complaint managers did not have the specialist skills needed, nor did they understand the risks. Mary also described how helpful it was when a community organisation was able to link her up with others who had contacted them seeking support and information after experiencing problems with a specific practitioner. This suggests that community support organisations need to be able to assess complaints against a database or register of complaints in order to identify patterns in complaints and multiple complainants about the same practitioner.

We put our name down with this [community group]. They had our name, we tried to find out through them what we could do about [practitioner]... So our name was down on their books, and [name] rang up and she also was looking for help, and they said, 'oh hang on a minute, someone else has mentioned [practitioners] name', and they asked if we wanted to liaise with [name]. And really if it wasn't for [name] nothing would have happened, full stop. (Mary TPC#6)

Henry, from a practitioner's perspective, also described a need for a central register of reported complaints in order to identify vexatious patterns of complaint by complainants who did not have a genuine motivation. Henry also noted the ethical issues associated with how such a register would be accessed and used.

I don't know how it fits with civil libertarians and privacy, but maybe if there was a register of complaints, a computer database that there has been complaints made about this person by these people... to all these bodies, then they would actually go 'hang on a minute, there is a bigger picture here'. They don't need to know the details of each complaint, but just if there was a database of it... It just means that if they get a series of complaints, they go, 'we need to look at this'. (Henry RP#2)

Alexander recommended that clients need specialist help to recover. He said there is a need for general medical practitioners and therapeutic practitioners to 'know what they are doing' to help people in the process of recovery. He also said there is a need to provide funding to provide referral to specialist services.

To see somebody who knows what they're doing to help them through it... you're not about to go to your GP and tell him how gullible you were... as part

of our current system we can't say 'we can give you several referrals, you find the one you feel most comfortable with and we'll pay'. (Alexander CM#10)

Alexander also said that generalist complaint managers did not have adequate skills to manage these types of complaints and that specialist training in the unique dynamics of counselling, psychotherapy and casework services was required. There was concern that the power of a counsellor or therapist was not well-understood unless a person was trained to understand and assess the dynamics involved.

A [practitioner] with an ego is the most dangerous thing out there. More dangerous than a criminal, because they can do extraordinary things with people, they can manipulate people to extraordinary degrees... by offering services for vulnerable people, people in need, and you can abuse that like you wouldn't believe. I don't think people really realise how easily and just how much a dysfunctional [practitioner] can manipulate people. (Alexander CM#10)

Henry said that those carrying out roles in investigation needed to be trained in the specialist skills of that role. For example he said it can't be assumed that practitioners know how to investigate, and that it is important to set up appropriate investigative processes for these unique types of situations.

Now the difficulty is that we have therapists doing ethics investigations without any training about investigation processes. So how do we actually teach the [organisation A), how do we teach [organisation B] that actually these processes are investigations? Because if they are therapists, we do therapy and they are not trained in investigations. So maybe one of the outcomes of this is how do we set up good investigative processes for these unique types of situations? (Henry RP#2)

Henry also said there was a need for those managing complaints to have specialist knowledge and skills in assessing whether there are agendas and misuse of complaint procedures to gain leverage in, for example, Family Court proceedings. Knowledge was needed to avoid naivety about the potential for vexatious complaints.

So I think the [organisation] is naive to look through a narrow lens, and not realise, hang on a minute, there is heightened manoeuvring here, there is a history of 10 years of Family Court action. Maybe they should go, no, let's get Family Court sorted first, and then we will come back and address it. (Henry RP#2)

Jen referred to the need for specialist units of complaint organisations, with a degree of 'independence' instead of potential conflicts of interest due to complaint management being conducted by line managers or professional bodies.

So, for instance that young woman [client of practitioner] who came to me and told me she was being injured by her partner and the [practitioner] said to her 'God would solve her problems', I should then be able to automatically take her with me, with her consent of course, to somebody outside of the institution, who doesn't deal with that person on a daily basis and doesn't have any pre-conceived notion, which is really hard in an organisation, because people get a name, and then that [client] should be able to just, without feeling like they are reporting to the police or reporting to someone who is going to sack the guy, just make a complaint. (Jen TPC#1)

Joan also reinforced this point and said independence and specialist skills for those managing complaints were essential.

I don't think the organisation or the profession should be doing it themselves. I think there should be a specialist unit that does these complaints across multi-disciplines. I think any profession doing their own is really limited. In the [organisation] what you notice all the time, it depends if people know who the complaint is about. It is too small a network so having something where people could outsource that as a particular skill or a unit is essential. (Joan CM#6)

Joan described the need for a dedicated specialist strategy and unit to manage sexual exploitation complaints because of the unique dynamics and needs of this group of complainants and respondents.

They had a strong advocate there in the [upper management of complaint organisation]. She was fantastic. She really saw the need a dedicated strategy for sexual exploitation complaints. Because she said that they consumed way too much of their time. They were the people that were ringing in every day. They often had acute mental illness. And the complaint process seemed to exacerbate that. (Joan CM#6)

It was also clear for Annie, that when there was no specialist advocacy role and no support role, there was little opportunity for parties to complaints to process and digest the complaint and to prepare responses. Specialist advocates for each party were seen as extremely valuable but hard to find due a lack of resources.

I think they respect the role of advocate... They clearly know what my role is. And there is a professional element to it... I think to use independent advocates is crucial. (Annie CM#7)

The views of participants regarding the need for specialist advocacy, support, hearing, and enforcing roles are consistent with some of the narratives published by

those involved in complaints about sexual boundary violations which confirmed that there was a lack of specialist knowledge and resources for many complainants (Boeckenhauer et al., 1998). Furthermore, in regard to the call for independence and specialist skills on behalf of the organizations managing complaints, Quadrio's (1994) case study research illustrated collusion and closed ranks among peers of the practitioners complained about, and the need for a group of highly skilled independent individuals to hear and manage complaints. Furthermore, in Schofield's (2008a) research about self-regulatory models for counselling and psychotherapy in Australia, there was not a focus on the types of knowledge and skills used or required by those involved in managing complaints within current models. She also noted that a gap in research was a lack of feedback from consumers and respondents who had used these systems (Schofield, 2008a). It is not possible to generalise across all complaint systems, but it appears from the responses from some participants in this study, that there is a need for a range of specialist knowledge, roles and resources to improve complaint management responses.

Interpersonal champions and sources of sanctuary. The fourth major theme was a need for what can be described as interpersonal champions and sources of sanctuary. These specific terms were not used by participants but have been interpreted as the most appropriate descriptors for the phenomena described. Interpersonal champions are defined as those who hold clearly superior interpersonal skills, and sources of sanctuary are defined as a protected psychological space or refuge.

Participants also described the qualities of those who were poor responders throughout complaints, and these descriptions assisted in arriving at a definition of the converse – a 'good' responder. The main qualities of poor interpersonal responses were

a demonstrated 'unwillingness' to hear or engage, to spend time, care, reflect and respond, and 'unreasonableness' of manner, expectations, or agendas.

Complainants and respondents described individuals they had contact with during the period of decision making who stood out to them because they made effective and helpful interpersonal responses. Many complaint managers also described the need to have support and effective supervision from experts with specialist knowledge and unique interpersonal qualities which were seen as innate in some people and not present in others. The interpersonal qualities of those involved were seen as being a powerful force in hindering or de-railing complaint processes. Helpful interactions provided an oasis where parties to complaints were replenished momentarily during the complaint process. The core qualities of these people were:-

- a willingness to hear and listen carefully, to collaboratively assess thoroughly
- to spend time, be timely and responsive
- to be determined and resourceful
- to maintain clear, consistent, realistic expectations (clearly state limits on role)
- to convey empathy
- to have a humble, (not arrogant or disinterested) interpersonal approach

For example, as a complaint manager Jessica described conditions where she felt contained and supported in grappling with a particularly complex complaint, about which there was considerable disagreement about how to proceed. Strong supervision, support and shared decision-making provided a sanctuary which improved conditions for her. Isolation made things worse.

Even though I was not in agreement with [colleagues] at the time, they were still a support. They were a group of people that I could talk with... They had to

make a call at the end of the day. But I knew that we were all sharing the struggle of that. So it felt less isolated than I felt at other times when I felt most stressed in my professional life. (Jessica CM#2)

Alexander described his experience talking with members of the public who needed someone to talk to about a problematic experience with a practitioner, and to deal with the associated emotions. He said the interpersonal trait of non-judgement was important.

... I've spoken to them and we've gone through the emotional stuff...having someone to talk to, who's not going to judge them... people are just happy to have someone listen, somebody who they believe is in some sort of authority...like they're getting somewhere, they're not going to have to re-explain their story a dozen times. (Alexander CM#10)

Joan's account reinforced that interpersonal traits are important in complaint processes.

So if you get a [manager representing organisation employing respondent complained about] that isn't skilled at being able to listen empathetically and not defensively, then that can go really wrong. (Joan CM#6)

Participant descriptions of interpersonal traits that were unhelpful also provided relevant data about converse need for helpful interpersonal responses to complaints. For example Alexander described defensiveness and a lack of self-reflection as a common, unhelpful reaction by respondents to complaints.

No, very few counsellors when they hear a complaint's been made against them will, reflect on their actions. They'll get defensive. (Alexander CM#10)

Annie described silence and lack of engagement with complainants during hearings as unhelpful interpersonal behaviour on the part of a particular high level complaint manager involved in a hearing process.

He did not engage...when it came to the interpersonal skills with the [complainant], they were not there. (Annie CM#7)

In summary, participant narratives pointed to the need for those responding to complainants and practitioners during complaints to have well developed attending skills, listening skills, to be timely and pro-active, to sensitively articulate boundaries on their role, and to be able to put into action values such as being non-judgemental and person-centred. The narratives from complaint managers also suggested it was equally important for them to experience these interpersonal skills from their supervisors and support networks, as they carried out their role as a complaint manager.

Unfortunately, the literature regarding complaints and regulation has not specifically focused on the interpersonal qualities of those involved in complaints. It may be that there is a lack of specific focus on interpersonal skills because it is assumed that these would automatically exist in those who manage complaints. However, one example of literature suggests that it may be assumed that complaint managers should not be expected to be supportive. In the book “Surviving complaints against counsellors and psychotherapists” (Casemore, 2001) there is no direct reference to the required interpersonal qualities of those involved in managing complaints. Instead, there is what could be viewed as a task centred approach such as in the chapter “Surviving a complaint – a practical approach”, with a list of who should be consulted, such as supervisor, employer, supervisor, lawyer, legal help lines, friends, colleagues, advocacy services, professional support networks, therapy and complaints officers. A warning is

included in the section about complaints officers that it is important not to expect support from the professional body managing the complaint. Jamieson (cited in Casemore, 2001) stated, “You would not be the first person to find the impartiality and role of such officers difficult to take at times” (p. 24). This seems to presume that those in roles such as complaint intake officers or other complaint managers need to adhere to an interpersonally aloof impartial stance.

Dedication to a humanized and holistic approach. This theme captures the sense that many participants said there is a need for care, commitment, and dedication on the part of those involved in regulatory systems. Dedication captures the sense that there is a stance of great care and value placed on the humans involved. Humanised is defined as focusing on human psychological, relational and physical needs such as health, wellbeing, emotional and cognitive state. This includes taking care, and paying attention to the likely impact on humans of the chosen interpersonal tone and mode of communication, including the place and layout of all interactions. It also includes care and attention when selecting the people who are made available to interact with parties to complaints, and that these people are dedicated and trained in the skills needed to attend to human needs. Holistic is defined as taking a broad focus on the whole context, rather than taking a narrow focus and discarding particular aspects of the context. Perhaps this theme could be best summed up as a need to carefully attend to the ‘human in context’.

For many participants, there needed to be to a more humanised and holistic approach to hearing complaints, rather than an approach which prioritizes technical rules and procedures. The phenomenon of a human and holistic approach appeared to include several key components. These components are phenomena that occur when certain values are actualised, and relational conditions are created to produce a

particular quality and tone of lived experience. The phenomena interpreted from participant narratives as being the components of what they experienced or yearned for in terms of a humanised and holistic approach included:-

- Dedication
- Understanding and expertise
- Constancy and dependability
- Support
- Enquiry

These phenomena were revealed in practical terms when participants described a range of specific needs, which included: -

- Opportunities to read information (especially easily accessible information on the internet) about ethical standards and complaint protocols.
- Opportunities for parties to complaints to consult verbally, either by phone or in person, before putting the complaint in writing.
- Opportunities for verbal dialogue and face to face meetings to process information.
- A range of methods of managing the complaint – avoid a ‘one size fits all’ approach and take into account the unique human context and mitigating factors.
- Permission for and encouragement of personal support people being included in communication, decision making and hearings.
- Information about the purpose, format of all meetings, and advice about what to prepare and whether there is the option for bringing a support person advocate or legal representative.

- Provision of a skilled advocate for each party to the complaint – in such a way that is affordable for those involved.
- Information about the name and role of any people who may be involved in decisions regarding the complaint, their role and information about availability and protocols for contacting them.
- Reasonable dependability and consistency in information about what to expect of the process of interactions, even if the outcome is unpredictable.
- A timely response – one that resolves the matter as quickly as possible, but also provides adequate time for parties to complaints to prepare and seek needed advice.
- An ‘enquiry approach’ was seen by some participants as congruent with human needs rather than a ‘breached or not approach’; ‘What happened here?’, rather than an immediate adversarial response, ‘Who did something wrong here?’

All of the above points suggest a need for dialogue and human exchange. This could be motivated by the need for human reassurance in the face of unfamiliar complaint protocols, emotional support in a time of high stress, support in articulating highly complex information and ‘evidence’ at a time when stress may impede cognitive functioning to do so, and the need for reference points from others when forming expectations of what might happen next.

Unfortunately, many of the participant narratives implied the need for a more humanised response because their experience was of the opposite. For example, Annie described the initial response from a large complaint organisation that they required complainants to put something in writing. She highlights that while it is an understandable requirement that a complaint be documented, there needs to also be the

option for a complainant to meet face to face with an advocate who humanises the process and can provide guidance regarding documentation.

The [large complaint organisation], when people ring up and they say just put something in writing... a lot of people aren't able to do that for many reasons... I think that face-to-face contact with somebody is really important at that initial stage. And I know it is like, it would be impossible to do that in terms of resources. But if someone says to you put something in writing, is there another option, or is there somebody that I can sit with that will help me to do this, which is an advocate. Put this in writing, do you feel confident to do that if not we can refer you to somebody so there is an option there. (Annie CM#7)

Annie also described a particular complaint in which an organisation managed a matter involving one of its own employees. They set the rules and the process in a rigid and dehumanised manner which did not meet a complainants' need for a support person.

So now after the fact another complaint has been made because he was not allowed to have a personal support person or advocate; so a complaint about the complaints process. So, you know, it's never ending. And it all comes back to the power imbalance in that meeting. There was a huge power imbalance. He was a very vulnerable man with mental health issues and he was not allowed to have a support person there. And who makes those decisions?; The powerful [respondents employer organisation]. What right have they got to make that decision about who comes to support him at the meeting? (Annie CM#7)

Joe, as a respondent to a complaint, had an experience where he was alone when he attended the first meeting with the organisation managing the complaint about him. It

had not crossed his mind that he would need a support person or lawyer as he had thought the complaint matter would be discussed collaboratively with the aim of developing strategies to resolve the issues. Instead, he was totally unprepared when the meeting involved several legal representatives representing his profession against him. Joe said that he was also totally unprepared for the cold formality of the response from an organisation representing his profession. He said there was a complete lack of effort to either provide, or even discuss that he may need to seek support throughout the process.

So, there was this quick movement into the legal process which took my breath away a bit. There was the fact that I wasn't, there were no parallel processes offered. For example, one of the things that I would have thought the [profession] would have done would be to put some person to work with me at least in an emotionally supportive way. Nowhere to be seen. (Joe CM#5)

Alexander highlighted the need for a timely response for complaints. He said a dedication to timeliness was important because it demonstrated that those managing the complaint prioritise the human needs of parties to complaints to have a stressful process completed as soon as possible.

Complaints are here in a very short period of time... usually within 72 hours of a complaint going to the [hearing panel manager], he will already have a letter out to both the complainant, the respondent and the [hearing panel members] letting them know what's happening and where things are up to, and who needs to do what. And then the process may take a few weeks, or a few months, depending on the complexity of the issue. But measured against most other systems it's still very quick. (Alexander CM#10)

On the other hand Henry, as a practitioner respondent, said that the requirement to provide a fast response to a complaint he received was unrealistic. He said there should be more time provided to respondents so they can seek advice, and manage to fit the process into their existing schedule.

And the [complaint management organisation] gave very short response turnaround times. I had to virtually drop everything to get this in. Their turnaround times were very unrealistic...So their understanding is that I've got to stop my world, to address this complaint. That was terrible. (Henry RC#2]

Jessica reflected on her role as a complaint manager, and the 'stilted', 'bureaucratic' tone she adopted as part of working within a rigid framework.

The conversations I had, just listening to myself, they felt stilted, and bureaucratic. And that's something that both complainants and [practitioners] have fed back to us that the process is very bureaucratic and cold and formal and I think I felt really immobilized by this really rigid framework that I couldn't step out of to... empathise and validate. So that is something that I am working on as I learn more about, and get to know the position better. (Jessica CM#2)

Joe's account as a respondent to a complaint, echoed Jessica's description, or a sterile, blunt, rigid framework in which the complaint about him was heard.

The experience of the [complaint organisation] was sterile. It lacked any, pause, transparent sense of justice...It was a blunt instrument that seemed to only serve the [organisation], and how [organisation] saw themselves being perceived by the public...And certainly none of the 'innocent until proven guilty', the general premise is the opposite in these types of things... It really was one of the worst

kinds of sanitising and not consistent with the principles I think, that [profession] operates under. (Joe RP#5)

Henry, when reflecting on his experience responding to vexatious complaints from one particular client over a period of more than a decade, said that one of the organisations complained to used what he called a ‘narrow lens’, or a ‘rules lens’ to look at the matter, when a broader, contextual lens focusing on the unique circumstances and motivations of the people involved in the case, was more appropriate.

Statutory, definitions and usage of terms. Did you say this did you not say this? Almost like, if I could put it in my experience, like criminal law. Criminal law is concerned about truths beyond reasonable doubt. Okay. Whereas civil law and family law is on the balance of probabilities. And it is like the [organisation A] and the [organisation B] were on about truths beyond reasonable doubt. I had a sense from [organisation C] it was quite different, more like, on the balance of the probabilities and that there is a broader picture here... And using the broader lens asks - what is happening here? (Henry RP#2)

Henry’s description of the different responses of different organisations that the client complained to highlights the variety in protocols. The organisation which asked ‘what is happening here?’ could be described as using an ‘enquiry approach’, gathering all relevant information rather than an immediate ‘breached or not’ application of a code or set of rules. Henry went on to explain why he thought an enquiry approach was needed to attend to the different human motivations and needs associated with each complaint. He explained that there are cases where a client has a distorted sense of reality and dubious motivations due to being unwell with mental health issues and can make repeated vexatious complaints to multiple organisations.

I think we actually need the broader lens. There is a place for the narrow lens, but I think that the narrow lens does not take into account the context of maybe, what if I am dealing with a disordered person, what if I am dealing with a vexatious person?... But in the narrow lens I provided a report to a party to a court proceeding and it was a technical breach of the law. (Henry CM#2)

Joe made the point as a respondent practitioner that there should not be 'one rule' for how to manage complaints. He said the priority should be on the need to protect individuals and this operates at a number of levels. He reinforced the point that there was a need to avoid a 'one size fits all' approach to complaint management. He discussed the need to enquire into whether there are 'pathological problems', or the practitioners own abusive background that led to breaches of boundaries. He also discussed the need for education and understanding for victims. This suggests that for each case, there might be a different focus depending on the unique human beings involved, and that a humanised and holistic approach should be used.

We have individuals who whether from character or pathological problems or their own abusive backgrounds as a victim are put in positions where those boundaries are confused... There are individuals who use that power imbalance and the clients' circumstances not for good but for really destructive ends. Is there one rule for how to manage that? I wouldn't think so. (Joe RP#5)

Justin, as a complaint manager said there needed to be flexibility and resources to offer a range of pathways for complaints. This was in order to meet the unique needs of the individuals and context of each one, rather than a 'one size fits all' approach. He suggested that a restorative justice framework was needed for some, but not all, complaints.

Stephanie's account as a complaint manager describes the flexibility used in the response to a young woman's complaint. The clients' preferred outcome was to work with her counsellor again which was at odds with the wishes of the practitioner. Those managing the complaint attempted to negotiate a flexible solution which prioritised the therapeutic needs of the client.

She wanted to work with her [practitioner] again - the woman that she had made the complaint against... So I suppose the discussions that occurred at those meetings were generally about that stuff... Because that [practitioner] was reluctant... the [practitioner] felt that the therapeutic relationship was a bit damaged by this process and that she felt that she was unsure whether their therapeutic work could continue, but what she would like to do was for them to work, maybe towards transferring her to another [practitioner] within the agency... So it wasn't the complainant's desired outcome but it was one that the agency could offer and then work with her to resolve it. And it seemed to go okay. (Stephanie TP#4)

Sarah's experience as a complainant also shows the need for legislation and complaint management protocols to be flexible enough to address the context for each complaint. In Sarah's situation, the family member who had received a harmful service from an unqualified practitioner was not able, for a number of reasons including being too traumatised, to enter a complaint process. Sarah said that legislation must provide rights for any member of the community to lodge a complaint about a practitioner, as a matter of public safety. She said it was not realistic to expect those being harmed to bear the sole responsibility of lodging complaints.

They would talk to [family member] but they would not talk to me because I was not the victim. [Family member] was the victim. (Sarah C#5)

Alexander summed up the essence of how complaint managers should approach the task of setting up a complaint process which grapples with complex human needs. He suggested that there is a need to arbitrate each decision based on the context of each complaint but to retain a clear, structured process. He said there should be considerable emphasis on dealing with power imbalances and protection from abuse of power in the process.

So the imbalances in that situation are really open to abuse, unless there's clear, structured, sort of like an arbitrated process through this whole context is sort of built up and then decisions are made. (Alexander CM#10)

Annie reinforced Alexander's points about the need to make sure that decisions made about the protocols for complaints needed to address any potential abuse of power. She gave an example that even when guidelines and protocols are 'set out beautifully' by an organisation, if these protocols do not work in the 'lived experience' of parties to complaints, then changes are required.

When the complaint process is not adequate and people experience that as they move through it, at the end of it I am dealing with people who are making complaints about the complaints process. For the [complaint] process with the [organisation] while it is all set out beautifully and those guidelines and these protocols and all of that, in peoples lived experience it is not working. (Annie CM#7)

In summary, the abovementioned participant narratives suggested a need for what has been interpreted as a humanised and holistic approach to complaint

management. This is congruent with some literature including that from Celenza (2008) who called for a humane and knowledge based approach to the management of sexual boundary transgressors. She argued for the importance of a therapeutic understanding of the different contexts for boundary violations rather than a singular punitive approach which positions the practitioner as a predator. Other authors such as Pope et al. (1993) echoed the need for more research, and a knowledge based response to preventing and addressing sexual misconduct. Casemore (2001) also suggested the need for resources and protocols which to attend to the serious human “hurt” that is involved in complaints.

The need for a humanised approach has not been specifically mentioned in much of the literature about complaints. For example, McLaughlin (2010) in his analysis of cases that have gone before the General Social Care Council in the United Kingdom did not specifically suggest a need for a more humanised and holistic approach, but he did critique the “wider issues around autonomy, privacy and equality in the procedures of the GSCC” (p. 314). His critique is focused on rights and procedural issues, rather than whether the GSCC complaint system meets human needs such as maximising the level of care.

In her study of complaints in the United States, Strom-Gottfried (2003) stated that more needs to be explored about the reasons why, in many cases, the adjudication of complaints about social workers took so long, and what were the impacts on parties to complaints. Again, this research does not identify a specific need to humanize complaint systems, yet it could be interpreted that it calls for more focus on timeliness and care around the impact of long drawn out matters.

Therefore, whilst critiques of complaint protocols exist in literature, they do not focus specifically on human needs, nor on what the individuals who have been involved in complaints say they want and need from complaints systems. Participant narratives in this study have provided some new information about the need for a humanized and holistic approach, but the small sample size and limited amount of data means that it is only possible to draw tentative conclusions and build a partial picture of what this means in practice.

Alongside the theme regarding a humanised approach, is the next theme which suggests that those hearing complaints needed to be neutral and impartial in order to provide a fair, objective process. Neutrality could imply a contradiction to the theme about the need for humanisation. The nuances in the different meanings of each of these themes will be discussed under the next sub-theme.

Neutrality and impartiality. Neutrality and impartiality appeared in a few participant narratives as an important phenomenon associated with decision making regarding complaints. Neutrality is defined as the state of not supporting or helping either side in a conflict or disagreement. It means an absence of decided views, expression, or strong feeling. Impartiality means treating all rivals or disputants equally, with fairness and justice, and providing independent and impartial advice. This theme is included here to contrast and provide exceptions to the previous theme about a humanised and holistic approach.

There is a tension between the needs stated by some participants for a humanised and holistic approach (as per the previous theme), and the needs stated regarding impartiality and fairness. It could easily be assumed that these principles are in competition with each other. For example, a caring, humanised response could mean

that neutrality and impartiality must be abandoned. The following narratives provide the opportunity to explore these tensions to see whether it is possible to arrive at a position where the polarisation between a humane response and a neutral, impartial response may not be necessary. There may be compatibility between the two if care is taken to apply each in a balanced manner depending on the type of interaction occurring regarding a complaint.

For example, Alexander reflected on the tensions in his role as a complaint manager, between being ‘helpful’ and ‘human’ to complainants and yet not getting ‘emotionally involved’. He said it was important to maintain neutrality as a complaint manager, and also not to raise expectations that complaint managers have the resources to provide in depth counselling.

...it’s very difficult because my position here is not as a counsellor but you end up becoming a counsellor to the client at times...However I don’t have the time or the resources, and I can’t get that emotionally involved at that level. But obviously as a human being, and even in that [complaint management role], I certainly feel I help as best I can. (Alexander CM#10)

Joe, as a respondent to a complaint, also reflected on the need for a balance between neutrality and impartiality, and the provision of support for the human needs of parties to complaints. In his experience, there was no attempt to balance the need for impartiality with support, and that was his strongest criticism of the process. He said there needed to be a process that offered advocacy, and support, alongside the more ‘arms-length’ neutrality.

I understand that these decisions have to be made at some arm's-length and there are all kinds of competing needs that [complaint organisations] deal with. But in

the absence of that other support process or counselling process or whatever, it was sterile, it was blunt and it was painfully unfair in my experience (Joe RP#5)

As a complaint manager on a hearing panel, Lisa described how challenging it is to be part of a hearing process, and to want to use particular interpersonal skills, but to forgo these because the neutrality required in the role was a priority.

I understand that part of the reason this process is so formal is to make sure that there is impartiality but I found that really hard at times. I think to some extent that it goes against everything you do as a [practitioner]. Because you feel sorry for both parties and we wanted to tell them 'I'm feeling for you', and you wanted to insert empathy and kind words and you wanted to really make them feel that you understand. But then you had to be neutral for both parties. Because if you gave one party too much airspace then you would worry that the other party is going to say you were biased. (Lisa CM#5)

Participant reflections regarding neutrality and impartiality are reinforced by Casemore, (2001).

Any actual or proven bias of favour to one party in a complaint, irrespective of which party, would compromise the whole proceedings and then be to the ultimate benefit of neither. Such behaviour would also lay the management of a case by the professional body open to challenge, and quite properly so. The adherence of complaints officers to the strict observance of impartiality is therefore ultimately in the best interests of both parties in a complaint.

(Casemore, 2001, p. 24)

The observance of impartiality may account for the experiences of parties to complaints who stated a need for systems to provide something different, more humane and less sterile. These themes need to be more fully explored to refine in greater detail exactly what aspects of complaints procedures can be humanised and can be addressed more holistically to meet human needs in the process, and what aspects of complaints must necessarily be provided with neutrality and impartiality. More needs to be explored regarding whether the two are compatible if applied in correct measure at different stages of the complaint process, which is what seems to be suggested by some research participants such as Joe. Regardless of whether they are compatible or not, the information from participant narratives in this study presents both phenomena as important.

It is noticeable that many of the themes regarding needs interact with each other, and every attempt is made in thematic analysis to avoid unintended polarisation between them. It can be argued that overall, the themes found in participant narratives suggest that there is a need for a humanised and holistic approach to be balanced with neutrality and impartiality, and that this formula might offer the strongest conditions for reflection and reparation. More details about reflection and reparation are provided in the discussion of the next theme.

Constructive ‘by-products’ of complaints. The words ‘growth’, ‘healing’, ‘learning’ and ‘change’ tended to be used by participants to refer to what has been interpreted as phenomena of reflection, responsibility, restoration, reparation and reform. These phenomena were interpreted to be needs valued by many participants. However, the nuances in participant descriptions led to the interpretation that these were regarded as potential ‘by-products’ of complaints, rather than being the primary ‘product’ or outcome. This concept of ‘by-products’ will be explained in more detail

below. Before doing so it must be noted that participant narratives generally contained more dominant messages about the need for legislated jurisdiction to protect public safety, ethics literacy and specialist resources, as stated in the earlier themes of this chapter. The capacity to apply strong sanctions against dangerous practice was the overriding concern in cases where practitioners and organisations responsible for harm were not able to reflect, repair, learn and grow. There was also a need for protection against vexatious complainants who misused complaints systems for dubious motivations.

It was challenging to thematically analyse narratives and to clearly define phenomena of reflection, responsibility, reparation, and reform. In the process of thematic analysis the concept of ‘by-products’ of complaints was arrived at because it captures a sense that even when the preferred outcome of parties could not be met, it was possible to create positive and constructive by-products of complaints such as learning, growth and repair. There was also a sense of incompleteness associated with these phenomena. For example, the need for reflection was not actively promoted nor discussed transparently among parties; responsibility may have been privately accepted but was not safely accepted in public; reparation was partial or nonexistent; reforms were not followed through on properly, even if there was some learning and growth. It should also be noted that many of the participant narratives interpreted for this theme are statements about events that occurred which illustrated a lack of reflection, responsibility and reform, as a means of implying the converse, that these were needed.

Pro-active critical reflection on any form of client feedback including minor complaints or ‘stuff they are not happy with’ was seen by some participants as very important. For example, Veronica compared the culture in Australia surrounding counselling and therapeutic professions, with the US.

So I notice that in the United States they are a lot more interested in critiquing themselves, and self critique, and client's critical reflections, and using that feedback. And really, their training over there to be a licensed professional counsellor, LPC, is way superior to what we do here in Australia. There seems to be from my experience, much greater willingness to invite client feedback about stuff that they are not that happy with. And I don't think there is that culture particularly in Australia. And I know myself, that I don't invite that particularly in my clients. (Veronica RP#3)

Joan made an observation that even with more serious complaints, there is a problem with our culture and that there is a need to more firmly follow through on any learning and growth from complaints, and reform of the systemic issues. She said she was aware of serious complaints involving boundary violation where there was a strong reaction initially and a call for action to address these which 'went nowhere'. She said there is a need for more transparency and analysis of complaint cases in order to learn and improve the gaps in the system.

But it just sort of like absorbed them up in this whole whirlwind of action and political sort of stuff, and there was just nowhere to go with it afterwards. The damage that is done will just fade into whatever is normal in your everyday. And that's a pity, because there's a hell of a lot to learn about good practice from what goes wrong. To do the analysis, you know, it is just really critical. (Joan TP#6)

Annie reinforced the point that critical reflection is crucial. She said that a big gap in many existing complaint systems is that they don't ask parties to complaints for feedback about the complaint process. Without feedback there is no opportunity to learn about improving the process.

The feedback. That is a big gap that is missing. So the complaint process is finished and there is no vehicle for feedback for the complainants. I think it is really important if we are going to improve and we are open to better processes. We need feedback from everybody who enters the complaint process. (Annie CM#7)

Alexander said that conditions for growth, learning and restoration could be maximised if it was made safe for practitioners to accept responsibility and apologise.

If somebody had admitted responsibility, and said, 'look, I did that, I didn't mean it, but I accept responsibility, and I'm really sorry that it hurt you or whatever, and you know, I'm sorry.' (Alexander CM#10)

Alexander reinforced the theme that regulatory provisions need to go further than assessing breaches of codes and deregistering, to create conditions where the causes of practitioner dysfunction can be dealt with. He said there needed to be reparative provisions to mandate that a practitioner gets therapy to address impairment.

They should be in therapy... unfortunately that's the problem, we can't mandate help... we have an obligation to them, not just to the community but to them - that they seek help to address that dysfunction so that they can continue living a normal, fruitful life. (Alexander CM#2)

This was reinforced by Jessica, who said here needs to be resources and a clear role for professional bodies to provide early support and intervention to address impairment.

I guess improved resources and support from places like professional bodies mainly around preventing impaired practice... The need to raise people's

awareness of when they might be becoming or have become impaired to work and are making poor decisions or choices. And down the track we will be seeing complaints come in. If they could have had some insight into their own issues around impairment back at this stage it could have prevented poor or unethical practice happening. (Jessica CM#2)

In summary, many of the recommendations made by participants categorised under the previous theme regarding the need for a humanised and holistic approach align with points made about conditions for reflection, responsibility, reparation and reform. It seems that many of the people interviewed for this research may have implicitly believed that if the human needs of parties to complaints were attended to as a priority, then there would be positive and constructive outcomes. When conditions for reflection, responsibility and learning were present, improved public safety, reparation, and reform could be by-products of complaints. When these conditions were not present, then deepening of trauma, adversarial conflict, self-protection, hostility, and a sense of futility and fatalism were more likely outcomes.

It is important to again note the limitations in the findings from this study, and that the themes regarding needs cannot be generalised. Also, participant narratives tended to describe the need for certain outcomes and processes such as reflection, responsibility and reform, but there was a lack of focus on specific suggestions of models and procedures that would guarantee all of these.

Conclusion

The themes in this chapter identify phenomena regarding needs that were interpreted from participant narratives. The clearest message is that the majority of those who have been involved in decision making regarding complaints valued

protection, accountability, equity, specialist knowledge, resources and ethics literacy.

In terms of improving the lived experience of complaint matters, they emphasised the importance of highly developed interpersonal skills in those around them throughout the complaint, as well as sources of support which can provide a sense of sanctuary.

Complaint models and protocols need to be designed with human needs in mind rather than an over-reliance on 'blunt', 'sterile', 'technical' protocols, yet at the same time there was a priority placed on the need for impartiality and fairness. The congruence and incongruence between the need for a humanised yet impartial response needs further exploration.

Most of the narratives referred to complaint matters where there were barriers to reflection, responsibility, reparation and reform, and therefore it was interpreted that these were what were needed as optimal by-products of complaints. However, there was a lack of certainty and clarity about exactly how complaint models should be designed to achieve these. There was also concern from two participants, Bruce and Simon, about risks of over-regulation and bureaucratic red tape.

The next and final chapter of this thesis provides an integrated critical discussion of the implications of the findings of this study, for policy and legislation, education, research and practice.

Chapter Seven

Implications and Conclusions

Introduction

The data sourced through this study is complex and confronting. It reveals human pain, suffering and conflict. Those who have inside knowledge and direct experience with complaints have reported that there have been problems with accountability systems that currently exist. The voice of those impacted by unregulated practitioners has been largely silenced because there is a lack of effective jurisdiction for their very serious complaints. This means there are uncharted domains about which not much is known about the practices of unregistered individuals. This thesis has exposed part of what could be described as the ‘underbelly’ or the ‘shadow’, of industries in which counselling, psychotherapy and casework are provided. Participants have clearly conveyed that phenomena associated with complaints regarding the practices of practitioners providing counselling, psychotherapy and casework, have included psychological trauma and risks to life, wellbeing, relationships and capacity to function. This contrasts severely with the principles of non-maleficence, or do no harm, that has been a foundation for such occupations.

Participants grappled with highly complex cognitive and emotional processes associated with complaints and the incidents that led to them, many of which are not well understood in the industry or wider community. Therefore it is important that the knowledge produced through this research is used in such a way that contributes to change and improvement. Consequently, this chapter provides a brief overview of key themes from the findings, and then focuses on a discussion of the implications and

recommendations for legislation and policy, education and training, best practice and future research.

Key Themes in Findings

This research project used a feminist and phenomenological methodology to source rich information about complex human experiences. Findings presented in Chapters Four, Five and Six centred on three key themes: impacts, power and needs. These were revealed in participant narratives as the “phenomenological core” (Smith et al., 2009, p. 159) of experiences and perceptions of complaints.

Layers of complex impacts. Participants in all three groups were impacted by a highly complex process of *managing expectations* of themselves and others while living through decisions about complaints. This was exacerbated in contexts where there were not clear, well resourced provisions or jurisdictions for complaint, nor clear protocols for complaint managers to follow. A range of *costs, risks, barriers and burdens* were faced throughout the complaint process and the risk and reality of unwelcome and unpredictable consequences were often a factor in the experience of complaints. This applied mostly to complainants who faced costs to their wellbeing as a major impact of the incidents that led to the complaint and the complaint process itself. Respondents also faced costs to their wellbeing, career and reputation, as well as financial costs in legal fees. Complaint managers also felt the impacts of a burden of responsibility and stress when attempting to evaluate situations where it was often not possible to source concrete evidence of facts, nor access the resources or power required to more effectively address the needs of parties to complaints within a semi-regulated industry. *Layers of psychological trauma* were revealed in descriptions of trauma which corresponded to symptoms of PTSD and acute anxiety. Some of the complainants

discussed situations involving impacts of severe psychological injury, and irreparable harm to relationships, careers and capacity to function. *Intense emotions* were also layered upon the other impacts, making the experience of complaints highly volatile, where it was difficult to maintain rational composure. Most participants were impacted by a sense of *futility and fatalism*, that there was no control and no point in complaints, and that they were useless in achieving the desired outcome. A few participants described the impacts of *learning and growth* after living through complaints, especially when the conditions surrounding the complaint process were conducive to such constructive outcomes.

Unmanaged cultural, relational and structural power dynamics. Chapter Five revealed phenomena associated with power in a variety of ways. The term ‘unmanaged power’ has been chosen to describe the core of this theme because it appeared that the significance and scope of power held by those in roles providing counselling, psychotherapy and casework, was perceived by many of those who have been involved in complaints as not being attended to or managed well. The forms of power that were made more visible through data analysis in this study have been categorized as *cultural power*, *relational power* and *structural power*. Within these categories, it appeared that *ideological power* influenced the cultural norms regarding a historical lack of robust accountability, individual blame and adversarial or avoidant approaches to complaints. *Epistemological power*, the power to produce knowledge, influenced the types of knowledge accessible to, and used by those involved in complaints. The forms of power apparent within phenomena associated with relational power included *nutrient power* which is used for another to advance their welfare, and also *integrative power* which is used with another to meet human needs and empower people. In terms of psychological manipulation and grooming, the type of power used

was *implicit coercion* and *exploitation*. The *power to set agendas* and to *alter the rights of others* was demonstrated in descriptions of roles and institutions.

Needs for accountability, knowledge and care. In Chapter Six, often needs were identified from descriptions of the converse, that is, cases where needs were not met. Major themes included needs for *legislated jurisdiction*, increased *ethics literacy*, as well as *specialist knowledge, roles and resources* for complaint management. Descriptions showed that great value was placed on *interpersonal champions*, those displaying superior interpersonal skills, as well as *sources of sanctuary* and care. Emphasis was placed by some participants on the need for dedication to a *humanized approach* as well as strategies to promote *constructive by-products of complaints* such as reflection, restoration, learning and growth. *Neutrality and impartiality* were seen as important, but not with a blunt, cold and overly technical manner. There was a need for impartiality and fairness to be conveyed without depersonalising or dehumanising parties to complaints.

Elements recommended for complaint management. Figure 1 shows the key elements that are needed for complaint management based on the findings of this study. If any of these elements are missing it is less possible to respond to complaints effectively. These are discussed in more detail in the remainder of this chapter.

Figure 1. Elements needed for complaint management

Implications and Recommendations

The remainder of this chapter discusses implications of key findings and makes recommendations in four areas: legislation and policy; education and training; best practice; and future research. It dialogues with the themes voiced by participants, and provides my analysis as a researcher. Although there is insufficient scope to go into theoretical depth in the analysis in this chapter, the implications and recommendations that follow, refer to; firstly, the ‘ethics of care’ approach, and; secondly, to an inherent tension between the ideologies of individualism and communitarianism. These concepts are briefly defined and the reason for their particular relevance to implications and recommendations are discussed below.

The ‘ethics of care’ approach (Held, 2005) is relevant because it grapples with the dual needs of justice and care that are at the core of complaints about the practices of counsellors, psychotherapists and caseworkers. An ‘ethics of care’ approach, which had its roots in feminist theory, was articulated by Held (2005) as a distinct moral theory or normative approach. It focuses on the broader contexts that individuals engage with, and the attributes and virtues of caring relationships, rather than just the virtues of individuals. She proposed how values such as justice, equality and individual rights can fit together with such values as care, trust, mutual consideration and solidarity.

The other concept that is significant for implications and recommendations is that there appears to be an ideological tension between the influence of individualism (associated with liberalism) and the need for a shift to communitarianism. I refer to ideological power because it was revealed in Chapter Six as one of the primary forms of power influencing the context of complaints. Individualism and communitarianism are

complex concepts and it is not intended to construct these as binaries, or to suggest that one provides all the answers over the other.

Legislation and policy.

Legislated jurisdiction. Twenty of the twenty-two participants were strongly committed to *legislated jurisdiction* for complaints and robust regulation of all occupations providing ‘talking cures’. The two exceptions were concerned about bureaucratic red tape and the risks of limiting a range of modalities of intervention methods, if the industry was over-regulated. However, they both supported legislated jurisdiction and registration if there was some way of avoiding these risks. A recommendation which would reduce these risks would be to have a mandatory register for all practitioners, of all qualification levels and types who wish to provide services to members of the public in any occupation providing counselling, psychotherapy, casework, support work, self development, and so on. By being on the register, practitioners would be bound by basic consumer protection laws, as well as a code of conduct with similar provisions to that which has been introduced by the NSW government for unregistered health practitioners in 2008. Further recommendations regarding a central register will be discussed below.

Independent body to administer a mandatory central register for all practitioners. A central register of all practitioners is proposed because there needs to be a method of identifying patterns in complaints about individual practitioners. The administering body needs to be independent, to avoid risks of conflicts of interest. It has been identified in findings that there have been risks of cover ups and collusion if peers or managers manage complaints in isolation and secrecy. Whilst one registration body should not be expected to manage all complaints about currently unregistered

practitioners, an independent mandatory central register could be set up as a repository for data about complaints managed by a range of other organisations, and possibly, to serve a watchdog function. If resources permitted, this body could provide an avenue for enquiry into cases where parties to complaints wish to appeal outcomes on grounds of conflicts of interest or procedural unfairness.

The present situation is problematic because unregistered practitioners are only subject to legislation governing conduct in the workplace if they work for a government, or government funded non-government organisation. The legislation that governs any complaint process is enshrined within the public sector employer's code of conduct, and complaint management guidelines. Often line managers are tasked with managing complaints, which presents complex power dynamics and conflicts of interest that may be diluted by an independent entity managing the complaint. In the absence of registration, there can be no mandatory requirement to report to a central body any serious notifications regarding the conduct, health and performance of a counsellor, psychotherapist, social worker or case worker. These are dealt with locally within organisations which makes it very difficult to track the activities of a practitioner in different locations. If the employee is terminated from employment, there is no way to prevent them working for another organisation or in private practice, and no way for consumers to check if they have been found to have breached conduct or performed poorly. There must be a capacity to maintain a central database of complaints and notifications regarding all providers of counselling, psychotherapy and casework in Australia.

Review efficacy of current jurisdictions. The implications of this study are considerable in terms of the need for further development of the forms of jurisdiction that currently exist for registered and unregistered occupations. Whilst registered

professions such as psychology and psychiatry provide a benchmark for legislated jurisdiction in Australia, the strengths and limitations of this system need to be examined.

For psychologists and psychiatrists, there is legislated jurisdiction for complaints of all kinds to be received by AHPRA. There is a clear distinction between a complaint and a notification, which suggests a triage model. Complaints can be about any aspect of a service, including the service by AHPRA or other health complaint entities (AHPRA, 2013a). Notifications however, are about a practitioner's conduct, health or performance, or impairment of a student's performance (AHPRA, 2013b). Legislation has made it mandatory for other health practitioners, employers, education providers and students to report notifications regarding a practitioners health, conduct or performance, or else face disciplinary action by their National Board (AHPRA, 2013b). These provide strong legislative frameworks.

It appears that notifications regarding complaints to AHPRA are generally dealt with within an investigatory approach, although other complaints can be dealt with via alternative dispute resolution such as mediated conferences between complainant and respondent, depending on the particular health profession and the protocols of the entity managing the complaint. The wide range of investigatory powers are enshrined in legislation, which means that a range of 'evidence' can be sought including file notes, witness statements, expert witnesses, and forensic or medico-legal reports. Parties to complaints, who can afford it, may use legal representation in their response to complaints. Although not explicitly stated as such, it appears that the core value underpinning the approach to complaints is future public safety. This is achieved by placing conditions on a practitioners practice, suspending or cancelling registration. There are also elements of a punitive approach through reprimand and fines. With

notifications, there appears not to be an emphasis on providing resources to address impairment, although as part of conditions, registrants may be referred to bodies that can assist. It is not prominent in written information, whether conditions on registration can include requiring registrants to pay compensation or return fees to clients. The key recommendation of this study, is that the efficacy of this legislation and policy needs to be reviewed to see if the desired purposes are currently achieved, or if changes are needed.

It is also recommended that the inequities in rights and responsibilities within complaint protocols other than those administered by registration bodies, be reviewed. Complaints about those unregistered counsellors, psychotherapists and social workers who do choose to be a member of one or more of the thirty-three voluntary professional associations (including the thirty-one member associations of PACFA, plus the ACA, and the AASW) are heard within very different types of complaint avenues, with different resources and procedures. Broadly, the approach used in professional associations appears to be one of “voluntary consensus standards-setting” or “peer review” (Trubek, Rees, Hoflund, Farquhar, & Heimer, 2008). Those hearing complaints form a consensus on how they view the facts and whether the standards have been breached. Unlike within the registered regulatory paradigm, protection of the public is not the foremost value embedded into the mechanisms offered by voluntary professional associations. Instead, the primary value is protection of membership status. Public safety cannot be protected because a practitioner who loses membership may freely practice in any role that does not require eligibility for membership of a voluntary professional association. There are elements of a developmental approach through supervision requirements, as well as a punitive approach through fines and reprimands. Without more information about the range of ways complaints are heard and managed

within the thirty three voluntary professional associations it is unknown whether restorative or systemic improvement approaches exist in complaint management responses.

Focus on those already hurt, as well as future public safety. In general, complaint procedures appear not to focus primarily on the needs of current parties to complaints, or on people close to parties to the complaint who have been hurt, but on the need to protect *future* public safety or association membership status. An ethic of care for the human needs of parties to complaints does not appear to be central to the process, and nor is an emphasis on restoration, and improvement in the systemic contexts in which the practitioner was practicing. The approach seems to be embedded within an ideology of individualism, and individual blame and culpability, without careful attendance to restoring the impacts on those who have been harmed. Refund of fees, compensation and therapeutic support would be important ways of focusing on those already hurt. The complaints discussed in this research demonstrate that multiple individuals and community members experience harm as a result of individual complaints, and much more needs to be done to attend to their needs.

Congruence in ideology, values and expectations embedded in policies and practice. One of the themes threading through many of the findings was that there were often gaps or incongruence between what was expected and what occurred. More than three quarters of participants referred to this. Some respondents to complaints felt that they got a ‘cold, sterile and cruel’ manner of response, when the industry is based on entirely different values, including care, compassion, and a commitment to understanding and grappling with humanity. Some complaint managers commented that the discourse around client ‘self-determination’ and ‘autonomy’ needs to be re-

constructed to make it clear that in many situations clients do not have the capacity to self-determine their actions in response to those of a practitioner in a position of power.

This theme of incongruence needs much deeper consideration in terms of understanding the implications for policy for complaint management organisations. Policies and procedures need to be examined in order to identify the ideologies and values that underpin them, and to see if these are congruent with what is intended, represented, and put into practice on many levels. For example, complaint organisations need to examine why policies based on adversarialism within a legalistic paradigm are used, and to consider whether this best serves the purpose of responding to complaints about counselling, psychotherapy and casework.

Alternatively, if an organisation aims to have policies based on an enquiry approach, consensus decision making based on agreed values, restoration and compensation, alternative dispute resolution or therapeutic jurisprudence, all of which are underpinned to varying degrees by an 'ethics of care' (Held, 2005) or communitarian (Etzioni, 1996) approach, then its policies need to reflect this. Communitarian ethics require a shift from focusing on individual rights to an ethic of responsibility. It is premised on the ideology that people are socially constituted and continually penetrated by culture, by social and moral influences and by each other (Etzioni, 1996). Therefore a communitarian response would require consideration of the context surrounding complaints, and the responsibilities of community members, not just the individual, to prevent and respond to harm. It would also focus on the impacts of complaints within the broad community of people surrounding each complaint, rather than an individualised, privatised response to the complainant and respondent only.

Policies to create a culture of safety for disclosure of errors or impairment.

There is a need to ‘make it safer’ within small and large organisations for practitioners to openly disclose mistakes and to accept responsibility rather than step rapidly into an adversarial, and often litigious, paradigm. It is also important when organisations have played a role in errors or not provided sufficient practice resources, to resist an individual culpability response. According to Joffe (1999) people tend to respond to risk and conflict with a “not me”, “others are to blame” reaction, because it is difficult to tolerate the frailty and lack of ability to control certain risks involving human beings (p. 1). She said that it had become a cultural norm to use blame as a powerful form of “othering”, and that this externalising process has been a method in which “the majority of people in a society are able to carve a sense of invulnerability for themselves” (Joffe, 1999, p. viii). She called for a framework for understanding “blame” and the “not me” response in which concepts are drawn from “psycho-dynamic and socio-representational tenets” (Joffe, 1999, p. viii). She said that “the role of subjectivity, of symbols and of emotional motivations has been severely underplayed in the risk literature” (Joffe, 1999, p. viii). This stance reinforces the findings that power needs to be owned and managed carefully and willingly, and that in terms of a transformation of institutional policy and culture, it must be made safer for individuals and organisations to take responsibility rather than blame.

Ethics audits as organisational policy. Each organisation that provides counselling, psychotherapy and casework services, ranging from non-government through to government organisations and private practitioners, needs to be required to provide evidence that they conduct regular ‘ethics audits’ on their policies, procedures and practices (Reamer, 2001; McAuliffe, 2005b). How are standards of practice and supervision set and enforced? How are risks prevented and managed? What codes of

ethics and conduct apply and are staff regularly trained in these? What are the grievance procedures, and how are natural justice, accountability and care embedded into complaint protocols? What support is available for practitioners and complainants involved in complaints? If an ethics audit was a policy requirement for all providers of services, this would create a jurisdiction for accountability within organisations. It is important that ethics audits are required for private practitioners, many of whom may currently operate outside such requirements.

Humanised policies and procedures. ‘Being heard’ and ‘providing an account’, need to be facilitated through humanised policies and protocols. Parties to complaints need to not be isolated and ‘left alone in the dark’, as one participant described it. Policies need to take into account the powerful impact of different modes and tone of communication used by the organisation. This includes whether they use formal language referring to technical complaint procedures only; or whether they provide information about human needs and emotions; or whether they have resources and are prepared to dialogue about the human experience of parties to complaints. The time, physical space and layout of meeting rooms used to conduct hearings needs to be considered in light of human needs, and also that each complaint is different and may require different arrangements. Policies need to be evaluated in terms of whether or not an organisation directs some resources to provide advocacy support for parties to complaints, or even, therapeutic support, as was suggested by some participants.

Policies regarding publication of complaint outcomes and proceedings.

Findings regarding the de-humanisation and disempowerment of parties to complaints suggest that ‘naming and shaming’ (which seems to have become part of an approach to justice that aligns with individualism) should be the motivation for publishing names of practitioners complained about. Individual blame and shame should be avoided in cases

where resource limitations or other factors largely accounted for the poor practice. Instead, publication of information about complaints should be motivated by goals of improving the ethics literacy of those reading the information. According to an 'ethics of care' approach (Held, 2005), it is important that there is discretion about whether the identity of parties is suppressed or not. The grounds for de-identifying names and details need to be considered on a case by case basis as it is clear that there is no 'one size fits all' rule.

The findings in chapter six about the need for increased public awareness strongly suggest that there needs to be more transparent publishing of complaint outcomes (whether with names identified or suppressed). At present, there is significant variation in the protocols for publication of complaint outcomes and names between registration authorities and voluntary professional associations. It is problematic if only a list of names of individuals who have been barred from membership is published and there needs to be contextual information provided as well in order to convey a fuller picture of the nature of each matter. Contextual information could include the date of complaint and hearing/s, allegations, relevant sections of code or legislation, mitigating factors, and outcomes. Findings regarding the need to humanise protocols used to deal with complaints, suggest that the tone and language used in publication of outcomes should be more humanised, rather than overly legalistic and formal. There should be the option of publishing a brief statement from parties to complaints in cases where there was an agreed need to do so, as part of a restorative approach. If contextual and humanised information (either with names identified or suppressed) is published then it is likely that critical reflection, learning and ethics literacy would be enhanced for those reading the publication of outcomes of complaints.

Education and Public Awareness

Ethics literacy. ‘Ethics literacy’ was reported in findings as both lacking and needed, for consumers, practitioners and regulators. Strategies to increase ethics literacy are multifaceted and would need to occur on multiple levels in multiple contexts. Ethics education and training is required in order to become qualified in psychology and social work, and enhancing ethics literacy has also recently been called for in undergraduate psychology education (Davidson & Morrissey, 2011). Yet, the findings of this study suggest that there may still be gaps in the type of knowledge, and in the extent of ethics literacy needed. Firstly, the myriad of complex ways that harm can result from the practices of counsellors, therapists and social workers, needs to be understood better. Because participants reported a culture of ‘un-owned power’, there needs to be education which makes power more visible and therefore better managed. A range of strategies to increase ethics literacy are referred to in Table 7, below.

Table 7

Recommended Strategies to Improve Ethics Literacy

Topic	Strategies
Ethics	<ul style="list-style-type: none"> • Mandatory training in ethical theory, moral philosophy, codes of ethics and ethical decision making models for those wanting to be practitioners • Knowledge of how to conduct and maintain regular ethics audits of an organisation or private practice • Supervisor training in how to make ethics a core part of supervision • Ongoing continuing professional education to refresh knowledge about ethics
Mental Health	<ul style="list-style-type: none"> • Core training in mental health literacy for practitioners, as well as those managing complaints
Power and Harm	<ul style="list-style-type: none"> • Training which identifies types of power dynamics and risks of harm involved in therapeutic relationships and strategies to manage power (for practitioners, supervisors and complaint managers) • Using case studies and de-identified summaries of actual complaints to convey the lived experience of those involved, as a preferred means of education. Humanise in order to enhance depth of awareness
Regulation and Complaints	<ul style="list-style-type: none"> • Inclusion of critical analysis of gaps and limitations in regulatory arrangements, in core content in relevant training and tertiary education programs • Public awareness campaigns, as well as requirement for all practitioners to provide brochures explaining regulatory provisions governing their work • Development of information packages providing information for complainants and respondent practitioners about what

they may expect and experience in complaint procedures. Include self-care strategies and resources they may wish to use. Humanise the tone and content of the information and focus on psychological first aid relevant to psychological injuries, as well as attending to the range of emotions associated with complaints.

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| Rights and Responsibilities | <ul style="list-style-type: none"> • Promotion of consumer awareness of rights and responsibilities as service users • Promotion of practitioner awareness of rights and responsibilities as practitioners. Focus on responsibilities for boundaries and evidence-informed practice. |
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Mental health literacy. The nature of psychological trauma, the intense emotions associated with complaints, and how to respond to these, need to be topics for training. Mental health literacy is crucial for those managing complaints in order to provide best practice within a therapeutic jurisprudence paradigm. Mental health literacy is important for all practitioners providing counselling, psychotherapy and casework, not only for competent mental health practice (Bland et al., 2009), but also to inform strategies practitioners can apply when responding to the grievances of clients diagnosed with, or displaying a distorted sense of reality. This is an uncomfortable topic given that it is important not to position clients and their grievances as lacking credibility. However, one of the significant contributions of two of the respondent practitioner participants was that they wished they had been specifically trained in how to assess and practice with clients displaying traits that are associated with borderline personality disorder. The context of these types of complaints and the specialist strategies needed to respond to them is one which needs further enquiry and education.

There also needs to be training for all in the industry about how to respond to complaints, depending on the variety of ways that these may be reported. Each practitioner needs to be clearly aware of the complaints and grievance procedures, and the resolution protocols that parties to complaints may be offered. There also needs to be education about duties and ethical obligations to report complaints made about other practitioners, and how these sensitive matters must be managed in practice, including when a client may not wish their confidential disclosure of matters concerning other practitioners, to be reported.

‘Power’ literacy. If the term ‘literacy’ is defined as competence in the language and skills used to comprehend and communicate about a particular area of knowledge, then it is important that literacy regarding cultural, relational and structural power be part of education and training. Power dynamics surrounding therapeutic practice and complaints need to be a much more central part of education and training for practitioners and within complaint management organisations. The theory and language of power as it relates to counselling, psychotherapy and casework needs to be used to make power more visible, and therefore easier to own and manage.

Best Practice

Strategies to prevent and manage harmful practice and complaints. The implications regarding best practice refer not only to the practices of practitioners providing counselling, psychotherapy and casework, their supervisors and managers, but to the practices of those managing complaints within a range of government and non-government organisations. Best practice refers to guiding principles that could be applied to inform a range of interactions, designed to firstly, prevent harm and complaints and secondly, to respond to them. Table 8 provides a detailed list of

recommended strategies regarding best practice, including: leadership; gate keeping; supervision and management; resourcing; contracting and expectation management; and evidence informed, critically reflective practice. All recommendations are informed by the literature review, and findings in Chapters Four, Five and Six.

Table 8

Strategies to Prevent and Manage Harmful Practice and Complaints

Practice	Strategies
Leadership	<ul style="list-style-type: none"> • Leadership, communication and modelling should be used to create an agenda to promote functional cultural norms and moral courage to address cases of harmful, risky or problematic practices. • The need for leadership and moral courage to act on regulatory issues extends to political leaders, leaders of a range of organisations and workplaces, supervisors and all practitioners. • Spell out the message that the locus of power over professional boundaries and practice resides firmly with the practitioner, their supervisors, managers and regulators. • Leaders promote a culture where it is safe enough to speak about and respectfully manage ‘taboo’ ethical topics, including feelings towards clients, incompetent and risky practice methods, impaired practice and burnout. • An enquiry approach and critical reflection should be promoted, rather than blame and defensiveness. • In order to reduce barriers to reporting of complaints, leaders of regulatory bodies, managers and supervisors, should ensure that they create a culture of willingness to listen, and willingness to adapt protocols to the needs of parties to complaints. The institution should extend itself, rather than make parties to complaints conform to it. For example, steps should be taken to reduce fears of recrimination for whistleblowers; hearing protocols and complaint forms should be flexible to meet the needs of complainants of a range of cultural backgrounds, as well as taking into account special needs based on health, literacy levels and remote locations.
Gate keeping	<ul style="list-style-type: none"> • Educational institutions need policies in place to enable educators to be informed about, and to not award qualifications in cases of a student’s substantiated ethical misconduct or impaired practice. Such substantiated matters should be required to be reported to a central register which can be accessed by other educational institutions and employers should a person apply for future study or work.

- Employers must also be required to report substantiated ethical misconduct and impairment to a central register.
- Avoid closing the gate forever. Gate keeping in any setting must be underpinned by a developmental approach, and practiced in such a way that addresses and assesses current and short term capacity for ethical conduct and practice. There should be provision for re-assessment of capacity over time. Some cases warrant gatekeepers imposing a long term ban from any therapeutic role; others require short term period of monitoring, conditional study or practice tasks, rehabilitation or supervision.
- Regulatory bodies must accept complaints from any person, instead of limiting the criteria to clients who directly received the service. The nature of the power imbalance between practitioner and client, and also, the barriers to reporting of complaints due to trauma, mean that often the direct client may not have the capacity to report.
- The timeframe between when the incidents occurred, and when the complaint is lodged needs to be open rather than restricted by a fixed number of years. The findings of this study strongly demonstrate that there are significant barriers to reporting of complaints which lead to under-reporting. Best practice for regulators and gatekeepers is to reduce barriers to reporting.

Supervision and
Management

- Mandatory, regular, funded, competent supervision with an emphasis on critical reflection, care and accountability.
- Those managing and hearing complaints must receive regular clinical supervision aside from line management, to support them in processing the impacts on them of involvement in complaint matters.

Advocacy
Services

- Dedicated specialist advocates need to be provided for complainants and respondents (in separate agencies or roles to avoid conflict of interest), to assist them with preparation and throughout the process of the complaint. The advocate role is independent from those processing and hearing the complaint, and is not an investigator, or intake officer.

Therapeutic
Support

- Referrals to therapeutic support should be made to attend to the psychological needs of parties to complaints.
- Those practitioners providing therapeutic support to parties to complaints must be suitably trained and qualified with specialist knowledge and skills in order to provide such services. Trust dynamics are heightened in this context. Generalist skills are not

sufficient.

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| Practitioner
Support Service | <ul style="list-style-type: none"> • Establish an independent specialist service, in the form of a non-government or statutory body staffed by experts who can provide a confidential safe place for practitioners to manage periods of impairment/burnout. • If funds are not available, assess and establish a referral network of suitably qualified staff that practitioners can access themselves. |
| Resourcing | <ul style="list-style-type: none"> • Provide funding for appropriately qualified staff and skilled supervision. • Monitor workloads and cap caseloads. • If regular monitoring of work is not occurring, the reasons need to be addressed by those making decisions about resources for supervision and management. |
| Contracting and
expectation
management | <ul style="list-style-type: none"> • Contracting and expectation management is initiated by and embedded into practice by practitioners, managers, supervisors, those managing complaints, and regulators. • Codes of conduct, codes of ethics and legislation include specific expectations of practitioners regarding mandatory reporting of cases they become aware of, of harmful practice, unethical conduct or impairment. • Make clear who will have access to client's information, or the information relevant to complaint matters, and the purpose of them having access to information. • Make clear what standards of evidence are used in hearings, and which types of evidence will be gathered as part of the assessment of the complaint. Proactively offer this information to parties to complaints in writing and on websites, and provide the name of a contact person to discuss any questions parties have. For example, evidence may include written statements from parties to complaints and third parties close to parties to complaints, witness statements, physical evidence, journals, diaries, emails, texts, case notes, supervisor notes, past employment records, medical files, prior complaints documentation, and criminal records. • Practitioners and complaint managers set the agenda when discussing expectations as well as being open to questions. Avoid |

assuming no questions mean expectations are clear.

- A timely, responsive, dedicated interpersonal stance, open to follow up contact and any further questions.
- Use a range of modes of communication when managing expectations including verbal (phone and face to face) conversation as well as written information sheets and resources; provide information on websites.
- Humanise information as much as possible – give name, role, phone number and availability of contact person/s, include vignettes of case examples in written information rather than using overly formal and technical language.
- Use written information such as diagrams to show steps in complaint process and names and roles of people involved.
- Give written information about a realistic timeline in which the complaint is likely to be dealt with.
- Report regularly on progress of complaint.
- Attend to the psychological needs of the person being communicated with, and use specialist strategies to manage expectations in cases of psychological distress, trauma and intense emotions.
- Have ‘self care conversations’ with clients and parties to complaints. Provide self-care information, referrals or support services to clients and parties to complaints as a means of supporting them in managing expectations of potential impacts of the service provided, or complaint process.

Evidence
informed,
critically
reflective practice

- Human services should be subject to principles of quality assurance and consumer protection measures. Evidence informed practice applies to regulators and complaint managers as well as practitioners.
 - Critical reflection and examination of values and evidence should be used to arrive at a professional and community consensus about which practices are appropriate in which contexts.
 - In order to be employed, or to gain an Australian Business Number enabling them to receive payment for services in private practice, practitioners should be required to demonstrate that they are appropriately qualified, supervised, and therefore have considered evidence and a range of literature regarding whether practice methods are ethical, safe and likely to be effective.
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- In order to preserve consumer's right to choose innovative methods and services, in cases where methods and practices do not have a strong traditional evidence base, the onus of responsibility is on the practitioner to be aware of, and inform consumers of potential risks or lack of benefit, from using the service, and what their grievance rights are.
 - Inflated promises of outcomes should not be offered to consumers. Outcomes should only be discussed on the basis that there is evidence that such outcomes are possible, or likely.
 - Supervisors should be involved in assisting practitioners to critically reflect on whether practices are sufficiently informed by evidence or not. Findings indicate that practitioners practicing in isolation without accountability pose higher levels of risk of problematic practices.
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Functional cultures and norms. Once legislation is in place to require a central register, and there is effective jurisdiction for regulation of all practitioners, best practice includes establishing functional cultural norms, policies and practices in a range of contexts. Best practice means equipping regulators with specialist knowledge about the unique dynamics of harm associated with complaints about the practices of counsellors, psychotherapists and caseworkers, as well as highly developed ethics literacy, mental health literacy, and most importantly, interpersonal and dispute resolution skills. Care, and the virtues of caring relationships (Held, 2005) are most powerfully conveyed through the interpersonal skills used by those who respond to complaints, so called ‘interpersonal champions’. Best practice involves applying the specific attributes listed in Chapter Six as much as is feasibly possible, in all complaint management interactions. These include a willingness to hear and listen, to collaboratively assess thoroughly; to spend time, be timely and responsive; to be determined and resourceful; to maintain clear, consistent, realistic expectations (clearly state limits on role); to convey empathy; to have a humble, (not arrogant or disinterested) interpersonal approach.

Aside from a humanised and holistic approach, it is important that best practice in regulation avoids a ‘one size fits all approach’, but does retain consistency and equity in jurisdiction. Trubek et al. (2008) evaluated the core features of contemporary regulatory responses across a broad range of health services and referred to the pluralism and lack of consistency between different regulatory responses, and a “striking variation in regulatory capacity” (p. 6). Their main critique was that there needs to be capacity to direct sufficient expertise and resources to regulate effectively and that “a narrow range of regulatory tools may limit the ability to resolve health care problems” (Trubek et al., 2008, p. 6). A range of tools and protocols appears to be the

hallmark of best practice when responding to complaints, depending on the context of each different complaint. Just as no two humans are the same, no two complaints are the same.

A small minority of participants who were concerned about the risks of over-regulation suggested that a best practice regulatory model would be quite different to the current professional registration model, and has room for a category of registrant who is not required to have an overly high level of restriction on qualification pathways and practice methods, but is fully accountable in cases of misconduct, impairment, systemic failures and harmful practices. This appears to be aligned with what Trubek et al. (2008) called a “reaction against top-down regulatory models, reminiscent of the earlier revolt against formalism” (p. 1). Trubek et al. (2008) commented that the global society now needs to open the door to new governance approaches, and that “these innovations build upon 100 years of experience with regulation” (p. 1).

A metaphor for an ideal complaint management response. I propose an institutional response where a range of specialist care and justice services are provided. Whilst not all complaint matters involve severe harm or psychological injury, it is likely that there is a need to have the facilities with which to manage the severe cases that are occasionally reported. A metaphor of the emergency department of a hospital is useful here. Some of the findings in Chapter Four showed that complaints, particularly serious ones, can involve great depth of injury and trauma – but the trauma is less visible because the injuries are psychological not physical. It is important to ensure that people experiencing severe psychological trauma associated with complaints are not left alone, ‘bleeding out’. It is very important that expert practitioners are employed in the emergency or intake department and that this first point of contact is managed in a very skilled manner. It may be that a referral is made to an outside specialist for ongoing

care, but the initial triage response must be highly skilled and there must be follow through.

After complaints are triaged into severity and urgency, there would be separate sections within the institution for the care of complainants and those close to complainants, and the care of respondent practitioners and those close to them. After assessment, treatment and care in each of these sections, an advocate could take statements and a report could be made to the enquiry panel whose task is to listen and assess each party's case and then hold an enquiry hearing similar to a coronial enquiry where all facts and relevant matters are heard outside of an adversarial paradigm. The enquiry panel could then report recommendations across broad domains, to relevant bodies and individuals with the power to enforce these. Mediation may be one recommendation, compensation may be another; supervision and support or referral to a specialist, independent non-government organisation funded to provide services to address practitioner impairment; restorative conferencing, a report to a vexatious complainant register may be others.

In general, if such an institution or elements of this type of institutional response could be developed further, this would be in the interests of the human needs of parties to complaints. Culturally, more focus is required on human needs, on a balance between, and dual provision of care and justice, and on a range of pathways and models for response, rather than a rigid, one-size fits all approach.

Future Research

The themes from this research study, along with the themes from the literature review send a clear message that there is a need for more research about power and harm, complaints and regulatory protocols.

Prevalence of harmful and problematic practices. Prevalence studies are needed to explore the rate at which problematic or harmful practices are experienced by members of the public, regardless of whether these are formally reported. While qualitative research projects with small samples provide important data, the prevalence and severity of harmful outcomes remains largely unknown. Further research could attempt to establish whether the forms of harmful practice revealed in this study, are indicative of a negligible, or significant proportion of services provided to consumers.

Power and psychological manipulation. Literature has tended to focus on sexual boundary violations, and there is a need for research about the forms of power associated with psychological manipulation. This knowledge is required to inform education programs aimed at enhancing ethics literacy and power literacy which would in turn promote better ownership and management of power.

Practice methods. Further research is needed about the types and prevalence of practice methods used by a range of occupations, and also, how consumers perceive and experience such practices. Consumers of counselling, psychotherapy and casework need to be assured that the services promoted to enhance their wellbeing, are promoted with substantial grounds. While there are risks of limiting innovation and choice in therapeutic modalities if strict guidelines for evidence based practice are used, there still needs to be a way in which consumers can be alerted to and informed about the basis upon which a practitioner promotes the purpose and risks of methods used. The principles of evidence informed, critically reflective practice, apply to regulators as well and therefore there is a need for further research to support the development of a stronger evidence base for different regulatory protocols.

Standards of evidence in complaint hearings. One of the most challenging phenomena uniquely associated with complaints about ‘talking cures’ is that it is not possible for complainants and respondents to produce concrete evidence of unwitnessed interactions relating to the facts of the matter, nor of the psychological injury that was present before the service commenced, and after the alleged harmful practice occurred. Much more research is needed about the means through which complaint managers assess evidence, and how an ‘enquiry’ approach can assure quality assessment processes are utilised. There needs to be a shift in focus from investigation of facts, to assessment of statements, and evidence of practice. Also, in cases where it is impossible to make a clear assessment of the truth of statements because there is an irreconcilable disparity between the factual accounts made by various parties, there needs to be more research about what the needs of complainants and respondents are, in terms of the language used to state findings of investigations, and attending to the impact on parties to complaints. What are the impacts and needs of parties to complaints where difficulties with standards of evidence meant there was insufficient evidence to arrive at an outcome?

‘Vexatious’ complaints and problematic respondent responses. This study provided evidence that some complaints involve people who are perceived as having significant difficulties in realistically evaluating their own actions and the actions of others. Some participants talked about unique dynamics associated with ‘borderline personality disorder’ and also ‘narcissistic’ or other pathological personality disorders, which result in a lack of capacity to engage in constructive and reasonable dialogue regarding complaints. More research is needed about how to assess and respond to these presentations for complaint managers, and for all practitioners. It seems that specialist knowledge of how to assess and manage these presentations may be crucial for anyone

working in the industries in which counselling, psychotherapy and casework are provided, and is part of core mental health literacy.

Costs of complaints. One of the gaps outside the scope of this study was the monetary costs involved in complaints. These costs are incurred in many ways. They include the costs to parties to complaints, and those impacted by complaints in lost income, costs of advice and treatment for resultant injuries. Costs also include the costs incurred by organisations responding to complaints, and the costs of different models of response. There needs to be more research about the cost of providing a regulatory jurisdiction for complaints, compared to the costs to members of the community in addressing the harm caused by the actions of unregulated practitioners in cases where there is no regulatory avenue.

Recovery and complaints. The findings of this study indicated that some participants emerged from experiences of complaints with outcomes such as learning and growth, and increased personal or professional knowledge and strength. Such experiences need to be researched in more depth to explore what internal and external factors contributed, and whether it is a form of post-traumatic growth. This information could assist parties to complaints and those around them, in facilitating recovery.

Evaluation of specific complaint management systems. This qualitative study broadly reflected the perceptions and experiences of twenty two individuals. Although clear themes emerged, more research is needed to ascertain to what extent these themes currently apply in specific settings. Research is needed which ascertains a range of detailed quantitative and qualitative data about the experiences of complainants and respondents using specific complaint systems. Quantitative data could focus on the length of time between incident/s leading to complaints and when the complaint was

reported; the timing of responses and decisions made by complaint managers; the method of hearing and outcomes. Data in response to questionnaires, scales and inventories about the health of parties to complaints throughout the complaint process would be a valuable source of information. Qualitative data could be gathered about the perceptions of those within different organisations about the culture of the organisation, focusing on exploring norms, and perceived strengths, limitations, and gaps in the resources and protocols used to prevent and respond to complaints. Data could also be gathered about the key differences in needs of different parties to complaints. This study focused on the themes across three perspectives, instead of the points of difference. A wealth of research in a range of settings could contribute to the development of knowledge about different models of regulation and about best practice in preventing and responding to complaints.

Occupational regulation theory and practice. As noted in Chapter Two, Frieberg (2011) proposed that the application of paradigms of “therapeutic jurisprudence” and “non-adversarial justice” have the potential to lead to “institutional transformation” (p. 300). He also highlighted how a recent focus over the past two decades has been on the development of knowledge in what he called the “discipline of regulation”, which he sees as a separate and independent area of study. He noted that the journal *Regulation and Governance* was only established as recently as 2006. This suggests that research and knowledge about the paradigms and processes best suited to different regulatory contexts has the potential for much greater development. There is a need for much more research about, and innovation in, the regulatory responses made to complaints about counselling, psychotherapy and casework. More research about alternative dispute resolution and what I would call ‘therapeutic restoration’ processes after complaints is needed.

Study Strengths and Limitations

The main strengths of this research are that firstly, the research design was robust and sufficiently well-designed to provide participant safety despite inherent risks, and enabled the collection of rich, vivid, detailed data which revealed the phenomenological core of the experience of complaints, across three perspectives of complainant, respondent and complaint manager. Secondly, the conceptual framework of phenomenology and feminist theory was applied in a coherent and congruent manner through the methods used for data collection and data analysis. Thirdly, the use of six strategies to ensure valid, trustworthy qualitative research was effective in ensuring that the findings are clearly based on the experiences and perceptions of participants. The final strength of the findings is that they are highly relevant to inform knowledge required in many domains in which counselling, psychotherapy, casework, and regulatory services are provided. The findings clearly inform legislation, policy, practice, education and future research.

Although the methodology and research design was strong, there are some limitations which were unavoidable because they apply to many small scale qualitative projects. Others arose due to difficulties in recruiting participants despite a careful recruitment process.

The small sample meant the results cannot be generalised as representative of all complaints about counselling, psychotherapy or casework. Another limitation was that retrospective dialogue about perceptions, events and experiences was highly subjective. The means to corroborate or investigate objective facts were not available. Self-report has these inherent limitations. However, this was moderated somewhat because in some

cases written documents were referred to. These provided concrete objective information about timelines and responses within complaint systems.

The other limitations are that the complainants in the sample were not the clients who directly received services, but instead, were persons close to clients, or practitioners who reported problematic practices by other practitioners. This limitation arose due to difficulties recruiting client complainants in the recruitment stage of the research. Attempts to do this were not successful and therefore it has been made very clear that the findings only relate to third party complainants not former clients. Also, three of the complainants reported on their experiences in relation to complaints about the same individual practitioner. This was unforeseen, and did limit the range of types of complaints discussed by complainants. However, it was not ethical to reject these participants on this basis – their complaint experience did meet the criteria for participation and provided valuable data about their unique individual lived experiences.

Similarly, the respondent group was quite limited, in that it included only those in private practice, due to the difficulty (only faced late in the recruitment stage) of needing to apply for ethical clearance through bureaucratic channels within large public sector organisations in order to seek government workers. There is also no representation of the experiences of respondents who worked within non-government organisations at the time of the complaint.

Furthermore, none of the participants in the third party complainant or respondent practitioner groups discussed experiences with counselling or psychotherapy provided by psychiatrists. Therefore the dynamics of complaints situated within psychiatry are not represented in the accounts from complainants and respondents, but only through the accounts of some of the participants in the complaint manager group.

In hindsight it would have been better to have excluded complaints about psychiatrists, because their role as a medical practitioner and the attributes of their clients as patients receiving mental health treatment are significantly different to the practice context of other occupations included in the criteria for complaints.

A further limitation was that due to the ethical sensitivity of the topic and the need to de-identify cases, it was not possible to place each person's decision making in its unique context. Occupations and organisations were not named. This means that conclusions cannot be drawn about specific occupations, organisations, professions, complaint bodies, or about particular periods of time and place in Australia. This limited the capacity to draw specific conclusions about the dynamics of decision making and recommendations for specific systems. Instead the focus is themes in the lived experience of decision making, and recommendations regarding the elements needed for effective complaint management from those who have had their own unique experience of complaints in Australia.

Conclusion

In conclusion, the findings of this study recommend urgent changes to current regulatory arrangements for unregistered occupations providing counselling, psychotherapy and casework. Equitable and effective jurisdictions for complaints are needed as well as policies which deliver more humanised, flexible processes for complaints. There is a need for transformation of many aspects of the cultures in which practitioners practice, as well as within regulatory institutions. There needs to be much more attention to power and the nature of psychological trauma and psychological manipulation. Systems and the individuals working within them need to enhance their ethics literacy and basic mental health literacy and focus their policies and protocols

more carefully around the fact that the service they provide is primarily a human service, and the humans using it are in crisis, and trauma, and in need of care and protection as well as accountability and justice.

APPENDICES

Appendix A

Secondary Research Questions – Semi Structured Interviews

Interview questions

Interviews will be semi-structured so you can discuss your perspective in a conversational way. Questions will not be asked in a set survey format because this is qualitative research about your individual experiences and perspectives. However, if you feel more comfortable being given a specific set of questions prior to consenting to participate, a list can be provided. If email is used, this gives the opportunity to reflect on a few questions at a time before answering. The researcher will respond to your answers and prompt for more information. You may pass on any question.

Questions for Complainants and Respondents:

- Who was involved and what service was provided (counselling, psychotherapy or casework)
- What was the complaint about and what circumstances led to it
- Who was told and why, or for what reasons was no-one told
- What were their responses and were these useful or otherwise
- What information did you use to make decisions and how did you source it
- What beliefs and perceptions did you have about those who had a role in dealing with the complaint, and how did these affect your decisions
- How did you believe others who had a role in dealing with the complaint perceived you, and how did this affect your decisions
- What was your wellbeing like throughout various stages of the decision making process and how did this impact on your capacity to make decisions
- What systems managed your complaint and what happened within those systems
- How were facts or evidence established and was this appropriate or problematic
- What key points need to be understood about these types of complaints compared to any other type of complaint
- What do you believe in hindsight was needed to avoid the circumstances which led to the complaint

- Did your experience suggest to you that complaint systems can achieve justice or resolution, and if so, how, or if not, what are the barriers
- Could you describe an ideal model for regulation of psychological services
- What specific changes need to be made to the existing semi-regulated system
- What impedes or prevents these changes

Questions for Complaint Managers:

- What is/was your role in relation to complaints and regulation
- What types of matters or decisions have you been involved in
- What knowledge/training do/did you use to inform your decisions or advice
- What gaps (if any) in knowledge are there for you, your organisation, and for the industry in general
- Has your involvement in decision making regarding complaints affected your wellbeing or been experienced as distressing in any way
- Can you give non-identifying examples of cases you have been involved in, to highlight which systemic responses are useful or not, and why
- What feedback has been provided to you by those involved in complaints
- How are facts or evidence established and is this appropriate or problematic
- What key points need to be understood about these types of complaints compared to any other type of complaint
- What do you believe is needed to minimize circumstances which lead to complaint/s
- Do your experiences suggest to you whether or not complaint systems can achieve justice or resolution, and if not, what are the barriers
- Could you describe an ideal model for regulation of psychological services
- What specific changes need to be made to the existing semi-regulated system
- What impedes or prevents these changes

Appendix B

Recruitment Letter and Flyer

Dear

RE: GRIFFITH UNIVERSITY RESEARCH PROJECT

I am writing to provide information for your consideration, about a research project I am currently conducting as part of doctoral studies through the School of Human Services and Social Work at Griffith University. The project is **“Decision Making regarding Complaints about Counselling, Psychotherapy or Case Work”**.

I am also writing to seek your consideration of whether it may be within the protocols of your organisation, to pass on information about the project to anyone who may be interested in participating. This may include those who have had contact with your organisation as complainants, respondents, and third parties (such as complaint intake and assessment officers, tribunal decision makers, and those who provide support to parties to complaints).

I would appreciate it also, if you would consider whether you may be willing, (if permitted within organisational protocols), to be interviewed yourself as a third party with experience in relation to complaint management and support services. Your perspective would be of great value to the project.

About the project

The research is about what it is like to live through decisions regarding complaints about the practices of counsellors, psychotherapists and case workers in Australia. It asks for individual perspectives and recommendations regarding the current semi-regulated system. Providers of these services include qualified psychologists, psychiatrists, social workers, counsellors and psychotherapists, as well as other practitioners with and without training relevant to counselling, psychotherapy and case work. Complaints may be about the effectiveness of services, as well as alleged ethical breaches, misconduct, and practitioner impairment. The project aims to generate Australian qualitative research data relevant to the development of regulation models for these types of services.

Three perspectives are sought for the project:

1) Complainants

Those who have reported, or seriously considered reporting a complaint to a board, professional association, complaint commission, employer or other organisation

2) Respondents

Those who have had a complaint made about their practice

3) Third parties

Those who have been in a formal role in relation to complaint management .e.g. complaint intake and assessment officers, investigators, board and tribunal members, ethics hearing panel members, policy makers, executive officers, lawyers, legislators, those who provide support services to parties to complaints.

A purposive recruitment strategy aims to seek 30 participants Australia-wide (10 from each of the three groups) willing to be interviewed by myself, either face-to-face or by email.

Because complaints can be about sensitive matters, careful strategies are used to protect privacy and the wellbeing of participants. Participants are only required to disclose their name to myself, not to the project advisors or anyone else. The anonymity of organisations and complaint management bodies is absolutely assured. Individuals, organisations, professions, times, locations, and potentially identifying incidents will not be included under any circumstances in published data. Participants are required not to identify any other parties to complaints in their interviews. Data will be presented in the form of themes and descriptions of the lived experience of decision making processes, as well as recommendations about regulation models. Feedback about specific organisations is not the focus of this project.

I value your time in considering whether it may be possible to assist in the recruitment stage by passing on the research advertising flyer, and/or being interviewed yourself.

Please do not hesitate to contact me or my principal senior advisor, Dr Donna McAuliffe on (07) 33821070, or (07) 33821201, for further information. I would also be pleased to meet with you to discuss the project further.

Yours sincerely

Deborah Sauvage

PhD Candidate School of Human Services and Social Work – Griffith University

Encl.



School of Human Services and Social Work
University Drive, Meadowbrook, QLD, 4131, Australia
Telephone +61 (7) 3382 1201 Facsimile +61 (7) 3382 1210

- Have you ever had concerns or made a complaint about the practices of a counsellor, psychotherapist, or case worker?
- If you have been a provider of counselling, psychotherapy or case work, have you ever had a complaint reported to you, or made about you?
- Or, have you ever been in a formal role where you gave advice or made decisions regarding complaint matters?
- If so, Griffith University would like to hear from you.

RESEARCH PROJECT: Decision-making regarding complaints about counselling, psychotherapy and casework

This research is about what it is like to live through decisions regarding complaints about the practices of counsellors, psychotherapists, and case workers in Australia. It asks three separate groups of participants (complainants, respondents and third parties) to reflect on and discuss their perspectives on any past complaint. This can be done either by email or face-to-face interview. It does not matter what the complaint was about, or whether or not it was reported. It may never have been discussed with anyone, or may have been through a formal hearing process. Influences on your decisions are of interest in this project, as well as any recommendations you wish to make about changes to current regulation and complaint systems.

Complaints can be about sensitive matters and therefore this project has some careful strategies in place to protect privacy. Your identity will not be disclosed to anyone; you will be required not to identify anyone else involved in the complaint; and what you discuss will be strictly de-identified and anonymous in the final interview transcripts. Your participation is voluntary and you may decline to answer any question, or withdraw if you find that participation is not right for you once the interview commences. You may check a list of key questions that will guide the interviews before you consent to participate.

You may have received this flyer through individuals and agencies within the human service industry. To respect your privacy, they will not identify anyone or pass on any names at all to the researcher. Their role is only to pass on this advertising flyer to anyone who may be interested.

Therefore if you wish to find out more, please email Deborah Sauvage d.sauvage@griffith.edu.au, or leave a message for Deborah with the School Secretary on (07) 3382 1201. Deborah is a full-time PhD research student supervised by senior advisors Dr. Donna McAuliffe (School of Human Services and Social Work - Logan) and Dr. Shirley Morrissey (School of Psychology - Gold Coast) through the School of Human Services and Social Work at Griffith University, Logan Campus, University Drive, MEADOWBROOK, 4131.

If you prefer to ensure your initial contact is as confidential as possible, it is worth considering using a private (not work) email account, possibly using a pseudonym.

Appendix C

Quantity of Transcript Data Collected per Individual/Participant Group

Participant Group/Pseudonyms	Number of words in transcript (including researcher questions and dialogue)
<u>Third Party Complainants</u>	
Bruce	16,676
Jen	12,032
Mark	11,872
Mary	14,045
Sarah	16,905
Zoe	18,357
Total:	<u>89,887 (28%)</u>
<u>Respondent Practitioners</u>	
Henry	18,927
Joe	15,559
Sally	13,003
Simon	13,152
Veronica	13,542
Total:	<u>74,183 (24%)</u>
<u>Complaint Managers</u>	
Alexander	20,203
Annie	19,885
Jessica	10,413
Joan	16,309
John	8,868
Justin	18,995
Lisa	13,951
Saskia	12,900
Stephanie	14,692
Tran	9,516
Zac	9,775
Total:	<u>155,507 (48%)</u>
TOTAL for three participant groups:	<u>319,577 (100%)</u>

Appendix D

Participant Information and Consent Forms



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RESEARCH PROJECT: Decision-making regarding complaints about counselling, psychotherapy and casework

INFORMATION SHEET

What is the research about?

This research is about what it is like to live through decisions regarding complaints about the practices of counsellors, psychotherapists and case workers in Australia. It asks those who have been complainants, respondents or third parties to reflect on and discuss their perspectives either by email or face-to-face interview. It does not matter what the complaint was about, or whether or not it was reported or responded to formally by a board or ethics panel. It may never have been discussed with anyone.

Who is conducting the research?

This research will be conducted through the School of Human Services and Social Work at Griffith University. A full-time PhD research student, Deborah Sauvage, will carry out the project under the supervision of Dr Donna McAuliffe from the School of Human Services and Social Work – Logan (Principal Advisor) and Dr Shirley Morrissey from the School of Psychology - Gold Coast (Associate Advisor).

Why is the research being conducted?

There is a current government agenda regarding the regulation of a range of health and human services in Australia. At present, out of all providers of counselling and psychological services, only those using the occupation titles psychologist, psychiatrist, psychiatric nurse and general medical practitioner (GP) are regulated and required by law to be licensed and subject to ethical standards and complaint procedures. Counsellors, psychotherapists, social workers and case workers may choose whether or not they are members of a voluntary professional association,

and to be subject to the ethical standards and complaint procedures of these associations. Previous research has not been conducted in Australia seeking the perspectives of complainants, respondents and third parties who have been involved in complaints within the present semi-regulated system. This research aims to find out from these three perspectives what changes to systems may be recommended. The overall objective of the research is to source data which may be used to inform regulation and complaint management models in Australia.

Participant experience

You will be asked to identify yourself only in order to establish a means of communication and to complete legally required research consent procedures. In interviews, you will be asked to recall and discuss what it was like to live through decisions about a complaint. Deborah will ask some key questions, which are slightly different for complainants, respondents and third parties. Interviews can occur either entirely via secure email communication; or through two audio-taped face-to-face interviews; or a combination of one face-to-face interview followed by email communication. Face-to-face interviews would be arranged at a neutral venue accessible to you, likely to be a private meeting room booked by Deborah at either at a university or public library. Email communication would occur between your email account and Deborah's secure university email account. It is up to you whether you feel more comfortable choosing email or face-to-face interviews. To maximise your privacy and control over who may potentially access the information it is important to consider not using a work email, and ensuring a home email is password protected. Emails will be responded to by Deborah within 24hrs, or you will receive an automated message stating when Deborah will reply. To minimise any distress due to opening up discussion of the complaint, participation should be completed within a timeframe of two weeks. However, if you prefer to share your experiences over a longer period, participation may take up to six weeks. Interviews can occur during the period Sep 2009 - Dec 2010.

Participant description

You must be over the age of 18, able to give voluntary and informed consent, and able to reflect on past decision making. If the complaint is currently being dealt with within a legal or other formal complaint system this may pose extra complexities and risks which mean that participation is not appropriate at this time. Participants are sought from three perspectives about separate complaints – complainants, respondents and third parties. Participants will find out about the research through an advertising flyer distributed through relevant individuals and agencies in the industry. These individuals and agencies will *not* identify you as a potential participant to the researcher, but simply pass on the flyer to you for you to follow up if you wish.

Complainants

Deborah will interview people who have reported, or seriously considered reporting but did not report, a complaint about any practitioner with any qualification who provided psychological services involving counselling, psychotherapy or case work in Australia. The complainant group can include:-

- Client
- Partner, family, or friend of client
- Member of public
- Colleague
- Supervisor
- Supervisee
- Worker who has concerns about practices of a past counsellor or therapist of one of their clients, which led them to report, or consider reporting a complaint

Respondents

Members of the respondent group will be practitioners, with any qualifications, who provided services involving counselling, psychotherapy or case work, and about whom a complaint was made, either informally and directly by the complainant during a session or in writing, or informally or formally within an organisation, or to an external body such as complaint commission, board or professional association.

Third Parties

Members of the third party group will be people who have been in a formal role which has required them to experience decision making regarding complaints from perspectives other than as complainant or respondent. This includes:-

- Ethics panel members involved in hearings and rulings about sanctions
- Ethics Office Bearers
- Complaint Intake officers
- Investigators, Lawyers
- Counsellors or workers mediating, treating, rehabilitating or responding to the needs of clients or therapists who have been complainants or respondents to complaints
- Industry stakeholders including policy makers and advisors
- Legislators

Interview questions

Interviews will be semi-structured so you can discuss your perspective in a conversational way. Questions will not be asked in a set survey format because this is qualitative research about your individual experiences and perspectives. However, if you feel more comfortable being given a specific set of questions prior to consenting to participate, a list can be provided. If email is used, this gives the opportunity to reflect on a few questions at a time before answering. The researcher will respond to your answers and prompt for more information. You may pass on any question.

Complainants and respondents will be asked:

- Who was involved and what service was provided (counselling, psychotherapy or casework)
- What was the complaint about and what circumstances led to it
- Who was told and why, or for what reasons was no-one told
- What were their responses and were these useful or otherwise
- What information did you use to make decisions and how did you source it
- What beliefs and perceptions did you have about those who had a role in dealing with the complaint, and how did these affect your decisions
- How did you believe others who had a role in dealing with the complaint perceived you, and how did this affect your decisions
- What was your wellbeing like throughout various stages of the decision making process and how did this impact on your capacity to make decisions
- What systems managed your complaint and what happened within those systems
- How were facts or evidence established and was this appropriate or problematic
- What key points need to be understood about these types of complaints compared to any other type of complaint
- What do you believe in hindsight was needed to avoid the circumstances which led to the complaint
- Did your experience suggest to you that complaint systems can achieve justice or resolution, and if so, how, or if not, what are the barriers
- Could you describe an ideal model for regulation of psychological services
- What specific changes need to be made to the existing semi-regulated system
- What impedes or prevents these changes

Third parties will be asked:

- What is/was your role in relation to complaints and regulation
- What types of matters or decisions have you been involved in
- What knowledge/training do/did you use to inform your decisions or advice
- What gaps (if any) in knowledge are there for you, your organisation, and for the industry in general
- Has your involvement in decision making regarding complaints affected your wellbeing or been experienced as distressing in any way
- Can you give non-identifying examples of cases you have been involved in, to highlight which systemic responses are useful or not, and why
- What feedback has been provided to you by those involved in complaints
- How are facts or evidence established and is this appropriate or problematic
- What key points need to be understood about these types of complaints compared to any other type of complaint
- What do you believe is needed to minimize circumstances which lead to complaint/s
- Do your experiences suggest to you whether or not complaint systems can achieve justice or resolution, and if not, what are the barriers
- Could you describe an ideal model for regulation of psychological services
- What specific changes need to be made to the existing semi-regulated system
- What impedes or prevents these changes

The expected benefits of the research

The potential benefit of participation is that you will have the opportunity to be heard and valued as you reflect back on your own decision-making. Furthermore, it is expected that the results will be of benefit to the wider community and the psychological and human service industry, in that your recommendations may be used to inform regulation and complaint management systems. This research does not seek to resolve any specific ongoing disputes that participants may have.

Risks to you

Some participants in similar research conducted overseas (Disch, 2001) reported that it was at times emotionally distressing to recall and discuss sensitive information, but that the benefits of being heard and valued, and the opportunity to inform change which may help others, outweighed any distress overall.

You may not know what risk to your wellbeing is involved until you start to participate and to feel the impacts as you share your experiences. Any strong or mixed feelings associated with the complaint may re-surface, along with pre-occupation with any dilemmas involved in decision making. Discussing these may be beneficial. However this may also trigger distress, anxiety, tears, anger, sadness, panic, pre-occupation which distracts from everyday activities, and inability to sleep. The experience of trusting Deborah with private, potentially uncomfortable information presents risks as well, especially in the context where trust is likely to have been impacted on in the past. Please be assured that Deborah is sensitive to the wide range of experiences clients and workers can face within counselling, psychotherapy and case work relationships.

If participation is too distressing, or just doesn't feel right for you, you may decide to suspend or withdraw participation at any stage up until a pre-advised date. If your participation prompts you to consider re-contacting any party involved in the complaint there may be a range of implications for you and others. The research team cannot give advice regarding further decisions about complaints. An information sheet can be provided with contact details of organisations which may assist.

When the results of the project are read, because the research seeks three groups' perspectives, there is a risk that you may disagree with or feel distressed by the content of other perspectives. Your feedback will be valued and noted as research data which may be relevant in any subsequent publications.

Confidentiality and privacy

For privacy reasons you will be required not to disclose any identifying information about others involved in the complaint. Your identity and contact details will only be known by Deborah, and will not be disclosed to supervisors or anyone else in Griffith University. Phone messages will not be left for you about the research to avoid any risk of breaching your privacy. Your consent forms and contact details will be kept separate from the interview transcripts. Current interview files will be password protected, and the laptop locked securely when not in use. Taped interviews will be transcribed by Deborah only, and erased immediately after transcription. You will be asked to check transcripts and emails as well as a summary of your perspective before these are finalised for analysis. Only de-identified printed transcripts of interviews will be stored and these documents will be permanently destroyed after five years.

If there has been past illegal activity by any party to the complaint it is important that this *can* be discussed and is not withheld out of fear of it being reported by the researcher. Illegal activity must be discussed in a non-identifying manner, and it will remain confidential. However, if you

disclose identifying information which indicates that there is clear, serious and immediate risk of harm to anyone, including yourself, you would be asked to advise relevant authorities in order for those authorities to act to prevent harm where possible; *or the researcher may be obliged to report this to advisors and relevant authorities*. Clear, serious and immediate risk of harm would include current intent to suicide, criminal activity, exploitation or violence.

You need to be aware that although your contribution will be strictly de-identified (i.e. your name, names of others, places, qualifications, professions, organisations, and specific dates or unique features of any event you describe will *not* be included), some anonymous, non-identifying quotes from transcripts, as well as broad themes and recommendations found in the research data will be provided to you in a participant report. It is optional whether you wish to receive this report. If you do wish to receive it, it will be provided by secure email, or by registered mail if sent in paper form, to the address you provide.

Furthermore, a brief synopsis of your perspective, and some anonymous, non-identifying direct quotes, will be included in the thesis, and may be included in other reports, publications, journal articles and presentations by the researcher. You can amend your consent to the use of information from interview transcripts at any stage prior to the completion of data collection.

Participants retain a copy of the email interview or the transcript of face to face interviews as evidence of the contact with the researcher. Please seek legal advice before participation in this research, in order to clarify if participation poses any legal risks in relation to current or future dispute resolution arising from complaint matters.

Your participation is voluntary

Your decision to participate should be made voluntarily, with full awareness of how the information you share will be used and reported, the potential risks and conditions of confidentiality, including your obligations not to disclose any identifying information. If you already know, or are likely to know Deborah Sauvage, Donna McAuliffe or Shirley Morrissey, as a colleague, client, educator or friend etc, it is important that you consider any potential impact of your participation on these existing relationships.

Because it could be a source of undue pressure on voluntary consent and would breach privacy, the research advisors cannot identify to Deborah, or make approaches to recruit anyone they know who was directly involved in a complaint in which any member of the research team had a formal role (Donna McAuliffe has been involved on past hearing panels with the Australian Association of Social Workers, and Shirley Morrissey with the Queensland Psychologists Registration Board). However, should you be a potential participant whose complaint was dealt with by Donna or Shirley in the past, and you found out about the research through means other

than direct approach by Donna and Shirley, you may participate without them being informed, because your identity will only be disclosed to Deborah.

The ethical conduct of this research

Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research. Any concerns or complaints about the ethical conduct of this research project should be discussed with the Manager, Research Ethics, on 3735 5585, or research-ethics@griffith.edu.au.

Feedback to you

A non-identifying participant report in which all participants will remain anonymous will be distributed at the completion of all interviews and analysis (in early 2011). Your feedback on the participant report is valued but optional. The participant report will not contain any identifying information, nor reference to specific cases, events or incidents. It will provide information about themes in the nature of the lived experience of these types of complaints, and also a list of recommendations from participants about what is needed in an effective regulation system.

Other information

If you wish to discuss any specific needs you have in order to enable participation, including if you wish to have a support person and/or interpreter involved, please discuss this with Deborah. Support persons and interpreters will be required to sign a confidentiality agreement. If you do not speak English well the Translating and Interpreting Service on 13 14 50 may help with making contact. If you have a hearing or speech impairment and have access to appropriate TTY or modem equipment, it may be arranged for this to be used in phone contact by calling 13 36 77. If you do not have access to appropriate TTY or modem equipment, the Speech to Speech Relay Service may be contacted on 1300 555 727.

Questions/ further information

Any questions about the research can be discussed with Deborah d.sauvage@griffith.edu.au. Deborah is not contactable through a direct phone line so email is preferred. If you prefer to protect your anonymity, it may be worthwhile to consider making contact through a private email address using a pseudonym. Alternatively, a phone message can be left by phoning (07) 3382 1201 and asking the school secretary to email a message to Deborah Sauvage, with your phone number and preferred times of contact by Deborah on that number.

Expressing consent

Your signature on the attached consent form confirms that you have read and agreed to the conditions stated on this information sheet, and that you agree to participate. Please retain this information sheet for future reference.



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**RESEARCH PROJECT: Decision-making regarding complaints about counselling,
psychotherapy and casework**

PARTICIPANT CONSENT FORM

Research Team

Ms. Deborah Sauvage (PhD Candidate)

Dr. Donna McAuliffe (Principal Advisor)

Dr. Shirley Morrissey (Associate Advisor)

Agreement

By signing below, I confirm that I have read and understood the information package and in particular have noted that:

- I understand that my participation in this research will involve identifying myself to the researcher only for the purposes of consent procedures and to establish a means of communication; that I will not be identified in any other way in the transcripts of interviews, dissemination of results, nor to advisors; that I will be required not to identify any other person/s involved in the matters I discuss; and that I may choose either face-to-face, phone or email interviews;
- I understand that my confidentiality is assured, except if I make a disclosure which identifies any person currently involved in *immediate* risk of harm, in which case I will be asked to report this to relevant authorities that may act to prevent this harm, *or the researcher may be obliged to report this to advisors and relevant authorities*;
- My preferred form of communication, including for interviews is:-
 - email communication on the email address nominated below

- 1 x 2 hour face-to-face interview at a university or public library meeting room accessible to me, followed by email communication on the email address nominated below
- 2 x 2 hr face-to-face interviews at a university or public library meeting room accessible to me, with no email communication.
- Please tick indicating your consent to either of the following:-
 - I consent** that an anonymous summary of my contribution, including non-identifying quotes from my interview transcripts will be included in the publication of the thesis and may be included in any other publications or presentations by the researcher.
 - I do not consent** for non-identifying, anonymous quotes from my interviews to be published in any form.
- The contact details I prefer the researcher to use are:

Email address: _____

Phone contact number (optional, if preferred): _____

Postal address (optional, if preferred): _____

- I have had any questions answered to my satisfaction;
- I understand the risks involved;
- I understand that there will be no direct benefit to me from my participation in this research;
- I understand that my participation in this research is voluntary and I enter into it for my own reasons, under no pressure from the research team or anyone else;
- I understand that if I have any additional further questions I can contact the research team;
- I understand that I have been advised to seek legal advice about whether my participation in this research may impact on future dispute resolution or court cases about the matters I discuss;

- I understand that I am free to withdraw at any time prior to the finalisation of analysis and report of data, without comment or penalty, and without my contribution being included in the results or any publications;
- I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on (07) 3735 5585 (or research-ethics@griffith.edu.au) if I have any concerns about the ethical conduct of the project; and
- I agree to participate in the project.

Name	
Signature	
Date	

Please return this completed form in an envelope marked *Private and Confidential* to:-

Deborah Sauvage d.sauvage@griffith.edu.au

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Griffith University – Logan Campus

University Drive, MEADOWBROOK, QLD 4131

Thank-you for your willingness to participate. Upon receipt of this signed consent form, you will be contacted by Deborah to arrange interviews.

References

- Abel, G., & Osbourne, C. (1999). Cognitive behavioural treatment of sexual misconduct. In J. Bloom, C. Nadelson, & M. Notman. (Eds.), *Physician sexual misconduct* (pp. 225-246). Washington, DC: American Psychiatric Press.
- Albrecht, J. M. (2012). *Reconstructing individualism: A pragmatic tradition from Emerson to Ellison* (1st ed.). New York, NY: Fordham University Press.
- Allen, A. (2011). Feminist perspectives on power. In E. Zalta. (Ed.), *The Stanford Encyclopedia of Philosophy* (Spring 2011 ed.). Retrieved from <http://plato.stanford.edu/archives/spr2011/entries/feminist-power/>
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, DC: Author.
- Anderson, S. K., & Handelsman, M. M. (2010). *Ethics for psychotherapists and counsellors: A proactive approach*. West Sussex, United Kingdom: Wiley-Blackwell.
- Anonymous. (2005). The unfolding and healing of analytic boundary violations: Personal, clinical and cultural considerations. *Journal of Analytical Psychology*, 50(5), 661-691. doi:10.1111/j.0021-8774.2005.00563.x
- Archer, M., Bhaskar, R., Collier, A., Lawson, T., & Norrie, A. (1998). *Critical realism: Essential readings*. Abingdon, Oxon: Routledge.
- Arnett, R. C., Harden-Fritz, J. M., & Bell, L. M. (2009). *Communication ethics literacy: Dialogue and difference*. Thousand Oaks, CA: Sage.
- Australian Association of Social Workers [AASW]. (2004). *A duty of care: A case for statutory regulation of social work*. Retrieved from http://www.aasw.asn.au/adobe/publications/Regulation_Final_Submission.pdf

Australian Association of Social Workers [AASW]. (2010). *Code of ethics (3rd ed.)*. Canberra, ACT: Author.

Australian Association of Social Workers [AASW]. (2013a). *Website - Homepage*. Retrieved from <http://www.aasw.asn.au/>

Australian Association of Social Workers [AASW]. (2013b, March 20). *e-Bulletin*. Canberra, ACT: Author. Retrieved from <http://www.aasw.asn.au/document/item/4248>

Australian Bureau of Statistics [ABS]. (2006). Self Report of Occupation Table (ANZCO) (OCC06P). *Australian Census of Population and Housing*. Canberra, ACT: Author.

Australian Bureau of Statistics [ABS]. (2011). Self-report of Occupation Table (OCCP[11] – 4 digit Level). *Australian Census of Population and Housing*. Canberra, ACT: Author.

Australian Centre for Posttraumatic Mental Health [ACPMH]. (2007). *Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder*. Melbourne, Victoria: Australian Government National Health and Medical Research Council.

Australian Community Workers Association [ACWA]. (2013a). *The accidental counsellor workshop*. Retrieved from <http://www.acwa.org.au/BookingRetrieve.aspx?ID=140333&A=SearchResult&SearchID=5471428&ObjectID=140333&ObjectType=48>

Australian Community Workers Association [ACWA]. (2013b). *Code of ethics*. Retrieved from <http://www.acwa.org.au/resources/code-of-ethics>

Australian Counselling Association [ACA]. (2013a). *Website – Homepage*. Retrieved from <http://www.theaca.net.au/>

- Australian Counselling Association [ACA]. (2013b). *Code of ethics and practice* (Version 10). Brisbane, Queensland: Australian Counselling Association.
- Australian Health Ministers Advisory Council [AHMAC]. (2011). *Options for regulation of unregistered health practitioners*. Retrieved from http://www.ahmac.gov.au/cms_documents/Consultation%20Paper%20-%20Options%20for%20Regulation%20of%20Unregistered%20Health%20Practitioners.pdf
- Australian Health Ministers Advisory Council [AHMAC]. (2013). *Website – Homepage*. Retrieved from <http://www.ahmac.gov.au/site/home.aspx>
- Australian Health Practitioners Regulation Agency [AHPRA]. (2011). *Annual report for the National Boards and the Australian Health Practitioners Regulation Agency 2010-2011*. Brisbane, Queensland: Author.
- Australian Health Practitioners Regulation Agency [AHPRA]. [2013a]. *Notification outcomes and hearing decisions*. Retrieved from <http://www.ahpra.gov.au/Notifications/Hearing-Decisions.aspx>
- Australian Health Practitioners Regulation Agency [AHPRA]. (2013b). *Complaints*. Retrieved from <http://www.ahpra.gov.au/About-AHPRA/Complaints.aspx>
- Australian Institute of Health and Welfare [AIHW]. (2007a). Welfare services resources. In *Australia's welfare 2007*. Retrieved from <http://www.aihw.gov.au/publications/aus/aw07/aw07-c07.pdf>
- Australian Institute of Health and Welfare [AIHW]. (2007b). *Disability and disability services*. In *Australia's welfare 2007*. Retrieved from <http://www.aihw.gov.au/publications/aus/aw07/aw07-c04.pdf>
- Australian Institute of Health and Welfare [AIHW]. (2007c). *Website – Homepage*. Retrieved from www.aihw.gov.au

- Australian Psychological Society [APS] (2007). *Code of ethics*. Melbourne, Victoria: Australian Psychological Society Limited.
- Australian Register of Counsellors and Psychotherapists [ARCAP] (2012, May 4). *Australian Register of Counsellors and Psychotherapists Media Release* [Press release]. Retrieved from <http://www.pacfa.org.au/news/id/252>
- Babiak, P., & Hare, R. (2006). *Snakes in suits*. New York, NY: Harper Collins.
- Baker-Miller, J. (1976). *Towards a new psychology of women*. Boston, MA: Beacon Press.
- Banks, S. (2010). Integrity in professional life: Issues of conduct, commitment and capacity. *British Journal of Social Work, 40*(7), 2168-2184.
doi.org/10.1093/bjsw/bcp152
- Banks, S. (2012). *Ethics and values in social work* (4th ed.). Basingstoke & New York: Palgrave Macmillan.
- Barker, P. (Ed.). (2011). *Mental health ethics*. London, England: Routledge.
- Barney, L., Griffiths, K., Jorm, A., & Christensen, H. (2005). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry, 40*(1), 51-54. doi:10.1080/j.1440-1614.2006.01741.x
- Barsh, A., & Lisewski, A. (2008). Library managers and ethical leadership: A survey of current practices from the perspective of business ethics. *Journal of Library Administration, 47*(3-4), 27-67. doi:10.1080/01930820802186357
- Bates, Y. (Ed.) (2006). *Shouldn't I be feeling better by now? Client views of therapy*. Basingstoke, England: Palgrave Macmillan.
- Berlinger, N. (2005). *After harm: Medical error and the ethics of forgiveness*. Baltimore, MD: The John Hopkins University Press.

- Berlinger, N., & Wu, A.W. (2005). Subtracting insult from injury: Addressing cultural expectations in the disclosure of medical error. *Journal of Medical Ethics, 31*(2), 106-108. doi:10.1136/jme.2003.005538
- Bernard, J., Murphy, M., & Little, M. (1987). The failure of clinical psychologists to apply understood ethical principles. *Professional Psychology: Research and Practice, 18*(5), 489-491. doi:10.1037/0735-7028.18.5.489.
- Biaggio, M., Duffy, R., & Staffelbach, D. (1998). Obstacles to addressing professional misconduct. *Clinical Psychology Review, 18*(3), 273–285.
doi:10.1016/S0272-7358(97)00109-8
- Bismark, M., Brennan, T., & Paterson, R. (2006). Relationship between complaints and quality of care in New Zealand: A descriptive analysis of complainants and non-complainants following adverse events. *Quality and Safety in Health Care, 15*(1), 17-22. doi:10.1136/qshc.2005.015743
- Black, J. (2002). Critical reflections on regulation. *Australian Journal of Legal Philosophy, 27*(1), 1-36. Retrieved from
<http://search.informit.com.au.libraryproxy.griffith.edu.au/fullText;dn=200206927;res=APAFT>
- Bland, R., Laragy, C., Giles, R., & Scott, V. (2006). Asking the customer: Exploring consumers' views in the generation of social work practice standards. *Australian Social Work, 59*(1), 35-46. doi:10.1080/03124070500449762
- Bland, R., Renouf, N., & Tullgren, A. (2009). *Social Work Practice in Mental Health*. Kew, Victoria: Allen & Unwin
- Bloom, J., Nadelson, C., & Notman, M. (1999). *Physician sexual misconduct*. New York, NY: American Psychiatric Press.

- Boeckenhauer, C., Michael, L., Ormerod, N., & Wansbrough, A. (1998). *Violating trust: Professional sexual abuse*. Sydney, NSW: Committee Against Health Professional and Clergy Abuse.
- Boland-Prom, K. W. (2009). Results from a national study of social workers sanctioned by state licensing boards. *Social Work, 54*(4), 351-360.
doi.org/10.1093/sw/54.4.351
- Bowen, G. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research, 8*(1), 137-152. doi.org:10.1177/1468794107085301
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation and treatment*. New York, NY: Sage.
- Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress, 18*(5), 401-412.
doi.org/10.1002/jts.20048
- Brindle, D. (2008, September 5). Social workers to get new guidance on conduct. *The Guardian*. Retrieved from
<http://www.guardian.co.uk/society/2008/sep/05/socialcare.guidelines>
- Brown, J. (1999). Boundary violations: A practitioner's personal account. *Psychotherapy in Australia, 6*(1), 44-48. Retrieved from
<http://search.informit.com.au.libraryproxy.griffith.edu.au/fullText;dn=549194862668342;res=IELHEA>
- Burnard, P. (1999). *Practical counselling and helping*. London, England: Routledge.
- Burr, V. (1995). *An introduction to social constructionism*. London, England: Routledge.

- Byrne, M. (2001). Critical incident technique as a qualitative research method. *Association of periOperative Registered Nurses Journal*, 74(4), 536-539.
Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11665387>
- Callinan, R., & Murray, D. (2001, April 28). Sex abuse claims hit \$18 million. *The Courier Mail*, pp. 1.
- Callinan, R., Murray, D., & Ware, M. (2000, May 27). Anger over student abuse. *The Courier Mail*, pp. 1, 4.
- Cardy, T. (2009, March 12). Perth psychiatrist, 80, jailed for sex with patients. *Perth Now: The Sunday Times*. Retrieved from <http://www.news.com.au/perthnow/story/0,,25176470-2761,00.html>
- Carter, K., & Delamont, S. (1996). *Qualitative research: The emotional dimension*. Aldershot, England: Avebury.
- Casemore, R. (Ed.). (2001). *Surviving complaints against counselors and psychotherapists: Towards understanding and healing*. Herefordshire, United Kingdom: PCCS Books.
- Celenza, A. (2008). Rehabilitation of sexual boundary transgressors: A humane and knowledge based approach. *Psychiatric Times*, 25(4), 1-6. Retrieved from <http://www.psychiatrictimes.com/articles/rehabilitation-sexual-boundary-transgressors>
- Celenza, A., & Gabbard, G. (2003). Analysts who commit sexual boundary violations: A lost cause? *Journal of the American Psychoanalytic Association*, 51(2), 617-636. doi:10.1177/00030651030510020201
- Chenoweth, L., & McAuliffe, D. (2012). *The road to social work and human service practice* (3rd ed.). Melbourne, Victoria: Cengage Learning.

- Child and Adolescent Sexual Assault Counselling Incorporation [CASAC]. (2012). *Grooming*. Retrieved from <http://www.casac.org.au/site%20docs/Grooming.pdf>
- Corley, M. (2002). Moral distress: A proposed theory and research agenda. *Nursing Ethics*, 9(6), 636-650. doi:10.1191/0969733002ne557oa
- Coroners Court of New South Wales. (2009). *Transcript of Inquest into the death of Rebekah Anne Lawrence by Deputy Coroner Malcolm McPherson*. Glebe, NSW: NSW Coroners Court.
- Council of Australian Governments (COAG). (2009). *National registration scheme*. Retrieved from www.coag.gov.au
- Coverdale, J., Nairn, R., & Claasen, D. (2002). Depictions of mental illness in print media: A prospective national sample. *Australian and New Zealand Journal of Psychiatry*, 36(5), 697-700. doi:10.1046/j.1440-1614.2002.00998.x
- Craig Hodges Consulting Pty Ltd. (2011). *Australia's views on regulatory requirements of counsellors and qualified therapists: Summary paper*. Retrieved from <http://www.aasw.asn.au/document/item/1819>
- Crisp, A., & Gelder, M. (2000). Stigmatisation of people with mental illnesses. *The British Journal of Psychiatry*, 177(1), 4-7. doi:10.1192/bjp.177.1.4
- Crone, K. G., Muraski, M. B., Skeel, J. D., Love-Gregory, L., Ladenson, J. H., & Gronowski, A. M. (2006). Between a rock and a hard place: Disclosing medical errors. *Clinical Chemistry*, 52(9), 1809-1814. doi:10.1373/clinchem.2006.072678
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, NSW: Allen & Unwin.
- Cumming, S. (2008, July). Registration: Our responses and future plans. *The Queensland Branch of the AASW Newsletter*, pp. 16-17.

- Danemark, B., Ekstrom, M., Jakobsen, L., & Karlsson, J. (2002). *Explaining society: Critical realism in the social sciences*. Abingdon, Oxon: Routledge.
- Davidson, G., Garton, A., & Joyce, M. (2003). Survey of ethics education in Australian university schools and departments of psychology. *Australian Psychologist*, 38(3), 216-222. doi:10.1080/00050060310001707237
- Davidson, G. R., & Morrissey, S. A. (2011). Enhancing ethical literacy of psychologically literate citizens. In J. Cranney, & D. S. Dunn (Eds.), *The psychologically literate citizen: Foundations and global perspectives* (pp. 41-55). New York, NY: Oxford University Press.
- Dawes, R. M. (1994). *House of cards: Psychology and psychotherapy built on myth*. New York, NY: Simon and Schuster Inc.
- Dawson, E. (1994). Professional misconduct in psychiatry: Sexual behaviour with patients. A report of recent New South Wales findings. *Australian & New Zealand Journal of Psychiatry*, 28(2), 197-204.
doi:10.3109/00048679409075629
- de Beauvoir, S. (1974). *The second sex*. New York, NY: Vintage Books.
- de Maria, B. (2009, March 2). Blueprint for silence on official wrongdoing. *The Australian, Business*. Retrieved from <http://www.theaustralian.news.com.au/business/story/0,,25123818-5018069,00.html>
- Denzin, N. K., & Lincoln, Y. S. (2011). *The sage handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Devlin, R., & Heffernan, P. (2007, November 9). The end(s) of self regulation? *Alberta Law Review*, 45(5), 2008. Retrieved from <http://ssrn.com/abstract=2101801>

- Dineen, T. (2001). *Manufacturing victims: What the psychology industry is doing to people*. Canada: Robert Davies Publisher.
- Disch, E. (2001). Research as clinical practice: Creating a positive research experience for survivors of sexual abuse by professionals. *Sociological Practice*, 3(3), 221-239. doi:10.1023/A:1011526211933
- Disch, E., & Avery, N. (2001). Sex in the consulting room, the examining room and the sacristy: Survivors of sexual abuse by professionals. *American Journal of Orthopsychiatry*, 71(2), 204-217. doi:10.1037/0002-9432.71.2.204
- Dworkin, R. (1998). Taking rights seriously. In L. May, S. Collins-Chobanian, & K. Wong. (Eds.), *Applied ethics: A multicultural approach* (pp. 51-60). Upper Saddle River, NJ: Prentice Hall.
- Edwards, W. (1954). The theory of decision making. *Psychological Bulletin*, 51(4), 380-417. doi:10.1037/h0053870
- Egan, C. (2009a, January 17). Bizarre secret cult ripping families apart. *Perth Now, The Sunday Times*. Retrieved from <http://www.news.com.au/perthnow/story/0,,24926123-2761,00.html>
- Egan, C. (2009b, January 24). More lives ruined by cult's bizarre control. *Perth Now, The Sunday Times*. Retrieved from <http://www.news.com.au/perthnow/story/0,,24959870-2761,00.html>
- Egan, J., Chenoweth, L., & McAuliffe, D. (2006). Email-facilitated qualitative interviews with traumatic brain injury survivors: A new and accessible method. *Brain Injury*, 20(12), 1283-1294. doi:10.1080/02699050601049692
- Eickhoff, F. W. (1987). A short annotation to Sigmund Freud's "Observations on transference love". *International Journal of Psychoanalysis*, 14(1), 103-109.

- Elkind, S. N. (1992). *Resolving impasses in therapeutic relationships*. New York, NY: The Guilford Press.
- Etzioni, A. (1996). *The new golden rule*. New York, NY: Basic Books.
- Flanagan, J. (1954). The critical incident technique. *Psychological Bulletin*, 51(4), 327-358. doi:10.1037/h0061470
- Freckelton, I. (2006). Ethics and the Legal Context, in Morrissey, S. & Reddy, P. (2006) *Ethics and Professional Practice for Psychologists*, pp. 14-24. Melbourne: Thomson Social Science Press.
- Fredon, M. (2003). *Ideology: A very short introduction*. Oxford, England: Oxford University Press.
- Freiberg, A. (2011). Psychiatry, psychology and non-adversarial justice: From integration to transformation. *Psychiatry, Psychology and Law*, 18(2), 297-314. doi: 10.1080/13218719.2010.543755
- French, J. R. P Jr., & Raven, B. (1959). The bases of social power. In D. Cartwright (Ed.), *Studies in social power* (pp. 259-269). Ann Arbor: MI: Institute for Social Research.
- Gabriel, L. (2005). *Speaking the unspeakable: The ethics of dual relationships in counselling and psychotherapy*. London, England: Routledge.
- Gallois, L., & Griffin, L. (1998). Paying for it: Sexual exploitation complaints against health service providers. In C. Boeckenhauer, L. Michael, N. Ormerod, & A. Wansbrough (Eds.), *Violating trust: Professional sexual abuse* (pp. 81-93). Sydney, NSW: Committee Against Health Professional and Clergy Abuse.
- Gartrell, N. (1998). A case of eroticized transference. In M. Hill, & E. Rothblum (Eds.), *Learning from our mistakes, difficulties and failures in feminist therapy* (pp. 6-12). New York, NY: Routledge.

- Gartrell, N., Herman, J., Olarte, S., Feldstein, M., & Localio, R. (1987). Reporting practices of psychiatrists who knew of sexual misconduct by colleagues. *American Journal of Orthopsychiatry*, 57(2), 287-295.
doi:10.1111/j.1939-0025.1987.tb03539.x
- Gartrell, N. & Sanderson, B. (1998). Sexual abuse of women by women in psychotherapy: Counseling and advocacy. In N. Gartrell. (Ed.). *Bringing Ethics Alive: Feminist Ethics in Psychotherapy Practice*, pp. 39-54. Binghamton, N.Y.: The Haworth Press.
- Geldard, D., & Geldard, K. (2001). *Basic personal counselling: A training manual for counsellors*. Frenchs Forest, NSW: Prentice Hall/Pearson Education Australia.
- Gillen, S. (2007, October 18). Wakefield child abuse scandal puts social work attitudes in spotlight. *Community Care*. Retrieved from <http://www.communitycare.co.uk/Articles/2007/10/18/106165/wakefield-child-abuse-scandal-puts-social-work-attitudes-in-spotlight.html>
- Grant, D., & Alfred, K. C. (2007). Sanctions and recidivism: An evaluation of physician discipline by state medical boards. *Journal of Health, Politics, Policy and Law*, 32(5), 867-885. doi:10.1215/03616878-2007-033
- Grenyer, B., & Lewis, K. (2012). Prevalence, prediction and prevention of psychologist misconduct. *Australian Psychologist*, 47(2), 68-76.
doi:10.1111/j.1742-9544.2010.00019.x
- Gross, Z. (1977). *Erotic contact as a source of emotional learning in psychotherapy*. Paper presented at the Annual Meeting of the American Psychological Association. San Francisco, CA: American Psychological Association.
- Grossman, F., Gilbert, L., Genero, N., Hawes., S, Hyde, J., & Maracek, J. (1997). Feminist research: Practice and problems. In J. Worell, & N. Johnson (Eds.),

- Shaping the future of feminist psychology: Education research and practice* (pp. 73-91). Washington, DC: American Psychological Association.
- Grunebaum, H. (1986). Harmful psychotherapy experiences. *American Journal of Psychotherapy*, 40(2), 165-176. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/3014911>
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 191-215). Thousand Oaks, CA: Sage.
- Gurman, A., & Messer, S. (Eds.) (2003). *Essential psychotherapies: Theory and practice*. New York, NY: Guilford Press.
- Guthiel, T., & Brodsky, A. (2008). *Preventing boundary violations in clinical practice*. New York, NY: Guilford Press.
- Hanisch, C. (1969). The personal is political. Retrieved from <http://www.carolhanisch.org/CHwritings/PersonalisPol.pdf>
- Harding, S. (2004). *The feminist standpoint theory reader*. New York, NY: Routledge.
- Hare, R. (1998). *Without conscience: The disturbing world of the psychopaths among us*. New York, NY: Guildford Press.
- Hasenfeld, Y. (1987). Power in social work practice. *Social Service Review*, 61(3), 469-483. doi:10.1086/644463
- Health Care Complaints Commission New South Wales [HCCC NSW] (2008). Code of Conduct Poster for Unregistered Health Practitioners. Retrieved from <http://www.hccc.nsw.gov.au/Information/Information-for-Unregistered-Practitioners>

- Health Quality Complaints Commission Queensland (HQCC QLD). (2008). *Annual report 2007-2008*. Retrieved from <http://www.hqcc.qld.gov.au/home/inner.asp?pageID=346&snav=212>
- Healy, K. (2012, 16 December), National Presidents Report. *Australian Association of Social Workers National e-Bulletin*, Retrieved 20th December 2012 from http://www.aasw.asn.au/communications?command=article&id=1334&contact_id=429506&message_id=1492&utm_source=communications&utm_medium=email&utm_campaign=National+President%27s+Report
- Hedges, L.E. (1999a). *In defence of the therapist: The false accusation argument*. Paper presented at the American Psychological Association Convention, Boston, MA.
- Hedges, L.E. (1999b). *Terrifying transferences: Aftershocks of childhood trauma*. Lanham, Maryland: Jason Aronson.
- Helbig, K. (2012, July 23). Medical malpractice report casts doubt on credibility of whistleblower Jo Barber. *The Courier-Mail*. Retrieved from <http://www.couriermail.com.au/news/medical-malpractice-report-casts-doubt-on-credibility-of-whistleblower-jo-barber/story-e6freon6-1226433023094>
- Held, V. (1993). *Feminist morality: transforming culture, society, and politics*. Chicago, IL: University of Chicago Press.
- Held, V. (2005). *The ethics of care*. London, England: Oxford University Press.
- Heller, D. (1985). *Power in therapeutic practice*. New York, NY: Human Sciences Press.
- Henderson, S., Andrews, G., & Hall, W. (2000). Australia's mental health: An overview of the general population survey. *Australian and New Zealand Journal of Psychiatry*, 34(2), 197-205. doi:10.1080/j.1440-1614.2000.00686.x
- Herman, J. (1992). *Trauma and recovery*. New York, NY: Basic Books.

- Hochman, J. (1984). Iatrogenic symptoms associated with a therapy cult: Examination of an extinct “new psychotherapy” with respect to psychiatric deterioration and “brainwashing”. *Psychiatry*, 47(4), 366-377. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/6096906>
- Hohfeld, W., & Cook, W. (Eds.). (1919). *Fundamental legal conceptions as applies in judicial reasoning and other legal essays*. New Haven, CT: Yale University Press.
- Holroyd, J., & Brodsky, A. (1977). Psychologists' attitudes and practices regarding erotic and nonerotic physical contact with patients. *American Psychologist*, 32(10), 843-849. doi:10.1037/0003-066X.32.10.843
- House, R. (2003). *Therapy beyond modernity: Deconstructing and transcending profession centered therapy*. London, England: Karnac Books Ltd.
- Hunter, E. (1953). *Brainwashing in Red China: The calculated destruction of men's minds*. New York, NY: Vanguard.
- Hutchinson-Mittendorf, S., & Schroeder, J. (2004). Boundaries in social work: The ethical dilemma of social worker-client sexual relationships. *Journal of Social Work Values and Ethics*, 1(1). Retrieved from http://www.socialworker.com/jswve/index2.php?option=com_content&do_pdf=1&id=11
- Hyde, M., & McGuiness, M. (1992). *Jung for beginners*. Cambridge, England: Icon Books.
- Iedema, R., Jorm, C., Wakefield, J., Ryan, C., & Sorensen, R. (2009). A new structure of attention? Open disclosure of adverse events to patients and their families. *Journal of Language and Social Psychology*, 28(2), 139-157. doi:10.1177/0261927X08330614

- Irons, R., & Schneider, J. (1994). Sexual addiction: Significant factor in sexual exploitation by health care professionals. *Sexual Addiction & Compulsivity*, 1(1), 4-21. doi:10.1080/10720169408400043
- Jain, A., & Ogden, J. (1999). General practitioners' experiences of patients' complaints: Qualitative study. *British Medical Journal*, 318(7198), 1596-1599. doi:10.1136/bmj.318.7198.1596
- Janis, I., & Mann, L. (1977). *Decision-making: A psychological analysis of conflict, choice and commitment*. New York, NY: MacMillan.
- Jenkins, K. (2007). Feminist methodologies: Unsettling multiple boundaries in development. In M. Smith (Ed.). *Negotiating boundaries and borders: Qualitative methodology and development research* (Studies in Qualitative Methodology, Vol. 8, pp. 83-103). Oxford, England: Elsevier.
- Joffe, H. (1999). *Risk and 'the other'*. Cambridge, England Cambridge University Press.
- Jones, J., Meehan-Andrews, T., Smith, K., Humphreys, J., Griffin, L., & Wilson, B. (2006). "There's no point in complaining, nothing changes": Rural disaffection with complaints as an improvement method. *Australian Health Review*, 30(3), 322- 332. doi:10.1071/AH060322
- Jorm, A., Christensen, K., & Griffith, K. (2006). The public's ability to recognize mental disorders and their beliefs about treatment: Changes in Australia over 8 years. *Australian and New Zealand Journal of Psychiatry*, 40(1), 36-41. doi:10.1080/j.1440-1614.2006.01738.x
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, 166(4), 182-186. Retrieved from

https://www.mja.com.au/journal/1997/166/4/mental-health-literacy-survey-publics-ability-recognise-mental-disorders-and?0=ip_login_no_cache%3D7ceac8eeeebe35a1ec3ffda7a36b36b4

- Kingsford-Smith, D. (2002). What is regulation? A reply to Julia Black. *Australian Journal of Legal Philosophy*, 27(1), 37-46. Retrieved from <http://search.informit.com.au.libraryproxy.griffith.edu.au/fullText;dn=200206927;res=APAFT>
- Klein, G. A., Orasanu, J., Calderwood, R., & Zsombok, C. E. (Eds.). (1993). *Decision making in action: Models and methods*. Norwood, NJ: Ablex Publishing Corporation.
- Kottler, J., & Carlson, J. (2003). *Bad therapy: Master therapists share their worst failures*. New York, NY: Brunner Routledge.
- LaDuke, S. (2000). The effects of professional discipline on nurses. *American Journal of Nursing*, 100(6), 26-33. doi:10.2307/3521834
- Lakhani, N. (2012, August 15). Exclusive: NHS watchdog claimed that whistleblower Kay Sheldon was 'mentally ill'. *The Independent*. Retrieved from <http://www.independent.co.uk/life-style/health-and-families/health-news/exclusive-nhs-watchdog-claimed-that-whistleblower-kay-sheldon-was-mentally-ill-8046640.html>
- Laurance, J. (2009, March 26). One in six psychiatrists has tried to 'turn gays straight'. *The Independent*. Retrieved from <http://www.independent.co.uk/life-style/health-and-wellbeing/health-news/one-in-six-psychiatrists-has-tried-to-turn-gays-straight-1654273.html>

- Law, M., & Kim, S. (2005). Specialization and regulation: The rise of professionals and the emergence of occupational licensing regulation. *The Journal of Economic History*, 65(3), 723-756. doi:10.1017/S0022050705000264
- Lifton, R. J. (1961). *Thought reform and the psychology of totalism*. New York, NY: W. W. Norton.
- Lilienfeld, S. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, 2(1), 53-70. doi:10.1111/j.1745-6916.2007.00029.x
- Lonne, B. (2008, November 25). *Social workers welcome Wood Inquiry but look for workforce strategy* [Press release]. Retrieved from http://www.aasw.asn.au/advocacy/socialpolicydesk/media_releases/mr2008-11-25_WoodInquiry.pdf
- Lott, D. (2000). *In session: The bond between women and their therapists*. New York, NY: Owl Books.
- Luepker, E. T. (1989). Sexual exploitation of clients by therapists: Parallels with parent-child incest. In G. Schoener, J. Milgrom, J. Gonsiorek, E. Luepker, & R. Conroe (Eds.), *Psychotherapists sexual involvement with clients* (pp. 73-79). Minneapolis, MN: Walk-in Counselling Center.
- Luepker, E. T. (1999). Effects of practitioners' sexual misconduct: A follow up study. *Journal of the American Academy of Psychiatry and Law*, 27(1), 41-63. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10212026>
- Lukes, S. (1974). *Power: A radical view*. London, England: Macmillan Press.
- Manitoba Law Reform Commission (1994). *Regulating professions and occupations* (Report No. 84). Winnipeg, Canada: Manitoba law Reform Commission.
- Mansbach, A., & Bachner, Y. (2008). On the readiness of social work students to blow the whistle to protect the client's interests. *Journal of Social Work Values and*

- Ethics*, 5(2). Retrieved from
<http://www.socialworker.com/jswve/content/view/92/65/>
- May, R. (1950). *The meaning of anxiety*. New York, NY: W.W. Norton.
- May, R. (1972). *Power and innocence: A search for the sources of violence*. New York, NY: W.W. Norton.
- Maynard, M. (1994). Methods, practice and epistemology: The debate about feminism and research. In M. Maynard, & J. Purvis (Eds.), *Researching women's lives from a feminist perspective* (pp. 10-26). London, England: Taylor and Francis.
- Mazerolle, P., & Cassematis, P. (2010). 'Whistle while you work': Lessons to be learned from the pan-Australian research. In D. Lewis (Ed.), *A global approach to public interest disclosure: What can we learn from existing whistleblowing legislation and research?* (pp. 128-158). Cheltenham, United Kingdom: Edward Elgar Publishing, Inc.
- McAuliffe, D. (2000). *Beyond the hypothetical: Ethical dilemmas in frontline social work* (Unpublished doctoral dissertation). University of Queensland, Brisbane, Australia.
- McAuliffe, D. (2003). Challenging methodological traditions: Research by email. *The Qualitative Report*, 8(1). Retrieved from
<http://www.nova.edu/ssss/QR/QR8-1/mcauliffe.html>
- McAuliffe, D. (2005a). I'm still standing: Impacts and consequences of ethical dilemmas for social workers in direct practice. *Journal of Social Work Values & Ethics*, 2(1). Retrieved from
<http://www.socialworker.com/jswve/content/blogcategory/10/34/>

- McAuliffe, D. (2005b) Putting ethics on the organisational agenda: The social work ethics audit on trial. *Australian Social Work*, 58(4), 357-369.
doi:10.1111/j.1447-0748.2005.00232.x
- McCoyd, J. (2006). Conducting intensive interviews using email. *Qualitative Social Work*, 5(3), 389-405. doi:10.1177/1473325006067367
- McLaughlin, K. (2010). The social worker versus the General Social Care Council: An analysis of Care Standards Tribunal hearings and decisions. *British Journal of Social Work*, 40(1), 311-327. doi:10.1093/bjsw/bcn136
- Middleton, W. (2004). Correspondence: Boundary violations. *Australasian Psychiatry*, 12(1), 81-82. doi:10.1111/j.1440-1665.2004.02066.x
- Milgram, S. (1974). *Obedience to authority: An experimental view*. New York, NY: Harper and Row.
- Morgan, B (pseudonym). (2013). *I was trapped in a therapy cult*. Retrieved from <http://www.rickcross.com/reference/brainwashing/brainwashing6.html>
- Morris, T. (2006). *Social work research methods: Four alternative paradigms*. Thousand Oaks, CA: Sage.
- Morrissey, S., & Reddy, P. (2006). *Ethics and professional practice for psychologists*. Melbourne, Victoria: Thomson Social Science Press.
- Morrow, S. (2005). Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counselling Psychology*, 52(4), 250-260.
doi:10.1037/0022-0167.52.2.250
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), 13-22. Retrieved from http://www.ualberta.ca/~iiqm/backissues/1_2Final/pdf/morseetal.pdf

- Murthy, D. (2008). Digital ethnography: An examination of the use of new technologies for social research. *Sociology*, 42(5), 837-855. doi:10.1177/0038038508094565
- Nachmani, I., & Somer, E. (2007). Women sexually victimized in psychotherapy speak out: The dynamics and outcome of therapist client sex. *Women and Therapy*, 30(1-2), 1. doi:10.1300/J015v30n01_01
- Nash, L., Daly, M., Johnson, M., Walter, G., Walton, M., Willcock, S., ... Tennant, C. (2007). Psychological morbidity in Australian doctors who have and have not experienced a medico-legal matter: Cross-sectional survey. *Australian and New Zealand Journal of Psychiatry*, 41(11), 917-925.
doi:10.1080/00048670701634960
- Nile, E., & Pickering, E. (1991, September). *Questions without notice*. Proceedings of the Deep Sleep Therapy Royal Commission, Hansard and Papers Legislative Council, Parliament of New South Wales. Retrieved from <http://www.parliament.nsw.gov.au/prod/PARLMENT/hansArt.nsf/V3Key/LC19910925015>
- QSR International Pty Ltd. (2008). NVivo 8. (Student Version). Melbourne, VIC: QSR International.
- O'Connor, E., Coates, H. M., Yardley, I. E., & Wu, A. W. (2010). Disclosure of patient safety incidents: A comprehensive review. *International Journal of Quality in Health Care*, 22(5), 371-379. doi:10.1093/intqhc/mzq042
- Office of Health Practitioner Registration Boards Queensland (2009). Home. Retrieved from <http://www.healthregboards.qld.gov.au/>
- Ofshe, R., & Singer, M. T. (1986). Attacks on peripheral versus central elements of self and the impact of thought reforming techniques. *Cultic Studies Journal*, 3(1), 3-24. Retrieved from <http://www.antisectes.net/singer-ofshe.htm>

- O'Sullivan, T. (1999). *Decision making in social work*. London, England: MacMillan.
- Oxford Dictionaries. (2013a). *Definition of complaint in English*. Retrieved from <http://oxforddictionaries.com/definition/english/complaint?q=complaint>
- Oxford Dictionaries. (2013b). *Definition of decision in English*. Retrieved from <http://oxforddictionaries.com/definition/english/decision?q=decision>
- Pargiter, R., & Bloch, S. (1994). Developing a code of ethics for psychiatry: The Australasian experience. *Australian and New Zealand Journal of Psychiatry*, 28(2), 188-196. doi:10.1080/00048679409075628
- Parslow, R., & Jorm, A. (2000). Who uses mental health services in Australia? An analysis of data from the national survey of mental health and wellbeing. *Australian and New Zealand Journal of Psychiatry*, 34(6), 997-1008. doi:10.1080/000486700276
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Pelcovitz, D., van der Kolk, B., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a criteria set and a structured interview for disorders of extreme stress not otherwise specified (DESNOS). *Journal of Traumatic Stress*, 10(1), 3-16. doi:10.1023/A:1024800212070
- Pelling, N. (2005). Counsellors in Australia: Profiling the membership of the Australian Counselling Association. *Counselling Psychotherapy and Health*, 1(1), 1-18. Retrieved from http://www.cphjournal.com/archive_journals/V1_I1_Pelling_1-18_7_05.pdf
- Pelling, N. (2007). Advertised Australian counselling psychologists: A descriptive survey of their practice details and self perceived competence in six counselling

psychology practice areas. *Counselling Psychology Quarterly*, 20(3), 213-227.

doi:10.1080/09515070701475784

Police Integrity Commission (2009). *Royal Commission into the New South Wales*

Police Service. New South Wales Government. Retrieved from

<http://www.pic.nsw.gov.au/RoyalCommission.aspx>

Pope, K., Sonne, J., & Greene, B. (2006). *What therapists don't talk about and why:*

Understanding taboos that hurt us and our clients. Washington, DC: American Psychological Association.

Pope, K., Sonne, J., & Holroyd, J. (1993). *Sexual feelings in psychotherapy*.

Washington, DC: American Psychological Association.

Pope, K., & Vasquez, M. (2007). *Ethics in psychotherapy and counselling: A practical*

guide (3rd ed.). San Francisco, CA: Wiley.

Pope, K., & Vetter, V. (1991). Prior therapist-patient sexual involvement among

patients seen by psychologists. *Psychotherapy: Theory, Research, Practice,*

Training, 28(3), 429-438. doi:10.1037/0033-3204.28.3.429

Prevention of Abuse Network [POPAN]. (1998). *What to look for when you go into*

therapy. London, England: POPAN.

Proctor, G. (2002). *The dynamics of power in counselling and psychotherapy: Ethics,*

policy and practice. Herefordshire, United Kingdom: PCCS Books.

Psychotherapy and Counselling Federation of Australia [PACFA]. (2013). *Home –*

Psychotherapy & Counselling Federation of Australia. Retrieved from

<http://www.pacfa.org.au/>

Punch, M. (1986). *The politics and ethics of fieldwork: Qualitative research methods*

series. Beverly Hills, CA: Sage.

- Quadrio, C. (1992). Sex and gender and the impaired therapist. *Australian and New Zealand Journal of Psychiatry*, 26(3), 346 – 363.
doi:10.3109/00048679209072058
- Quadrio, C. (1994). Sexual abuse involving therapists, clergy and judiciary: Closed ranks, collusions and conspiracies of silence. *Psychiatry, Psychology and Law*, 1(2), 189-198. doi:10.1080/13218719409524842
- Quadrio, C. (1996). Sexual abuse in therapy: Gender issues. *Australian and New Zealand Journal of Psychiatry*, 30(1), 124-131.
doi:10.3109/00048679609076080
- Queensland Nursing Council (2008). *Annual Report 2007-2008*. Retrieved from <http://www.qnc.qld.gov.au/home/index.aspx>
- Reamer, F. G. (1992). The impaired social worker. *Social Work*, 37(2), 165-170.
doi:10.1093/sw/37.2.165
- Reamer, F. G. (1995). Malpractice claims against social worker: First facts. *Social Work*, 40(5), 595-601. doi:10.1093/sw/40.5.595
- Reamer, F. G. (2001). *The social work ethics audit: A risk management tool*. Washington, DC: National Association of Social Workers Press.
- Rhodes, M. (1991). *Ethical dilemmas in social work practice*. New York, NY: Routledge.
- Roback, H. B. (2000). Adverse outcomes in group psychotherapy: Risk factors, prevention, and research directions. *Journal of Psychotherapy Practice and Research*, 9(3), 113-122. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10896735>
- Roback, H., Strassberg, D., Iannelli, R., Reid-Finlayson, A., Blanco, M. & Neufeld, R. (2007). Problematic physicians: A comparison of personality profiles by offence

- type. *The Canadian Journal of Psychiatry*, 52(5), 315-322. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/17542382>
- Robson, C. (2002). *Real world research: A resource for social scientists and practitioner researchers* (2nd ed.). Oxford, MA: Blackwell Publishers.
- Rodwell, M. (1998). *Social work constructivist research*. New York, NY: Garland Publishing.
- Ross, J. (1995). The fate of relatives and colleagues in the aftermath of boundary violations. *Journal of the American Psychoanalytic Association*, 43(4), 959-962. doi: 10.1177/000306519504300402
- Royal Australian and New Zealand College of Psychiatrists [RANZCP]. (2013). *Homepage*. Retrieved from <http://www.ranzcp.org/>
- Ruskin, R. (2011). Sexual boundary violations in a senior training analyst: impact on the individual and psychoanalytic society. *Canadian Journal of Psychoanalysis*, 19(1), 106-223. Retrieved from <http://pep.gvpi.net/search.php?author=Ruskin%2C+R>
- Sampford, C., Blencowe, S., & Condlin, S. (Eds.). (1999). *Educating lawyers for a less adversarial system*. Leichhardt, NSW: The Federation Press.
- Sands, A. (2000). *Falling for Therapy*. London, England: Macmillan Palgrave.
- Satre, J. (1946). Existentialism is a humanism. In W. Kaufman (Ed.), *Existentialism from Dostoyevsky to Satre* (pp.287-311). Oklahoma: Meridian Publishing Company.
- Schoener, G., Milgrom, J., Gonsiorek, J., Luepker, E., & Conroe, R. (1989). *Psychotherapists' sexual involvement with clients: Intervention and prevention*. Minneapolis, MN: Walk-In Counseling Center.

- Schofield, M. (2008a). *Best practice self-regulation model for psychotherapy and counselling in Australia: Final report*. Melbourne, Victoria: Psychotherapy & Counselling Federation of Australia.
- Schofield, M. (2008b). Australian counsellors and psychotherapists: A profile of the profession. *Counselling and Psychotherapy Research*, 8(1), 1-4.
doi:10.1080/14733140801936369
- Schofield, M., & Khan, A. (2008). Australian women who seek counselling: Psychosocial, health behaviour, and demographic profile. *Counselling and Psychotherapy Research*, 8(1), 12-20. doi:10.1080/14733140801889097
- Schwartz, L. L., & Kaslow, F.W. (2001). The cult phenomenon: A turn of the century update. *The American Journal of Family Therapy*, 29(1), 13-22.
doi:10.1080/01926180126140
- Seys, D., Wu, A.W., Van Gerven, E., Vleugels, A., Euwema, M., Panella, M., ... Vanhaecht, K. (2012). Health care professionals as second victims after adverse events: A systematic review. *Evaluation and the Health Professions*, 36(2) 135-162. doi:10.1177/0163278712458918
- Simpson, K. (2007). Hearing voices: Negotiating multiple ethical commitments in development research. In M. Smith (Ed.), *Negotiating boundaries and borders: Qualitative methodology and development research* (Studies in Qualitative Methodology, Vol. 8, pp. 155-173). Oxford, England: Elsevier
- Simpson, R. (1998). *Initial responses to the Wood Royal Commission Report on Paedophilia* (Briefing Paper No. 08/1998). Retrieved from <http://www.parliament.nsw.gov.au/prod/parlment/publications.nsf/key/ResearchBf081998>

- Singer, M. T., & Lalich, J. (1996). *'Crazy therapies': What are they? Do they work?* San Francisco, CA: Jossey-Bass Inc. Publishers.
- Singer, M. T., Temerlin, M. K., & Langone, M. D. (1990). Psychotherapy cults. *Cultic Studies Journal*, 7(2), 101-125. Retrieved from http://www.icsahome.com/logon/infoserv_elib/elibrary_articles_byicsapub_culticstudiesjournal_07.02.asp
- Sloan, L., Edmond, T., Rubin, A., & Doughty, M. (1998). Social workers' knowledge of and experience with sexual exploitation by psychotherapists. *Social Work*, 43(1), 43-53. doi:10.1093/sw/43.1.43
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Speilrein, S. (2001). Unedited extracts from a dairy (1906/1907?) (trans. into English by P. Bennet & B. Wharton). *Journal of Analytical Psychology*, 46(1), 155-171. doi: 10.1111/1465-5922.00221
- Stacy, H., & Lavarch, M. (Eds.). (1999). *Beyond the adversarial system*. Leichhardt, NSW: The Federation Press.
- Strom-Gottfried, K. J. (1999). Professional boundaries: An analysis of violations by social workers. *Families in Society: The Journal of Contemporary Social Services*, 80(5), 439. doi:10.1606/1044-3894.1473
- Strom-Gottfried, K. J. (2003). Understanding adjudication: Origins, targets, and outcomes of ethical complaints. *Social Work*, 48(1), 85-94. doi:10.1093/sw/48.1.85
- Strom-Gottfried, K. J. (2004). *Ethics in social work practice: A primer*. Boston, MA: McGraw Hill.

- Strom-Gottfried, K. J. (2006, October 12). *Ethical actions in challenging times*. Chapel Hill, NC: The University of North Carolina School of Social Work. Retrieved from <http://ssw.unc.edu/files/EthicsLectureBooklet.pdf>
- Strom-Gottfried, K. J. (2007). *Straight talk about professional ethics*. Chicago, IL: Lyceum.
- Swain, P., & Bigby, C. (2009). Social security and welfare rights. In P. Swain, & S. Rice (Eds.), *In the shadow of the law: The legal context of social work practice* (3rd ed., pp. 339-359). Annandale, NSW: The Federation Press.
- The Clinic for Boundary Studies (2013). *Webpage – Homepage*. Retrieved from <http://www.professionalboundaries.org.uk/Home.aspx>
- The Government of the State of New South Wales. (1997). *Royal commission into the New South Wales police service: Final report* (Vol. 4, The Paedophile Inquiry). Retrieved from <http://www.pic.nsw.gov.au/files/reports/RCPS%20Report%20Volume%204.pdf>
- Therapy Exploitation Link Line [TELL]. (2013). *Webpage – Welcome*. Retrieved from <http://www.therapyabuse.org/>
- Toffler, A. (1991). *Powershift: Knowledge wealth and violence at the edge of the 21st Century*. New York, NY: Bantam Books.
- Tong, R. (1995). *Feminist thought: A comprehensive introduction*. London, England: Routledge.
- Trubek, L. G., Rees, J. V., Hoflund, A. B., Farquhar, M., & Heimer, C. A. (2008). Health care and new governance: The quest for effective regulation. *Regulation and Governance*, 2(1), 1–8. doi:10.1111/j.1748-5991.2007.00030.x
- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. London, England: Althouse Press.

- Walton, M., Smith-Merry, J., Healy, J., & McDonald, F. (2012). Health complaint commissions in Australia: Time for a national approach to data collection. *Australian Review of Public Affairs*, *11*(1), 1-18. Retrieved from http://www.australianreview.net/journal/v11/n1/walton_etal.html
- Waring, T., Hall, J., & Altmaier, E. (2008). *The regulation of psychology in Australia*. New York, NY: Oxford University Press.
- Wartenberg, T. (1990). *The forms of power: From domination to transformation*. Philadelphia, PA: Temple University Press.
- Whittemore, R., Chase, S., & Mandle, C. (2001). Pearls, pith and provocation: Validity in qualitative research. *Qualitative Health Research*, *11*(4), 522-537.
doi:10.1177/104973201129119299
- Wilkins, M., McGuire, J., Abbott, D., & Blau, F. (1990). Willingness to apply understood ethical principles. *Journal of Clinical Psychology*, *46*(4), 539-547.
doi:10.1002/1097-4679(199007)46:4<539::AID-JCLP2270460424>3.0.CO;2-0
- Willemyns, A. J. (2010). *Under the carpet: The politics and trauma of patient harm* (Unpublished doctoral dissertation). Queensland University of Technology, Brisbane, Australia. Retrieved from <http://eprints.qut.edu.au/46266/>
- Wincze, J. P., Richards, J., Parsons, J. P., & Bailey, S. (1996). A comparative study of therapist sexual misconduct between an American state and an Australian state. *Professional Psychology: Research and Practice*, *27*(3), 289-294.
doi:10.1037/0735-7028.27.3.289
- Wingenfeld -Hammond, S., & Freckleton, I. (2006). Being the subject of a complaint to a regulatory board. In S. Morrissey, & P. Reddy (Eds.), *Ethics and professional practice for psychologists* (pp.150-162). Melbourne, Victoria: Thomson Social Science Press.

World Health Organisation [WHO]. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva, Switzerland: World Health Organisation.

Yapko, M. D. (1994). *Suggestions of abuse: True & false memories of childhood sexual trauma*. La Jolla, CA: Simon & Schuster.