COMPLAINTS AND COMPLAINING IN COUNSELLING AND PSYCHOTHERAPY: ORGANISATIONAL AND CLIENT PERSPECTIVES

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Abstract

Complaints and complaining in counselling and psychotherapy have been largely ignored in the research literature. The research in this thesis used various methods to address different but related questions within this area. An in-depth analysis of the documentary archive of complaints made to the British Association for Counselling and Psychotherapy (BACP) was undertaken. Descriptive statistics were compiled relating to the Association's Professional Conduct Procedure and Article 4.6 procedure. Thematic analysis was used to examine allegations in complaints letters and the resulting categories were then used to produce descriptive statistics. An online questionnaire was developed to explore the reasons why clients do not bring formal complaints in cases where they have experienced poor or harmful therapy. Finally, in-depth semi-structured interviews were undertaken and analysed using interpretative phenomenological analysis to explore these themes in more detail.

The findings show that BACP has lower rates of complaints received and upheld than in comparable literature; male therapists are disproportionately represented among those complained about; and lay people are underrepresented as complainants. This is the first systematic research to examine therapy complaints in the UK in an area that has received minimal research attention internationally. The online survey found differences in reasons for not complaining between lay people and clients who are themselves therapists, while the interviews revealed a complex constellation of reasons for not complaining. These findings make an original contribution to debate about regulatory issues in counselling and psychotherapy and have implications for policy-makers as well as practitioners.

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A4.6	Article 4.6 Procedure
ACA	American Counseling Association
APA	American Psychological Association
BACP (formerly BAC)	British Association for Counselling and Psychotherapy (formerly British Association for Counselling)
BPS	British Psychological Association
CHRE	Council for Healthcare Regulatory Excellence
CPD	Continuing professional development
HPC	Health Professions Council
IPA	Israel Psychologists Association
IPN	Independent Practitioners Network
MCA	Member complained against
PCD	Professional Conduct Department
PCH	Professional Conduct Hearing
PCP	Professional Conduct Procedure
PHAP	Pre-Hearing Assessment Panel
UKCP	United Kingdom Council for Psychotherapy

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Introduction

There are currently an estimated 100,000 practitioners in Britain delivering psychological talking therapies (Mental Health Foundation et al, 2006). These practitioners go by a range of professional titles including 'counsellor' and 'psychotherapist'[1] and work in a number of sectors such as NHS primary and secondary care, the education sector, the voluntary sector and in private practice (Aldridge & Pollard, 2005). Their work deals with many issues such as relationship problems, bereavement or depression, and the clients they work with present with difficulties that range in severity from the worrying to the life-threatening. There is considerable demand for therapy to treat such difficulties, with one report suggesting that lack of access to psychological therapy contributes to an annual cost to the NHS of £338 million for antidepressant medication alone (Mental Health Foundation et al, 2006). The authors go on to argue that

> "Offering timely access to evidence-based psychological therapies could help to reduce these costs. It can help young people achieve better educational outcomes. It can help people stay in work rather than go on benefits. It can prevent unnecessary suffering among people of all ages, cultural backgrounds, and with a range of mental and physical health conditions." (p2)

Certainly, there is considerable research demonstrating that counselling and psychotherapy are helpful and effective interventions for clients, with one study finding that approximately 60% of psychotherapy clients improved to a clinically significant degree (Hansen et al, 2002). However, the picture is not entirely benign, and therapy can be harmful as well as helpful.

That therapy can have harmful effects is of concern to a range of stakeholders: individual clients; therapists; therapy organisations; legislators; and the wider public. The practice of

[1] Debate about whether there is a difference between the activities of counselling and psychotherapy is beyond the scope of this thesis. The terms *counselling(or)*, *psychotherapy(ist)* and *therapy(ist)* will be used interchangeably throughout when referring to the activity of psychological talking therapy and its practitioners.

counselling and psychotherapy is subject to increasing public scrutiny. Headline-grabbing cases in the press (Davies, 2007; Hinsliff, 2007; Strudwick, 2011; Strudwick, 2012) feed a public image of counsellors and psychotherapists as manipulative and dangerous, undermining confidence in the profession as a whole. Professional organisations may have confidence that such behaviour is restricted to a small minority, but without hard evidence it is difficult to challenge assertions of complacency from the press or campaigning groups, or to argue convincingly that there is effective protection of clients from those who would harm them.

Safeguarding the public from rogue practitioners with poor training or who are incompetent is one argument for a move towards statutory regulation of counselling and psychotherapy. The previous UK government produced a white paper (Department of Health 2007) that called for regulation because "what [counsellors and psychotherapists] do carries significant risk to patients and the public if poorly done" (p81). The prevalence of misconduct and harmful practice in counselling and psychotherapy is not known. Research into the nature and incidence of complaints may produce valuable information for the various stakeholders in the regulatory debate.

Since my counsellor training I have been interested in how practitioners make therapeutic and ethical decisions. How do I make decisions in the service of my clients when there is little certainty about what actions are helpful and therapeutic, or which might be harmful? My questions about this were the motivation behind my first research project into therapists' dilemmas (Symons & Wheeler, 2005), but my interest has led to further questions. What does good practice look like? What about poor practice? How can I be sure that I am avoiding poor practice and acting therapeutically when I make decisions about how I respond to my clients?

I am a psychodynamic counsellor and a senior accredited member of BACP. I have experience of working with clients in a range of settings including higher education, the voluntary sector and private practice. I work as a lecturer in psychodynamic counselling and psychotherapy, so I am involved with the professional training of counsellors and supervision of trainees. I have had considerable personal therapy and have never raised a

complaint against a therapist. As a client, a supervisee and a trainee, while I have experienced some painful, challenging and occasionally flawed responses from the professionals working with me, I have not had an experience that I would consider harmful or that would merit a formal complaint. As a practitioner I have not had a formal complaint raised against me, though I have made errors at times in my work that, had things worked out differently, might have led to someone wishing to complain.

The research detailed within this thesis has been conducted within these public and personal contexts and is informed by the researcher's experience as a therapy consumer and practitioner within the wider political landscape in which psychotherapy is conducted in the UK.

Structure of the thesis

Complaints in counselling and psychotherapy have received little direct research attention, but there is considerable research in areas that link to complaints. Chapter 1 examines the literature relating not only to the minimal amount of research into complaints, but also the nature of malpractice, issues of professional accountability, the therapists responsible and the clients affected. The literature review presents a detailed case for the research conducted for this thesis and highlights issues that informed the development of the research questions.

Chapter 2 considers the researcher's ontological and epistemological assumptions and discusses their role in the development of research questions and choice of research methods. These philosophical beliefs are examined in relation to researcher reflexivity and the process of considering ethical concerns that was central to conducting this research.

Chapters 3 and 4 comprise Part 1 of the research conducted for this thesis: an analysis of the archived complaints held by the British Association for Counselling and Psychotherapy (BACP). Chapter 3 describes the development of the research questions addressed within this project, and considers the methodological challenges associated with documentary

research. BACP's Professional Conduct Procedure and Article 4.6 process are described and illustrated, since understanding the details of these processes was an essential part of the research process. Ethical concerns specific to this project are considered and details of the research design and procedure are given.

Chapter 4 discusses findings from the analysis of BACP complaints, presenting descriptive statistics relating to the numbers of complaints, complainants, members complained against, outcomes and sanctions. In addition, detailed analysis of the nature of complaints is presented. Limitations of the research and implications of the findings are discussed.

Part 2 of the research investigates the reasons why some clients do not make formal complaints in cases of poor or harmful therapy, and this research is discussed in chapters 5, 6 and 7. The project comprised two stages: an online questionnaire; and face-to-face interviews.

Chapter 5 describes the process of developing research questions for this project, arising from findings in Part 1. Methodological considerations associated with the development of questionnaires and the use of online research methods are discussed, along with issues related to attempting to access a difficult to reach group of people. Ethical concerns, particularly in relation to conducting interviews, are discussed before the research procedure is detailed.

Chapter 6 presents findings from the online questionnaire, giving demographic information about respondents and the distributions of responses. Findings from principal component analysis are given and used to determine any differences in reasons for not complaining between different client groups. Chapter 7 presents findings from the analysis of the individual interviews. Both chapters include discussion of the limitations and implications of the findings.

Chapter 8 summarises the ways in which the research in this thesis contributes to the existing research and examines the significance of this contribution. Recommendations for the practice of psychotherapy, for professional organisations and policy-makers are made

based on the research findings. Finally, priorities for future research in this area are suggested.

Chapter 1 – Review of literature

> "Complaints are the most obvious examples of how things have gone wrong: that even if in the end the complaint is not upheld, clearly something has gone sufficiently wrong for things to get to such a point." (Jacobs, 2001, p50)

This chapter explores issues within the literature relating to misconduct in the practice of counselling and psychotherapy. Literature discussing the nature of malpractice, clients affected by this practice and therapists who practice poorly is examined. Research relating to complaints is evaluated with particular focus on the methodological challenges of undertaking research in this area. The chapter concludes with a summary of the issues that provided the starting point for development of the research questions addressed in this thesis.

The chapter draws on sources of empirical research, published accounts of cases of misconduct, and reports from professional organisations and government departments. Discussion of the literature is treated thematically as follows:

1. The risks inherent in counselling and psychotherapy.
2. Prevalence of sexual boundary violations, and literature relating to therapists and clients in cases of this type of misconduct.
3. Issues relating to professional accountability, its effectiveness and limitations in protecting members of the public and the standing of the profession.
4. Complaints research and what this contributes to understanding of malpractice.

The search strategy for this literature review involved the use of electronic databases accessed via Athens, including PsychINFO, PsychARTICLES and MedLine. In addition, professional reports from organisations such as the Council for Healthcare Regulatory Excellence (CHRE), British Association for Counselling and Psychotherapy (BACP) and the Health Professions Council (HPC) were accessed through online searches.

Counselling and psychotherapy: an inherently risky business?

> "Any intervention which is able to help can also, in the wrong hands, cause harm." (Stone, 2002, p79)

That some clients do not improve as a result of their therapy and, in some cases, get worse, has received far less research attention than its effectiveness (Cooper, 2008). However, research evidence supports the notion that therapy can have harmful effects. While rates of deterioration in no-therapy controls have been demonstrated to be less than 5% (Levy et al 1996; Lambert & Ogles 2004), there is some evidence to suggest that a significant number of clients deteriorate while in therapy, around 5–10%, and up to 10–15% in therapy with substance mis-users (Lilienfeld, 2007). Worryingly, one study found that approximately 20% of clients felt that something about their therapy was problematic or harmful (Levy at al, 1996). Alliance ruptures – "a tension or breakdown in collaborative relationship between patient and therapist" (Safran et al, 2002, p236) occur relatively frequently, having been identified in 11-38% of therapy sessions; they are seen by some as intrinsic to therapeutic work (Barrett et al, 2008). Alliance ruptures have the potential for poor client outcomes and to cause harm but, Safran and Muran (2000) argue, if the therapist pays sufficient attention to repairing such ruptures, there is the possibility of more positive outcomes.

Repairing ruptures becomes difficult in cases where clients withdraw from the therapist or the therapy (Safran & Muran, 2000), but this is not uncommon. Research demonstrates that clients tend to defer to their therapists by remaining silent about their negative reactions to their therapists and withholding criticism or by saying they agree when in reality they disagree (Regan & Hill, 1992; Hill et al, 1992; Rennie, 1994). Such deference is concerning as it increases the power invested in the therapist and therefore adds to the ingredients that can lead to harm of the client. Similarly, clients who terminate therapy prematurely tend to report satisfaction with their treatment, even when they have negative reasons for ending (Hunsley et al, 1999). There may be many reasons for clients behaving in this way, including fears that the therapist

may retaliate if challenged, because they are seen as the expert, or because the client feels powerless (Thompson & Hill, 1991; Hill et al, 1993).

Henkelman and Paulson (2006) argue that therapists must take responsibility for being aware of the elements in the alliance which prove hindering to the client, encouraging clients to share experiences of their therapy that would otherwise remain unspoken. This might be ambitious given that there is increasing research evidence to suggest that therapists have a skewed picture of their own effectiveness (Barrett et al, 2008). One research study showed that therapists tend to underestimate the possibility of the client worsening in therapy (Boisvert & Faust, 2006). In addition, recent research shows that therapists tend to overestimate their own effectiveness, with the majority in one study rating themselves on average in the 80th percentile (Walfish et al, in press). Research also suggests that therapists show a self-serving pattern in considering reasons why clients prematurely terminate therapy, preferring to attribute such endings to factors such as the client or setting or environment rather than to their own practice (Murdock et al, 2010); this supports Hunsley et al's (1999) earlier finding that therapists struggled to correctly identify clients' negative reasons for terminating therapy.

Harm in therapy can be caused in myriad ways: through the incompetence of the practitioner, giving rise to mistakes; poor practice; negligence; or malpractice. Palmer Barnes (1998) defines these as follows:

- Mistakes: "an unintended slip in good practice." (p47)
- Poor practice: "a failure of good practice, whether intentional or not." (p48)
- Negligence: "a want of proper care or attention and involves carelessness." (p51)
- Malpractice: "practice or behaviour that is intentionally, emotionally, financially, physically or sexually abusive." (p51)

These definitions include ideas both of intentional and inadvertent substandard practice. The concept of intent in harmful practice is further explored by Bond (2010) who discusses different areas of client exploitation and puts particular emphasis on the difficulties in defining exploitation of clients when it is "less premeditated or even wholly unintentional." (p131).

Both Bond and Palmer Barnes offer descriptions of different types of exploitation of clients. Financial exploitation occurs when arrangements with the fee are mismanaged or manipulated,

for example when there is a lack of clarity about costs incurred due to cancelled sessions. Emotional exploitation can be difficult to define, but may occur when "the counsellor's neediness is such that the client's needs are eclipsed, or under the pretence of working to meet the client's needs, the counsellor is really seeking satisfaction of her own." (Bond, 2010, p151).

Neukrug and Milliken (2011) point out that what is considered ethical or unethical practice develops over time, as attitudes change and in the light of research and changes in public and professional opinion. An example of this can be seen in Bond's discussion of "ideological exploitation" (2010, p131), a development of his ethical thinking which does not appear in the earlier edition of his book. This is defined as instances where the beliefs and values of the counsellor are imposed upon the client, perhaps in order to support those beliefs. He offers an example relating to the religious beliefs of therapists, but also discusses the issue of 'recovered memory' or 'false memory' of sexual abuse and how these issues can be worked with in a way that allows the therapist to reinforce their own beliefs rather than allowing for the exploration of the client's reality and meaning. He suggests that his views regarding ideological exploitation as a form of unethical practice may be controversial but argues convincingly for this to be considered alongside the areas discussed previously.

Malpractice through sexual contact in therapy is also discussed by both these authors. Palmer Barnes (1998) defines physical malpractice as when physical touch in therapy, which may be appropriate and therapeutic in some approaches, becomes exploitative through becoming sexual touch. Additionally, she introduces the concept of "institutional incest" (p57) which relates to sexual activity within training organisations where having sexual intercourse with the guru or leader is "part of the initiation" (p57).

Given the potential for harm it is surprising that malpractice has not received more research attention. If, as the existing research suggests, therapists have something of a Pollyanna view of their effectiveness in practice, underestimate the possibility of client deterioration in therapy, and take clients' deference in therapy at face value, then perhaps the need for research into harmful or anti-therapeutic effects of therapy is not evident to many. Castonguay et al (2010) argue that all therapists need to be informed in training that they could be responsible for

harmful therapeutic effects experienced by clients, but perhaps this is a problematic message that is difficult for therapists to accept.

Power, responsibility and boundaries

> "...the counsellor's personal commitment to being ethical is so important. One person's vulnerability creates a corresponding obligation on the other in their exercise of power and professional expertise." (Bond, 2010, p15)

By its very nature, psychotherapy requires a client to trust their therapist in order to be effective, and, by doing so at a time when the client is vulnerable, the therapist is given considerable power which can be used for good or ill (Bond, 2010). The privacy of the relationship, the openness involved in relating painful or troubling issues, and the level of intimacy in sharing deep feelings mean that an asymmetric power dynamic is inherent in the work, requiring careful management by the therapist (Martin et al, 2011). It is the practitioner's responsibility to ensure that this power dynamic is managed and maintained properly (Smith & Fitzpatrick, 1995). The therapist has an ethical responsibility to avoid harm to the client (BACP, 2010), but the therapist's misuse of power can be experienced as harmful and abusive by clients (Valentine, 1996).

Working within agreed limits and parameters – the boundaries of psychotherapy – is part of what enables therapeutic practice by providing safety for clients.

> "Boundaries are agreed limits, within which psychological safety is provided, and it is the responsibility of the therapist to maintain them. They may also be seen as implicit and explicit 'rules' which are part of the formal nature of all therapy. They protect both clients and therapists." (Kent, 2010, p1)

The exact nature of boundaries and the implications they have for the client and the therapy are matters of some debate (Harper & Steadman, 2003). The boundaries, originally called ground rules by Freud (1912), sometimes referred to as the frame (Milner, 1952; Gray 1994) or therapeutic space (Luca, 2004a), comprise concrete or overt elements (such as the actual fee

paid to the therapist), but also carry a symbolic function in the therapy (such as the idea that the fee also represents the emotional cost involved in having therapy). Some boundaries can usually be expected irrespective of the type of therapy offered. These include a private setting, an agreement about the scope and limits of confidentiality, the duration and frequency of sessions, managing breaks, and the end of the therapy. Some boundary issues will have different applications or relevance in different theoretical orientations (Kent, 2010). While the therapeutic use of physical touch such as a hug is acceptable in some humanistic therapies, for example, it would be regarded as inadvisable or taboo in other approaches (Tune, 2001). Similarly, therapist self-disclosure is not normally considered acceptable as part of psychodynamic practice, but some personal sharing by the therapist would be considered to be an essential component of the therapy by person-centred practitioners, under appropriate circumstances (Mearns & Thorne, 1988).

The impact of the differences between theoretical orientation and how boundaries are worked with in practice is a matter of some debate, particularly in relation to issues of harm in therapy. Anecdotal accounts suggest that person-centred counsellors are more likely to breach boundaries (Casemore, 2001), while psychoanalytic therapists are more likely to be punitive and withholding (Bates, 2006; Valentine, 1996). There is limited and somewhat contradictory research in this area. Borys and Pope (1989) found that psychodynamic therapists were the least likely to become sexually involved with clients. In more recent research, however, Jackson and Nuttall (2001) found that psychosocial therapists were least likely to engage in such behaviour. The amount of time between studies might account for this variation, as might methodological differences between the studies. But as Jackson and Nuttall state, the range of theoretical approaches is considerable and many practitioners identify with multiple approaches, making distinctions based on modality problematic.

Dilemmas of firmness and flexibility

> "...most clients will test the frame at some point, consciously or unconsciously. [...] At this point, theory and practice experience combine as the therapist faces a treatment dilemma in striking a balance between firmness and flexibility." (Symons & Wheeler, 2006, p20)

At the heart of discussion in the literature relating to therapeutic boundaries is debate around the need for flexibility as opposed to firmness in applying and maintaining those boundaries. Factors both internal and external to the therapy can challenge the boundaries (Luca, 2004). External pressures to the boundaries can come from the setting. The challenges of providing therapy in the health service (Jones et al, 1994; Kosviner, 1994; Zinovieff, 2004), statutory sector (Smith & Smith, 1994), education (May, 1994), the workplace (Hawkins & Miller, 1994; Tehrani, 1996; Carroll, 1997), voluntary agencies (Llewellin, 1994) and private practice (Fanning et al, 1994) have all received attention. Consideration has also been given to the implications of the setting for the frame in its entirety (Hoag, 1992; Milton, 1993; May, 1994; Warburton, 1995; Seaton, 1996) or its constituent parts such as confidentiality (Phillips, 1991; Davies, 2000), frequency of sessions (Mander, 1995) and fee practice (Monger, 1998). Internal pressure to the boundaries can come in the form of challenges from the client because while boundaries offer safety by making the intimate and often painful work of therapy possible, they also raise anxiety (Viderman, 1974; Gray, 1994; Luca 2004b).

In the face of challenges arising in the maintenance of boundaries, Gabbard and Lester (1995) suggest that they should be thought of as "a dynamic and flexible set of conditions" (p39). However, this view conflicts with other literature advising therapists to "ensure that as secure a frame as possible is offered to the client" (Warburton, 1995, p432). Mitchell (1993) recognises that securely held boundaries which are appropriate for one patient who experiences them as safe and containing, may not be so for another who may experience them as rigid, cold and brutal. As Gray states, "for some [the frame] might not be experienced as a safe place, but instead could feel like a prison" (1994, p12).

Wosket (1999) advocates boundaries which are appropriately "elastic" (p165), stating that "[f]ar from being unprofessional and unethical, flexible boundary management may

demonstrate a professional and unsimplistic attitude towards client care." (p165). Elasticity of boundaries is a concept that is supported by Luca (2004a) who also describes boundaries as "a gentle envelope" (p3), while Gutheil and Gabbard (1993) describe a "membrane around the therapeutic role" (p190). Exploring the significance of any boundary changes with the client is important and failure to address these changes can leave clients feeling unsafe (Gray, 1994). Therapists are also cautioned that consideration needs to be given to why the change has been made and to ensuring that it is in the interests of the client rather than the therapist (Kent, 2010). Research evidence supports the notion that "boundary extensions" such as phoning or visiting a sick client were positively associated with clients' perceptions of the benefits of therapy (Jones et al, 2003, p291). When combined with Cooper's conclusion (2008) that therapists who are willing to offer more than their clients might expect, or "go the extra mile" (p144), the argument for a flexible, responsive approach to holding boundaries is supported.

Gutheil and Gabbard (1993, p190) propose a differentiation between "boundary crossings" (where a change to the boundaries may have a benign effect) and "boundary violations" (where a harmful "transgression" of boundaries is made by the therapist). Norris et al offer more detail regarding these distinctions,

> "Boundary violations differ from boundary crossings, which are harmless deviations from traditional clinical practice, behaviour, or demeanor. … Neither harm nor exploitation is involved. Boundary violations, in contrast, are typically harmful and are usually exploitative of patients' needs – erotic, affiliative, financial, dependency or authority" (2003, p518).

Luca (2004b) points out that use of such language in itself suggests an orthodox view of boundaries where a strict adherence to the frame should be observed. However, the distinction between boundary crossings and violations is a useful one in considering the possible harmful effect of therapy upon clients.

The seemingly paradoxical requirements of boundary management — to be neither flimsy nor unbending — can cause difficulties for therapists in practice. Gabbard and Lester (1995) contend that in attempting to meet their clients' needs, therapists may make decisions that better meet their own needs and that this can lead to errors in managing boundaries. Dorpat

(1984) goes as far as to suggest that repeated frame errors on the part of the therapist are more significant in bringing about a premature termination of therapy than the client's pathology. The therapist's task is to maintain boundaries in a way that is responsive to the changing and unique needs of individual clients while also providing robust and safe conditions, but this can prove to be something of a challenge. Hermansson (1997) notes the considerable dilemmas that can arise for therapists in the management of therapeutic boundaries, while Symons and Wheeler (2005) argue that practitioners can experience great difficulty in resolving such dilemmas. Richards' research (2000) identified that when working with suicidal clients, therapists experience a huge pull to make changes to the boundaries which could be unhelpful or damaging to the client. Dilemmas and uncertainty can leave therapists feeling unconfident and incompetent; such feelings are associated with poor therapeutic processes and outcomes (Thériault & Gazzola, 2005).

So how do therapists resolve such dilemmas? This is difficult to know with any certainty as there is some suggestion in the literature that the realities of making changes to boundaries in everyday practice are seldom talked about, even though such practice might be commonplace. As Valerio states, "Boundaries get broken all the time in psychotherapy. [...] All psychotherapists know this; few of us admit or talk about it" (2004, p116). Abramovitch (2007) argues that such secrecy is rooted in feelings of shame and is a potential warning sign that the therapist's practice needs appropriate consultation and discussion. However, shame associated with managing boundaries might make therapists all the more reluctant to access the support of supervision (Celenza, 1998).

The dilemmas inherent in maintaining appropriate boundaries mean there is a danger the therapist may become rigid, unyielding and dogmatic (Luca, 2004b). Furthermore, increased public scrutiny of psychotherapy and a fear of potential litigation or complaints from clients can leave some therapists practising defensively (Clarkson, 2000). Many writers caution against this reactionary rigidity which may prove counter-productive or harmful to the client. McGrath (1994) and Hermansson (1997) contend that this is an unnecessary over-compensation which limits the therapeutic potential of counselling and argue that a dynamic engagement with boundary issues is vital to strike a balance which is both ethical and appropriately responsive to clients' needs. Valerio (2004) suggests that strict adherence to

therapeutic boundaries benefits the therapist rather than the client, while Owen (1997) argues that such practice in itself represents an abuse of power by the therapist. As Mollon states,

> "...it must be recognised that a rigid or dogmatic adherence to a strict psychoanalytic frame, in such a way that ordinary humanity and courtesy are compromised, can definitely be damaging – and can model not sanity but a brittle and anxious clinging to rules and procedure" (2004, pxiv).

Research into boundaries and their relationship to therapy outcomes is relatively meagre (Cooper, 2008). Boundary violations of a sexual nature such as kissing, fondling or having sex with clients are, unsurprisingly, strongly associated with negative perceptions of therapy (Jones et al, 2003). Interestingly, this research also demonstrated that instances where the therapist interacted socially with a client outside therapy sessions, what the authors term "social boundary violations" (p291), were unrelated to perceived outcomes, suggesting that clients did not feel that such behaviour was harmful to them.

Working appropriately with boundaries is considered to be a vital aspect of safe and effective therapy, but it is also one that is far from straightforward. Evidence for the usefulness of flexibility and responsiveness of boundaries is not an argument for therapy without boundaries. Similarly, the need for safety and robustness in holding the frame should not be interpreted as a case for punitive, rigid boundaries. Responsibility rests with the therapist to find a way of reconciling these seemingly contradictory requirements, but this can become problematic when therapists put their own needs before those of the client.

Sexual exploitation of clients

Sexual exploitation committed by people within caring professions, including counselling and psychotherapy, has received increasing media attention in recent years as public awareness of and concerns about the impact of such behaviour grow. A report by the Council for Healthcare Regulatory Excellence (CHRE) (Halter et al, 2007) highlights the comparative

absence of research into sexual boundary violations in therapy, when compared with other health professions. Nonetheless, sexual boundary violations represent the area of misconduct in counselling and psychotherapy that has received the most research attention.

Sexual exploitation of clients in therapy is variously described as 'sexual relations', 'sexual contact' and 'sexual boundary violations', but precisely how this might manifest itself is more difficult to define. The BACP Ethical Framework for Good Practice in Counselling and Psychotherapy states that

> "Sexual relations with clients are prohibited. 'Sexual relations' include intercourse, any other type of sexual activity or sexualised behaviour" (2010, p9).

In attempting to define sexual misconduct in psychotherapy, Palmer Barnes maintains that it runs the gamut from "intimate touch to full sexual intercourse" (1998, p56). Bond (2010) also considers sexual exploitation and highlights the difficulty in defining sexual activity, pointing out that the ambiguity of some activities such as kissing or hugging means that both the intention of those involved and how the contact is received and understood must also be considered. A hug from a therapist who intends to offer non-sexual warmth and comfort to a client could easily be experienced as unwanted, terrifying and sexually intrusive by a vulnerable client with a history of sexual abuse, for example. In spite of apparent therapeutic intentions, such an instance might reasonably be considered a sexual boundary violation given the therapist's responsibility for maintaining the safety of the therapy. Hetherington (1998) argues that physical touch is ambiguous in its nature, increasing the possibilities of confusion for therapist or client, and also points out that by offering physical touch a therapist can increase the power difference in the therapeutic relationship. Gender may contribute an additional dimension of confusion, with one research study finding that men are more likely to perceive sexual intent when touched by a woman than women are when touched by a man (Abbey & Melby, 1986). Gabbard and Peltz (2001) argue that any distinction between sexual and non-sexual boundary violations is arbitrary, as while there may be no physical contact, there can be an eroticised atmosphere that is fostered or allowed to continue with no attempt to consider its meaning in the therapeutic work.

The rationale for a prohibition on sexual contact in therapy is founded on clear evidence that clients on the receiving end of such activity experience serious and enduring psychological harm (Halter et al, 2007). Benowitz (1994) examined the experiences of female clients sexually abused by female therapists and found a raft of harmful effects including increased isolation, decreased trust, guilt and shame, and symptoms of post-traumatic stress disorder (PTSD). There were, however, some reported positive effects of the experiences including feeling more attractive and having learned about boundary issues in relationships. Luepker's study (1999) surveyed 87 women with problems relating to practitioner sexual misconduct and compared their recollections of difficulties before and after the misconduct, finding evidence of serious and long-lasting harmful effects. This study found increases in the incidences of major depressive order (from 40% prior to 93% post), suicidal ideation (from 38% to 80%) and suicide planning (from 24% to 58%). Luepker found that 95% of respondents met the criteria for PTSD, and respondents also reported feelings of self-blame and shame. Moreover, 67% reported harm to people close to them, especially children, as a result of their experiences in therapy. Somer and Nachmanil (2005) interviewed 24 people who had had sexual contact with their psychotherapists, reporting that participants viewed their experiences as either abusive or romantic, with those participants who described the contact as romantic indicating more positive perceptions of the experience, although the emotional well-being of this group deteriorated after the sexual contact finished, falling to below pre-treatment levels.

Brian Thorne: 'Beyond the Core Conditions'

The ambiguity of sexualised contact with a client is vividly illustrated by Brian Thorne's controversial paper, '*Beyond the Core Conditions*' (1987). In this essay, Thorne describes work with one client, Sally, with whom he worked for three years from 1980, after she presented for counselling with her husband, having experienced sexual difficulties in their marriage. Thorne gives details of a considerable range of unconventional practice such as taking them on for therapeutic work having previously known both Sally and her husband socially, changing to seeing Sally individually, changing the duration and frequency of sessions, and agreeing that she should attend a week-long residential event at which he was to be a staff member. He

recounts how over the course of the work with Sally, there was a considerable amount of physical touch such as touching her hand or wiping away her tears, but also including massaging her stomach, shoulders and buttocks. Later in the work he encouraged Sally to remove her clothes while with him on a number of occasions and, towards the end of their work together, he also removed his clothing and they had a naked embrace.

In Thorne's description of his unorthodox methods, he maintains that his practice required him to be honest, to have integrity and courage to act in this way in order to meet the therapeutic needs of the client. He suggests that the work was powerfully therapeutic for the client and states that the client's issues were resolved by the end of therapy. He argues that stretching the limits of the therapy in this way was necessary to achieve a positive outcome for the client who had previously undergone unsuccessful therapy.

Thorne recognises that his practice with this client is extremely unusual, but his belief is that he has engaged with his client both ethically and responsibly. The difficulty in assessing Thorne's behaviour – or that of any therapist who physically touches a client but stops short of sexual intercourse – is that when it is declared that the motive for such activity is to help the client, it is not possible to know with certainty whether this is true. He states,

> "...I believe that it is within the area of sexuality probably above all that it is most difficult for any human being to know with a reasonable degree of certainty whether there is a real caring for and loving of the other, or whether there is in fact more of a sense of fulfilling a personal need." (Thorne, 1985, p58)

He goes on to say that, "it is right and proper that we should be cautious for we know that our capacity for self-deception is great" (p72). It is difficult, however, to read his account without qualms that he is deceiving himself both about his motives and about the true impact of his actions.

Thorne's paper was published over 20 years ago and prompted considerable discussion and debate. Nevertheless, it continues to be controversial and was cited as recently as 2010 in public concerns about the lack of statutory regulation of counselling and psychotherapy (Newman, 2010).

A slippery slope?

> "…sexual misconduct usually begins with relatively minor boundary violations, which often show a crescendo pattern of increasing intrusion into the patient's space that culminates in sexual contact. A direct shift from talking to intercourse is quite rare; the "slippery slope" is the characteristic scenario." (Gutheil & Gabbard, 1993, p188).

Therapy is, of its very nature, an intimate activity and working with sexual feelings is part and parcel of that activity (Mann, 1997). There is evidence that therapists frequently experience sexual attraction to their clients (Pope & Tabachnik, 1993; Bridges, 1998; Giovaziolas and Davis, 2001; Fisher, 2004; Martin et al, 2011). But how should such feelings be managed and worked with appropriately? It has not always been accepted that sexual contact with clients is harmful (Pope, 1990a). This is echoed in the fact that research demonstrates considerable variability in therapists' attitudes towards what constitutes a sexual boundary violation, particularly in respect of more sexually ambiguous behaviours such as hugging (Halter et al, 2007). Martin et al (2011) found that while the therapists who participated in their research were in universal agreement that sexual activity between therapist and client is wrong, there was less clarity about some boundary issues such as touch, flirtation, or using fantasies about clients for their own gratification. In addition, while a prohibition on sexual relationships with current clients is clearly accepted (BACP, 2003), attitudes among therapists regarding whether or when such relationships with ex-clients constitute an abuse is less clear (Salisbury & Kinnier, 1996; Housman & Stake, 1999; Shavit & Bucky, 2004; Martin et al, 2011).

The lack of agreement regarding ambiguous boundary crossings can contribute to risk of harm in therapy when practitioners begin to engage in innocuous boundary crossings that lead to boundary violations of increasing concern and harm to the client – the "slippery slope" highlighted by Gutheil and Gabbard (1993, p188). The idea of a slippery slope is supported in a range of literature relating to sexual boundary violations. Client accounts include descriptions of a gradual erosion of boundaries leading eventually to sexual contact (for example, Anonymous, 2005; Richardson et al, 2008; 'Poppy', 2001). Halter et al (2007) contend that sexual boundary violations are more likely when other non-sexual boundaries are mismanaged

or distorted. This blurring of boundaries can begin with extending session times or making contact between sessions which might seem innocuous and well meant to both client and therapist (Gabbard & Peltz, 2001). The slippery slope model would suggest that the erosion of boundaries does not end there and, as Tjeltveit and Gottleib (2010) suggest, even with the best intentions therapists can slip into unethical behaviour. After initial boundary changes, the practitioner continues to deviate from the frame, subverting the therapy as the practitioner's needs become more of a focus (Celenza, 1998; Sarkar, 2004). Simon (1991) suggests that therapist self-disclosure is the most common boundary violation to occur prior to sexual boundary violations. The therapist then initiates physical touch such as hugging, then kissing, and then more overtly sexual touch (Hetherington, 1998).

The notion of a slippery slope has been questioned, however, and there are limitations in its helpfulness as a concept (Kroll, 2001). Descriptions of the slippery slope model in the literature can convey a sense of inevitability: that if a boundary is crossed, this will lead necessarily to sexual boundary violations. Gutheil & Gabbard (1993) point out that this is not the case, while Gottleib and Younggren (2009) dispute the idea of an unavoidable domino effect and argue for a more complex understanding of boundary crossings. Recent research with therapists who avoided serious sexual boundary violations with clients showed that practitioners who had engaged in minor non-sexual boundary crossings had interpreted this behaviour as a warning sign and had used their awareness to help them avoid more serious and harmful boundary violations (Martin et al, 2011). The concept of the slippery slope might be helpful in highlighting to therapists that a potentially therapeutic boundary crossing motivated by the needs of the client is not completely innocuous and requires reflection, particularly if further boundary crossings follow. As Simon (1999) suggests, violations are not the cause of mismanaged boundaries, but the symptom.

A more useful model involves placing boundary crossings on a continuum (Smith & Fitzpatrick, 1995; Gabbard & Peltz, 2001) ranging from non-sexual boundary crossings to boundary violations and sexual boundary violations. Such an idea can allow therapists to respond creatively and flexibly to the needs of their clients, without suggesting that by making a change this will somehow inevitably result in harm to the client. Similarly, the notion of a continuum encourages practitioners to consider their responsibility in making changes to the

boundaries, to be alert to warning signs in such behaviour and to take responsibility for not making further boundary crossings. An awareness of the significance of boundary crossings on a continuum can enable practitioners to reduce the risk of acting unethically by reflecting in depth on their practice (Simon, 1989; Gottleib & Younggren, 2009; Tjeltveit and Gottleib, 2010).

Paying attention to the boundaries to prevent violations suggests that the therapist involved wishes to avoid harming their client, but this may not always be the case. More flexible attitudes to boundary violations might serve to encourage those who are likely to commit them (Halter et al, 2007). The literature demonstrates that some therapists who commit sexual violations deliberately subvert the therapy by manipulating the boundaries in order to meet their own needs at the expense of the client, which increases their own power in the dynamic and serves to trap the client (Celenza, 1998). This experience of gradual entrapment is vividly described in client accounts (for example, 'Jones', 2010, 'Poppy', 2001). Such successive breaking of boundaries in this case has more in common with a grooming process through which the erosion of boundaries "serves to break down client resistance [to sexual contact with the therapist]" (Hetherington, 2000b, p15). This type of manipulative behaviour is also seen in perpetrators of child sexual abuse (Halter et al, 2007). In such cases, the concept of the slippery slope is once again unhelpful. While it can highlight a process whereby sexual contact with clients is made possible by a gradual erosion of the usual boundaries, the slippery slope suggests the therapist has no control over their management of boundaries, and hence allows the therapist to disown responsibility for any subsequent boundary violations.

The issue of sexual misconduct in counselling and psychotherapy has received greater research attention than any other area of malpractice, but it provides a useful lens through which these issues can be viewed more widely. Harmful effects to the client through exploitation are evident as is the scope for the therapist to use difficult and ambiguous aspects of therapeutic practice in the service of the client or in the gratification of their own needs. The reality of sexual misconduct demonstrates that some therapists do not uphold their responsibility to practise ethically.

Prevalence of sexual boundary violations

While discussion of malpractice in counselling and psychotherapy raises important issues about therapists' power and responsibility, it is unhelpful without any indication of how widespread such practice might be. Research into the prevalence[2] of misconduct as a whole is sparse, but sexual boundary violations have received some research attention, in spite of the problematic nature of conducting research in this area. Halter et al (2007, p36) found that studies attempted to determine prevalence within the health professions in a number of different ways:

- Analysis of reports of complaints or disciplinary proceedings
- Practitioner reports of colleagues
- Professionals self-reporting sexual contact with clients
- Client reports of sexual contact by therapists

Literature relating to the analysis of complaints or disciplinary proceedings is discussed in detail later in this chapter, while each of the remaining three areas is discussed below.

There have been several surveys of professionals regarding their experiences of working with clients who report having had sexual contact with previous therapists (PTS). A summary table of literature in this area relating specifically to surveys conducted with professionals within the talking therapies is shown at Table 1.

[2] As highlighted in Halter et al (2007), the terms *prevalence* and *incidence* are commonly confused. *Prevalence* is a measurement of all individuals affected by a particular phenomenon within a particular period of time, while *incidence* is a measurement of the number of new individuals affected by the phenomenon within a specific period of time. So, in relation to the material above, prevalence would give an estimate or calculation of the proportion of therapy clients who experienced sexual boundary violations in a given year, for example, and would be expressed as a percentage. This would include ongoing cases. Incidence would give the number of clients who had experienced sexual boundary violations for the first time in that year. Incidence conveys information about the risk of being affected by the phenomenon, whereas prevalence indicates how widespread the phenomenon is.

Table 1: Responses from professionals about clients who report having had sexual contact with a previous therapist (PTS).

Author & year of publication	Sample group; no of respondents	Findings
Gartrell, Herman, Olarte, Feldstein & Localio (1987)	5,574 randomly selected psychiatrists from American Medical Association register. 1,423 respondents (26%)	**65%** PTS. Relates to 3,031 patients (2,760 female).
Leggett (1994)	500 Fellows of Australia & New Zealand Royal College of Psychiatrists. 344 respondents (68.8%)	**68.7%** PTS. 50.3% had at least two patients disclosing this.
Parsons & Wincze (1995)	678 licensed therapists, Rhode Island, USA. 331 respondents (49%)	**26%** PTS.
Wincze, Richards, Parsons & Bailey (1996)	1,057: All psychiatrists, psychologists, social workers, therapists and counsellors in Western Australia. Compared with Parsons & Wincze (1995) study above. 479 respondents (48%)	**22%** PTS. Cultural and training differences between samples in the two studies, but similar findings.
Garrett (1998)	1,000 randomly selected members of the Division of Clinical Psychology of the BPS.	**22.7%** PTS. 38% reported knowing through different sources of other members who had sexual involvement with patients.

The studies show that between 22% (Wincze et al, 1996) and 68.7% (Leggett, 1994) of practitioners surveyed report treating clients or patients who disclosed having had sexual contact with a previous therapist. The wide variation in these studies' findings can be accounted for in methodological differences as no single clear definition of 'sexual contact' is used across the research papers. In addition, it is difficult to know whether professionals within each study are reporting knowledge of the same cases, which would lead to higher prevalence figures. The most recent study on the list, of clinical psychologists (Garrett, 1998) is the only research of this nature conducted in the UK.

Studies in which professionals are asked to report their own sexual behaviour with clients (SRSC) offer a particularly interesting and powerful insight into the prevalence of this kind of

malpractice, although they are not without their limitations. A summary table of literature in this area relating specifically to surveys conducted with professionals within the talking therapies is shown at Table 2.

Table 2: Responses from professionals self-reporting sexual contact with clients (SRSC), where sexual contact includes intercourse and/or non-coital erotic contact.

Author & year of publication	Sample group; no of respondents	Findings
Holroyd & Brodsky (1977)	1,000 from 27,000 PhD psychologists (USA) 666 respondents (66.6%).	**4%** SRSC, including **2%** sexual intercourse. 4.1% reported intercourse with former patient within 3 months of therapy termination.
Pope, Levenson & Schover (1979)	1,000 American Psychological Association members. 481 respondents (48.1%).	**7%** SRSC.
Gartrell, Herman, Olarte, Feldstein & Localio (1986)	5,574 randomly selected psychiatrists from American Medical Association register. 1,423 respondents (26%)	**6.4%** SRSC, n=84. Involved a total of 144 patients and multiple occurrences for some respondents.
Gartrell, Herman, Olarte, Localio & Feldstein (1988)	1,113 psychiatry residents (doctors) on AMA register. 548 respondents (49.2%)	**0.9%** SRSC. 72.1% reported sexual attraction towards a patient.
Akamatsu (1988)	1,000 randomly selected psychotherapists from APA register. 395 respondents (39.5%)	**11%** reported intimate relationships with former clients. Average time between end of therapy and start of relationship = 15.6 months.
Thoreson, Shaunessy & Frazier (1995)	1,000 randomly selected female ACA members. 377 respondents, (37.7 %)	**0.7%** SRSC.
Lamb & Catanzaro (1998)	1,000 randomly selected APA registrants. 596 respondents (59.6%)	**8%** SRSC with at least one client. 69% of these after the termination of therapy.
Harris (2001)	375 psychotherapists & social workers in Alaska. 151 respondents (43.5%).	**4%** SRSC with current clients. **6%** SRSC with former clients.
Lamb, Catanzaro & Moorman (2003)	1,000 randomly selected APA registrants. 368 respondents (36.8%) Repeat of Lamb & Catanzaro (1998) study above.	**3.5%** SRSC with at least one client. 57% of these after termination of therapy.

Once again, these studies demonstrate considerable variation in their findings, with rates of therapists disclosing sexual contact with patients ranging from 0.7% (Thoreson et al, 1995) up to 11% (Akamatsu, 1988). It remains difficult to make comparisons across these studies, however, given differences in sampling and survey instruments, as well as different definitions of sexual contact. Broadly there appears to be a trend towards lower numbers in the more recent studies. To date, no studies of this sort have been conducted in the UK.

Halter et al (2007) highlight that studies such as these, which rely upon self-reporting of breaches of professional conduct, are likely to result in underestimates of prevalence as there are many reasons why respondents might not admit to such behaviour, even when anonymity is assured. Similarly, they comment that an apparent reduction in prevalence rates over time coincides with increased guidelines from professional organisations regarding misconduct of this kind, and greater awareness among practitioners of the penalties they might open themselves up to if this kind of behaviour is discovered. It is difficult, therefore, to determine whether lower prevalence indicated in the more recent studies reflects a lower incidence of sexual contact with clients, or, as suggested by Halter et al (2007), a greater sense among perpetrators of the need for secrecy and deception to avoid penalties imposed by professional organisations.

A small number of papers attempt to explore prevalence by asking clients about their experiences of sexual contact with therapists (SCT). A summary table of literature in this area relating specifically to surveys conducted with professionals within the talking therapies is shown below at Table 3.

Table 3: Responses from clients regarding sexual contact with therapists (SCT).

Author & year of publication	Sample group; no of respondents	Findings
Jacobson & Richardson (1987)	100 psychiatric patients. Interviewed and full histories taken.	**81%** SCT.
Armsworth (1989)	30 women who reported incest in adolescence or childhood and had sought psychological therapy. Individual interviews.	**23%** SCT.
Lamb & Catanzaro (1998)	1,000 randomly selected APA registrants. 596 respondents (59.6%) Sample also asked whether they had had sexual contact with their own therapist, supervisor or trainer.	**12%** SCT.

Methodological issues probably account for the huge variation in reported figures between these studies and make it extremely difficult to draw conclusions about prevalence from them. Studies which use interviews have chosen convenience or purposive samples and cannot be seen as representative. Nonetheless, the Lamb and Catanzaro (1998) study is interesting in highlighting that a number of therapists who are or who have been clients of therapy themselves have experienced sexual contact from their own therapist, supervisor or trainer. There are no comparable studies conducted within the UK.

Prevalence of sexual boundary violations and, by extension, of other forms of misconduct in counselling and psychotherapy is problematic to research and difficult to determine. A wide range of methodological issues mean that there is considerable variation in findings relating to prevalence, although there appears to be a trend towards lower figures in more up-to-date studies. Whether this downward trend is due to improvements in practice and a genuine reduction in incidence of sexual malpractice is a matter of debate.

Therapists who harm

> "...therapists who abuse [...] are essentially lonely and depressed individuals with a deep antipathy towards the practice of psychotherapy." (Hetherington, 2000a, p284)

If therapy itself has inherent risks, what part does the therapist play when the work becomes harmful to the client? Is there, as Hetherington suggests, a model of a typical abusive therapist?

There are some detailed attempts to classify the characteristics of therapists who have engaged in sexual boundary violations, although much of this is drawn from the clinical impressions of those who have worked with transgressors or from accounts in the literature rather than from empirical research. Descriptions of perpetrators of sexual boundary violations concentrate either on offering one profile of a typical therapist who has committed sexual boundary violations, or suggest a range of characteristics of these therapists. Each of these types of descriptions will be considered separately and compared.

The idea of a profile of a typical therapist who violates sexual boundaries in therapy allows for a brief summary of characteristics that might identify such a practitioner. According to Smith and Fitzpatrick (1995),

> "...the most common profile to emerge is that of a middle-aged male therapist who is professionally isolated and is currently undergoing some personal distress or midlife crisis, often including marital problems." (p504)

Although a number of authors attempt broader descriptions of the characteristics of perpetrators of therapist abuse, two papers offer detailed and comprehensive breakdowns of abuser typology. Based on their work with over 1,000 perpetrators, Schoener and Gonsiorek (1988) describe six categories of therapists who commit sexual boundary violations, and offer a framework for assessing whether individual therapists might be rehabilitated back into therapeutic work with clients, as well as discussing options for how this might be achieved. Gabbard and Lester (1995) based their categories on a much smaller group of therapists (70),

and propose four types of abusers, with briefer thoughts on possible rehabilitation. The types described share many characteristics, summarised in Table 4.

Table 4: Types of perpetrator of sexual boundary violations.

<table>
<tr><th>Gabbard & Lester (1995, pp92-121)</th><th>Schoener and Gonsiorek (1988, pp227-8)</th></tr>
<tr><td>No equivalent</td><td>Uninformed and naive
Typically trainees or poorly trained
Lack of understanding about boundaries and ethics
Lack of understanding that sexual contact with clients is harmful and unethical
Rehabilitation possible, but with difficulty</td></tr>
<tr><td colspan="2">Lovesickness ⟷ Healthy or mildly neurotic
Majority of analysts who become involved with clients
Therapist under extreme stress of life events such as divorce or bereavement
Professional isolation, lack of contact with others
Frustration at therapist's needs not being met in personal relationships
Feelings of euphoria, intense feelings of love, judgement and reality testing become impaired
Sexual activity takes place, but often report that sex was not the point
Usually isolated cases – sexual activity tends not to extend to other clients
Therapist is usually aware of the implications of their actions and might self-report
Considered good candidates for rehabilitation due to capacity to take responsibility for actions and to seek help</td></tr>
<tr><td colspan="2">Masochistic surrender ⟷ Severely neurotic
A tendency to choose clients who are very difficult to treat who other therapists have given up on
Clients' demands are experienced as tormenting
Therapists' difficulties with their own aggression makes it difficult for them to set limits
Over-identification with the client's suffering
Marked and enduring emotional difficulties such as low self-esteem or depression
Feelings of guilt lead to self-punishing or self-sacrificing behaviour
"Going out in a blaze of glory" (Gabbard & Lester, 1995, p116)
Disagreement about whether such therapists will seek help
Rehabilitation is "theoretically feasible", but the "prognosis is more guarded" (Schoener & Gonsiorek, 1988, p228)</td></tr>
</table>

(Table continued below)

Predatory psychopathy and paraphilias ⟷ Character disorders with impulse control problems
Sociopathic or narcissistic character disorders

- "These predatory clinicians are not rare" (Gabbard & Lester, 1995, p94)
- Harm to several clients
- Involves sadistic or perverted acts, can attract media attention
- Therapist may have been identified in training as dishonest or unethical, but difficult to address as legal or other action is taken by the therapist
- Narcissistic
- Perhaps risen to top of profession
- Can get away with unorthodox practice because of reputation and status
- Described as cunning and master manipulators of clients and colleagues
- Charismatic and expert at presenting a plausible appearance of ethical and professional behaviour
- Not good candidates for rehabilitation although they may appear to co-operate and can mimic good emotional health

Psychotic disorders ⟷ Psychotic or borderline personality disorders

- Considered rare
- Sexual contact with clients takes place at a time when the therapist experiences their own psychotic breakdown, or ability to perceive reality is impaired
- Psychosis would be likely to be apparent outside the therapy room
- Unpredictable response to the sexual contact coming to light – might confess, might deny
- Rehabilitation considered unlikely to succeed

The view that therapists who abuse are qualitatively different from the non-abusing majority is tempting but problematic. Described by Norris et al (2003) as a "bad apple" model (p518), this idea simplistically attributes abusive behaviour to a small number of individuals who can be identified and eradicated from the field in order to protect the integrity of the majority who are not susceptible in the same way. While the categories listed above highlight the differences in the ranges of characteristics and motivations of therapists who commit sexual boundary violations, Levine (2010) points out that nearly all these types share some characteristics: issues to do with narcissism; and a propensity for acting on their impulses rather than reflecting on them. He suggests that all therapists will share some of these characteristics on a spectrum of difficulty, saying that, "...each of us contains powerful unconscious forces that can drive us towards boundary crossings and boundary violations" (p50).

Research shows that only a small minority of therapists commit sexual boundary violations, but the contemporary view contends that it is unhelpful to think that all therapists are not vulnerable to experiencing difficulties with boundaries (Norris et al, 2003). Sherman and Thelen (1998) demonstrate a high correlation between the level of distress experienced by therapists through life events and the level of impairment to their therapeutic work, a conclusion supported by Luchner et al (2008). Norris et al (2003) state that denial of such potential difficulties – "This couldn't happen to me" (p517) – is also a factor in the continuance of sexual boundary violations. They caution all therapists to be aware of "trouble spots" (pp518-20) such as:

- Life crises, particularly (although not exclusively) in mid-life or later life
- Transitions, such as changes in jobs or changes in financial circumstances
- Illness of the therapist
- Loneliness, resulting in the therapist seeking a 'sympathetic ear'
- Idealisation of clients, particularly seeing a client as 'special'
- Pride, shame and envy which can contribute to a view that the usual rules do not apply
- Problems setting limits, particularly in the face of testing of boundaries by clients
- 'Small town' issues when working in smaller communities where dual relationships or contact outside the therapy may be more likely to occur
- Denial – ignoring or minimising the significance of boundary issues early on

They contend that boundary difficulties are universal issues for therapists and that, as such,

> "clinicians young and old, and in all settings, must overcome their understandable but damaging reluctance to fully examine this topic in every setting" (p522).

Research conducted by Schröder and Davis (2004) supports the idea that all therapists will experience difficulties in their work at different points in their careers. How these difficulties are dealt with by the practitioner is important, as mishandling or ignoring them can disrupt the

therapy or lead to a poor outcome. Their work categorised therapists' difficulties in practice into three main types (pp331-2): transient difficulties, linked to the therapist's level of experience and characterised by a lack of knowledge or skills; paradigmatic difficulties, which relate to aspects of the therapist's personality that may be unique to them; and situational difficulties linked to external circumstances that the therapist has no control over, and struggling with clients that therapists at all levels of experience would encounter difficulties with. The concept of transient difficulties relates to practice which is unintentionally harmful, characterised by "benign intent backed by insufficient knowledge and experience" (Walker, 2001, p121). There is scope for such difficulties or mistakes (Palmer Barnes, 1998) to be addressed through training and personal development. Thériault and Gazzola (2005), however, note that lack of experience and knowledge is not the only factor in practice difficulties. Therapists' feelings of stress, distress and incompetence, often linked to personal issues (such as situational difficulties described above) can adversely affect their practice. They argue that the susceptibility of therapists to such feelings means that they need to be active about self-care throughout their careers.

The question of rehabilitation

The issue of how to respond to therapists who have committed sexual boundary violations is contentious. Schoener and Gonsiorek (1988) propose a process for in-depth assessment of therapists found to have violated sexual boundaries in their practice to determine whether rehabilitation might be possible and, if so, how this might be achieved. They highlight that rehabilitation is not always possible (as shown in Table 4) and in such cases the therapist should be supported out of the profession, perhaps being offered career counselling to help them identify alternative options. In cases where rehabilitation plans are developed, the authors recommend that therapists are closely monitored by the professional organisation and reviewed to check compliance in assessing the success of the plan. Rehabilitation plans can comprise a range of interventions including: personal therapy; limitations on practice, such as not working with particular categories of client; supervision (lifelong supervision is not the norm in the USA); further training; change to therapeutic style, such as a requirement to

refrain from physical contact of any kind with clients; and organisational changes, such as amending policies and guidelines in the therapist's work setting.

Some writers argue, however, that true rehabilitation is not possible. Hetherington (2000a), for example, states that there is no research evidence that rehabilitation plans effect permanent change. Some research suggests that recidivism rates among therapists who have committed sexual boundary violations are as high as 80% (Pope, 1989). There is evidence that using training or additional personal therapy might be positively linked with the tendency to abuse (Pope, 1990b). In addition, low numbers of clients who come forward in cases of sexual misconduct in therapy, and evidence that even close scrutiny of a therapist's work in supervision is no guarantee that the therapist is not engaging in such practice, mean that it is unlikely that supposedly rehabilitated therapists who reoffend would be discovered (Pope, 1989). This suggests that rehabilitation potentially exposes future clients to harm as it allows the therapist to continue to practise in spite of evidence that they have not been able to manage boundaries and protect clients appropriately.

Hetherington (2000a) argues that the idea of rehabilitation of therapist abusers affords the perpetrators protection from punishment for their actions and from facing the consequences of their actions. Pope (1989) asks whether rehabilitation should be an option at all or whether such behaviour is serious enough to preclude any further practice with clients. He suggests that organisations responsible for standards in psychotherapy and counselling can be left open to criticism when allowing therapists who have committed sexual boundary violations to be rehabilitated. By implicitly tolerating risk of harm to clients, the organisations demonstrate a lack of integrity or accountability, and Pope urges therapists collectively to uphold a higher standard.

The search for a typology of therapists who abuse clients is an attractive idea; if successful, it might allow the profession to identify such practitioners and remove them from practice,

thereby protecting the public effectively. Contemporary thinking, nonetheless, recognises that all therapists are susceptible to difficulties that can lead to poor or harmful outcomes for clients, a model that requires individual therapists to take responsibility for self-care and to monitor whether their practice is impaired at times of stress. However, work to identify therapist characteristics can contribute to debates about the appropriateness and nature of rehabilitation in cases of malpractice.

Client experiences

> "Clients can never be entirely objective about their own therapy, but that does not mean that their point of view has no general value. Without it, any scrutiny of therapy will not be a truly balanced one." (Sands, 2000, pvii)

There are a number of accounts written by clients detailing their experiences of harm while in therapy and these fall into several broad themes. Descriptions of sexual abuse by therapists feature heavily, painting a shocking picture of manipulative therapist behaviour.

> "…he immediately put his arms around and held me very tightly. […] He released his arms and touched my nose with his finger, which seemed to me a rather romantic gesture and I began to feel very apprehensive at what he was going to do to me. He held me again, tighter this time and said, "I know what you need is to be taken to bed, but I'm afraid that is out of my jurisdiction". He continued to hold onto me as if waiting for an answer. As he pressed against me, again, I could feel his erection." (Richardson in Richardson et al, 2008, p119)

Accounts of sexual contact also include descriptions of harassment and relationships in therapy when the client was a member of a training institution (Anonymous (a), 1991; Anonymous (b), 2005), linking to Palmer Barnes' concept of institutional incest (1998). The majority of accounts describe instances of sexual contact with therapists, of sexual relationships that took place during therapy or after therapy had ended or had been ended abruptly by the

therapist in order to allow the sexual relationship to begin. These accounts demonstrate a range of boundary crossings and violations that took place prior to the sexual contact beginning, lending some support to the notion of the slippery slope and painting a chilling picture of a process of manipulation or grooming that has been discussed earlier.

> "…my experience all began with such tiny breaches of the counselling codes of ethics, that gently and gradually escalated to a point of no return." ('Poppy', 2001, p8)

Another theme from clients' accounts of poor therapy is of experiencing their therapist as aggressive and bullying, describing behaviour seen as attacking and harmful.

> "…I wrote a letter before my visit in which I laid out my reasons for needing to see her. My letter must have really upset her for some reason because immediately I walked in to her consulting room she became angry. It was horrible. It is still indescribable. I didn't expect such a reaction. She even accused me of trying to destroy the relationship" (Schepisi, 2006, p56).

Other experiences include therapists who behaved in changeable, unpredictable and unreliable ways agreeing to offer a hug, for example and then refusing to do so without any explanation. This kind of behaviour left clients feeling confused and betrayed.

> "During one of our first sessions I asked her if she ever hugged clients and she replied, "You only have to ask". I had a hug the next session but the following week she said she couldn't offer me any further hugs for the time being. For the rest of the time I was seeing her I kept trying to change her mind again…" (Field, 2008, p87)

Another aspect of work described in these accounts is of developing excessive levels of dependency on the therapist; the relationship with the therapist is felt to be special and begins to exclude other areas of support, cutting the client off from other people around them and focusing entirely on the therapist, and the therapist fostering this.

> "He asked to see my childhood photos; and we talked at length about my relationship with my mother. He said I should cut the apron strings and be more independent and assertive. As a result of this I had a huge argument with her and we fell out." (Adams, 2008, p124)

The final theme found in these accounts is that of the therapist being ineffective rather than abusive. The therapist did not seem to be able to work in a way that could reach the issues that the client needed to explore.

Client risk factors

Client characteristics and vulnerabilities in cases of misconduct are worthy of investigation, but there is limited research in this area, most of which relates to sexual misconduct. Responsibility for sexual boundary violations rests with the therapist and consideration of client risk factors should not undermine this view but can provide useful information to therapists about the potential difficulties that might arise in therapeutic practice (Pope, 1990b). Research points to some client factors associated with risk of sexual misconduct, although Halter et al (2007) state that these factors cannot be understood to be predictors of sexual boundary violations. Women form the majority of victims in reported cases of sexual boundary violations (Halter et al, 2004), although Hetherington (2000b) points out that this finding may be skewed due to male clients not reporting incidences of abuse. Kluft (1990) researched 18 clients (1 male and 17 female) who were incest victims with dissociative disorders and who were subsequently sexually exploited by their psychotherapists. This research found that the clients displayed many similar characteristics, such as being unable to perceive or respond to dangerous situations, which may mean that such clients are more likely to experience revictimisation in their therapy. Similarly, Armsworth's qualitative study (1990) looked at six women, again with histories of incest, who had subsequently been sexually involved with 'therapists' (three were psychiatrists, the remainder were clergy) and identified a possible link between the effects of the earlier abuse and their vulnerability in a therapeutic relationship. Somer and Saadon (1999) highlight clients' existing vulnerabilities to possible sexual exploitation in therapy, including past trauma such as childhood abuse. Similar aspects of vulnerability in clients were found by Disch and Avery (2001), BenAri and Somer (2004) and Frueh, Knapp et al (2005).

As well as existing difficulties which might increase their vulnerability to sexual boundary violations, Hetherington (2000b) points out that clients' preconceptions of the therapy also play a part, as they will be hoping and expecting the therapist to help them and will tend to co-operate with the therapist in the hope of receiving that help: "Faced with a therapist with whom they increasingly invest their time and feelings, as they once did with parents over whom they had no choice, they enter into collaboration, accommodating therapist errors with introjections." (p15). Brodsky (1985) suggests that clients tend to repress their awareness of the sexualised nature of therapists' behaviour until it reaches a point of undeniability. This can be seen in 'Poppy's' account of her experiences in therapy,

> "During this time he brought up the subject of sex. He spoke at length on the subject, in a kind of caressing and gentle tone. The atmosphere in the room seemed to me to be electric, and yet as always, I told myself that it was probably part of the therapy, and any other interpretation was possibly just my imagination." ('Poppy' 2001, p2)

The combination of conditions inherent in therapy along with therapist characteristics, as well as clients' tendency to defer to their therapists (Regan & Hill, 1992; Hill et al, 1992; Rennie, 1994) and any existing vulnerabilities in the client relating to past abuse, allows a picture to emerge of a complex constellation of factors in sexual boundary violations.

Impact on clients

> "Overall, [my first experience of therapy] left me with a pervasive and lingering sense of fragmentation, distraction and anxiety. [...] The memory of the trauma to which the therapy led, however, remains, and, in particular the hurt it caused. Had I not left when I did, the subsequent feeling of being both mentally dislocated and emotionally skinned alive might have been less intense, but who can say what might have happened if I had stayed?" (Sands, 2000, pp198-9).

Halter et al (2007) highlight that sexual boundary violations have lasting and demonstrable harmful effects on clients. In the foreword to a collection of client accounts of abuse in therapy, Schoener (2008) compiles a list of harmful effects as described by the clients:

- Not receiving the help that was originally sought.
- Trust in professionals is damaged, making it harder to seek help in future.
- Needing further therapeutic help because of the harmful effects of abusive therapy, including depression, anxiety and post-traumatic stress disorder.
- Suicide.
- Damaging effect on relationships including partner relationships and relationships with children.
- Low self-esteem and confidence.
- The impact of long and complicated complaints processes.

Accounts from clients offer a vivid contribution to knowledge about the impact of poor or harmful therapy, describing traumatic and lasting effects. Jones (2010) describes enduring effects of a long-term sexual relationship with her therapist, including depression, isolating herself from the support of friends and family, and difficulty in trusting the therapeutic help on offer from other therapists. As she says, "Years later, sex with my analyst continues to have a disastrous effect." (p658). The harmful effects of misconduct are not confined to the therapy room. Anonymous (a) (1991) describes an experience of sexual harassment by a counselling tutor/supervisor while she was in training that she says,

> "...has changed my life forever. I know that although the trauma has lessened considerably, it will never disappear." (p506).

Client accounts such as these support findings from research about the harmful impact of sexual boundary violations as discussed earlier in this chapter, but they also illustrate the adverse effects of non-sexual boundary violations, an area that has received minimum attention in the research literature. They offer powerful insights into therapy that has clearly gone badly wrong from the client's point of view and, as such, offer useful points of learning for therapists who wish to avoid such outcomes. Client support groups argue that publishing their accounts is a way of empowering clients who have been silenced and who feel that they have little or no redress for what has happened to them. In addition, these accounts offer other members of the public access to information about possible danger signs in therapy and have the potential to raise awareness of the issue of malpractice.

Professional accountability

> "When therapists abuse, the accrediting, training and employing organisations are all to some extent accountable." (Hetherington, 2000b, p20)

Counselling and psychotherapy are not currently regulated by statute in the UK, meaning that there is no legal requirement for anybody who wishes to work as a counsellor or psychotherapist to have had appropriate training or to adhere to any ethical standards for their practice. There are a number of professional bodies representing counselling and psychotherapy in the UK, the major ones being BACP and the United Kingdom Council for Psychotherapy (UKCP). Many of these organisations seek to raise standards by developing guidelines for standards of training, codes of ethics and practice, by raising the profile of counselling and psychotherapy for the public, and by acting as a point of contact for information. Practitioners who wish to be associated with the values of the organisation may apply to join and, after demonstrating that they have achieved the specified training and

experience, can apply for registration or accreditation. An additional feature of such bodies is that they set out the parameters for good practice in codes of ethics and practice or similar documents. Members of the organisation must agree to abide by these codes and can be investigated if an allegation is made that the codes have been breached.

While there are numerous such bodies, BACP is the UK's largest member organisation for counselling and psychotherapy, with a membership in excess of 36,000. In the past it has produced a range of codes of ethics and practice to reflect the different counselling and counselling-related activities undertaken by its members: counselling (BAC 1984; 1990; 1992a; 1997a); supervision of counsellors (BAC 1988; 1996a; 2000); training counsellors (BAC 1985; 1995; 1996b; 1997b); and using counselling skills (BAC 1989; 1999; 2000). These codes set out elements of good practice and specified aspects of work that were not allowed, as well as detailing the procedure for bringing complaints and for investigating allegations of malpractice. Over time, the codes received minor amendments, such as the inclusion of clauses relating to oppression and difference, as ideas about good practice developed. In a similar way, the Complaints Procedure has undergone change and amendment over the years (BAC 1986; 1991; 1992b; 1994; 1998).

More recently, however, these multiple codes which were often specific and prescriptive, were dropped in favour of one, over-arching document, the Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP, 2003, 2007, 2010). This document differs from the previous codes not only because it applies to all members irrespective of their counselling activity, but also in its nature. Rather than relying on prescriptive statements about what constitutes appropriate and ethical practice, the Ethical Framework instead details the qualities required by practitioners to work ethically and the kinds of ethical and practice issues that require careful management, while encouraging practitioners to think carefully about their practice.

If something goes irreparably wrong in therapy (or supervision or training), clients can seek redress through bringing a complaint against their therapist to the organisation in which they work, such as the NHS, or to the relevant professional body. However, of the estimated 100,000 practitioners in Britain delivering psychological talking therapies, fewer than half are members

of one of the major professional organisations that set standards and provide codes for ethical practice (Aldridge & Pollard, 2005). If the therapist does not work for an organisation or is not a member of a professional body, then the client has neither redress nor a formal means of raising concerns about the therapist. It might be that in such circumstances a client would choose to take civil legal action against a therapist, but such action would be costly and difficult (see Power, 2002, for example). Furthermore, finding out which professional body a therapist is a member of is a potentially arduous and confusing task if the therapist has not made their professional affiliation clear.

The previous Labour government sought to regulate the psychological therapies to ensure that anyone calling themselves a counsellor or psychotherapist would be registered and subject to agreed professional standards of proficiency. Thus the government white paper 'Trust, Assurance and Safety - The Regulation of Health Professions in the 21st Century' (HMSO, 2007) was produced which initiated the process of regulation through the Health Professions Council (HPC). The HPC has a robust complaints procedure that would provide a forum through which dissatisfied clients and customers could register their discontent with the treatment they received from registered members. The recently published command paper 'Enabling Excellence' (DoH, 2011) states that statutory regulation will no longer be pursued, instead making use of enhanced voluntary registers. The document states that the government intends to make the Council for Healthcare Regulatory Excellence (CHRE) the national accrediting body for health professionals who are not currently regulated by statute.

Whatever the outcome of government proposals and whether counselling and psychotherapy remain self-regulated or ever become regulated by statute, the effectiveness of processes for addressing malpractice and misconduct will continue to come under scrutiny. As Pettifor and Sinclair state,

> "The very existence of an ethical complaint process raises questions of its effectiveness in assuring protection of others from unethical behaviour and in raising ethical awareness" (1991, p63).

When subjected to such questions, the complaints processes of both statutory and self-regulation have limitations in protecting members of the public from harm, as is illustrated below.

The Derek Gale case

An instance of malpractice that was widely covered in the public domain provides a case to demonstrate the problems faced by professional bodies in responding effectively to allegations of harm by therapists. Derek Gale was registered as an art therapist with the HPC (regulated by statute), but also described himself as a psychotherapist and was registered with UKCP (self-regulated). Gale's view of boundaries in therapy was that they could be restrictive to therapeutic practice, stating that, "if we were less keen on boundaries and more keen on change, our therapeutic endeavours would be far more successful" (Gale, 1999, p124). In the same paper he argues for a more flexible approach to therapy and describes instances in his own therapeutic practice when he disclosed his own problems to clients, touched and hugged clients, and conducted therapy in locations such as cafés and hotel rooms. He describes these actions as being experienced as very helpful by his clients and he confidently asserts that he can work effectively in this unorthodox manner, while stating that other therapists might not be able to do so. He closes the paper by saying that,

> "...obsession with boundaries, rules and professionalization does deprive the client of something, because we all have to operate at the speed of the slowest. This kills innovation and provides no space for genius. So in trying to protect the client from the unscrupulous, we deprive him or her of genius." (1999, p131)

With this comment he is speaking directly about Brian Thorne's client case discussed earlier (Thorne, 1984). He also appears to be suggesting that his own practice is not "unscrupulous" but rather that he too is a "genius".

Gale's practice came under public scrutiny after complaints were made about him to the HPC by a number of clients and reports of this appeared in the press (Pearlman, 2007; Brown, 2009;

Grant, 2009). The allegations against him included that he fell asleep during sessions, conducted nude encounter groups, inappropriately touched clients and made sexual suggestions to them, that he smoked cannabis with clients, swore at them and spoke about his own sexual fantasies in sessions. The complainants alleged that these activities occurred over a considerable period of time, in some cases over 20 years, as part of Gale's work from his home-based practice. During the hearing, Gale described himself as, "a non-mainstream practitioner who adopted a confrontational and provocative position in relation to his clients" (Rose, 2009).

The case received some considerable attention in the media, perhaps because of the shocking and prurient details that emerged about his conduct, but also because he made it clear that while suspended from the HPC register as an art therapist (a title which is protected under statutory regulation) he would continue to offer therapeutic services to clients – he would simply call himself a 'therapist' or 'psychodrama therapist' (Rose, 2009; Adams, 2009). This was seized upon by campaigning groups such as Mind, which highlighted the need for statutory regulation of counselling and psychotherapy given that he could continue to offer services to clients using the titles of counsellor or psychotherapist (Mind, 2009).

Derek Gale was struck off the HPC register as an art therapist in 2009 when the Conduct and Competence Panel upheld a number of serious allegations made against him in regard to at least four clients (HPC, 2009, 2010). This means that, by law, he cannot practise art therapy. His registration with UKCP was similarly suspended in 2006 pending the outcome of disciplinary proceedings and he was removed from their register in 2009 (UKCP, 2009). It is not clear whether Derek Gale currently continues to practise in therapeutic roles not regulated by statute.

Professionals' non-reporting behaviour

> "...as anyone who has ever served on an ethics committee quickly learns, it is often close to being common knowledge within the professional community that a psychologist is violating ethical principles, but no one is willing to file a complaint. This is the case, even though ignoring the existence of an ethical violation is an ethical violation in itself" (Bernard et al, 1987, p489).

To some degree the effectiveness of complaints processes is dependent upon clients or their representatives coming forward to make formal complaints about their therapists, or on fellow professionals who become aware of aberrant practice making a report. There is evidence to suggest that many clients do not complain when they experience harmful practice (Pope & Bouhoutsos, 1986; Pope and Bajt, 1988), an issue which will be examined in more detail later in this chapter. In addition, there is considerable evidence that practitioners struggle to address the malpractice of colleagues when they become aware of it.

Recent research by Martin et al (2011) explores therapists' experiences of sexual attraction in therapy. This project also highlights an issue relating to situations where therapists became aware of concerning practice through a variety of means, such as gossip about a colleague, disclosure by a client about their previous therapist, a supervisee's disclosure of difficulties in practice, or a client who is also a therapist disclosing doubtful practice. Participants described uncertainty about whether to report colleagues formally in such instances. Similarly, Gizara and Forrest (2004) demonstrate the difficulties that supervisors have in intervening in the event of fitness to practice issues in trainees. Haas, Malouf and Mayerson (1986) found that in cases where a client disclosed sexual contact by a previous therapist, the majority would encourage the client to report this, but only 17% would report the member themselves. Reluctance to take action against colleagues is also highlighted by Bernard et al (1987) above, Levenson (1987), Biaggio et al (1998) and Levine (2010).

Reasons for inaction in cases where therapists become aware of poor or harmful practice by colleagues are many and varied, and the literature in this area discusses both individual and institutional inaction. In the case of individuals, as discussed earlier, becoming aware of a colleague's malpractice can raise dilemmas for therapists (Martin et al, 2011). Gabbard et al

(2001) describe the impact of this as "completely discombobulating" (p668), stating that the person's capacity to think clearly can be affected by hearing such allegations resulting in a wish to dismiss the information without proper consideration. Allied with this is the suggestion that allegations about fellow professionals, particularly allegations regarding sexual boundary violations, can elicit disbelief, which Sandler and Godley (2004) suggest may be due to horror linked to the incest taboo. Gabbard et al (2001) discuss the difficulty of "speaking the unspeakable" (p660) while Pope (1990a) talks about how therapists who are aware of the sexual misconduct of others may duplicate the dynamics of a sexually abusive family and "keep the 'family secret'." (p236).

In addition to the negative impact on the professional of discovering or suspecting malpractice by a colleague, lack of awareness of the obligation to act may be a factor as stated by Biaggio et al (1998). They also argue that confusion about what constitutes ethical malpractice or unease about grey areas can inhibit therapists from taking action. Lack of knowledge or understanding only goes so far in explaining inaction, however. Research conducted by Bernard et al (1987) suggested that even in cases where psychologists understand what action they should take, a significant proportion would not do so if they were aware of a colleague's misconduct.

Linked to the idea of confusion around what constitutes ethical practice is Pope's contention (1990a) that some therapists view the act of reporting a colleague as being unethical in itself. Research by Pope et al (1987) that surveyed 1,000 APA members found that while 34.5 % of respondents had filed an ethical complaint against a colleague at some point, a substantial minority of those surveyed viewed taking such action as unethical. Responses to the survey showed that 2.4 % of those questioned believed that reporting a colleague's harmful practice is always unethical and a further 11.8% felt that it is unethical most of the time. Similarly, while approximately one-third (31.0%) of participants stated that they had helped a client to bring a complaint against a psychologist, 29.0% considered this action to be usually or always unethical. The study does not explore the thinking behind such attitudes, but findings showing a considerable proportion of practitioners who would not take formal action against colleagues whose practice is harmful highlight an area that requires further exploration.

One possible explanation for considering the reporting of colleagues to be unethical might be linked with concerns about confidentiality. Levenson (1986) highlights that a therapist with a client who is also a practitioner and who discloses professional misconduct as part of their own therapy, can experience a tremendous dilemma in feeling bound to uphold their agreement of confidentiality to their client, while also having a responsibility to the wider public and the clients who could experience continuing harm if they do not act. This is a similar concern for those therapists whose clients disclose mistreatment by a previous therapist (Gabbard et al, 2001). Levenson (1986) argues that confidentiality should not override all other ethical considerations and that the practitioner must reflect on the situation in order to decide whether the risk posed by the therapist is sufficient that it would warrant a breach of confidentiality. However, the difficulty of engaging with this dilemma can lead to excessive delays and reluctance to act when that might be necessary (Wiener, 2010). Clearly, making such a decision is not easy and is also potentially risky for the reporting practitioner who might themselves become subject to a complaint or legal action. The binary view of reporting versus not reporting does not allow for alternative ways of addressing the misconduct to be considered. Supporting the client and helping them take action should they feel they would wish to might be an alternative option, as is working with the therapist who has disclosed in therapy to determine what additional professional support they might receive.

Another factor that might play a part in practitioners not reporting the unethical behaviour of colleagues relates to a commitment among psychotherapists to reflect and understand human behaviour rather than to take action. This view favours a relational rather than adversarial approach to the resolution of grievances, and is considered more compatible with the activities of counselling and psychotherapy (Totton, 2001; Hill, 2001; Kearns, 2011) Weiner (2010) highlights that analysts put considerable energy into reflecting on processes and understanding meaning, and that this can lead to delays in taking action in cases where abuse by therapists comes to light. Similarly, Gabbard et al (2001) describe how empathy for a colleague can get in the way of decisiveness, unsurprising when therapists' experiences of being complained about can be traumatic ('Chris', 2001). But Gabbard et al also point out that "compassion can be used in a collusive way to promote inaction." (2001, p669).

For those practitioners considering making a formal report against a colleague, an additional consideration is fear of the possible repercussions of speaking out. Levenson (1986) suggests that fears of being ostracised or of retaliatory action can prevent therapists from acting against a colleague, arguing that to do so is difficult and can leave the therapist isolated. He discusses how the strength of professional relationships with colleagues can leave an individual practitioner fearful of being regarded as traitorous, being shunned or losing referrals and therefore risking their livelihood. Biaggio et al (1998) agree that fear of the possible professional and personal repercussions can be a powerful motivation to keep silent. Similarly, Gabbard et al (2001) point out that whistle-blowers can receive negative responses ranging from not being taken seriously and having their allegations ignored, to having their professional reputation and judgement attacked. The stakes are high for the professional experiencing the dilemma of reporting a colleague and making a decision to act can take considerable courage.

Ineffective organisational responses

> "...silence in the face of misconduct not only fails to assist colleagues in getting corrective help, but may also contribute to the perpetuation of further exploitation of clients." (Biaggio et al, 1998, p274).

If individual therapists can struggle to take action, there is also evidence that organisational responses to emerging evidence or allegations of misconduct of a member have not always been effective or robust, with some writers suggesting that the whole issue of misconduct can be glossed over or covered up. Abramovitch (2007) alludes to a culture of silence that exists in some professional organisations or training institutions that "have terrible ethical skeletons in their communal closets" (p451). Anonymous (b) (2005) feels that the needs of the institution to which she complained were prioritised over her own needs. Similarly, Hetherington (2000b), writes of a "collusive silence" (p19) between professionals who fail to report colleagues whom they suspect of abuse in therapy. Gabbard et al's research (1995) revealed a "high tolerance level" (p660) within some organisations towards sexual misconduct, stating that "a form of

denial and collusion occurs at all levels of organized psychoanalysis." (p665). Sandler (2004) makes similar claims in relation to a notorious case regarding Masud Khan, a member of the British Psychoanalytical Society from 1950 until he was eventually expelled in 1988[3]. She contends that a high level of collusion existed within the organisation, meaning that Khan's misconduct and harm of patients was allowed to continue for some years. She states that,

> "when the non-controversial signs of misconduct emerged following the formal complaint, it was very difficult for some of the people involved to believe and accept the facts put before them" (Sandler, 2004, p37).

As well as highlighting the organisational failings in protecting the public from harm by therapists, there is a suggestion in the literature of unwillingness to allow evidence of malpractice to receive public airing. Pope (1990a) details cases from the 1970s and 1980s where research papers or case studies relating to sexual abuse by therapists were suppressed rather than published, suggesting that there was some fear of the effect such papers would have on the reputation of the talking therapies that led to a collusive response to keep incendiary material out of the public sphere.

Such behaviour, as well as being questionable ethically, is also counterproductive as the interests of the profession can only be served in this area through a demonstrable willingness to act appropriately to address cases of misconduct and malpractice (Palmer Barnes, 1998). As Hetherington remarks,

> "Open dialogue on the issue of abuse within psychotherapy is essential to the credibility of a profession which purports to combat the deleterious effects of abuse and which advocates the therapeutic effects of disclosure" (2000b, p20).

[3] Masud Khan was an Indian-born British psychoanalyst, whose training analyst was Donald Winnicott. Khan was a charismatic, skilled and influential member of the British Psychoanalytic Association. Over time, his practice became more and more unorthodox as he indulged in social relationships with analysands and, in some cases, sexual relationships. A detailed examination of this case is given in Sandler, A. with Godley, W. (2004) Institutional responses to boundary violations: The case of Masud Khan. *International Journal of Psychoanalysis*. 85: 27-44.

Gabbard et al (1995) call for courage from individuals and organisations to address misconduct robustly. Biaggio et al (1998) offer ideas about how to consider allegations and suggest a range of different interventions that individual therapists might make before formal reporting. Wiener (2010) also suggests that practitioners must respond more robustly in cases where they become aware of malpractice, but points out the usefulness of a "benign third" (p666), a representative from an independent organisation that can consider any complaint or allegation from an outside perspective.

Whatever the reasons, collective or individual failure to act when misconduct becomes known is concerning and prevents practitioners from getting appropriate help and support, leaving their clients unprotected from continuing malpractice (Biaggio et al, 1998). This contributes to an image of therapists as collusive and concerned with protecting the reputation of their profession rather than the clients with whom they work.

Clients taking action – opportunities and obstacles

> "Valuing the safety of their perpetrators over their own safety, victims do everything possible to keep the relationship a secret." (Jones, 2010, p651).

In cases where a client has experienced harm in therapy, bringing a formal complaint to the relevant professional body can represent a positive step for clients. Pope and Bouhoutsos (1986) see taking action in this way as a courageous act that can help dispel feelings of powerlessness and victimisation, as well as being altruistic in its motivation to prevent harm to other clients. Jones (2010) agrees that the hope of preventing harm to others was a major motivating factor in her bringing a formal complaint against her analyst. Vinson's research (1987) supports this view, finding that some women who filed complaints after sexual involvement with their therapist found this to be a positive experience, resulting in them no longer feeling like victims, provided that the decision to take such action was their own. Anonymous (a) (1991) concurs, describing how taking action against a member of teaching staff who sexually harassed her while she was in counselling training enabled her to tackle the

loneliness she felt having been victimised, and helped her to feel empowered and to move on from the experience.

The possibility of empowerment of clients through taking such action does not always result in formal complaints. Bond (2010) contends that most client grievances go unreported and that for many people it makes more sense simply to end the therapy rather than potentially exacerbate their difficulties by going through a protracted complaints process. Pope and Bouhoutsos (1986) estimate that legal action or complaints are filed in only 4% of cases of sexual malpractice by therapists. Coe (2008) suggests that the majority of people, he says up to 90%, who may have reason to complain decide not to pursue formal action because of the difficulties they may face in doing do. As he says, if incidence of complaints is used to draw conclusions about the prevalence of malpractice in psychotherapy, then such a statistic raises questions about how widespread such behaviour might be. His figures do not come from research, however, but from contact with clients to the Witness helpline and so it is not possible to ascertain whether 90% is a realistic figure and whether they would have justifiable complaints.

So, what prevents clients from bringing complaints against their therapists? It may be, as Casemore (2001) suggests, that many people with grievances about their therapy choose not to take action because what they want is a simple apology from their therapist rather than a formal process. Research and anecdotal evidence suggests that clients experience barriers to complaining. In a scoping review conducted for the HPC, Gulland (2009) digests a range of empirical research conducted across various health professions and considers the barriers to complaining that are influenced by different client characteristics. The research presented shows differences in complaining behaviour based on gender, ethnicity, age, social class and income, health and disability status, availability of support networks, and difficulty accessing appropriate information (Pleasance et al, 2004). Gulland (2009) asserts that there are also psychological barriers that prevent people complaining, such as not wishing to appear ungrateful or difficult, being fearful of reprisal, and scepticism about the usefulness of complaining.

Some research suggests that there are clients who are not aware of having experienced harm in therapy, particularly where sexual boundary violations have occurred (Grunebaum, 1986). Research conducted by Claiborn et al (1994) demonstrates that many clients misunderstand the risks of therapy and are unable to identify ethical breaches in practice. Such views of therapy are supported in some client accounts, such as Anonymous (b) (2005) who describes that it took her some years to realise the negative impact on her and states that, "At the time I felt anything but a victim" (p672). Similarly, Jones (2010) describes how she did not recognise the negative effects of the sexual relationship with her therapist at the time it occurred; "During the abuse, I was unable to comprehend the harm he had done to me or to others." (p655). In such cases, clients may not consider alerting professional organisations to the concerning conduct of their therapist, or may only realise the full impact of their therapist's actions many years after the therapy, when the option to take action may have passed, due to time limits for making complaints. As well as underestimating or discounting the harm done to themselves, clients sometimes do not bring complaints out of a sense of protecting their therapist (Vinson, 1987) and, as Jones cited above (2010) points out, this concern to protect the therapist can take precedence over their own need for safety.

Sands (2000) states that feelings of shame for needing therapy in the first place can make it more difficult for victims of abuse in therapy to speak out. Kayberry's research (2000) with victims of abuse in supervision also shows that feelings of shame, guilt and self-blame can prevent people from making a formal complaint. Vinson's study (1987) suggests that the disabling effects of guilt and shame only go so far to explain why clients do not complain about sexual abuse by their therapists. Her research found that the overriding factor in complainant behaviour was whether the client knew that they could take legal or complaint action; in none of the client cases that she examined did such feelings prevent people from making a complaint and those clients who did not have knowledge about the relevant processes subsequently complained once they did know, in spite of reporting feelings that delayed their taking action. Sands (2000) agrees that information regarding complaints and the processes involved is not made easily accessible to clients, and that the requirement to describe often confusing and ambiguous events in writing is another hurdle that can be difficult to overcome. Jones (2010), however, found that writing about the events in order to bring a complaint, while difficult, was

ultimately helpful in allowing her to see the abuse in her therapy more clearly and to separate emotionally from her analyst.

Coe (2008) suggests that many clients fear stigmatisation by those with responsibility for hearing complaints and that this prevents many people from coming forward. This view is supported by accounts in the literature, as Anonymous (b) states,

> "I expected to be judged for my actions and for being a whistleblower, or what we called in my childhood a tattle-tale." (2005, p680).

Jones (2010) concurs that stigmatisation of victims by the public and by health professionals makes it very difficult for clients to come forward. Some clients who do make complaints describe their therapist making use of personal client material in their own defence, stating that the very action of bringing a complaint is evidence of pathological behaviour and thereby attempting to dismiss the allegations. As described by Schepisi,

> "When I made the complaint, she pathologised me by labelling me as dissociative. [...] ...she claimed I was having delusional ideas because I had made a complaint." (2006, p57).

Kayberry's research with counsellors abused in supervision (2000) found similar concerns; some were fearful of bringing complaints because they were concerned about the impact on their professional careers if this behaviour were pathologised. Vinson (1987) also found that clients who worked as mental health professionals were similarly reticent about complaining as they feared possible repercussions to their careers.

Many clients fear that they will not be believed if they speak about experiences of abuse in therapy. Vinson (1987) describes how one research participant in her study was careful to gauge staff's response regarding the validity of her allegation when she contacted the relevant board to make a complaint. Clients fear that their word will not carry sufficient weight with professional committees that investigate ethical complaints, as described by Anonymous (b),

> "To my mind, most of the members of the committee (with the exception of the chairperson) seemed to be looking at me with suspicion, evincing a sceptical attitude that questioned the legitimacy of my complaint" (2005, p681).

Anonymous (a) (1991) describes how the tutor she complained about not only attempted to discredit her by alleging that she had been suffering from stress, but also persuaded another female student with whom he had had an affair to make a written statement saying that she was lying. Some clients are able to break silence only when they discover evidence that supports their experience, as in the case of 'Poppy' (2001) who felt able to speak to her GP after she read in a local newspaper that her ex-therapist had been convicted for sexual assault of two female clients, three years after her own relationship with him had ended.

In addition to fears about not being believed, some clients describe an expectation that the professional organisation will close ranks around the therapist and the client's allegations will be futile. Russell (1993) describes a situation where a client made a complaint only to find that the therapist they made the allegation about was on the committee that considered the complaint. Kayberry (2000) found that supervisees felt discouraged from bringing complaints as they feared that other counsellors and supervisors considering the complaint would struggle to believe that their professional colleagues could abuse supervisees, a view that has some support in the literature discussed earlier relating to non-reporting behaviour among professionals.

In cases where victims bring formal complaints or action against their therapist, there are mixed experiences of the processes and outcomes, with Totton (2001) suggesting that most people who are involved in complaints in any role, including as clients, are "deeply dissatisfied" (p100) with the process. Coe (2000) highlights that bringing a formal complaint can be a distressing and difficult experience in itself, one which requires determination and strength which may be in short supply owing to the harmful effects of abusive therapy. Within the health professions more widely, Gulland (2009) identifies that bringing complaints can be problematic as it can be difficult for clients to access clear information about complaints procedures, exacerbated by the complexity of the relevant organisational structures and of the formal processes. Clients who have brought formal complaints have found the process to be lengthy and complicated, sometimes taking several years to reach resolution (Adams in Richardson et al, 2008; Kayberry, 2000; Power, 2002).

The difficulties involved in raising a formal complaint are clearly conveyed by Strudwick (2011), a journalist who took action against a psychotherapist who attempted to 'cure' him of being gay. He comments that,

> "As the hearing progressed, I discovered the strain all complainants go through. I was cross-examined at length by Pilkington's barrister and by the panel. How would someone with mental-health problems cope with that? And it isn't just the emotional challenges that could deter a complainant. Without being well educated and having free legal help to interpret the BACP's jargon-dense literature and legal letters, I would have found the process incomprehensible and intimidating." (para 22)

For some complainants, having their complaints upheld did not result in the outcome they had hoped for. Anonymous (a) (1991) describes how her complaint to the university about her tutor resulted in him receiving a written reprimand on his file, an action considered by the university to be an unusually robust response. As he was still teaching and supervising trainee counsellors, however, she subsequently pursued complaints with two professional bodies of which he was a member. He withdrew his membership of these organisations before the complaints or sanctions could be taken forward and continued to practise without affiliation. Jones (2010) had her complaint upheld and her analyst lost his licence to practise. She comments, however, that the publicity around this decision was insufficient to alert the analyst's other clients and that he, too, continues to practise without a licence or professional membership. Kayberry's research (2000) highlighted an incident where one supervisee abused in supervision brought a complaint against her supervisor which was ultimately upheld, but this practitioner also continues to practise. Masters (in Richardson et al, 2008) describes a similar situation where her complaint to a hospital about her mental health worker was upheld, but because he admitted what happened and had been a newly-qualified worker at the time, he was not dismissed, a result that left Masters feeling furious and disbelieving.

Sands (2000), having written to the relevant professional organisation about her analyst, was initially offered a meeting with him and a mediator, but was subsequently told that this would not be possible and was instead offered a meeting with members of the ethics committee. She found this meeting to be unhelpful as she was not allowed to ask the questions about what had happened that she had hoped to explore. Although she received a letter after this meeting

recognising that she had been distressed in therapy, both the process of the meeting and the wording of this letter left her feeling disbelieved, that she had no grounds for complaint, and that nobody had been prepared to take any responsibility for what had happened in her therapy.

Finally, Anonymous (b) (2005) had an experience of her complaint being upheld after the analyst involved acknowledged the violations that had occurred in her therapy. She comments, however, that,

> "...their institutional needs took priority over my psyche. [...] ... the energy of the process was consistently toward serving what was best for the institute fathers rather than what was best for me, even as late in the game as the processing of my ethics complaint" (p682).

The factors which contribute to clients not bringing complaints in cases where they might have reason to complain are worthy of exploration given that the effectiveness of complaints processes rely, to some extent, on clients coming forward.

False allegations?

> "There are other complainants for whom there will be no satisfaction other than the crucifixion or immolation of the therapist, even when the therapist is completely innocent." (Casemore, 2001, p118)

While some clients who have experienced harm do not complain, there are others who make spurious complaints. This is worrying for therapists although it appears to be more of a concern for male rather than female therapists. Pope and Tabachnik's research (1993) demonstrated that while 41.9% of male therapists surveyed often or most frequently felt afraid that a client might file a formal complaint against them, only 0.7% of female therapists experienced similar fears.

The subject of false allegations or malicious complaints has received scant attention in the literature. Williams (2000) highlights the lack of data relating to incidence of groundless complaints, but asserts that not all complaints are based in fact, although many such complaints may appear credible. He considers anecdotal reports to discuss six possible reasons for clients to make false allegations against therapists (p77):

- Financial gain by suing for non-existent injury
- Vengeance or retaliation
- Pathological issues such as schizophrenia or personality disorders
- 'Recovered' memory
- Doctrinaire suggestions from a subsequent therapist
- Escape from unwanted treatment.

Sederer and Libby (1995) support the view that possible financial gain or revenge as well as issues in the client's pathology such as severe trauma, may be factors in false allegations against therapists. Ironside (1995) presents a case of a false allegation of sexual abuse by a therapist made by a child patient. His view is that such allegations are likely to increase with potentially devastating consequences for the accused therapist. Thompson (2008) agrees that false allegations of misconduct can have a powerfully negative impact on practitioners, and states that the danger is exacerbated as regulatory bodies may be unprepared to consider whether some complaints may be false. Van Horne (2004) and Williams (2000) also mention this as a concern. Gutheil (1992) suggests that all claims of sexual misconduct by therapists should be considered for falsehood and offers systematic methods for evaluating allegations. Williams (2000) cautions that false accusations may not be preventable and that "one must be mindful of the fact that some who pose as victims are, in fact, either cunning predators themselves or misguided accusers." (p81).

If, as Williams suggests,

> "...accusers often are portrayed as helpless victims of psychotherapists who exploited them. [...] Emotion can overshadow reason, lending inappropriate credibility to complaints" (2000, p77),

then perhaps practitioners are sometimes disadvantaged in this discussion. Fears among therapists of becoming the victim of such an allegation can make considering the validity of clients' grievances much more difficult. Clarkson (2000) suggests that members of the public are "encouraged, aided and abetted by sensationalist media" (p101) to be suspicious of and attacking towards therapists.

Complaints processes exist to address issues of malpractice and rely on the willingness of clients and practitioners to make appropriate use of them. Just as abusive therapists can harm clients and damage the good standing of counselling and psychotherapy, false allegations by clients can injure the livelihoods of blameless therapists and the profession's reputation. Difficulties arise in attempting to reconcile these apparently opposing aims. Complaints procedures require balanced, robust and effective implementation by the relevant professional body in order to resolve this tension.

Complaints research

> "If complaints procedures are envisaged as a net, it is a net with a large mesh, through which an unknown but possibly large number of smaller but possibly significant grievances escape." (Bond, 2010, p13)

The problematic nature of researching misconduct in counselling and psychotherapy, and of estimating the prevalence of such misconduct, can in part be addressed by examining formal complaints made to professional organisations. The numbers of complaints submitted and upheld give some indication of the incidence of malpractice, while analysis of what is complained about may usefully point to areas of concern in practice that suggest training needs or the need for clearer guidance from organisations. Similarly, demographic details in complaints relating to who complains and who is complained against may provide information relating to risk factors in therapy.

In spite of such possibilities, complaints research in counselling and psychotherapy is scant, with only a handful of empirical studies worldwide to date. The picture from research studies can be augmented with a similarly sparse number of published reports from professional or regulatory bodies. However, even when combined, there is minimal examination of incidence of malpractice as evidenced by complaints or formal investigations by professional bodies (Halter et al, 2007). Detailed examination of the research and reports reveals that comparisons across these publications is problematic owing to the variety of methods used, the lack of information given regarding complaints processes, and the different levels of detail regarding characteristics of complainants and those complained against.

This section will examine the range of literature relating to counselling and psychotherapy complaints, including empirical studies and reports from professional organisations. The literature will be assessed through the following themes: the nature and scope of the study or report; numbers and rates of complaints received and upheld; the nature of the complaints allegations; characteristics of those complained about; and characteristics of complainants. Strengths and limitations of the sources will be discussed in order to draw conclusions about

the existing literature and to suggest areas for future research. A tabulated summary of the content of each study or report is given at Table 5.

Table 5: Summary of complaints reports and research studies.

Report / study	Time period	Total thers in sample	Complaints received		Complaints upheld		Nature of com-plaint	Practi-tioners	Natu re
			No.	rate	No.	rate			
APA	1979-2010		✓	✓	✓				
Herlihy, Healy, Cook & Hudson (1987)	Not given	ca 12,000	✓	(✓)	✓	(✓)	✓		
Neukrug, Healy & Herlihy (1992)	Not given	72,403	✓	(✓)	✓	(✓)	✓		
ACA (various authors)	1989-2009		✓		✓				
St Germaine (1997)	1991-2	32,991	✓	(✓)	✓	(✓)	✓		
Neukrug, Milliken, & Walden (2001)	1993-8	141,403	✓	(✓)	✓	(✓)	✓		
Van Horne (2004)	1995-2001	124,944	✓	✓	✓	✓			
Shefler & Achmon (2004)	1987-2002		✓		✓		✓	✓	
Griffin (2004)	Apr 2002-Jun 2004		✓		✓				
BPS (2007a)	2007	ca 45,000	✓	(✓)	✓	(✓)	✓		✓
HPC (2010)	July 2009 –Mar 2010	15,583	✓	✓	✓		✓	✓	✓
HPC (2011)	Apr 2010 – Mar 2011	17,165	✓	✓	✓		✓	✓	✓

(✓) = Information does not appear in the paper, but can be calculated from other information present.

Scope of the studies and reports

In the UK there are currently reports in the public domain from only three professional bodies containing information relating to complaints about counselling and psychotherapy. The first relates to complaints made to BACP and gives a flowchart showing the number of complaints processed from the end of April 2002 to June 2004, as well as showing the outcomes of these complaints (Griffin 2004). These details are presented to illustrate information about the complaints procedures rather than offering in–depth analysis of the figures, and the information it contains is minimal. A second report, produced by the Professional Conduct Board and Investigatory Committee of the British Psychological Society (BPS) is available only online (BPS, 2007a). This brief report gives limited details regarding the numbers and outcomes of complaints, and includes a breakdown of the areas of psychology in which complaints were made. The report's purpose is to summarise the committee's work over the year as part of a wider annual report about the society's activities, rather than considering the research potential of the data available. Similar reports for previous or more recent years are not available, making comparisons or identifying trends impossible.

In addition to these two reports from counselling- and psychotherapy-related organisations, there is report information about related non-medical health professions that can usefully be included for comparison. The HPC produces an annual report on fitness to practise within the professions it currently regulates that gives considerable detail regarding numbers, rates and outcomes of complaints received, comparing these figures with previous years and identifying trends. The most recent report (HPC, 2011) covering the period from 1 April 2010 to 31 March 2011 includes data relating to practitioner psychologists who, since 1 July 2010, are subject to statutory regulation by the HPC. It includes both outstanding complaints transferred from the BPS as well as new complaints received post-regulation. The report is comprehensive in its scope, analysing information about complainants and registrants complained against, including breakdowns of data relating to each individual profession. Detailed information about each stage of the processes for investigating complaints is given in the report. In addition, anonymised case studies are used to illustrate different types of complaint and their outcomes, such as cases of misconduct or cases where the allegation was not well founded.

Outside the UK, two organisations routinely produce reports about complaints and investigatory processes relating to counselling and psychotherapy: the American Psychological Association (APA); and the American Counseling Association (ACA). Both organisations have a considerable number of reports spanning more than 20 years published in their respective members' journals giving information about the work of their ethics committees (see APA 1979 – 2009; ACA 1989 – 2008). The most recent APA report (2009) gives details of the numbers and nature of complaints investigated in the preceding year, comparing these figures with information from reports from the previous five years to identify trends. Similarly, the latest ACA report (2008) gives details about complaints received, their nature and outcomes, as well as information about other activities of the ethics committee, such as educational events and developments to the ethical code. While these amount to a considerable amount of information covering many years of complaints, the numbers of formal complaints in each year are so small, and there is insufficient detail about cases from year to year to be able to draw anything but the most general conclusions.

Systematic research studies relating to the number and nature of complaints in counselling and psychotherapy are limited to a small handful of papers of varying depth and scope, but they offer a useful insight into different aspects of information that can be gleaned from complaints. A number of studies make use of surveys sent to relevant licensing bodies asking for information relating to the number and nature of complaints, while one study examines archived complaint material held by a professional body. Van Horne (2004) surveyed all psychologist licensing boards in the United States and Canada, considering numbers of complaints received, investigations and outcomes for each year for the period between 1995 and 2001. Returned surveys relate to almost 125,000 licensees, meaning that this study offers a broad picture in terms of the number of practitioners and the pattern of complaints over time. The author pays considerable attention to the need for research of this nature and discusses the implications of her findings for regulators, the profession, the public and individual psychologists. The article also highlights difficulties in interpreting data without detailed contextual knowledge about steps taken in different jurisdictions regarding, for example, raising awareness among the public about appropriate professional behaviour.

Similarly, Herlihy et al (1987) examined ethical complaints received and processed by state counselling boards. This study was followed up five years later as the number of state licensing boards rose (Neukrug et al 1992). Further increase in the number of states with professional counsellor licensure prompted another update (Neukrug et al, 2001). In this most recent study, 45 state licensing boards were surveyed regarding the number of credentialed counsellors[4] overseen, the nature of ethical complaints received, how these cases were responded to, and action taken to promote ethics education. Responses to the surveys relate to licensing boards responsible for in excess of 133,000 counsellors, making this research the furthest-reaching in terms of numbers of practitioners. Comparisons with the previous studies allow for trends in complaints to be identified.

St Germaine (1997) surveyed 55 addiction counsellor certification boards to determine the frequency and categories of ethical complaints between 1991 and 1992, using a modified version of the questionnaire used by Herlihy et al (1987). Responses were received from 40 boards, representing approximately 33,000 certified addiction counsellors. Findings are relevant to generic counselling and psychotherapy given the relative lack of research in this area, but specific conclusions relating to the field of addiction are also highlighted.

Rather than survey a professional body, Shefler and Achmon (2004) examined archived complaints documents held by the Israel Psychologists Association (IPA), for a period covering 17 years. This research looked at the numbers and outcomes of complaints as well as the characteristics of the complaints, as mapped against six basic principles of the IPA's ethical code. Limited demographic information about the complainants and the psychologists complained against was analysed, yet any findings relating to the complainants do not appear in the report. This research was given as a conference presentation rather than a published paper, and while it merits attention here given the scarcity of research in this area, the level of detail presented in the findings is necessarily limited.

Although the amount of research relating to complaints in therapy is scarce, this is reflected in other non-medical health professions (Gulland 2009). While the number of systematic studies and professional reports in this area is small, taken together their data relate to significant

[4] The term 'credentialed counselors' is used by the authors to denote practitioners who are registered, certified or licensed and who are monitored by state licensing boards.

numbers of therapists and a considerable period of time from which some useful information might be gleaned.

Numbers and rates of complaints received and upheld

Numbers of complaints received and upheld are reported in each of the papers, but these figures, ranging from 43 complaints received in a two-year period (Griffin, 2004) to 2,325 in one year (Neukrug et al, 2001), are effectively meaningless without details of the numbers of members or registrants as a whole in the relevant organisation, in order to calculate a rate of complaints. This information is given in only two cases, although there is sufficient information in some cases to calculate the rate, while in others this is not possible at all, as will be demonstrated below.

The lowest rate of complaint is stated by the APA (2010) at 0.07% for 2009, slightly down from 0.09% in the previous four years. In the UK, the BPS reports receiving 115 complaints relating to members in 2007 (BPS, 2007a), and while no rate is given, the stated membership is approximately 45,000 in 2006 which would give an approximate rate of 0.26%. These complaints relate not only to counselling and psychotherapy, however, but to a wide range of activities undertaken by BPS members. Since practitioner psychologists have been regulated in the UK, complaints details relating to their work appear in the most recent HPC report (2011). According to this report, 118 cases were received over the course of the year. The total number of cases represents 0.69% of the practitioner psychologist registrants, which is considerably higher than the figure of 0.35% which is the rate of complaints among all HPC professional registrants.

St Germaine (1997) reports a total of 372 complaints during 1991 and 1992 relating to 32,991 addiction counsellors, meaning that a rate of 0.56% per year can be calculated. It is the study with the widest reach in terms of the number of practitioners that presents the highest rate of complaints. Van Horne's survey (2004) of Canadian and American licensing boards presents rates of complaints at approximately 2% consistently across the years of the survey from 1996 to 2001. A closer look at the numbers in the study allows for more accurate calculation of the

rates in order for possible comparison with the other studies, and shows a rate of 1.45% in 2001, having fallen from 1.60% in 1996. While Neukrug et al (2001) provide both the number of complaints received (2,325) and the total number of practitioners covered by the responding licensing boards (141,403), it is possible to calculate only an approximate yearly rate of complaint, given that some boards were not functional until the latter years of the study. Using the figures provided, however, an annual rate of 0.29% of complaints received is calculated.

No rate of complaint is given by Griffin (2004), Shefler and Achmon (2004), or the ACA (2008) and insufficient information means that this cannot be calculated in these cases.

As with the information regarding the number and rates of complaints received, data relating to upheld complaints are patchy. The duration of complaints processes means that reports are often unable to present meaningful information about the outcomes of complaints as many of the cases received are unresolved at the time of the report. In the case of Griffin's report (2004), for example, while 13 of the 43 received cases were upheld, a further 5 were still in process at the time of publication. Similarly, reports from other organisations (BPS, 2007a; APA 2010; ACA 2009) do not contain sufficient information regarding the numbers of upheld complaints. The HPC report (2011) contains considerable information regarding numbers and proportions of complaints upheld as well as rates of upheld complaints compared with registrants, but information regarding outcomes is available for only 19 complaints against practitioner psychologists. It is not possible to calculate a rate of upheld complaints from this, however, as the figures included relate only to cases that concluded within the reporting period. Many complaints received during the period are likely to be ongoing and the outcomes reported are almost certainly for cases that were transferred by the BPS when the HPC took over regulation of practitioner psychologists.

Research studies are able to give somewhat clearer analysis of upheld complaints as they consider complaints over extended periods of time, meaning that sufficient time has passed for cases to be closed, although there are still limitations in these sources. Shefler and Achmon's study (2004) discusses the proportions of complaints investigated and upheld, including the nature of any sanctions, but the authors highlight difficulties in researching archived documents which were incomplete and where much relevant documentation has not survived.

In addition, such numbers as they do present cannot be used to calculate a rate of upheld complaints as no details of the numbers of members are given.

Van Horne (2004) goes into some detail about the numbers and proportions of complaints that are closed "with a determination of no violation" (p173), those that are investigated but lead to "informal (nonreportable) actions" (p173), and those investigations that lead to "formal and reported disciplinary actions" (p174). This highlights one of the difficulties of comparing data and findings across studies and reports – different terms are used to describe outcomes and different processes are used by different bodies. For the purposes of this discussion, only the complaints in this final category will be considered as 'upheld'. Upheld complaints ranged in number from 214 in 1996 to 165 in 2001, the equivalent of a rate of upheld complaints, ranging between 0.195% and 0.132%. In comparison with this, the Neukrug, Milliken et al (2001) study states that 241 complaints were formally investigated. No information is given in the paper about the different complaints processes that the many licensing boards use and whether there are consistent or varied approaches, so it is not possible to know how decisions are made about whether to investigate. However, further information given about these 241 cases shows that disciplinary action of different kinds was taken in every case, so it appears that this number relates to complaints that have been upheld. As with the number of complaints received, this study gives no figure to show how this relates to the total number of counsellors covered in the research, but with the information available the rate can be calculated at 0.03% per year, although this figure can only be approximate given the caveat stated above. This contrasts with findings in St Germaine (1997), however, where 172 complaints resulted in disciplinary action, meaning that a rate of upheld complaints compared with licensed practitioners of 0.26% can be calculated, considerably higher than in the more recent studies. In addition, 87 cases were incomplete at the time of the survey, suggesting that this rate might be even higher if further complaints were upheld.

Nature of complaints

Examining complaints, particularly the allegations made by complainants, offers a singular opportunity to gather information about what goes wrong in therapy, and while some attempt to use the information in this way is made in the reports and research studies, there are mixed results and many limitations. The BACP report (Griffin, 2004) and the Van Horne (2004) study give no indication of the nature of complaints whatsoever. In contrast, the HPC report (2011) does present information regarding the nature of the complaints which have been upheld, but this is done in very general terms such as 'misconduct' or 'health issues', due to the wide-ranging nature of activities that it regulates. That said, in the two cases that resulted in practitioner psychologists being struck off the register, one was due to "inadequate communication with colleagues, failed to maintain service user records" (p59) and the other due to having "engaged in sexual relationships with vulnerable service users" (p68), while one further practitioner was suspended for "inappropriate clinical treatment, failure to maintain professional boundaries" (p64).

Similarly, the BPS report (2007a) gives a limited breakdown of the main aspects of complaints in broad descriptive terms. The largest single category is 'competence', for example, at 21.60%, followed by 'assessment' at 19.00% and 'general' at 17.20%; some smaller, more specific categories such as 'confidentiality' (4.30%) and 'dual relationships' (7.80%) are also given. However, the nature of the activity that has led to the complaint is not clear from these labels. In addition, the complaints relate to all BPS members and so many of these complaints relate to non-therapy activities such as research. Such general labels and descriptions allow for a simple breakdown of the complaints into categories, but their value is limited in terms of offering insights into what complainants say has gone wrong in therapy, meaning that conclusions about areas of problematic practice that need addressing cannot be drawn.

The ACA reports (1989-2009) take a similar approach, giving six general categories for 'informal inquiries' made, but not for formal complaints investigations. The APA reports (1979-2010) offer some analysis of the nature of complaints received, but consider only those complaints that were opened (formal cases), meaning that this information is available for 12 cases for the most recent year and for similar numbers in previous years. Five of these cases

relate to sexual misconduct, while other areas of complaint included non-sexual dual relationship and insurance or fee issues. As in the reports mentioned above, lack of detail about what activities are included in the organisation's definition of sexual misconduct, or what events were alleged by complainants means that this information is of limited use. The small numbers involved perhaps offer some explanation of the limited examination of the nature of complaints, as it may be virtually impossible to give meaningful detail about the kinds of misconduct alleged without risking a breach of confidentiality, since anything more than broad general comments may render individuals identifiable.

Shefler and Achmon (2004) offer an analysis of the complaints they examined by mapping them on to six basic principles of ethics and also against a number of rules for professional behaviour, both taken from the IPA's Code of Ethics. Rather than choosing a reductive method and giving only one label for each complaint, they have been mapped against as many principles as were relevant, recognising that ethical complaints can encompass a range of behaviours and can represent misconduct in a variety of ways. The authors show that complaints were raised against issues such as 'lack of professional responsibility',' lack of honesty and integrity' and 'dishonouring human rights'. While some brief examples to illustrate each principle are given, these have limited usefulness in showing what allegations have been made about psychologists' practice. The study shows that 'confidentiality' was an issue for 19.32% of cases and sexual abuse for 6.25%. The authors identify a downward trend in the complaints in these areas over the study period and their interpretation is that these figures are low, although they do not have any figures from comparable studies to make any further claims about this. They suggest that issues of sexual abuse and confidentiality receive considerable attention in training and in therapy literature, which might account for why these issues appear less frequently in the complaints.

Neukrug, Milliken et al (2001) take a different approach to the classification of complaints. Ten categories were identified from the most common complaints identified in earlier surveys (Herlihy et al, 1987; Neukrug, Healy et al, 1992) and in a review of related literature. Respondents to the survey coded the complaints against the individual categories, although a considerable number (1,307 out of 2,325) were not coded for reasons such as poor record-keeping. This method of classification shares limitations with the reports discussed above, such

as being a reductive process, and offering only limited insight into the complaints allegations. Its strengths lie in the opportunity for comparison with the earlier research studies that it has been based upon, allowing trends in complaints to be identified.

The largest single category of complaints coded was 'inappropriate dual relationship' at 24%, a significant increase since the 1992 study (Neukrug, Healy et al) where complaints of this nature represented 7% of the total. The category of 'sexual relationships with clients' comprised 7% of complaints and was the fourth highest area reported, although this represents a decrease from 20% since the 1992 study. This figure is broadly in line with findings from the Israel study at 6.25% (Shefler & Achmon, 2004), which also reports a decrease in complaints of this nature. Neukrug, Milliken et al (2001) suggest a number of factors reducing the incidence of these complaints, such as explicit prohibition of sexual relationships with clients by many professional bodies, criminalisation of this behaviour in some states, and that sexual boundary violations have received increasing attention in training and professional development activities for practitioners.

The category of 'breach of confidentiality' in this study (Neukrug, Milliken et al, 2001) is also worthy of attention. These represent 5% of the complaints in this survey, the same as in the 1992 study (Neukrug, Healy et al), but an increase on the figure of 2.6% in the 1987 study (Herlihy et al). The authors' view is that issues around confidentiality are given good attention in counsellor training, hence the relatively low number of complaints in this area. Interestingly, the figure for complaints about confidentiality in the Shefler & Achmon study (2004) is considerably higher at 19.32%. It may be that methodological differences go some way to accounting for this as complaints have been mapped against multiple categories rather than against one only as in the Neukrug, Milliken et al (2001) study.

St Germaine (1997) made use of a modified version of Herlihy et al's questionnaire (1987). The most common complaints in this study were for 'sexual relationship with a current client', representing 16.40% of the total. When combined with complaints about 'sexual relationship with a former client' the figure rises to 22.00%. This is broadly comparable with the Neukrug, Healy et al study (1992) where such complaints represented 20%, but considerably higher than the Neukrug, Milliken et al study (2001) at 7%. While a possible trend of reduction in

misconduct of this nature over time might account for a higher rate in 1997 than in 2001, such a trend would suggest that St Germaine's figures in 1997 might be lower than Neukrug, Healy et al's figures in 1992. The second most common complaint was 'inability to practise effectively due to drug or alcohol use or other mental or physical condition', representing 12.3% of the total complaints. Compared with the findings of Neukrug, Healy et al (1992) of less than 0.5% of complaints of this nature, this is a considerable difference. The author states that many addiction counsellors are recovering addicts themselves who might be prone to relapse at times of stress, which might account for this difference. This could also be a factor in the higher rate of sexual misconduct complaints, but as this study uses the reductive system of classifying each complaint into only one category it is not possible to know whether drug or alcohol use also features in any of the sexual misconduct complaints.

Characteristics of practitioners complained against

Examining information relating to those practitioners who have complaints brought against them might offer useful insights into risk factors, particularly if information regarding training, level of experience or theoretical approach is available. Clearly, such information is unlikely to be easily available as part of complaints proceedings where documents are not compiled for research purposes. Characteristics of the practitioners complained against are not examined by most of the studies or reports (BPS, 2007a; Griffin, 2004; Van Horne, 2004; Neukrug, Milliken et al, 2001; St Germaine, 1997; ACA, 1989-2009; APA, 1979-2010), perhaps out of concern to preserve the anonymity of those complained about.

The two remaining papers consider the gender of those complained about. The 2011 HPC report does not include a breakdown by gender split, but the 2010 report does, stating that at the time the breakdown of registered practitioner psychologists was 74% female and 26% male, but that the breakdown of those complained against is 58% female and 42% male. Similarly, Shefler and Achmon (2004) show that 89 men (54%) and 75 women (46%) had complaints brought against them, stating that this reveals, when compared with the proportion of males and females among members of IPA (these details are not given), that three times as many men are complained against than women.

Characteristics of complainants

Complainants are given only cursory attention in the complaints literature, with data relating to them appearing in only three reports (BPS, 2007a; HPC, 2010, 2011), perhaps once again because of concerns regarding confidentiality. Information in the BPS report (2007a) is extremely limited, stating that 43% of complaints were made by clients, 13% by professional colleagues and 44% by other types of complainant, without giving details of what is meant by this. According to the HPC report (2011), of the 118 cases brought against practitioner psychologists, 85 (72.00%) were brought by members of the public, with the remainder brought by employers, the police, other registrants or professionals, and small numbers in other categories. It is noteworthy that this figure for complaints brought by members of the public is significantly higher than the proportion of such complaints against HPC registrants as a whole, where members of the public represent 33.60% of complainants. It is difficult to account for such a considerable difference, particularly without similar contextual data from other studies or reports.

Strengths, limitations and unanswered questions

The papers discussed above offer many useful insights into therapy misconduct and complaints, but they also share many limitations. The information available is patchy and there is insufficient detail in many of the papers relating to the data, or about procedures involved in managing complaints to make use of them for comparison with other, more comprehensive reports. A particular difficulty arises from examining complaints given that archived complaints material has not been produced for the purposes of research and so may not easily yield information that can be interpreted or compiled for research (Gulland, 2009). In addition, records may be incomplete and resulting gaps in data may be difficult to interpret (Van Horne, 2004; Shefler & Achmon, 2004; Neukrug et al, 2001). A lack of standardisation about record-keeping can make completion of questionnaires problematic or, alternatively, interpretation of complaints records to describe the nature of complaints may vary across organisations that are surveyed as part of the same study, making replies inconsistent (Van Horne, 2004; Shefler & Achmon, 2004; St Germaine, 1997). The range of procedures adopted by different bodies, the complex nature of complaints processes and the often sparse information in reports about these processes also means that comparison across this literature is problematic.

There is considerable difficulty in making use of complaints research to estimate the prevalence of misconduct in counselling and psychotherapy. However, the numbers and rates of complaints are low overall – consistently below 1%. While this reflects complaint behaviour and not the prevalence of malpractice, this does not fit with exaggerated media portrayals of an epidemic of misconduct in counselling and psychotherapy. There also appears to be a downward trend over time in terms of the numbers of complaints. There is some evidence in the studies above of a reduction over time in complaints regarding sexual misconduct, which the researchers link to greater awareness among therapists relating to this as an area of misconduct.

As Van Horne (2004) points out, interpreting the meaning of figures derived from complaints is difficult. Low rates of complaints received could be because the relevant licensing board is using means such as training to address misconduct and avoid situations escalating to a formal complaint. Alternatively, low numbers might mean that the relevant boards are not responding

effectively to issues of malpractice, or that the level of misconduct is also very low and few clients feel the need to raise issues. These can all only be tentative conclusions given the limited information available.

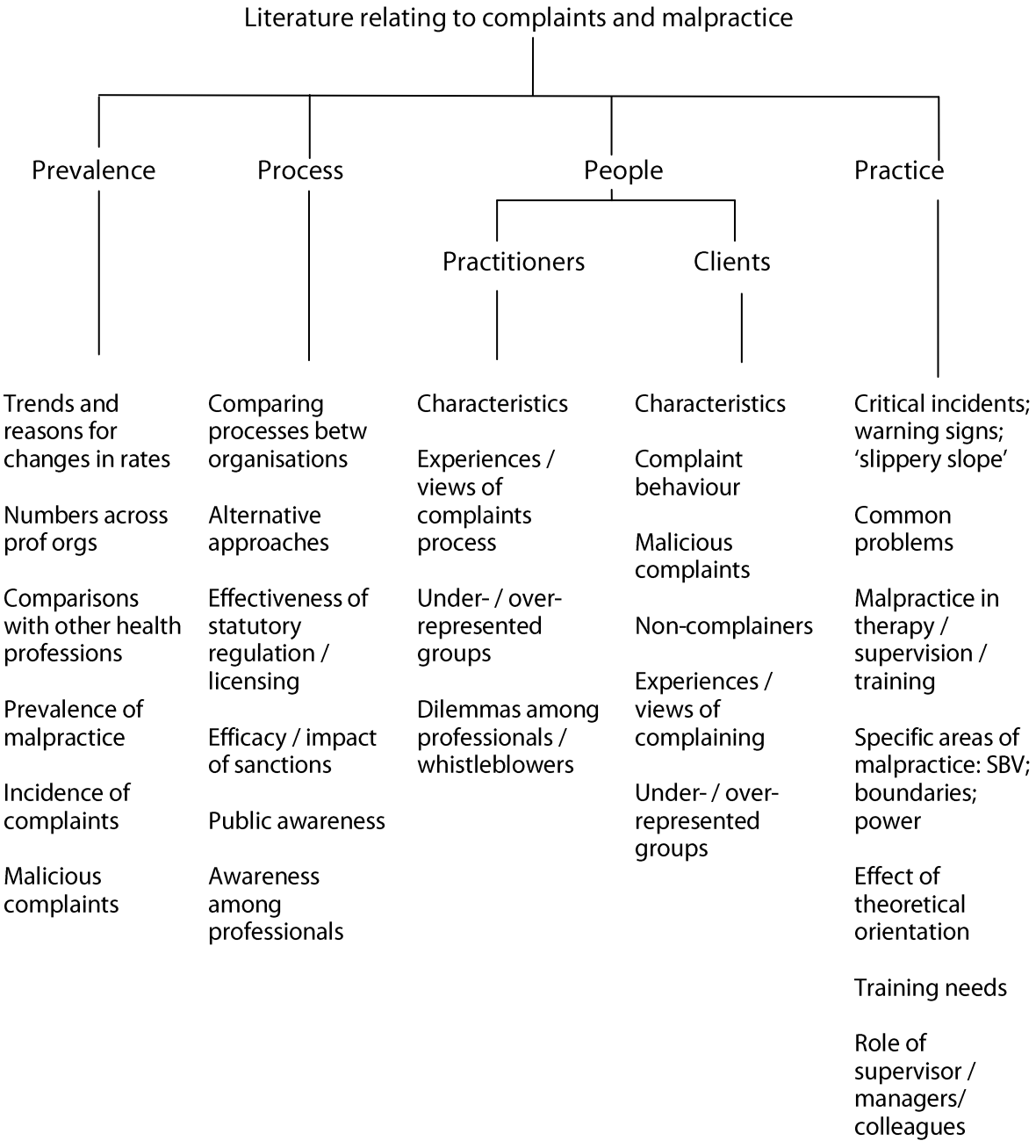
Making use of the reports to learn about what goes wrong in therapy by considering what people complain about also has limited usefulness. Many of the reports do not include any information about the nature of the complaints, perhaps out of a concern to protect confidentiality. Other reports make use of general terms such as 'confidentiality' or 'competence' that offer little meaningful information about the events in therapy that have led to the complaint, and therefore do not allow for more detailed recommendations to be made for practice about problematic situations. In addition, many reports that offer information about the nature of complaints reduce the complaint to one single type of misconduct, failing to recognise that there may be many events that take place before a person reaches a point where they take formal action. In any case, even were more data available, it is difficult to know whether patterns in what people complain about reflect the issues of misconduct that they face in therapy, or only what they feel it is appropriate to make a complaint about (Gulland, 2009).

The areas that receive the least attention in all the studies are those relating to the demographics of those bringing the complaints and those complained against. In part this is due to the nature of material which was not compiled for the purposes of research. This is a neglected area that could yield fruitful information for analysis in future.

Conclusion

Examination of the literature relating to complaints and malpractice in psychotherapy reveals a considerable number of issues for consideration and a notable lack of research that might shed light on these concerns. The issues highlighted in this chapter are summarised in Figure 1.

Figure 1: Issues highlighted in the literature.



These issues provided the starting point for the development of research questions that have become the focus of this thesis. Specific research questions investigated in this research are presented and discussed in detail in chapters 3 and 5.

That these issues have received insufficient research attention to date may, in part, be due to the nature of the terrain. These are sensitive issues where different stakeholders – the practitioners, professional organisations, victims of therapy abuse, client campaigning groups and governments – have strong views about how such research should be used and whom it should serve. In addition, there are considerable methodological and ethical issues requiring attention in the investigation of any of these areas. A lack of research evidence in this area is problematic as it fosters misinformation, fear and recriminations, leaves professional organisations open to criticism of a lack of accountability (Van Horne, 2004), fosters concerns based upon anecdotal evidence that any allegations against therapists are not taken seriously (Sands, 2000; Richardson et al, 2008), and fuels fears among practitioners about the potential risks of having a complaint brought against them (Pope & Tabachnick, 1993; 'Chris', 2001). However, the potential benefits of conducting research in this area should not be overlooked. If, as cited at the start of this chapter, complaints are the most obvious examples of how things have gone wrong in counselling and psychotherapy, then researching complaints could offer useful opportunities for learning and practice development. There is much that can be discovered that could contribute to improvements in practice, to the benefit of both the public and profession alike.

Chapter 2 – Research philosophy, reflexivity and ethics

This chapter presents the ontological and epistemological assumptions that underpin the research in this thesis. The philosophical position adopted by the researcher is stated with reference to relevant literature. The importance of reflexivity throughout the research process is discussed along with details of how this has been integrated into the thesis. Finally, the importance of ethical concerns throughout the research is described and linked with the philosophical position of the researcher and the process of reflexivity.

Ontological and epistemological assumptions

> "It is important that we explore our philosophical assumptions and hold them up for examination so that we can be truly accountable for our ethical decision-making." (Robson et al, 2000, p545)

The epistemological position taken throughout this research is situated between constructivism-interpretivism and critical-ideological (Ponterotto, 2005). The constructivism-interpretivism paradigm rejects positivist notions of a single objective reality that can be observed, measured and tested (Dickson-Swift et al, 2008). Rather, the ontological assumptions underlying this approach are that multiple, equally valid realities exist that are socially constructed and influenced by factors such as gender, culture or social status (Grbich, 2007). Constructivism-interpretivism is a position which maintains that reality is constructed and perceived through the mind of the individual and that there are, therefore, as many realities as there are individuals (Ponterotto, 2005). Each individual's reality is shaped by their values, beliefs and experiences (Dickson-Swift et al, 2008). In this position, there is an interactive link between researcher and participants, where understanding of the experiences and phenomena under investigation is co-constructed

between them (Liamputtong, 2007). The researcher seeks to understand the experiences of the participants within their social context, as well as accounting for the way in which the researcher's understanding is also situated in and influenced by their own social context.

Although the constructivist-interpretivist position recognises the environmental factors that influence people's perception of reality, it fails to account adequately for the impact of power differences within these social constructs. The critical-ideological or emancipatory position seeks to address this actively in its approach to research, emphasizing the influence of power imbalances within society and seeking to empower research participants with a view to challenging and changing those inequalities (Willis, 2007). Research within this paradigm aims to give voice to those who are otherwise silenced (Mertens, 1999). In doing this, however, the researcher must not only recognise power in the social constructs in which participants live their lives, but must also acknowledge and seek to minimise the power imbalances inherent in conducting research (Whitmore, 2001). Typically this involves a high level of involvement of participants throughout the research process as well as a transparency with participants about research aims and the researcher's attitudes, views and expectations (Letherby, 2010).

Both constructivist-interpretivist and critical-ideological positions have been strongly linked with qualitative research methods and, some would argue, they necessitate such an approach (Dickson-Swift et al, 2008). It is with this view in mind that Mason (1996) proposes that researchers should consider their ontological and epistemological position before beginning research, arguing that choice of methodology is linked to particular philosophical underpinnings. White (2009), on the other hand, considers this to be unnecessarily confusing and states that it is not essential for conducting robust research. His view is that research design decisions should be driven by choosing those methods which will best answer the research question rather than through philosophical allegiances. Similarly, Johnson and Onwuegbuzie (2004) take a pragmatic view that researchers should draw on a wide variety of methods depending on what best fits that which is being investigated, rather than being limited to particular methods because of their philosophical beliefs.

The position taken in this thesis is neither that epistemological assumptions predicate one particular methodological approach, nor that choice of methods is driven solely by the research question and is therefore somehow divorced from the philosophical assumptions of the researcher. Rather, individual research questions suggest appropriate methods to answer them, but the researcher's formulation of research questions is inevitably influenced by their epistemological position, which will also influence how different methods are used in the course of the research. The research discussed in this thesis consists of two projects: an analysis of archived complaints made to the BACP; and an exploration of reasons why clients who have experienced poor or harmful therapy choose not to complain. Methods in each of the projects have been chosen with a view to what best answers the chosen research questions.

The research conducted for this thesis cannot claim to have been conducted from an emancipatory research position, as it has not set out to transform or empower the lives of those whose experiences are investigated within it. It is more accurate to describe the epistemological position of this research as constructivist-interpretivist. However, elements of emancipatory philosophy have informed the design and approach throughout, particularly in relation to the dynamics of power between the researcher and participants and the ethical implications of this, but also in considering the social constructs and political context in which the research and its participants exist.

Researcher reflexivity

Reflexivity is defined in numerous ways and there is considerable variation in definitions and understanding about what is meant by the term (Lynch, 2000; White, 2001). Willig, (2001) describes two types of reflexivity: personal and epistemological. In her view, personal reflexivity requires the researcher to reflect on their own personal beliefs, attitudes, views and values to consider how these have shaped the research, as well as thinking about how the research has impacted upon and developed the researcher. Epistemological reflexivity

involves the researcher considering how the research question and research design choices have affected findings and conclusions.

Where Willig's (2001) ideas about reflexivity address its focus or nature - whether the researcher or the research is examined - McLeod (2001) considers its direction. He highlights a distinction between constructivist and constructionist approaches to reflexivity. While both consider reflexivity to be important, the constructivist approach is inward-facing, requiring the researcher to look ever-deeper into their own expectations, beliefs and thoughts. A constructionist approach, in contrast, involves a more outward-looking reflection on how the researcher's beliefs and expectations are shaped within cultural, social and historical contexts. He concludes by introducing the notion of critical reflexivity, a process of highlighting both the researcher's personal experience in relation to the project and the wider context within which the researcher conducts the research. White (2001) describes this as "…a process of looking *inward* and *outward* to the social and cultural artefacts and forms of thought which saturate our practices" (p102, original emphasis).

If both the internal, personal elements and the external, contextual aspects of the researcher's work require consideration, this suggests an ongoing, iterative process. Etherington (2004) emphasises that this is more than simply self-awareness and describes reflexivity as

> "… a dynamic process of interaction within *and* between our selves and our participants, *and* the data that inform decisions, actions and interpretations at all stages of research." (Etherington, 2004, p36, original emphasis)

It is clear from these definitions that reflexivity carries an important methodological function: that of ensuring quality and rigor. It might also be argued, however, that researcher reflexivity also serves an ethical function (Guillemin & Gillam, 2004; Etherington, 2007) in that it encourages reflection on dilemmas that arise and facilitates "rigorous attentiveness to the quality and integrity both of the research itself and of the dissemination of the results of the research" (BACP, 2001, p7). Reflexivity offers a process

that allows the researcher to attend to the power issues that arise within the research and which participants experience and, in so doing, is compatible with the philosophical position stated in this thesis.

The ongoing process of reflection is facilitated by the researcher noting their thoughts, ideas, feelings and experiences throughout the research process, usually making use of a journal for this purpose (White, 2001). The contents of such journals are usually private, but qualitative researchers are increasingly encouraged to share their reflexivity in research reports, with McLeod going as far as to say that it is essential that the researcher shares the challenges and "the hidden stories that bring their research to life" (1996, p312). This raises questions for the researcher about the nature and scope of reflexive statements in research reports: what kind of reflexive material should the researcher share, how much should be included and to what ends?

McLeod (2001) discusses the use of reflexive statements in published qualitative research articles, offering an example where the authors state their biases and expectations of the research as well as the steps they have taken throughout the research process to limit the effects of these preconceptions. Such a statement is in accord with Elliott et al's (1999) assertion that "owning one's own perspective" (p221) as a researcher and stating this in the research allows the reader to place the research findings into a context and to evaluate the design and the findings. As Stiles states, this "… allows readers to incorporate the investigator's part of the story into their understanding and to adjust their understanding to compensate for the investigator's biases." (1993, p614). McLeod (2001) points out, however, that what is missing from statements like this is detail about other elements of the researchers' experience that might also impact on the research, such as their theoretical orientation or whether they have experienced the phenomenon being researched. He highlights that, in theory, there are many elements of a researcher's life and experience that can influence how they construct the research and what they find, meaning that potentially there is a huge amount of information that the researcher might share.

Rennie and Fergus (2006) write about the inclusion of, "the *right amount* of expressed reflexive awareness when conveying the understanding of the texts under study" (p497,

emphasis added), but offer no guidance as to how the researcher should decide what constitutes the right amount. This might be an especially relevant concern when reflexivity is understood as an ongoing, organic, iterative process as described above, as opposed to a simple parking of assumptions and beliefs that the researcher takes into the research at the beginning. Etherington (2004) suggests that the acid test is whether reflexive statements are "essential to the argument" (p37). Decisions about what is essential will also depend on the researcher's subjective views and Etherington does not offer a systematic approach to making these decisions. Without a clear rationale for what to include, there is a danger of producing writing that is open to criticisms of "solipsism, self-indulgence, navel gazing or narcissism" (Etherington, 2004, p31) or "narcissistic, disguised autobiographies" (McLeod, 2001, p204). In addition, one criticism of reflexive statements is that they can be written as a type of confessional, where the writer shares the mistakes they have made as a way of suggesting that their work is now improved, thereby closing down criticism and debate (White, 2001).

What is needed is a systematic and purposive approach to making reflexive statements, one that makes explicit the thinking behind their inclusion in a research report. Stiles (1993) discusses aspects of good practice in qualitative research and highlights three elements that relate to how reflexivity might be addressed in reports:

- "Disclosure of Orientation" (p602) – the researcher should disclose their expectations, biases, values and beliefs held at the start of the research (this links to McLeod's (2001) description earlier).
- "Explication of Social and Cultural Context" (p603) – this involves making explicit the wider context within which the researcher and participants exist, with a view to alerting the reader to the specific perspective within which the research originates.
- "Description of Internal Processes of Investigation" (p603) – the researcher is encouraged to include details of their thoughts and feelings during the research process and how these influenced their changing understanding of the phenomena under investigation.

These provide useful guidance in themselves, but they also imply a helpful question to focus the researcher in making decisions about what to include in reflexive statements and why: what does the reader need to know in order to fully assess the impact of the researcher on the design, data collection, analysis and presentation of findings?

The ontological and epistemological position adopted in this thesis means that reflexivity has been engaged with actively throughout the entire research process. The researcher has undertaken a continuous process of self-reflection throughout the research projects, explored and documented in a research journal. The reflexive statements that appear in this thesis are drawn from this journal and have been chosen for inclusion through a systematic application of Stiles' ideas (1993). Information about the researcher given in this chapter (to follow) and in later chapters addresses the disclosure of orientation. Reflexive statements that appear elsewhere in the thesis are included to demonstrate the impact of the researcher's individual reflection upon research design, data analysis or in resolving ethical dilemmas. In so doing they seek to contextualise the perspective of the researcher and to describe the thoughts and feelings that shaped the research process. The statements demonstrate the researcher's engagement with epistemological and personal reflexivity as described by Willig (2001), and of critical reflexivity – turning the attention both inward and outward – as highlighted by McLeod (2001). Such statements in the text are kept brief in order not to distract from the primary focus of the thesis, and are indicated to the reader by being presented as boxed text and titled 'reflexive statement'.

Beginning the research journey - a reflexive statement

When the opportunity arose to conduct research into counselling complaints, I felt ambivalent. On the one hand, it was clear that this was precisely the area that my curiosity compelled me to explore – how better to learn how to improve my practice than to look at what can go wrong? At the same time, I was immediately aware of how sensitive an area this would be and also that this topic would raise uncomfortable professional and personal questions.

In informal conversations with other therapists I soon discovered that the subject of complaints in psychotherapy was something about which everybody had an opinion they were not afraid to share. I was warned that this was a journey that would cause needless difficulties for other therapists and for the profession as a whole. A journey that was not needed and which would attract unwelcome attention to professional organisations and perhaps even lead to reputable therapists losing their livelihoods. A journey that, some told me, would likely unleash hell for me both personally and professionally. While considering whether to undertake this research, a colleague warned me that if I chose to do so then I would almost certainly have a complaint brought against me as this was clearly something I unconsciously needed to work through. This was not the encouragement I needed at the start of a six-year process!

I also received many positive responses from colleagues and peers, but the force of the negative reactions I received scared and discouraged me. At the same time, I was intrigued by what seemed to me to be defensive and fearful reactions from people who appeared to want to ignore the possibility of therapy ever going wrong, of mistakes happening or of complaints having any merit. My psychodynamic instincts told me that this was an indication of the potential value of this research, but that I would need to proceed with consideration for the sensitivity of the issues that I was seeking to explore.

Research ethics informed by research philosophy

> "Those researching sensitive topics may need to be more acutely aware of their ethical responsibilities to research participants than would be the case with the study of a more innocuous topic." (Lee, 1993, p2)

Ethical issues have been at the heart of the design of the research projects presented in this thesis. If, as McLeod asserts, "[t]he ethical issues that arise through the conduct of the research are the same as those that occur in the context of counselling practice" (1994, p166), then perhaps particular vigilance is required when researching issues of ethical malpractice in counselling. As Lee (1993) states above, conducting research in a sensitive area also requires the researcher to be scrupulous about the consideration of their responsibilities. In addition, the philosophical position described earlier in this chapter requires the researcher to be attentive to power dynamics involved in research which has implications for how ethical concerns are addressed and resolved.

The research has been conducted with reference to BACP's Ethical Guidelines for Researching Counselling and Psychotherapy (Bond 2004), and the Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP, 2010) which encourage engagement with ethical dilemmas rather than seeking simplistic solutions in published standards or written guidelines. The researcher sought to think continually about the ethical questions posed by the projects as they developed (Abrahams, 2007; West, 2002). A number of ethical issues relating to the needs of vulnerable participants were common to both projects and are discussed here. Details of specific ethical approvals or concerns relating to individual projects are discussed in depth in chapters 3 and 5.

Complaints in counselling and psychotherapy are sensitive for both complainant and the therapist complained against. Counselling is an activity requiring trust and safety, and those people who make complaints are likely to have done so in cases where that trust has been at best challenged or at worst abused (Halter et al, 2007). Approaching a therapist's professional body in order to make a complaint can feel like a risky activity, if it can be

countenanced at all (Coe, 2008). The adversarial process can leave complainants feeling as though they are on trial and not believed. There are issues of power for people in approaching a large organisation that may be seen to exist primarily to protect the counsellor and this may be complicated if the client is from an already vulnerable social group (Sands, 2000; Vinson, 1987; Gulland, 2009; Pleasance et al, 2004). Some people bringing complaints are additionally vulnerable, perhaps because of a history of abuse or because of mental health difficulties (Halter et al, 2007). It is not only complainants who are potentially vulnerable in this research. Practitioners who have complaints raised against them might find they are ostracised or vilified by professional colleagues, resulting in a loss of earnings and a threat to their livelihood, whether a complaint is upheld or not (Van Horne, 2004; Williams, 2000). Even without such material threats, the experience of being investigated can feel intrusive, painful and traumatic ('Chris', 2001).

Given the vulnerability of all the potential participants in this research, the commitment to avoiding causing additional harm (Bond 2004) was of paramount importance. Issues of power and consent were of particular significance in the research given that these are also issues that can arise in cases of malpractice. Seeking consent from research participants involves providing full and clear information about the possible risks and benefits of the research (Hart & Crawford-Wright, 1999), ensuring that agreement is given voluntarily and free from coercion (Robson et al, 2000). In addition, since the notion of *fully* informed consent is contentious (West, 2002), it is considered good practice to endeavour to seek consent on an ongoing basis, checking with participants at different points in the research that they are happy to proceed and offering them the opportunity to withdraw should they wish (McLeod, 2001). Detailed discussion of procedures that were implemented in order to work actively with ongoing informed consent in the project to investigate why people don't complain is given in chapter 5.

The question of seeking informed consent was problematic in the analysis of BACP complaints. In this case, the archived complaints material had not been collected for research purposes and so those involved had not given consent for their accounts to be used in this way. This presented a considerable dilemma for the researcher prior to starting the

research. The option of contacting complainants and members who were complained about in order to seek their consent for their case material to be used in the analysis was considered. However, after considerable discussion and consultation with the research supervisors and with the Head of Professional Conduct and Head of Research at BACP, this option was rejected as it was considered that making approaches to people after complaints had been closed was likely to cause unnecessary distress. This lack of consent from those involved in the research presents an ethical difficulty. In such cases, where the research presents unavoidable risks to the participants, Bond (2004) makes it clear that researchers should consider whether it is "ethically justifiable" (p5) to proceed. Conducting this research and making the findings available through publication might be of benefit to various groups with a stake in processes designed to protect both the public and the profession. In consultation with the supervisors and BACP it was decided that these possible benefits meant that an examination of the complaints was justifiable, but the lack of consent and concerns for the safety of participants led to decisions to limit the depth of the research. While concern to minimise the potential for harm was important in the design and execution of all elements of the projects, it was particularly instrumental in decisions about what to omit from the research.

A key element in seeking to protect participants in both studies was the maintenance of confidentiality. This is important in all research in counselling and psychotherapy (Bond, 2004; McLeod, 2001; Robson et al, 2000), but perhaps particularly so in complaints research where participants might have good reason to be mistrustful of the fidelity of a researcher who wishes to make use of their personal material. A range of systems and processes was used throughout the research to ensure confidentiality and anonymity of participants (specific details of these are discussed in chapters 3 and 6). Clear information about how the researcher set about managing confidentiality was offered to participants as part of the consent process (Robson et al, 2000). Care not to inadvertently disclose identifiable information was a key concern in the researcher's descriptions of the nature of complaints and in choosing quotes from questionnaire and interview participants.

Although the researcher's responsibility to the research participants was the most important consideration (Bond, 20024), the responsibility for self care was another significant area during these projects. Hart and Crawford-Wright (1999) highlight potential emotional risks to researchers in engaging with distressing material, while Etherington (2004) and Abrahams (2007) highlight the high degree of stress and anxiety that a researcher can encounter if the research area is sensitive. Exposure to stories of malpractice and abuse in therapy was an integral part of this research, both in the BACP complaints material and the questionnaire and interview responses. Research supervision (Bond, 2004) and the use of a research journal as a method of reflecting on the experience of conducting the research (Janesick, 2000; Abrahams, 2007) were both used not only in order to address methodological issues but also as a means of supporting the researcher with what, at times, was emotionally challenging work.

Conclusion

Ontology, epistemology, methodology, reflexivity and ethical awareness are not discrete aspects of this research, but are interrelated. The research has been conducted from an epistemological position which recognises that reality is constructed within a social context, but which also pays attention to the importance of power in individual experience and in research processes. Rather than being bound to one methodological approach by this philosophical position, the researcher acknowledges the influence of their assumptions in the choice and formulation of research methods, but takes a pragmatic approach to choosing methods. An ongoing process of reflexivity allows the researcher to examine their beliefs and assumptions, as well as facilitating the attention to power dynamics that is part of this philosophical position, and informs the consideration of ethical issues.

PART 1 – RESEARCHING THE BACP COMPLAINTS ARCHIVE

Chapter 3 – Methods

This chapter details the research design used to conduct an in-depth analysis of complaints made to BACP. The first section considers the research questions that this project aimed to answer and methodological considerations raised by these questions. Next, the two procedures used by BACP for considering complaints and allegations of misconduct are described in detail and illustrated in a flowchart diagram. This is followed by a discussion of the design of the research project with attention given to specific difficulties that shaped the project. Researcher reflexivity and ethical concerns encountered within the design process are also discussed. Finally, details of the methods used for each stage of the project are given.

Research questions and methodology

This research set out to examine the archive of complaints at BACP. McLeod (2001) suggests that documentary research is of value, particularly given that the documents have not usually been compiled for research purposes and so the material within them has not been influenced by the researcher. Scott (1990) states that archives represent a large source of documents for social science researchers, while Velody (1998) argues for the importance of such documents which offer a wealth of considerable meaningful data. Official documents held by public bodies or private organisations usually have restrictions to their access that require the researcher to gain special permission (McCulloch, 2004). The large amount of material held in archives can also be intimidating for the researcher to negotiate (McCulloch, 2004). Steedman (2001) gives an evocative description of the fear and anxiety that researchers can experience when faced with the mountain of paperwork that can comprise a single record, let alone an entire archive.

Aside from the volume of written material contained in an archive, there are myriad pitfalls that can beset the documentary researcher: difficulties with the archive index; incomplete or missing records (McCulloch, 2004); and the problems of developing a system for examining and using the material in the documents (Velody, 1998). In the case of the complaints archives, there are additional problems related to the reasons for which documents such as complainants' letters have been written. Lloyd-Bostock and Mulcahy (1994) state that these letters are written for a particular purpose, to be persuasive and convincing. Similarly, Nettleson and Harding (1994) point out that complaint letters set out to present the complainant in a particular way, as reasonable. By extension, it is not excessive to suggest that this is true for letters written by therapists in response to complaints allegations. Each of these issues can make analysis of the complaints archives problematic.

Specific research questions were defined after a review of the published complaints research literature and an initial examination of the nature of information available within the BACP complaints files. The questions were developed in order to make the best possible use of the archive and in order to gain a breadth of information across the four areas of prevalence, process, people and practice, given that so little previous research has involved complaints directly. Some limits on the scope of the questions were agreed with BACP given the confidential and sensitive nature of the complaints documents and this is described in more detail later in this chapter. The research questions are illustrated below in Table 6 to show how they relate to these four areas for research.

Table 6: Research questions for analysing BACP complaints.

BACP complaints				
Prevalence	Process	People		Practice
		Practitioners	Complainants	
How many are received each year? How many are upheld per year? How do the numbers of complaints compare with membership numbers?	How many complaints reach each stage of the process? How long from receipt, through stages and to closure? What sanctions are imposed?	What are the demographic characteristics of those complained about? Including: gender; training; theoretical orientation	What are the demographic characteristics of those who complain? Including: gender; lay person / therapist	What do people complain about? What is the frequency of different types of complaint?

These questions, for the most part, suggest quantitative methods, and the complaints archive was used to compile a database of information in order to produce descriptive statistics to answer these questions. To answer questions about the nature of complaints and sanctions, the project also uses a version of thematic analysis (Braun & Clarke, 2006). In this instance, the qualitative methods used might be best described as 'small q' qualitative methods as they are used not to explore meaning or experience, but rather to produce data from large amounts of text that can then be used quantitatively (Kidder & Fine, 1987, cited in Willig, 2001, p11).

BACP ethical codes and professional conduct procedures

The British Association for Counselling and Psychotherapy (BACP) is the largest and broadest professional body representing counsellors and psychotherapists in the UK. Its remit is one of developing and informing its members while also protecting members of the public. BACP provides information and advice to inform policy and procedures concerned with counselling and psychotherapy, and it has been active in contributing to government consultation regarding statutory regulation.

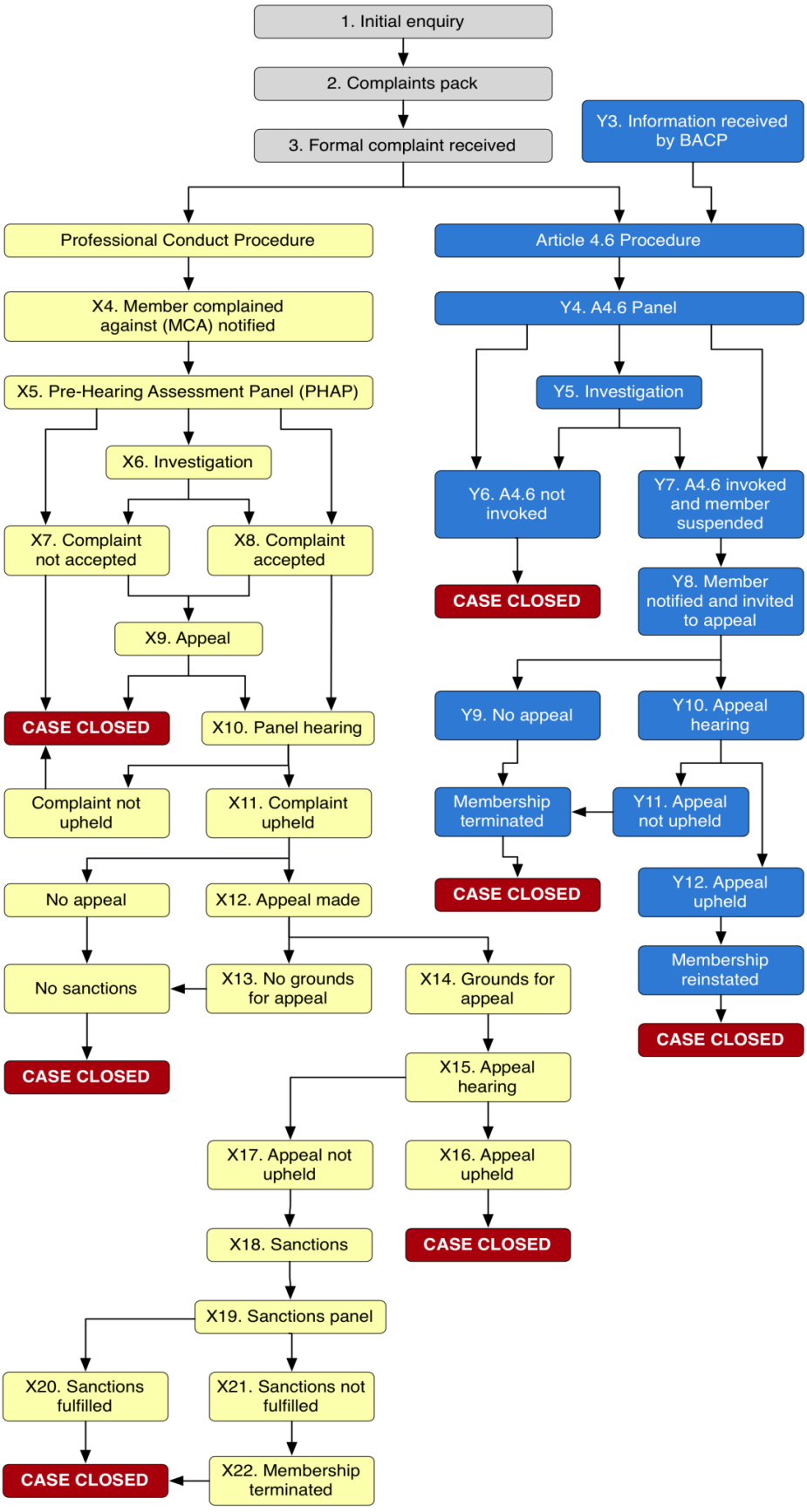
In order to meet its aim of protecting members and the public, BACP sets and maintains standards which its members are required to meet. These ethical requirements have been detailed in various Codes of Ethics and Practice which have been amended and developed over a period of years: for Counsellors (BAC 1984, 1990, 1992a, 1993, 1996a, 1998a); for Supervisors (BAC 1988, 1996b, 2000); for Trainers (BAC 1985, 1995, 1996, 1997); and for Counselling Skills (BAC 1989; 1999). In a similar way, the Complaints Procedure has undergone change and amendment over the years (BAC 1986, 1991, 1992b, 1994, 1998b).

The current Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP 2010) brings together the association's ethical requirements for members, irrespective of their area of practice. It encourages ethical thinking rather than proscribing specific behaviours in practice. The Complaints Procedure has become the Professional Conduct Procedure (PCP) and is integral to this document. The processes by which complaints to BACP are made and considered are described below.

Process – making a complaint to BACP

Figure 2 illustrates the BACP complaints processes. Numbers in the text below refer to the relevant boxes in this flowchart.

Figure 2: BACP Professional Conduct Procedure & Article 4.6 procedure.



Initial telephone enquiries (box 1) to staff at BACP are handled by the Professional Conduct Department (PCD). Details about the complaints procedure are provided and an information pack about how to make a complaint is sent to the enquirer (box 2).

Formal complaints made to BACP must be formulated correctly in order to proceed to the complaints process – they must be made in writing, must state what the alleged malpractice was and when it took place, and must be against a practitioner who is both a current member at the time of the complaint and who was a member at the time of the alleged malpractice. Complaints are usually considered under the Professional Conduct Procedure (PCP). Very serious allegations of misconduct, such as exploitation or abuse of clients, are considered under Article 4.6 (A4.6) of the Memorandum and Articles of Association. Decisions about which procedure is appropriate are initially taken by the Head of Professional Conduct. Each of these procedures will be described in turn. Detailed procedural information is available in the Ethical Framework (BACP 2010) and the Memorandum and Articles of Association.

Professional Conduct Procedure

In order to illustrate the type of issues that might be considered under the PCP, a fictional example of a written complaint is given below at Figure 3. This example is used by BACP staff for training purposes and is reproduced with their kind permission.

Figure 3: Fictional PCP complaint letter.

1 Main Street, Sunny Town, Blogshire

1 February 2007

BACP
Professional Conduct Department
Lutterworth

Dear Sirs

I wish to make a complaint against Mr Tom Armstrong, who is a BACP member. I don't know where Mr Armstrong lives, but I saw him at his consulting rooms at 15 Church View, Upper Blogton.

I started seeing Mr Armstrong for counselling on 1 May 2000 and saw him every week, apart from holidays, throughout that time. In December 2005 Mr Armstrong suggested that I should start seeing him twice weekly and so we started this on 16 December 2005 and I have been seeing him twice weekly ever since until 18 August 2006, which ended up being my last session; we never had a formal ending because of the consequences of his actions and this too has had an enormous impact on me, as you can probably imagine.

I started having counselling because I have issues with my family. I was the eldest of two daughters; my sister being 8 years younger than me. My sister was, I felt, always the apple of my parents' eyes and she could never do any wrong. She married a very successful consultant surgeon, has a very successful career herself as a barrister and has two lovely children. My career as a social worker has not been so successful for various reasons, as was my marriage which ultimately failed, and I have not been able to have any children, through no fault of my own; my husband changed his mind and said he didn't want any at the time we, I thought, were ready to start a family.

I baby sat for my sister a lot. She tended to just drop the kids off at my house and I was always very happy to look after them; James is now 5 years old and Georgia is 3 years old and they are adorable.

Although I have issues around family, I do not have issues with James or Georgia – they are innocents in my eyes and I was, and always will be, very protective of them. That is why I was so surprised that Mr Armstrong did what he did.

I have been suffering with a bit of depression and low self-esteem for some time and this is why Mr Armstrong suggested that I start to see him twice weekly, especially as it was coming up to Christmas; a time of year I find very difficult, although this was the first

Christmas that he had suggested this. The work we did was very intense and I felt worse almost immediately it started. We worked on many deep family matters that I found quite distressing. I acknowledged that I was intensely jealous of my sister and everything that she has, including the children that I so desperately wish were mine.

In one of our sessions on 12 July 2006, I was feeling particularly low and I suppose, on reflection, a little bitter because of an incident that I had recently experienced with my sister where I started to realise that she took me for granted and that I had been effectively used by her and her husband. I admit that I did say to Mr Armstrong that when I next had the children, I would do something to them to make my sister and the rest of them pay for the way they'd treated me. I think I mentioned something like taking James and Georgia to the seaside and driving the car over the cliff and that way we'd all be dead together. Mr Armstrong tried to get me to talk about this so called 'plan' in more depth in the session, but there was no 'depth' to it and I kept telling him that, so we didn't explore it for very long. Mr Armstrong raised it again with me in the next session which surprised me because I thought I had assured him that it wasn't a 'plan' and I remember thinking that he must have thought I'd really meant it and not accepted my assertion that it was just a fleeting fantasy. I would never hurt James and Georgia. I just sort of laughed it off and said something like: "Gosh, you know I wasn't serious, what on earth made you think I'd do something like that for real. I told you last session that it was just a bitter outpouring at that time"! He never asked me about it again in subsequent sessions.

Then on 20 August 2006 I was called urgently to a meeting with my line manager. I was given a copy of a letter that Mr Armstrong had sent to the Safeguarding Children Co-ordinator in which he details my history of depression, low self-esteem – the whole lot, and finishes it off by stating that I threatened to kill myself and my nephew and niece and that, in his opinion, I should not be working as a social worker (copy attached). This letter was obviously circulated to my line manager and whoever else and, as a result, I have been removed from my post and am currently on 'garden leave'! I suspect I'm going to lose my job over this.

As if that was not bad enough, the following day on 21 August 2006 my sister, her husband and my parents came to my house and accused me of threatening to kill James and Georgia. The scene was horrendous and one I never wish to live through again. My whole family have now said that they no longer wish to see me and I am no longer able to see James and Georgia. I am utterly devastated. I don't know who told my family but can only guess that it was either Mr Armstrong or someone in Social Services on the strength of the content of the letter from Mr Armstrong dated 14 August 2006. Either way, I see him as being totally and utterly responsible for the devastation in my life - I have not only lost my family, but my job and livelihood as well.

It took me a couple of days to get my strength together, and on 23 August 2006 I telephoned Mr Armstrong and asked him why he had written this letter, did he realise the devastating consequences that it would cause and, more importantly, why had he not told me he'd taken this course of action especially as he'd written this letter on 14

August and I last saw him on 18 August! All he said was that he was ethically and professionally responsible for the welfare of, not only myself, but others too and that this gave him a "good and sufficient reason to breach my confidentiality". He never raised this matter with me again after that following session and he waited until 14 August, approximately a whole month later, to write this letter. I trusted him and that trust has been betrayed. I don't feel that I will ever be able to trust anyone again, especially with such sensitive material. I will never go for therapy again.

I don't know what else to do. It has taken me weeks to just be able to write this letter of complaint to you. My life is now in ruins over what was just a rambling, fleeting fantasy and he knew that. I have no history of ever wishing to cause harm to myself or others, despite feeling depressed.

Yours sincerely

Sassy Smith

Enc: Letter from Mr Armstrong dated 14 August 2006

Upon receipt of the formal written complaint by BACP (box 3), the member complained against (MCA) is notified and sent a copy of the complaint in full (box X4). The material provided by the complainant is considered by a Pre-Hearing Assessment Panel (PHAP) to determine whether there is a *prima facie* case to answer (box X5) – that is, whether there is sufficient evidence to warrant a full hearing (box X10), whether further information is required before a decision can be made (box X6), or whether there is no case to answer (box X7). The PHAP panel is made up of three people, usually made up of two members of BACP and a lay professional. Panel members receive specific training in the skills required to undertake this work.

Either the MCA or the complainant may appeal against the decision of the PHAP under certain conditions. Any appeal (box X9) is considered by an Independent Appeal Assessor (IAA).

Complaints where there is a case to answer progress to a Professional Conduct Hearing (PCH) (box X10). The PCH panel is made up of three people who have not previously been involved with the case at PHAP. Again, the panel usually comprises a lay person, and two members of BACP. One of the BACP members will be chosen for having sufficient

knowledge and understanding of or working within the same theoretical orientation as the MCA. A member of the Professional Conduct Team acts as clerk to the proceedings.

At the PCH both the complainant and the member complained against make opening statements and respond to questions from the panel. After the hearing, the panel considers the case and the evidence, and makes a decision based on the written and verbal submissions of both the MCA and the complainant, and any witnesses. The standard of proof applied at these hearings is the civil standard; that is, the panel must decide whether, *on the balance of probabilities,* the activity that gave rise to the complaint has occurred (Griffin 2004). There must be sufficient evidence to support each of the allegations and the panel has to decide whether it is more probable than not that the events complained about occurred. Based upon the evidence in the written submissions and the PCH, the panel decides whether or not the complaint is to be upheld. In cases where a complaint is upheld by the panel (box X11), sanctions may be imposed on the member (box X18). Complainants and MCAs are notified in writing within 28 days of the outcome of the PCH.

MCAs may make an appeal against the PCH decision (box X12) on certain grounds: if the facts were found against the weight of the evidence; if the sanction is disproportionate and unfair; if there is evidence of a procedural impropriety; or if there is new evidence that was not available at the time of the PCH. Any appeal must be made in writing and must be made within 28 days of notification of the PCH decision. If an appeal is made, the grounds for appeal are considered by an IAA. The appeal may progress to an appeal hearing (box X15), or may be rejected (box X13) if there are insufficient grounds. Decisions of complaints that are upheld and not appealed, or which are appealed but do not progress to an appeal hearing, are published in *Therapy Today* and on the BACP website.

In cases where the IAA determines that there are grounds for an appeal (box X14), an appeal hearing is convened (box X15). At the appeal hearing a panel made up of three people (two BACP members and one lay person who have not previously been involved with the case) reviews all the written evidence and meets with the complainant, MCA and any representatives accompanying them. The panel can decide to allow the appeal against the original decision (box X16) or to uphold the original decision (box X17). Complainant

and MCA are notified of the appeal panel decision within 28 days of the hearing. The decision of the appeal panel is final. Complaints decisions in cases where appeals are not upheld are published in *Therapy Today* and on the BACP website.

In cases where sanctions have been imposed (box X18), the MCA is given a timescale to comply with them and must report back to a sanction panel after this time (box 19). The sanction panel decides whether the sanctions have been satisfactorily fulfilled (box X20) before closing the case. In cases where sanctions have not been complied with (box X21) membership may be terminated (box X22). Final outcomes of sanction panels are recorded in *Therapy Today* and on the BACP website.

Article 4.6 process

The Article 4.6 process[5] exists in order that the Association can address very serious allegations of counselling malpractice, such as abuse of clients or cases where a member's actions could bring counselling and psychotherapy into disrepute. The process allows the Association to take action quickly upon receipt of a serious allegation against a member.

In order to illustrate the type of issue that might be considered under A4.6, a fictional example of a written notification of misconduct by a member is given at Figure 4.

[5] Since this research was conducted the Article 4.6 process has become the Article 12.6 process.

Figure 4: Fictional A4.6 case.

Somewhereshire Council
Council Buildings
Civic Road
Somewhere
Somewhereshire
SM3 1SE

7th May 2008

Dear Sir/Madam,

I am writing to inform you that Ms X, whom we understand to be an accredited member of BACP, has today been dismissed from her post as Counselling Services Manager due to gross misconduct.

A complaint was received from one of our employees who was seeing Ms X for counselling at our Staff Counselling Service. The complaint alleged that Ms X was drunk during a counselling session. During our investigation, Ms X admitted that she had been drinking alcohol prior to client sessions. Ms X has received two previous formal warnings for alcohol use at work.

I hope that your organisation will find this information useful and trust that you will take any necessary action.

Yours faithfully,

A. Personnel-Person
Human Resources Manager

As with PCP cases, a complaint might be raised by someone who has directly received counselling from the MCA, in which case a formal letter of complaint would be required (box 3 of flowchart at Figure 1). Alternatively, a third party, such as a client's partner or a counsellor's employer, might write to make an allegation which is considered under A4.6. In contrast with PCP cases however, the A4.6 cases might not have a direct complainant, but the process might be set in motion by the Association acting on information from public sources such the press (box Y3).

Information that makes up the allegation is passed to an A4.6 panel (Y4) and the MCA notified, although they are not expected to respond at this stage. The A4.6 panel is made up

of three people, usually two members of BACP and one lay person. In contrast with the PCP hearings, the panel does not meet with the complainant or notifier or with the MCA. The A4.6 panel considers the evidence and decides whether the information is of sufficient seriousness to warrant immediate suspension of membership (box Y7), whether further investigation is required (box Y5), or whether A4.6 need not be invoked (box Y6). The current procedure allows the panel to investigate the allegations in much more detail than in the past before making their decision.

Reasons for invoking A4.6 are:

- Bringing BACP into disrepute
- Bringing the reputation of counselling and psychotherapy into disrepute
- Bringing BACP's private business into the public domain
- Impeding the legitimate activities of BACP
- MCA misrepresenting their membership status (as a qualification to practise or other)
- Serious breach of the Ethical Framework and PCP cannot be used or is inappropriate under the circumstances

The MCA is notified of the outcome of the A4.6 panel. If A4.6 has been invoked and membership has been suspended, the MCA is invited to appeal this decision within 28 days (box Y8), stating their case in writing. If no appeal is made (Y9), the MCA is notified that their membership is terminated and this is published in *Therapy Today* and online at the BACP website. When an appeal is made, the case is heard by an appeal panel (box Y10). The appeal panel is made up of three people, two of whom are members of BACP and one lay person, none of whom were involved with the original A4.6 panel. The MCA attends the appeal hearing and may bring a representative. The panel considers the evidence and submissions from the MCA before arriving at a decision. The MCA is notified of the outcome of the appeal within 28 days of the hearing. The appeal panel may accept the appeal and reinstate the MCA's membership (box Y12) or deny the appeal and terminate membership (Y11), in which case the decision is made public in *Therapy Today* and on the BACP website. The decision of the appeal panel is final.

Research design

The process of designing the research project was not entirely smooth. Difficulties associated with using non-research material for research purposes were encountered relating to missing data and confusion regarding technical terminology. The final design of the project in three stages is the result of responding to the emerging findings, and difficulties encountered in this evolving process are discussed below.

Design issues

The first issue encountered related to missing data. When all the documents had been entered into the database, it became clear that there were gaps in the data as the file numbers indicated that some cases were missing. This was partially accounted for by BACP's current policy regarding retention of documents relating to complaints, which is to destroy them seven years after the case is closed. This means that for some cases which were resolved quickly there were no longer records, whereas for other cases which took longer to resolve, the record remains, even though the case was triggered far longer ago than seven years. In other cases, where complaints were upheld and membership terminated, minimal records have been kept in order that the Association can take appropriate action should the person reapply for membership. The database was amended to include as many records as possible, but this means that there were incomplete numbers of cases in the early years covered by the database, as well as in the final years since open cases were not included. It also means that figures relating to the proportion of cases upheld are unreliable for the early years because cases not upheld have been destroyed earlier.

The second omission noticed in compiling the database was that cases that had not been accepted at a PHAP were not included. This is because when a PHAP decides that there is no case to answer, the case is not classified as a complaint by the PCD. The confusion around terminology was related to the use of the word complaints. Initially, the main researcher used the word complaints to refer to any written grievance received by BACP

and considered under any of its processes. This is not, however, how the word complaint is understood in the PCD where it has a specific meaning. This was important because the documents were held and archived within the PCD and the staff within the department either brought the paperwork to the researcher or pointed out the relevant files on the shelves; the researcher was not aware that the word complaints had such a specific, narrow definition within the team. On discussing this with the PCD team, an additional 29 PCP cases that had not been accepted by a PHAP and had been filed separately were identified. These were subsequently added to the database and the statistics recalculated.

Additionally, once the PCP database was completed and the analysis of the nature of complaints was underway, it became clear that complaints of the most serious nature were not present in the database. On discussion with the PCD team, it emerged that the A4.6 cases had not been included in the documents passed to the researcher. Once again, this seems to have been a misunderstanding between the researcher and the PCD team. The team had not made the researcher aware of these cases as they are not described as complaints, a term that the department uses only to refer to PCP cases. Discovering this misunderstanding meant that the researcher was able to find out more about the A4.6 process and the second stage of the research project was developed from this point.

Having completed the data collection from the PCP and A4.6 cases, limited conclusions about what leads to complaints were possible. In the PCP, clauses under the Codes of Ethics and Practice or Ethical Framework can be invoked for a wide range of activities. Clauses under 'boundaries', for example, might be invoked when the misconduct includes dual relationships or poor timekeeping. Similar limitations were encountered with the A4.6 cases where the reasons for invoking this procedure, such as 'bringing BACP into disrepute' might be cited for misconduct ranging from sexual abuse of clients to mismanagement of the ending of counselling. In addition, comparison across the PCP and A4.6 cases of what leads to complaints was not possible given these different methods of recording.

Developing the design – a reflexive statement

Reading the documents in the complaints cases proved to be not only a time-consuming task but also an emotionally challenging one. Both complainants and those complained against often wrote lengthy letters in which they included considerable detail about events. Reading the allegations in the complaints letters was at times shocking, horrifying or unbelievable, while at other times I experienced a strange disconnection or lack of interest. I felt keenly that I was in a privileged position to be able to see this information, but also sometimes experienced a prurient, voyeuristic sense of having access to something forbidden. Complainants' accounts of their experiences were powerful and evocative, often leaving me upset or angry that such things might happen within therapy. Similarly, the written responses of those complained against also evoked strong reactions within me. On occasion I noticed a disturbing sense of being able to recognise some aspects of my own practice, which caused me to feel vulnerable about the therapeutic, supervisory and training work I was doing. At other times I felt strongly that I wanted to distance myself from therapists whom I viewed as abusive and lacking in responsibility.

Overall, having access to the complaints material encouraged me to deepen my reflection on my own practice. What was most striking, however, was how engagement with complainants' and members' letters forced me to ask difficult questions of my own practice that I might not otherwise have done. As a researcher this highlighted the potential usefulness of the complaints material for other practitioners, but this also raised a dilemma given that the level of access that I had to the complaints could not be produced in detail in any written results. How could the accounts of what had happened in therapy (or supervision or training) be analysed in such a way as to offer something meaningful from which practitioners might be encouraged to reflect on their own practice?

It was decided that a limited qualitative analysis of complaints allegations would produce more meaningful information about the events that lead to complaints, and also provide a means of comparing complaints across the PCP and A4.6 cases. This analysis was not intended to provide an in-depth consideration of the experiences of complainants as this was considered inappropriate without their explicit consent.

Ethical considerations

The University of Leicester's procedure for considering the ethics of research projects was followed and approval granted (Appendix 1). Approval for the project was also given by BACP which agreed for its documents to be scrutinised in line with specific standards of confidentiality (Appendices 2 and 3). In addition, this project was conducted with reference to BACP's Ethical Guidelines for Researching Counselling and Psychotherapy (Bond 2004).

The complaints analysis does not directly involve any participants, for example through interviews or the use of questionnaires, but makes use of sensitive written material from complainants and members of the Association against whom a complaint has been made. The people in both these groups can therefore be regarded as indirect participants. Complaints in counselling and psychotherapy are sensitive for both complainant and member complained against and "[r]esearch concerning socially sensitive issues may create areas of vulnerability for people who are fully functioning in all other ways" (Bond 2004). This suggests that complainants and members complained against can be considered to be potentially vulnerable indirect participants in this research.

Given the vulnerability of complainants and MCAs, gaining informed consent for their complaints material to be used in this research was problematic. Since 2007, complainants and MCAs have been informed in the written material they receive from BACP that documents associated with the complaints might be used for research purposes, but this was not the case prior to this date. On the one hand, it is good practice to ensure that participants are fully informed about the research process and possible risks to them before agreeing to participate, as well as having the option to withdraw consent for participation (McLeod 1994). On the other hand, approaching complainants and members complained against was both practically problematic and ethically questionable. The archive at BACP holds complaints that are up to ten years old, so practical issues such as whether contact details were up to date and, therefore, if confidentiality could be protected when making contact was a concern. In addition, contacting people regarding cases which had closed

perhaps up to ten years ago could in itself raise difficult and painful feelings, and perhaps cause unnecessary harm.

These potential risks raised a dilemma about this research which was considered by the main researcher, the research supervisor and representatives of BACP, in line with the Ethical Guidelines:

> "Whenever unavoidable risks are identified, the researcher should consider, in consultation with appropriate others, whether it is ethically justifiable to carry the research forward and, if so, what safeguards are required." (Bond 2004)

For the purposes of this project it was agreed that the fact that the research would comprise anonymous, descriptive statistics avoided excessive intrusion into the experience of those involved with the complaints. This, combined with procedures described below was considered to mitigate sufficiently the possible risks of the research and therefore the project could proceed without complainants or MCAs being approached for their explicit consent.

Protecting the identities of participants was of paramount importance in this research and steps were taken throughout to ensure and maintain strict confidentiality. Approval from BACP for the project was granted only upon agreement that the researcher would adhere to procedures to protect the identities of people involved with the complaints. The complaints documents were not removed from BACP premises and were examined on-site, within the PCD's office space. The main researcher and any non-BACP staff assisting in the research agreed to the strictest standards of confidentiality and signed a contract with BACP to this effect (Appendices 2 and 3). As a further precaution, preliminary write-ups of this research were checked for confidentiality by the PCD.

Another consideration in having access to the complaints paperwork is the possibility of reading material relating to practitioners who are known to the researchers or whom they might meet in future. In order to avoid this, it was originally planned that the main researcher and any research assistants involved with the project would use copies of complaints documents with names and other identifying details erased. It quickly became

clear that this would not be practical given that some complaints cases run to many hundreds of pages and that copying these documents would involve excessive time and resources. For this reason the complaints material has been accessed directly by the researcher, complete with identifying information relating to complainants and MCAs. It was agreed that any dilemmas arising regarding the identity of those involved with the complaints would be discussed with research supervisors. In the event, no such dilemmas arose.

Methods

The project comprised three stages: analysis of the Professional Conduct Procedure complaints; analysis of the Article 4.6 procedure complaints; and analysis of the complaints allegations. Throughout the project, the research was conducted by the main researcher, but BACP gave some staff time from members of the research team for assistance with data input and assessing the validity of the qualitative analysis. The data were taken from written case files of the complaints. Each case file contains a substantial amount of written material, including: the initial complaint letter, plus any supporting documentation provided by the complainant; correspondence between BACP and the complainant and member complained against; copies of emails and notes of phone calls; documentation sent to panel members; the panel's report; information about appeals and more.

Stage 1 – PCP cases

Archived material was available for PCP cases dating back to 1996. All fully formulated complaints where there was an existing hard copy document record held at BACP premises were examined, including archived and recent cases which had completed the adjudication process, up to a cut-off point of October 2006. Ongoing cases were not included as part of the project.

A small number of cases were selected as part of a pilot project in order to devise an appropriate data collection form for the research. From this work decisions were made about what data to extract from the case files as follows:

- Biographical information about the complainant: gender; occupation; membership of BACP and accreditation status.
- Biographical information about the MCA: individual/organisation; gender; theoretical orientation; accreditation status; the context of the clinical or professional relationship with the complainant – private practice, supervision, training etc.
- Clauses of the relevant Codes of Ethics and Practice, or the Ethical Framework for Good Practice in Counselling and Psychotherapy, under which the complaint was made.
- Whether the MCA or the complainant made use of support at the adjudication panel hearing, and what form this took.
- In cases where complaints were upheld, whether sanctions were imposed and what these were.
- Details and outcomes of any appeal.
- Significant dates in the process and duration of cases from receipt of complaint to PHAP, full hearing, appeal and closure.

Not all headings in the database applied to all cases: for example, if a case did not proceed to a full hearing (such as when a complaint is withdrawn). Likewise, some information, (such as the theoretical orientation of the member complained against) was not available in all cases. In cases where information about accreditation was not available in the complaint record, this was checked with the membership department of BACP. In line with the agreement with BACP, care was taken to ensure that all data extracted from the written files for input to the database was identifiable by case number only to protect the anonymity of those involved.

The cases examined spanned a period that began with Codes of Ethics and Practice as well as the more recent Ethical Framework. Some complaints were considered against more than

one Code of Ethics, for example if the complaint was about both a member's counselling and supervisory practice. Each complaint is raised against any number of relevant clauses of the Code of Ethics and Practice, meaning that multiple entries for the nature of the complaints were noted in the database. All information available was recorded and analysed using Excel software to produce descriptive statistics. Using the data to produce descriptive statistics was also part of the confidentiality agreement with BACP so that no individual cases or people can be identified in the research report.

During the timeframe of the cases included in the project (1996–2006) the Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP 2002) replaced the Codes of Ethics and Practice. Twenty-eight of the cases identified were brought against the new Framework, meaning that these cases were not easily comparable. The main researcher and two assistants independently mapped the 28 complaints on to the relevant previous Codes, assigning them clauses that matched the nature of the complaint. The coding was discussed at a reconciliation meeting before final coding was agreed.

Information regarding sanctions also required categorisation and coding. The main researcher and one assistant independently considered descriptions of the sanctions and, using a thematic analysis, grouped these into categories before meeting to share findings and to agree the final coding.

Stage 2 – Article 4.6 cases

All A4.6 cases where there was an existing hard copy document record held at BACP premises were examined, including archived and recent cases which had completed the adjudication process, up to a cut-off point of November 2007. Archived material was available for A4.6 cases back to 1998. Ongoing cases were not included in the project.

The A4.6 cases were examined using the PCP data form as a template. As the process for the A4.6 differs from the PCP, the database was modified to reflect the information that could be extracted. Information recorded on the database was as follows:

- Biographical information about the complainant, limited to the following: gender; geographical location; occupation; membership of BACP and accredited status.
- Biographical information about member complained against: individual/organisation; the context of the clinical or professional relationship with the complainant – private practice, supervision, training etc; gender; geographical location; theoretical orientation; accredited status.
- Relationship between complainant and member complained against.
- Reasons recorded by the panel for invoking Article 4.6 procedure.
- Details and outcomes of any appeal.
- Significant dates in the process and duration of cases from receipt of complaint to hearing, appeal and closure.
- As with the PCP cases, information was not available under every heading for every case. All information that was available was recorded and analysed using Excel software to produce descriptive statistics.

Stage 3 – Categorisation of complaints

All cases identified in parts 1 and 2 of the project that had been accepted as having a case to answer by a PHAP or where Article 4.6 procedure had been invoked were considered for categorisation. Cases where a decision had been made that there was no case to answer were excluded from this analysis. Initial letters written by complainants were read and summarised into a list of the events described in order to facilitate coding, while protecting confidentiality. Many of the complaint letters are lengthy and include information not only

about what happened that led to the complaint, but also accounts of the impact of the alleged malpractice. The summary process was intended to highlight the events of the cases rather than the complainants' experiences in order to ensure that there was a more manageable amount of material for the initial coding.

Using thematic analysis (Braun & Clarke, 2006), the summaries were read and initially coded into related categories and subcategories. The summaries were then revisited and checked against the categories which led to amendments of the original categories and subcategories to better reflect the material in the complaints. In some cases, where clarification was required, the original complaint case was referred to in order to ensure accuracy. This process was repeated a number of times, referring back to the summaries and the complaints and then amending the categories and subcategories to ensure they accurately reflected what is described in the complaints.

In order to validate the coding, a sample of 18 cases across the range of complaints was randomly selected. Descriptions of the categories and subcategories were given to a research assistant in order to test the clarity of the definitions, and to check whether the complaints would be coded in the same way. Minor amendments were made to the category definitions in the light of this checking. The results given in the following chapter represent the eighth iteration of this work. In line with the confidentiality agreement with BACP, and to protect the anonymity of those involved in the complaints, the descriptions and definitions of complaint categories were checked with the Head of the Professional Conduct Department before being disseminated.

The complaints cases were then mapped against the categories and subcategories to produce descriptive statistics. Many of the complaints were mapped under multiple categories and subcategories, reflecting the range of different events described in the complaint letters.

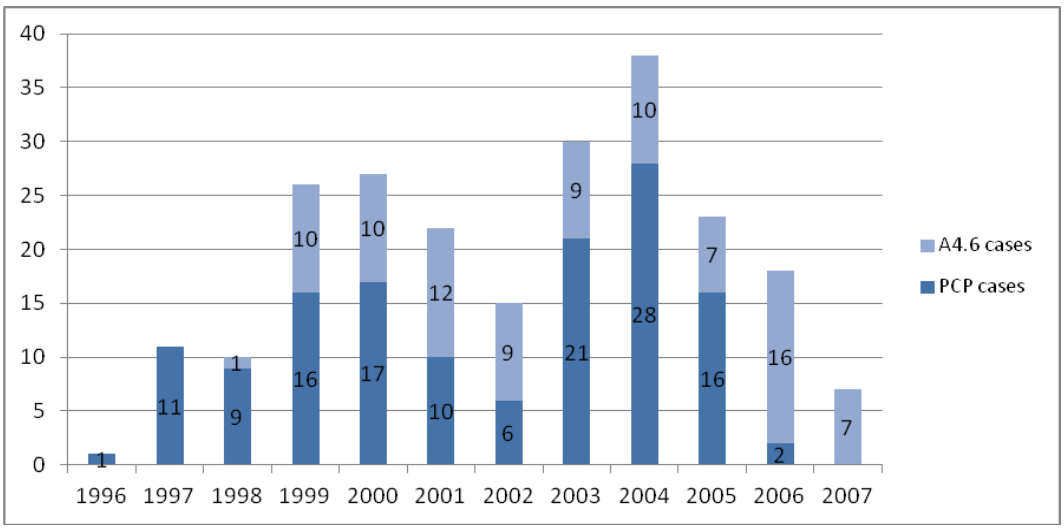
Chapter 4 – BACP complaints findings and discussion

This chapter presents findings from the analysis of BACP complaints. Figures for the numbers and rates of complaints are presented before more detailed results relating to the Professional Conduct Procedure (PCP) and Article 4.6 (A4.6) cases, members complained against (MCAs) and complainants. Findings relating to the categorisation of complaints are presented first in summary with figures for the distribution of complaints across the categories. This is followed by detailed descriptions of the categories and subcategories. Throughout the chapter comparison is made with findings from related research where this is possible. The chapter then discusses the limitations of the research and considers the implications of the findings.

Total PCP and A4.6 cases

The total number of complaints identified in the project was 228, comprising 137 PCP and 91 A4.6 cases, and covering a period from 1996 to 2007. The distribution of these cases by year is shown at Figure 5.

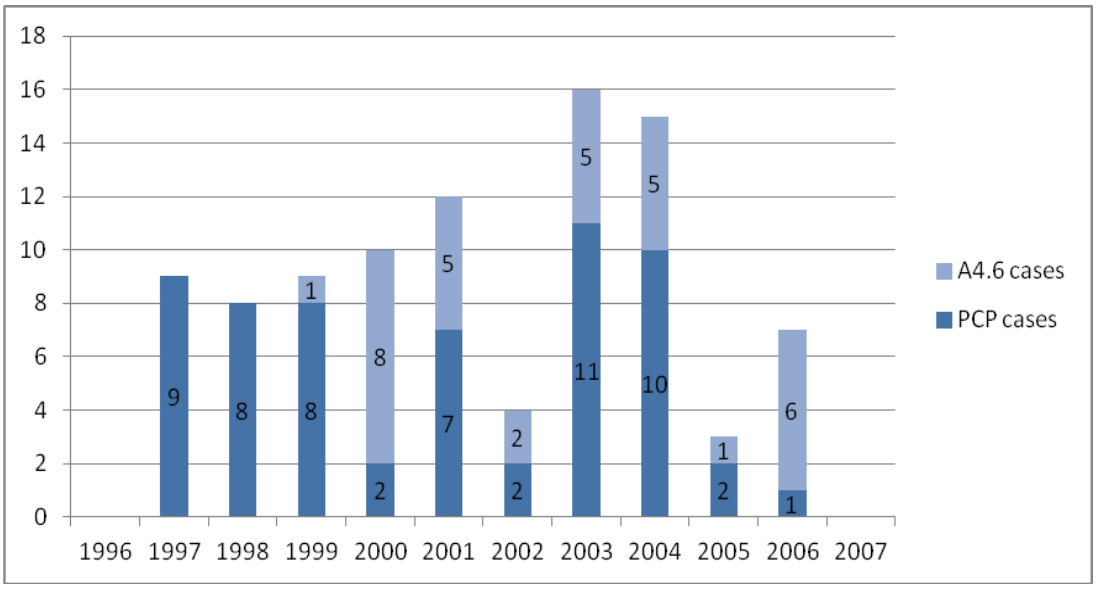
Figure 5: Total complaints per year.



Figures for the early years of the project are incomplete due to the destruction of records seven years after case closure. Figures in the final two years of the project are also incomplete as this research considered only closed cases and excluded ongoing complaints. Nonetheless, it can be seen that while the numbers of PCP complaints have fluctuated over the years, the numbers of A4.6 complaints have remained relatively consistent.

The total number of upheld complaints in the project was 93 (60 PCP and 33 A4.6). The distribution of these complaints is shown at Figure 6. For the purposes of this analysis upheld here refers to PCP complaints that were upheld at PCH and after any appeal, and A4.6 cases that were invoked and either not appealed, or upheld after appeal.

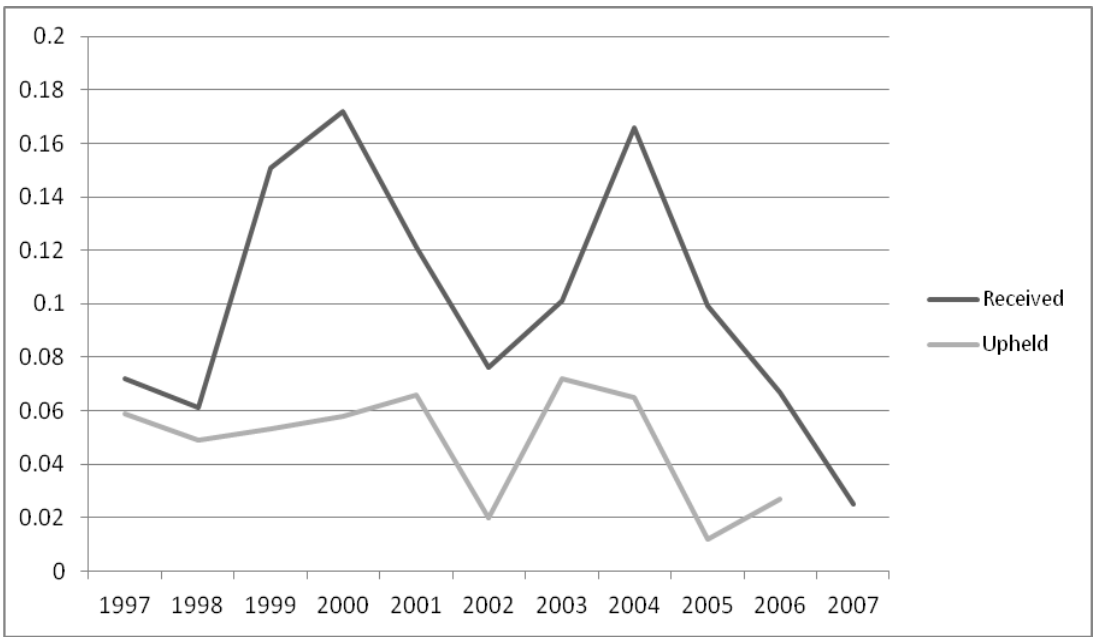
Figure 6: Total upheld complaints per year.



The numbers of received and upheld complaints were compared with total membership figures per year (shown at Appendix 4) and annual rates for complaints received and upheld were calculated, as shown at Figure 7. If the years 1997-8, and 2006-7 are excluded due to incomplete data, the rate of complaints received ranges between 0.076% as the lowest value (2002) to 0.172% as the highest value (2000). The highest value represents an incidence of less than two complaints for every 1,000 members. Similarly, if the years 1996-8, and 2006-7 are excluded due to incomplete data, the rate of upheld complaints as a percentage of membership ranges from 0.012% as the lowest value (2005) to 0.072% as the highest value

(2003). The highest value represents an incidence of slightly more than one upheld complaint for every 1,500 members.

Figure 7: Rates of complaints received and upheld by year.



Although there is a wide range of figures available in the published literature relating to rates of complaints, direct comparison is problematic given the variety of procedures that these figures relate to. The most useful comparison is with practitioner psychologists in the UK with a rate of 0.69% for complaints received in the one full year that they have been regulated (HPC, 2011). There are no comparable figures for upheld complaints relating to practitioner psychologists available in the HPC report (2011), as this relates only to the first full year of registration. When compared with international studies, the most accurate figures come from Van Horne's study (2004) which examines complaints in Canada and the USA. These range from 1.33% in 1999 to 1.60% in 1996 for complaints received, with the most recent figure for 2001 at 1.45%. Rates of upheld complaints are reported as ranging from 0.124% in 2000 to 0.204% in 1998, with the most recent figure being 0.132% in 2001.

Sanctions

A range of sanctions was imposed in PCP cases, the nature of which is discussed in more detail later in this chapter. In 13 of the 60 upheld cases, however, sanctions were made against the professional status of the MCA either through termination or suspension of membership or accreditation. When combined with the 33 upheld A4.6 cases, all of which resulted in termination of membership, this results in a total of 46 cases or 49.5% where the MCA's professional status was sanctioned.

Comparable figures in the published literature are minimal. Neukrug et al (2001) state that professional credentials were revoked or suspended in 55% of cases where sanctions were imposed, while St Germaine (1997) gives a figure of 45% for the same actions. Although there are too few completed cases brought against practitioner psychologists in the HPC report (2011) for comparison, figures for sanctions against registrants as a whole show that 57% were struck off, suspended or chose voluntary removal from the register.

PCP cases – detailed findings

Covering a period of almost ten years from October 1996 to January 2006, 137 PCP complaints were found. Of these, 84 (61.3%) were assessed by a PHAP as requiring a full hearing. Fifty cases (36.5%) were assessed as having no case to answer and are therefore not analysed further in this research. A further three cases (2.2%) were transferred to the A4.6 process and analysis relating to these cases is presented with the A4.6 results.

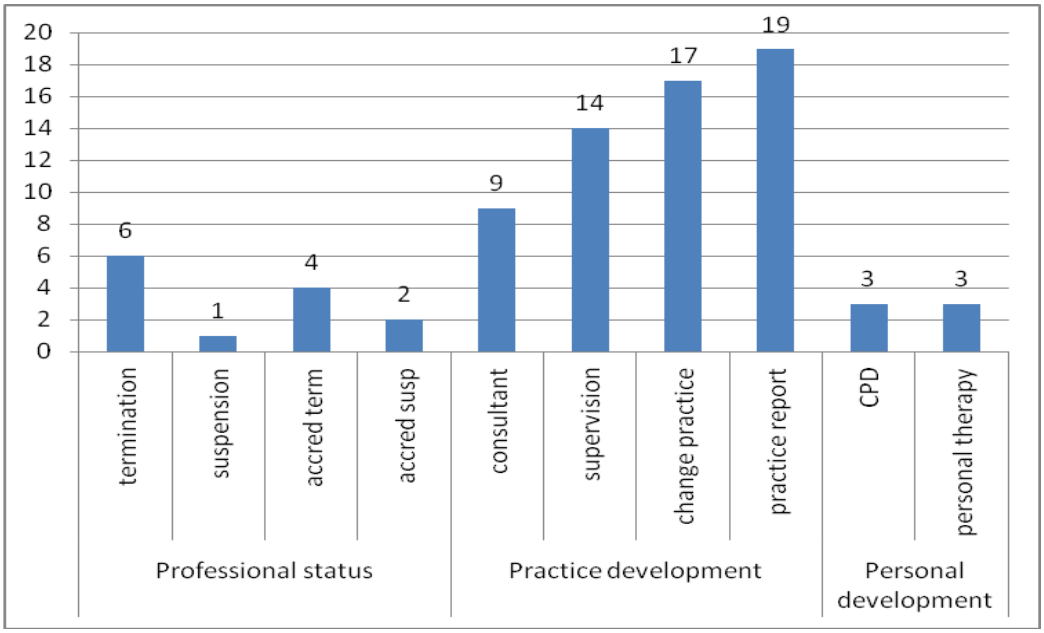
Of the 84 cases assessed as requiring a full hearing, seven (8.33%) did not proceed to full adjudication either because the complaint was withdrawn by the complainant or because the hearing was unable to take place due to the complainant's non-attendance at the hearing. These cases are included in the analysis as far as is possible.

Of the remaining 77 cases that proceeded to a full hearing, 64 (83.1%) were upheld and 13 (16.9%) were not upheld. Eighteen of the upheld cases (28.1%) were appealed. Of these, four

had their appeal allowed. Thirteen did not have the appeal allowed while a further one had the appeal partially allowed. When these 14 cases are combined with the 46 cases that that did not appeal the outcome, this results in a total of 60 upheld cases, 71.4% of cases that proceeded to a full hearing, and 43.8% of total PCP cases received.

Sanctions were imposed in 54 cases, representing 64.3% of cases considered at a full hearing, and 39.4% of the total PCP cases received. A breakdown of sanctions by type is shown at Figure 8.

Figure 8: PCP sanctions by type.

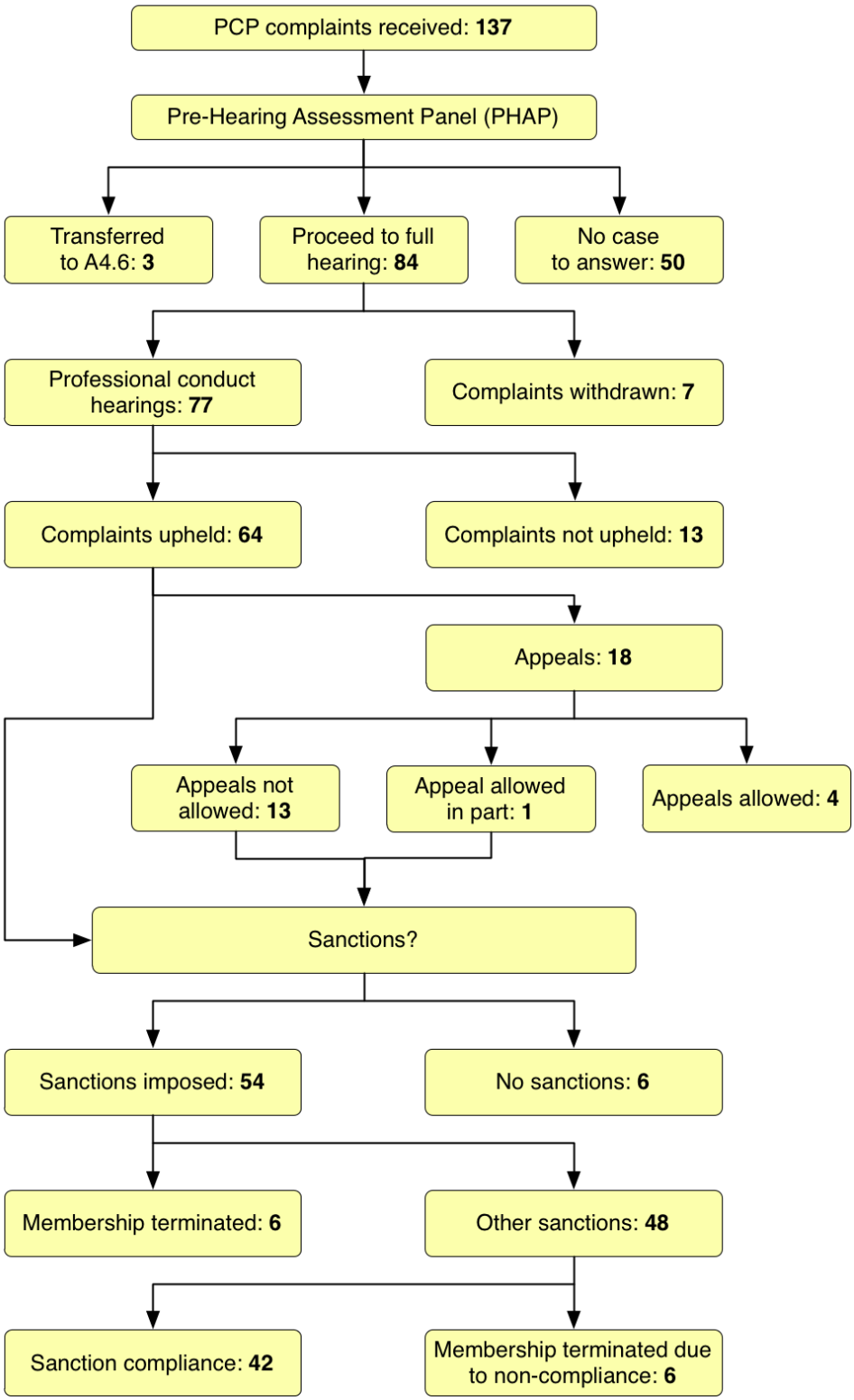


Many cases received multiple sanctions meaning that a total of 78 individual sanctions were identified. As described earlier, in 13 cases resulting in sanctions, members' professional status was sanctioned, with membership or accreditation being suspended or terminated. However, 59 of the sanctions (representing 75.6% of the sanctions in PCP cases) were educative, with the majority resulting in requirements for the practitioner to make changes to their practice, perhaps by undertaking further supervision or further training, or for an organisational member to appoint an external consultant to assist with developing policies

and practice. Six sanctions (7.7%) required additional personal development, such as further training or personal therapy.

Findings for the PCP cases are summarised in the flowchart at Figure 9.

Figure 9: Summary of PCP findings.



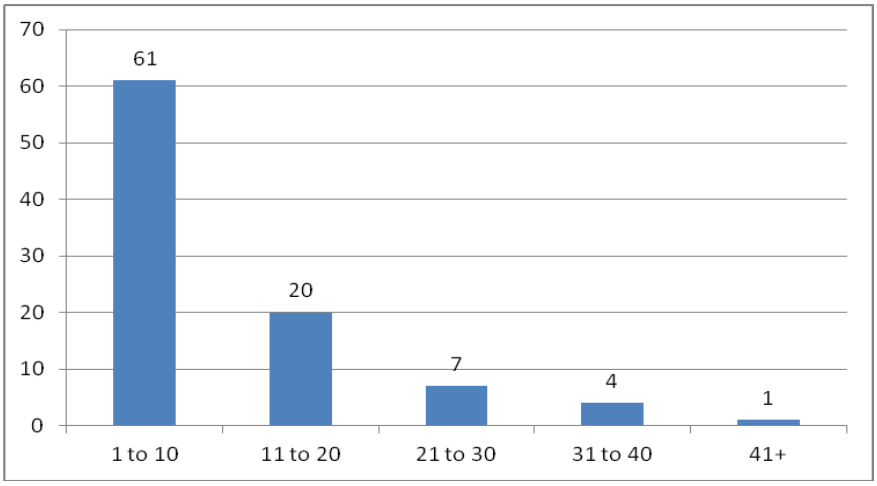
Duration of PCP cases

The nature of the PCP means that cases are closed at different stages. If the PHAP decides that there is no case to answer, for example, this case will be completed much more quickly than a case that proceeds to a full hearing or which goes on to an appeal. It was therefore decided that statistics describing the full duration of all cases would not be as useful as an analysis of the duration of cases to different relevant milestones: PHAP, and full hearing. Insufficient data were available for cases that proceeded to an appeal and so these are not considered here. Duration was calculated by counting the number of weeks from the date of receipt of the formal complaint. Fractions of weeks were rounded to the nearest full week, so three days or less would be rounded down and four days or more would be rounded up.

Duration from receipt to PHAP

Of 137 PCP complaints considered by a PHAP, 93 included the information required to analyse data regarding duration from receipt to the PHAP hearing. The distribution of these findings is shown at Figure 10. This data analysis considers the duration of cases until the final PHAP decision and so includes some cases where additional investigation was required after the first PHAP, resulting in longer durations in these cases. The duration of cases ranged from one week to 41 weeks. The mean duration was calculated as 8.90 weeks and the median duration was seven weeks.

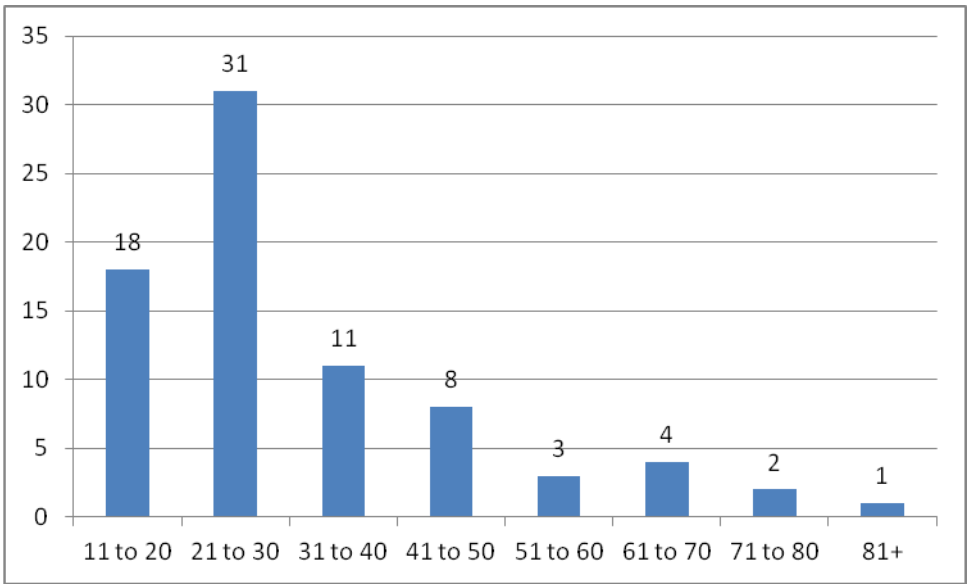
Figure 10: Duration in weeks from receipt to PHAP.



Duration from receipt to panel hearing

Of the 84 PCP cases assessed by a PHAP as requiring a full hearing, relevant information on dates was available for 78. The duration of these cases ranged from 14 weeks to full hearing, to 102 weeks for the longest case. The mean duration was calculated as 31.87 weeks and the median duration was 26.5 weeks. The distribution of these findings is shown at Figure 11.

Figure 11: Duration in weeks from receipt to full panel hearing.



There are no findings relating to duration of cases in any published research relating to counselling and psychotherapy complaints. The HPC report (2010) includes details of the durations of all their cases from receipt of allegation to final hearing, showing a mean duration of 15 months (approximately 64 weeks) and a median of 14 months (approximately 60 weeks).

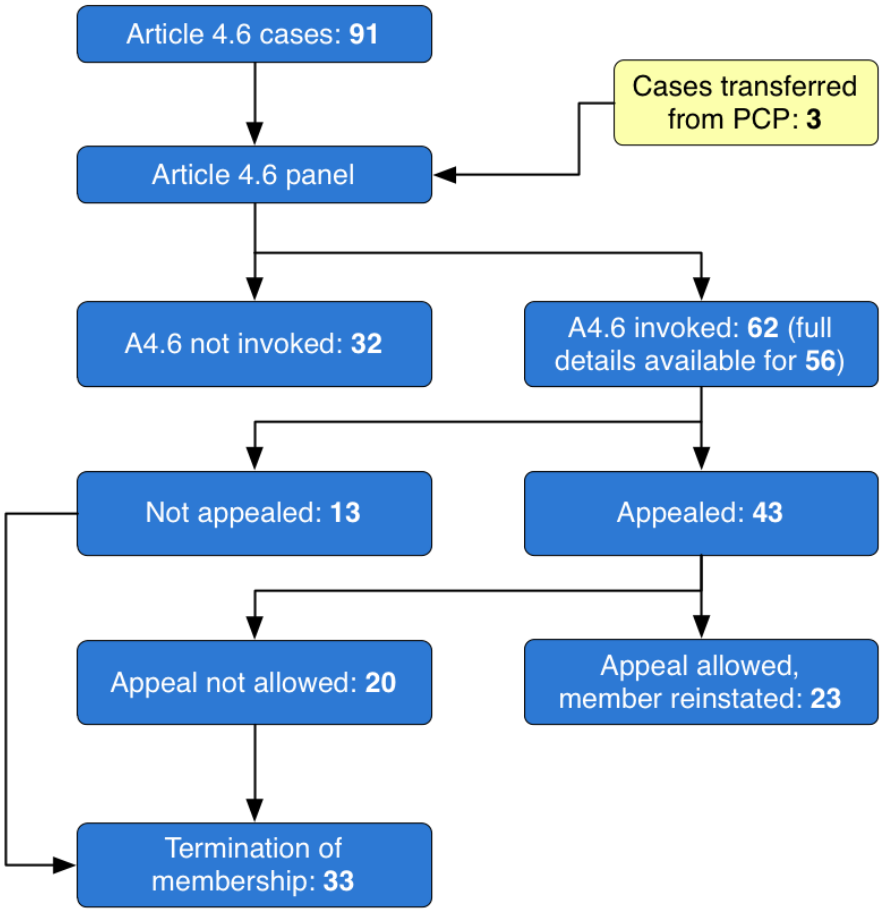
A4.6 cases – detailed findings

The A4.6 analysis identified a total of 94 completed cases from November 1998 to November 2007 (this includes three cases transferred from PCP). Of the 94 A4.6 cases that went to a panel, 32 (34.0%) did not have Article 4.6 invoked and are not analysed further in this research. Of the remaining 62 cases (66.0%) where Article 4.6 was invoked, there were incomplete paper records for six and it was therefore not possible to include them in the analysis, leaving a total of 56 cases examined as part of this research.

Of the 56 cases where A4.6 was invoked, 43 (76.8%) were appealed. Twenty-three of the appeals were allowed and the MCA's membership reinstated. When the 20 appealed cases that were not allowed are combined with the 13 cases that were not appealed, there is a total of 33 cases that resulted in termination of the MCA's membership, representing 35.1% of the total A4.6 received and 53.2% of cases where A4.6 was invoked.

The A4.6 findings are summarised in the flowchart at Figure 12.

Figure 12: A4.6 summary of findings.

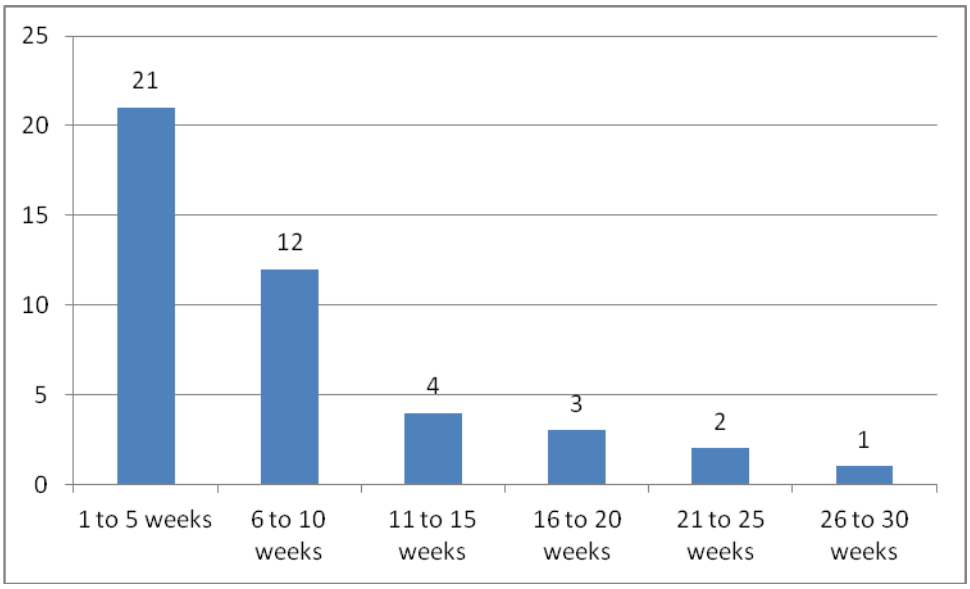


Duration of A4.6 cases

The nature of the A4.6 process means that cases are closed at different stages – if the panel decides that there is no case to answer, for example, this case will be completed much more quickly than a case where A4.6 is invoked or which goes on to an appeal. It was therefore decided that statistics describing the full duration of all cases would not be as useful as an analysis of the duration of cases from receipt to relevant milestones: A4.6 panel, and appeal hearing. Duration was calculated in full weeks as for the PCP cases.

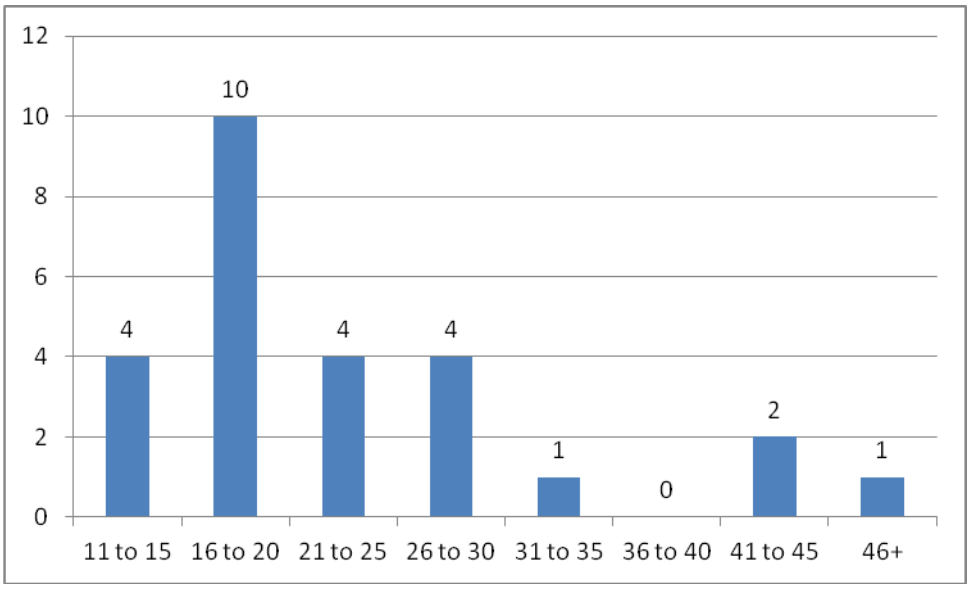
Of the 94 complaints considered by an A4.6 panel, 43 included sufficient information to analyse data regarding duration to the panel hearing. The duration of cases ranged from one week to 30 weeks. The mean duration was calculated as 8.13 weeks and the median duration was six weeks. These findings are shown at Figure 13.

Figure 13: Duration in weeks to A4.6 panel hearing.



Of the 43 cases that proceeded to an appeal, duration data was available for 26 cases. The duration of these cases from receipt to appeal hearing ranged from 11 to 47 weeks. The mean duration was calculated as 21.85 weeks and the median duration was 19.5 weeks. A breakdown of these findings is shown at Figure 14.

Figure 14: Duration in weeks from receipt to appeal panel.



There are no data in the published literature relating to duration of cases for any process similar to the A4.6 process.

Members complained against

The data relating to PCP and A4.6 MCAs were analysed to determine individual or organisational member status, accreditation status, the nature of activity the member was engaged in that prompted the complaint, gender, and theoretical orientation. There is a limited amount of data in the published literature relating to practitioners who are complained about, but any relevant information is included in the findings here for information.

Sixty-four (76.2%) of the 84 PCP complaints that progressed to a full hearing were made against individual members of BACP with the remaining 20 complaints (23.8%) brought against organisational members. Of the 56 A4.6 cases, 48 (85.7%) were brought against individual members and the remaining eight (14.3%) against organisational members. Membership figures obtained from BACP (Appendix 4) show that over the period of the complaints covered in this research, organisational members represented only 5.5% of the total membership in 1997, falling to 4.3% in 2007. There have been, therefore, a disproportionate amount of complaints brought against organisational members in both the PCP and A4.6 complaints.

Of the 64 individual members complained against in the PCP cases, 31 (48.4%) were accredited at the time of the complaint, 21 (32.8%) were not, and data about their accredited status were not available for 12 (18.8%) cases. Among the A4.6 cases, of the 48 individual MCAs, nine (18.8%) were accredited at the time of the complaint, 30 (62.5%) were not, and data about accredited status were not available for nine (18.8%) cases. According to BACP figures, the proportion of accredited members has increased from 10.9% in 1997 to 26.5 % in 2007, indicating that a disproportionate number of accredited members have had complaints made against them in the PCP cases, but the proportion for A4.6 cases is more in line with the membership split.

As members can be complained about while conducting different activities such as counselling, supervision or training, the complaints were analysed to determine which activity prompted the complaint. In the PCP cases, 50 (59.5%) were brought against members in their work as therapists, 18 (21.4%) against trainers, and eight (9.5%) against supervisors. A further eight cases (9.5%) were brought against members in a combination of roles such as therapist and trainer or supervisor and trainer. Of the 56 A4.6 cases, 41 had information available regarding the nature of the work conducted by the MCA giving rise to the complaint. In 33 of these cases (80.5%), the members were working as therapists, three (7.3%) were trainees and five (12.2%) were trainers. No A4.6 cases were brought against members in the capacity of counselling supervisor.

Of the 64 individual members in the PCP cases, 21 (32.8%) were male and 43 (67.2%) were female. In the A4.6 cases, of the 48 individual members complained against, 22 (45.8%) were male and 26 (54.2%) were female. It is not possible to obtain accurate figures from BACP about the gender split of the membership over the entire period that this project covers, but from the figures that are available (Appendix 4), it appears that male members have represented between 15.8% (2001) and 16.8% (1997) of the total membership, suggesting that men are disproportionately represented as MCAs in both the PCP and the A4.6 cases.

Gender is the one area within the published research literature that provides some limited data for comparison. The 2010 HPC report states the breakdown of registered practitioner psychologists as 26% male and 74% female, while the breakdown of those complained against is 42% male and 58% female (no such gender breakdown is given in the 2011 HPC report). Shefler and Achmon's analysis of complaints to the Israel Psychologists Association (2004) shows that 89 men (54.3%) and 75 women (45.7%) had complaints brought against them and although they do not give the gender split of the membership, they state that this represents three times as many men than women are complained about.

The theoretical orientation of the MCA was available in the paperwork for only 31 PCP cases, and for six A4.6 cases, an insufficient number to produce any meaningful results.

Complainants

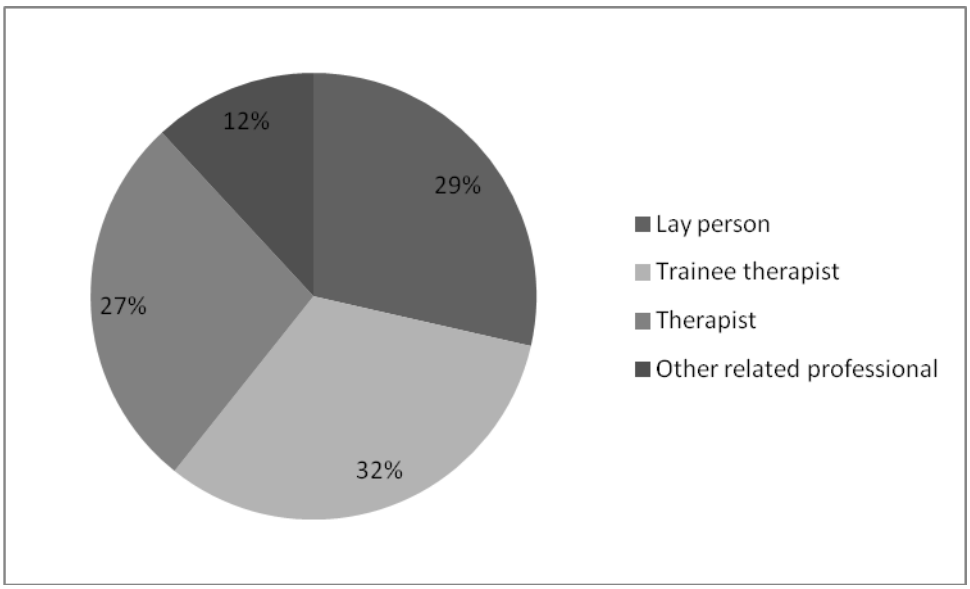
The data relating to PCP and A4.6 complainants were analysed to determine the complainant's gender and professional status. Links are made to comparable data from the published literature where this is possible.

Information about complainants was available for all 84 PCP cases. In the 56 A4.6 cases that have been analysed, information was available about complainants in 47 cases. Of the 84 PCP cases, 17 (20.2%) were male and 73 (86.9%) were female. In the A4.6 cases, information

about the gender of individual complainants was available in 33 cases, where eight (24.2%) were male and 25 (75.8%) were female. There are no corresponding data in any of the published complaints research articles.

In order to determine the proportion of people complaining who are not therapists or working in a similar capacity (referred to as lay people throughout these findings), complainants were classified. This information was available for all 84 complainants, is shown at Figure 15 and breaks down as follows: 24 complaints (28.6%) were brought by lay people, 27 (32.1%) by trainees, 23 (27.4%) by therapists, and a total of 10 (11.9%) by other related professionals such as counselling psychologists. Added together, this suggests that 60 complainants (71.4%) were already working within the field of therapy or were training to do so.

Figure 15: PCP - classification of complainants

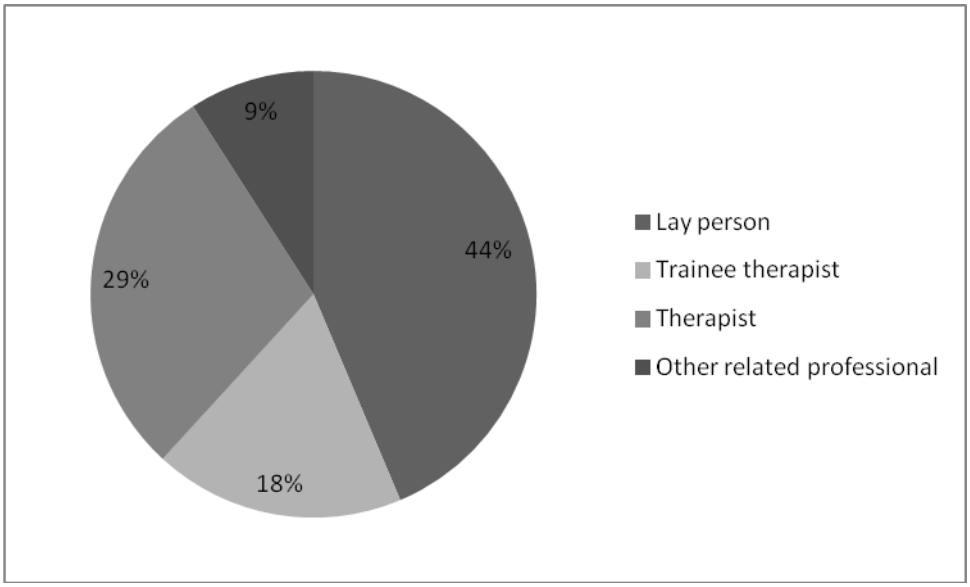


Third party complaints are not possible under the PCP and so complaints against members in their capacity as supervisors or trainers must, by definition, brought by trainees, supervisees or other professionals directly involved with the MCA. It is not surprising, therefore, that the proportion of lay people complainants seems low when looking at the total PCP complaints. Additional analysis was conducted to examine the proportion of lay

person complainants in the complaints against MCAs in their capacity as therapists. This breakdown is shown at Figure 16.

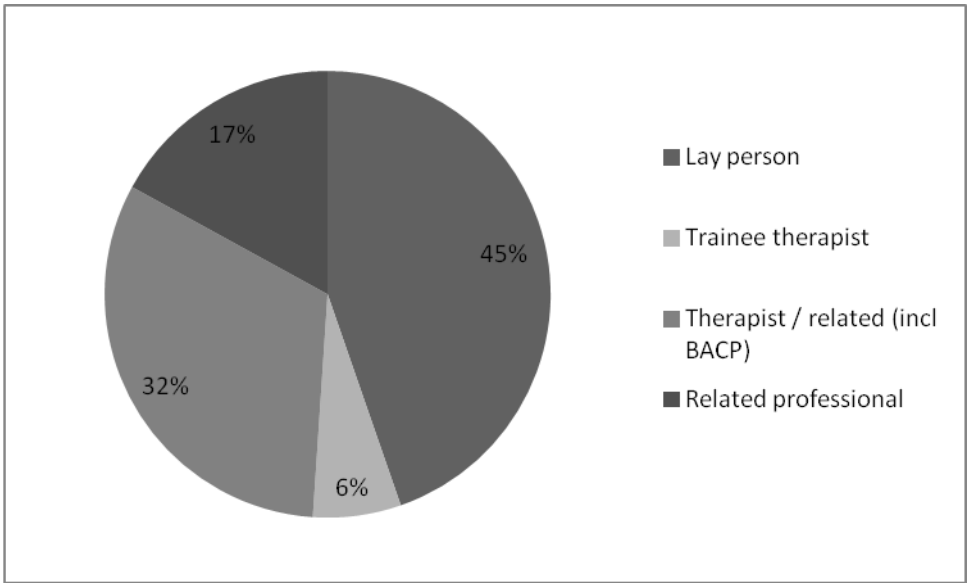
Of the 55 cases identified where clients brought complaints against their therapist, 24 complainants (43.6%) were lay people, 10 (18.2%) complainants were trainees, 16 were therapists (29.1%), and five (9.1%) were from related professions.

Figure 16: PCP - classification of complainants, clients only.



Sixteen of the 47 (34.0%) A4.6 cases that had information about complainants were brought by 3rd parties, that is, someone without a direct relationship with the MCA but bringing a complaint on behalf of the MCA's client. When the MCAs were classified into professional groups as discussed earlier, 21 (44.7%) were lay people, three (6.4%) were trainee therapists, 15 (31.9%) were therapists, supervisors or trainers (cases where BACP acted to bring the complaint were included in this group), and eight (17.0%) were from related professions such as counselling psychology. These figures are shown at Figure 17.

Figure 17: A4.6 - classification of complainants.



There is limited comparable information in the published literature relating to complainants' professional status. The BPS report (2007a) states that 43% of complaints were made by clients, though it is not clear whether all of these clients would be classified as lay people under the criteria discussed earlier. Of the remaining complainants, 13% are listed as professional colleagues and 44% as other types of complainant, without giving details of what is meant by this. According to the HPC report (2011), of the 118 cases brought against practitioner psychologists, 85 (72.0%) were brought by members of the public, with the remainder brought by employers, the police, other registrants or professionals and small numbers in other categories. It is noteworthy that this figure for complaints brought by members of the public is significantly higher than the proportion of such complaints against HPC registrants as a whole, where members of the public represent 33.60% of complainants.

Complaints categorisation

Findings from the categorisation of complaints are presented with an overview of the categories, followed by illustrations of the numbers within these categories relating to PCP and A4.6 cases. Detailed definitions of subcategories follow.

Summary of categories

A total of 140 cases, comprising 56 where A4.6 had been invoked and 84 PCP cases accepted by a PHAP as having a case to answer were considered for categorisation. These cases covered individual counselling, group work, supervision and training. Cases where a decision had been made that there was no case to answer were rejected for this analysis. The complaints were coded into 370 events which were grouped into six categories as shown in Table 7.

Table 7: Categories of complaint incidents

370 events from 140 cases (A4.6 and PCP)					
Boundaries & contracting	Misuse of power	Sexual misconduct	Dishonesty	Negligence	Other
143 incidents 4 constituent categories	94 incidents 6 sub-categories	52 incidents 5 sub-categories	37 incidents 4 sub-categories	36 incidents 4 sub-categories	8 incidents

The **Boundaries and contracting** category contains the largest number of incidents and has been coded into four constituent categories, each containing a number of subcategories. This category includes incidents relating to confidentiality, dual relationships and endings

in therapy as well as frame issues such as gifts, time boundaries and contact outside therapy sessions.

The **Misuse of power** category represents incidents described by complainants where the MCA used their power inappropriately in ways which manipulate, punish, isolate or otherwise harm the client. Incidents within this category range from inappropriate advice-giving to threats and intimidation. While other categories in this study can also be understood to contain incidents that constitute an abuse of power (dishonesty, sexual misconduct, boundaries and contracting, for example), this category classifies incidents that are distinct from them.

The **Sexual misconduct** category represents incidents described by complainants where there is an element of sexual behaviour on the part of the therapist (or supervisor or trainer). This category includes allegations of sexual intercourse with current or ex-clients and different types of physical, sexual touch, but the category has a broad definition and also includes incidents where complainants describe a sexualised dynamic or self-disclosure of a romantic or sexual nature by the therapist. The category of sexual misconduct and all its constituent subcategories could also have been categorised within boundaries and contracting, but this category classifies boundary incidents that are distinguished by their sexual nature.

The category of **Dishonesty** includes incidents where the therapist has lied, perhaps about the nature of their qualifications or where the therapist has committed a criminal act such as fraud. As mentioned above, this category also includes incidents which could be understood as an abuse of power, such as giving a misleading or falsified professional opinion or evidence.

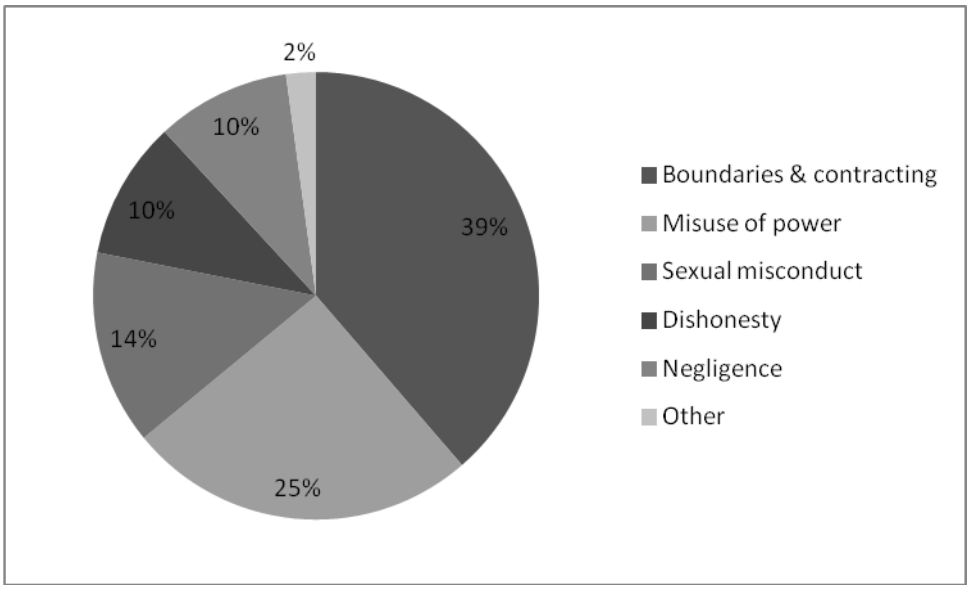
The **Negligence** category represents incidents where the therapist has failed to act appropriately or professionally, or has acted without sufficient concern for their duty of care towards their client. This might include a failure by the therapist to follow policies of their employer or by not having sufficient supervision.

The final category, **Other**, includes eight incidents (all from PCP cases) which did not fit any of the emergent categories and could not be included elsewhere. As these are all distinct events and cannot be described in general terms, they will not be discussed further in the chapter to protect confidentiality.

Distribution of complaints across categories

The distribution of incidents within the categories is shown at Figure 18 and described in detail below.

Figure 18: Distribution of incidents within complaints categories.



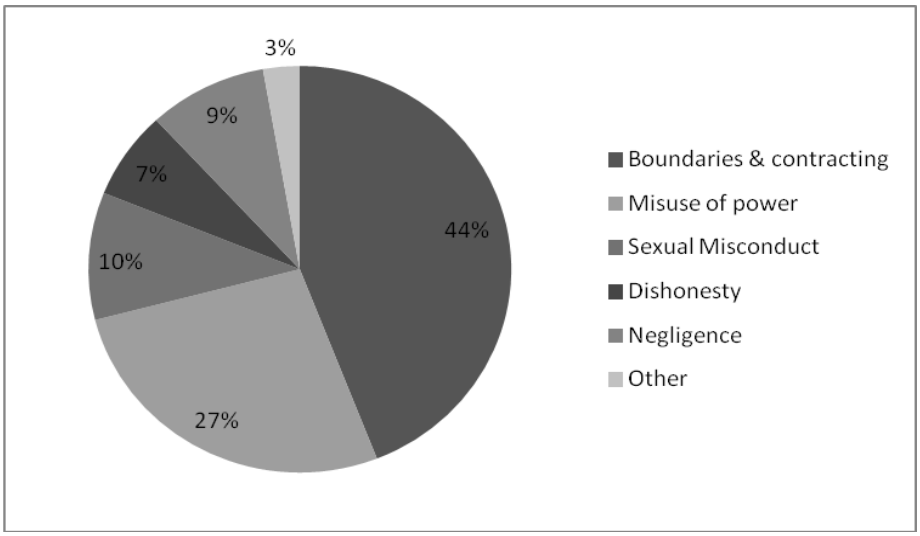
Boundaries and contracting represented the greatest proportion of complaints with 143 incidents (representing 39% of the total), followed by **Misuse of power** (94 incidents, 25%) and **Sexual misconduct** (52 incidents, 14%). **Dishonesty** (37 incidents, 10%) and **Negligence** (36 incidents, 10%) were least represented in the figures.

It is possible to make limited comparison with findings from the research literature, although this needs to be done with caution given the different methods used. The largest single category of complaint in the Neukrug et al study (2001) was inappropriate dual relationships at 24%. The St Germaine study (1997) found that sexual relationships with current or former clients comprised the most common complaints at 22%, while Shefler and Achmon's study (2004) found that the largest category of complaints was psychodiagnostics and evaluation at 28.3%. In the UK, the BPS report (2007a) cites competence as the highest category of complaint at 21.60%.

In order to illustrate the differences between the types of complaints within the A4.6 and PCP cases, the numbers for these will now be shown separately. These findings will not be compared with the published literature as it is not possible to ascertain whether any of the reports or published studies has a comparable two-track approach for considering complaints.

The 84 PCP cases yielded 286 coded events which were distributed between the categories as shown in Figure 19.

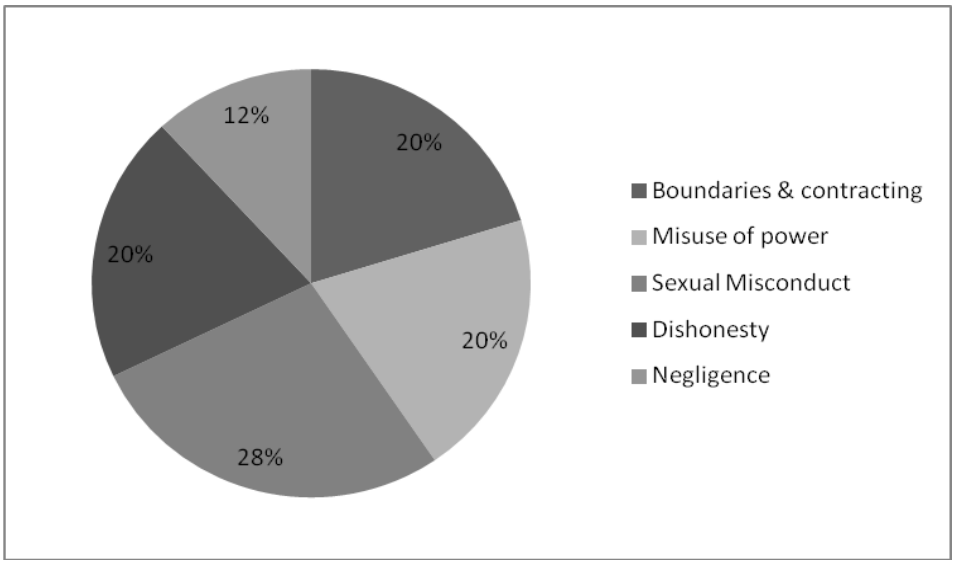
Figure 19: Distribution of PCP incidents within categories.



Boundaries and contracting is the largest single category with 126 incidents and representing 44% of the PCP total, with **Misuse of power** representing 27% and consisting of 77 incidents.

The 56 Article 4.6 cases yielded 85 coded events which were distributed between the categories as shown at Figure 20.

Figure 20: Distribution of A4.6 incidents within categories.



It can be seen that broadly there is a much more even distribution of events within the categories in the A4.6 cases. At 28% **Sexual misconduct** represents the greatest proportion of incidents (23 events), considerably more than the 14% that this category represents when the A4.6 and PCP cases are viewed together. Similarly, the categories of **Dishonesty** and **Misuse of power** (20% each, consisting of 17 events each) are more highly represented within the A4.6 cases, while the **Boundaries and contracting** category falls from 39% in the combined cases to 20% (17 events). This is to be expected given that the A4.6 process exists to allow BACP to respond swiftly to the most serious complaints and allegations of misconduct.

Detailed descriptions of subcategories

This section will describe the subcategories in detail. The **Other** category, containing eight different incidents that could not be coded elsewhere, all PCP cases, will not be described to protect confidentiality.

Category 1 – Boundaries and contracting

The **Boundaries and contracting** category contains four constituent categories and a total of 17 subcategories relating to issues such as confidentiality, dual relationships, and time boundaries. Incidents in the complaints analysis coded under sexual misconduct can also be understood to constitute misconduct around the boundaries of therapy, but they have been separated out for clarity. The constituent categories and subcategories are shown at Table 8.

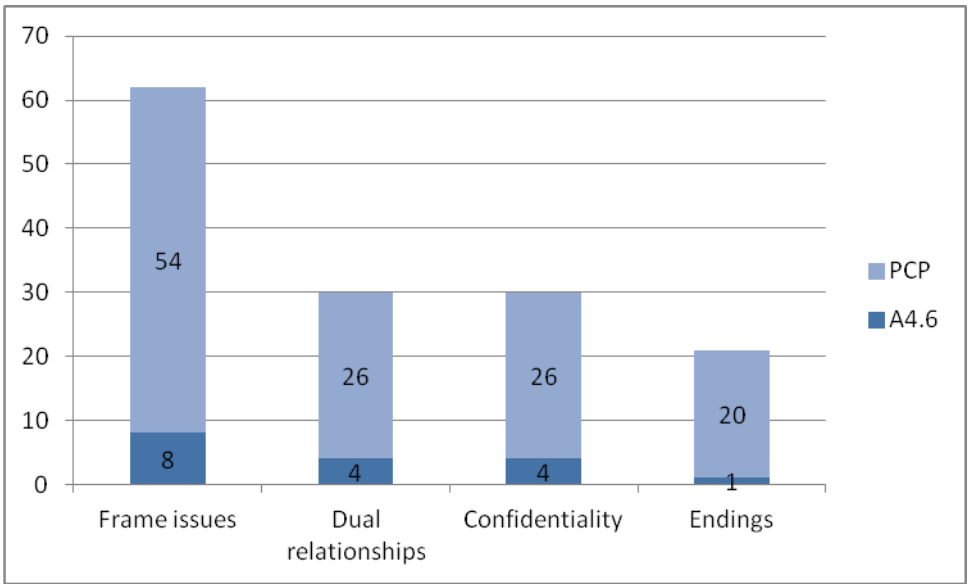
Table 8: Boundaries and contracting.

Boundaries and contracting (143 incidents)			
Frame issues (62)	Dual relationships (30)	Confidentiality (30)	Endings (21)
6 subcategories: - Contracting - Therapist self-disclosure - Time boundaries - Contact outside sessions - Touch - Gifts	5 subcategories: - Counsellor & social - Counselling two people known to each other - Counsellor & trainer - Counsellor & colleague - Supervisor & manager	4 subcategories: - Disclosure to non-professionals - Disclosure to professionals - Written records - Disclosure within training	2 subcategories: - Abrupt - Unclear

One hundred and forty-three incidents were coded under the **Boundaries and contracting** category which break down into four constituent categories as shown at

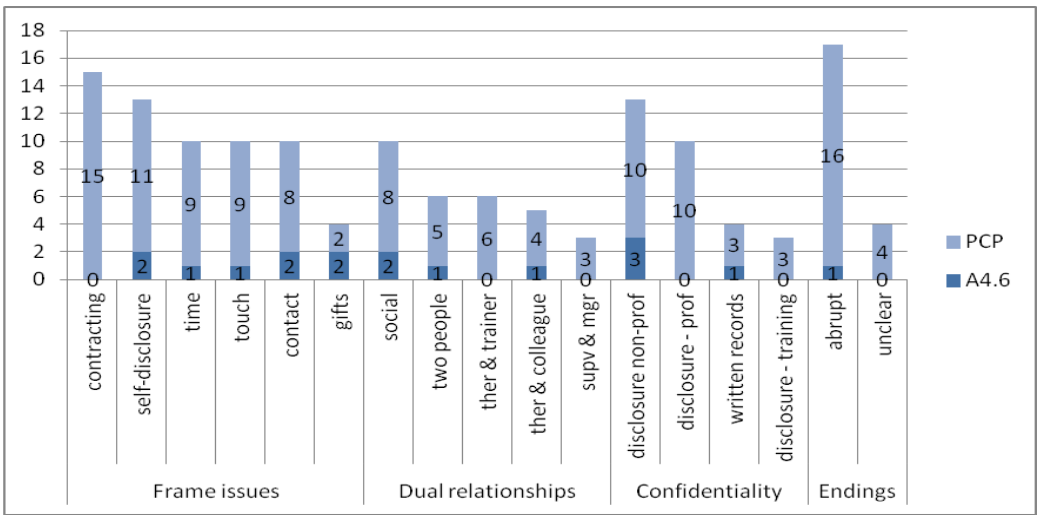
Figure 21.

Figure 21: Boundaries and Contracting – breakdown of coded incidents.



When mapped against the subcategories within these categories, the 143 incidents break down as shown at Figure 22.

Figure 22: Boundaries and contracting - breakdown by subcategory.



The **Frame issues** constituent category includes incidents relating to the boundaries such as time or physical touch. This category contains six subcategories, defined as follows:

1. *Contracting* – Lack of clear contracting by the therapist, where the nature of the work is not made clear, for example whether the sessions are counselling or assessment for counselling. The therapist makes un-negotiated changes to the therapy contract.
2. *Therapist self-disclosure* – The therapist discloses information about their life, their past or their feelings.
3. *Time boundaries* – The therapist takes insufficient care over the time boundaries of therapy. This might involve starting sessions late, excessively running over session times, or a lack of transparent time boundaries so the client does not know how long a session is supposed to last.
4. *Touch* – The therapist physically touches the client. This includes hugging, patting, touch apparently intended as comfort, as well as overtly infantilising touch such as holding the client in a way which mimics holding a baby.
5. *Contact outside sessions* – The therapist makes contact with the client outside therapy sessions through phone calls, emails, or by visiting the client at home. Alternatively, the therapist encourages the client to make contact with them outside the therapy sessions.
6. *Gifts* – The therapist gives gifts to the client or encourages the client to give gifts to the therapist.

There are no comparable categories in the previously cited research studies.

The **Dual relationships** constituent category represents incidents where the counsellor and client have a relationship outside the therapy. This category does not include sexual relationships as these are coded under sexual misconduct. There are five subcategories defined as follows:

1. *Therapist and social relationship* – The therapist begins a 'friendship' with the client or sees them socially outside the therapy.
2. *Therapy with two people known to each other* – The therapist knowingly and simultaneously counsels two people who are related or who know each other.
3. *Therapist and trainer* – The therapist also acts as trainer towards their client as part of therapist training or CPD.
4. *Therapist and colleague* - The therapist sees someone as a client who works within the same organisation and with whom they have a non-counselling working relationship.
5. *Supervisor and managerial responsibility* – The supervisor also has managerial responsibility for their supervisee

Events coded under **Dual relationships** represent 8% of all complaints in the BACP analysis. There are similar categories in some of the published literature, but a lack of definitions of what these include makes direct comparison problematic. The Neukrug et al study (2001) reports inappropriate dual relationships at 24% of complaints received, the largest single category of complaint in their findings. In contrast, St Germaine reports inappropriate social or business relationship with a current client at 4.57%. In the UK, the BPS (2007a) report that dual relationships accounted for 7.80% of complaints against psychologists.

The **Confidentiality** constituent category represents incidents where breaches of confidentiality occurred. There are four subcategories defined as follows:

1. *Disclosure to 3rd parties – non-professionals* – The therapist breaches the client's confidentiality by disclosing the fact or the content of the counselling to other individuals such as those known to the client, or non-professional contacts of the counsellor.
2. *Disclosure to other professionals* – The therapist breaches the client's confidentiality by disclosing the fact or the content of therapy to professionals involved with the client such as a GP or psychiatrist, without the client's consent and without sufficient good cause.
3. *Inappropriate use of written records* - The therapist makes use of written material relating to the client or the therapy in inappropriate ways, for example to send unsolicited mail or for service reports.
4. *Disclosure within training* - The trainer breaches a student's confidentiality by sharing information with other course members about the student's progress, or personal information disclosed in a one-to-one or small group setting.

Confidentiality represents 8% of complaints in this research. Within the published literature, confidentiality is identified as an area of complaint in more studies than other areas. Neukrug et al (2001) find 5% of complaints were for breach of confidentiality, St Germaine (1997) finds 8.33%, and Shefler and Achmon (2004) find 10.9% of total complaints were related to confidentiality. In the UK, the BPS (2007a) reports that 4.30% of complaints related to confidentiality, which seems low in comparison.

The **Ending** constituent category represents incidents relating to how the ending of therapy was handled. There are two subcategories defined as follows:

1. *Abrupt ending* – The therapist ends the counselling suddenly, with little or no notice, or a supervisor, placement or training agency forces the counsellor to terminate therapy abruptly with their client. This subcategory includes cases where counselling has been ended abruptly by therapists prior to having sexual contact with a client.
2. *Unclear ending* - The therapist and client end the counselling, but the ending is managed in such a way that contact continues sporadically, or the counsellor does not process the ending with the client appropriately.

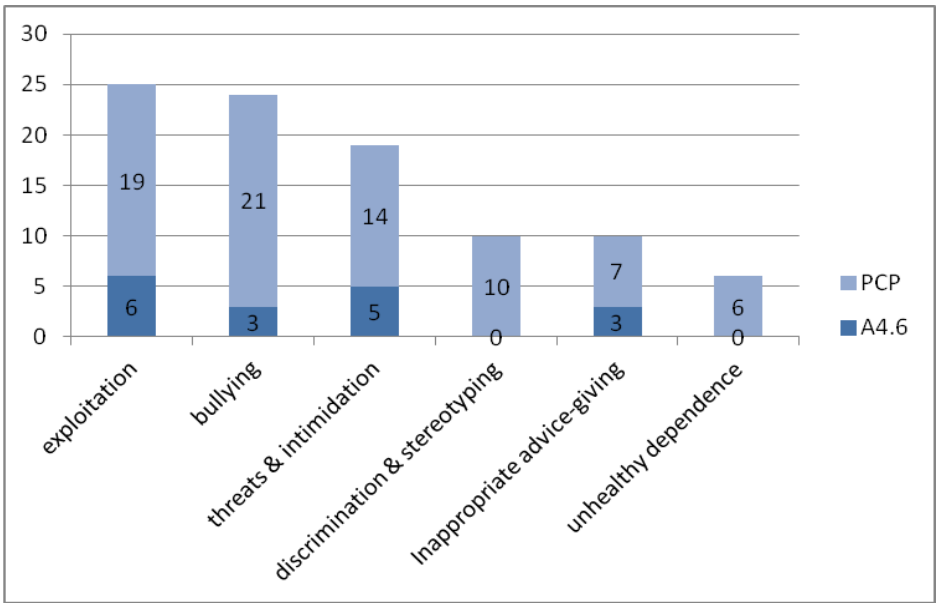
There are no comparable categories in the research literature.

Category 2 – Misuse of power

This category represents incidents as described by complainants where the MCA used their power inappropriately. Other categories in this study can also be understood to constitute misuse of power (sexual misconduct, boundaries and contracting, for example), but this category examines incidents not covered by other categories.

Ninety-four incidents were coded under the **Misuse of power** category, which break down into the six subcategories as shown at Figure 23.

Figure 23: Misuse of power - breakdown by subcategory.



The six subcategories are defined as follows:

1. *Exploitation of the client* – The therapist uses the client to meet their own needs. This might be emotional as in cases where the therapist uses the therapy sessions to deal with their own emotional distress, or financial as in cases where the therapist is more concerned about the fee than the welfare of the client.

2. *Bullying* – The member complained against bullies the complainant through harsh language or name-calling, or punishes client behaviour through being cold and withholding.
3. *Threats & intimidation* – The therapist makes verbal threats to harm the client in the counselling room or in their life outside therapy; the therapist acts in a physically or psychologically threatening way.
4. *Discrimination & stereotyping* – The therapist makes racist, sexist, heterosexist, or other discriminatory assumptions or remarks about the client, or provides a lesser service to a client on the basis of an identity difference.
5. *Inappropriate advice-giving* – The therapist is inappropriately directive and tells the client what to do; the therapist makes unhelpful or dangerous suggestions such as suggesting that a client stops taking medication necessary for their health.
6. *Encouraging unhealthy dependence* – The therapist encourages the client to rely solely on them; encourages or tells the client to withdraw from other relationships outside the counselling, isolating the client from other support.

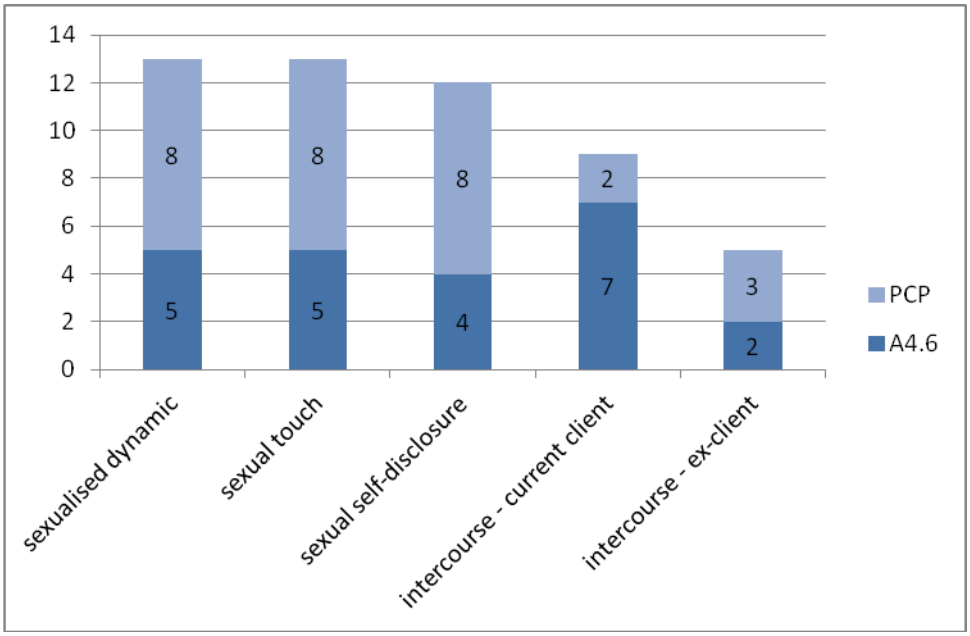
The **Misuse of power** category accounts for 25% of the BACP complaints. There appear to be no directly comparable findings in the published research. Shefler and Achmon's study (2004), however, includes a category of "Avoiding offence", which is described as "humiliation of clients, deceiving, lying, racial remarks etc" (p9) which appears to be similar. This category accounts for 20.45% of complaints in that study, although the limited definition makes comparison problematic.

Category 3 – Sexual misconduct

This category represents incidents described by complainants where there is an element of sexual behaviour on the part of the therapist (or supervisor or trainer).

Fifty-two incidents were coded under the Sexual misconduct category, which break down as shown in Figure 24.

Figure 24: Sexual misconduct - breakdown by subcategory.



Identifying complaints incidents in the analysis rather than simply coding individual complaints under one category allowed for additional examination of the cases **sexual misconduct** and showed that each individual case with incidents coded in this category contained incidents coded under other categories as well. The possible implications of this are discussed later in this chapter.

There are five subcategories defined as follows:

1. *Sexualised dynamic* – The therapist works in a sexualised manner in the therapy, although there is no physical touch. This might involve intrusive questions about a client's sex life or suggestive comments about the client or others.
2. *Sexual touch* – The therapist touches the client in a sexual way. This might include touching genitals, breasts or other parts of the body, sexual kissing or hugging. This may be apparently consensual between the client and the therapist or may have been overtly forced by the therapist.
3. *Sexualised therapist self-disclosure* – The therapist discloses sexual or romantic feelings towards the client or discloses their own physical arousal to the client either through words or suggestive body language.
4. *Sexual intercourse with current client* – The therapist has sexual intercourse with the client during the counselling relationship. This might take part during counselling sessions or outside session time. This may be apparently consensual between the client and the therapist or may have been overtly forced by the therapist. For the purposes of this research, sexual intercourse is defined as full genital intercourse and/or oral stimulation of the genitals.
5. *Sexual intercourse with ex-client* - The therapist has sexual intercourse with the client after the counselling relationship has ended, although it may or may not have been ended by the therapist for this reason. The sexual intercourse may be apparently consensual between the ex-client and the therapist or may have been overtly forced by the therapist. Sexual intercourse is defined as above.

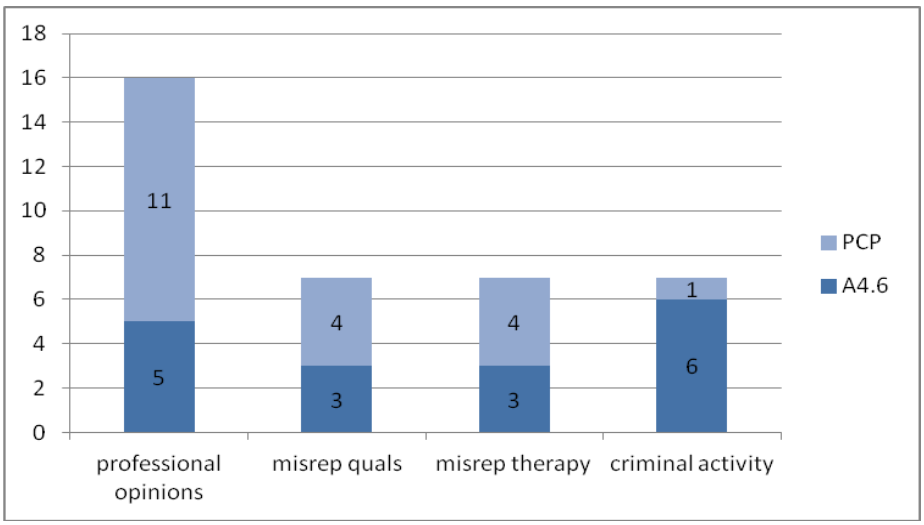
The **Sexual misconduct** category represents 14% of complaints in this study. Figures in the published literature vary considerably. Neukrug et al (2001) report 7% of complaints being about sexual relationship, St Germaine (1997) reports a total of 22% of complaints in categories of sexual relationship with current or former clients, while Shefler and Achmon (2004) report an incidence of 3.5% complaints about sexual abuse. It is not possible to know from these studies exactly how sexual relationship or sexual abuse are defined but it is possible that different definitions might account for some of the variation in numbers. It

seems unlikely, for example, that these studies have included sexualised dynamics or sexual self-disclosure on the part of the therapist within their definitions, as is the case with the BACP complaints discussed here. If these elements are not included, the *sexual intercourse with ex-client*, *sexual intercourse with current client* and *sexual touch* subcategories combined represent 7.3% of the total coded incidents.

Category 4 – Dishonesty

Thirty-seven incidents were coded under the **Dishonesty** category, which break down across the four subcategories as shown in Figure 25.

Figure 25: Dishonesty - breakdown by subcategory.



This category describes incidents where the therapist has been dishonest. There are four subcategories defined as follows:

1. *Professional opinions* – The therapist provides a professional opinion about a client without basis in fact; the therapist makes malicious accusations of the client; the therapist misrepresents supervisees or trainees in assessment or references.

2. *Misrepresentation of qualifications* – The therapist falsely claims to have counselling or other qualifications which they do not possess; the therapist misrepresents what membership of BACP means in terms of qualification to practice.
3. *Misrepresentation of the counselling* – The therapist alters or falsifies written documentation relating to the content of the counselling or the amount of counselling sessions. The therapist lies about the counselling in supervision.
4. *Criminal activity* - The therapist has committed a criminal act which may have led to police involvement and criminal conviction. Incidents may include fraud, drug use or others.

The **Dishonesty** category represents 10% of the complaints incidents in this analysis. While none of the cited research studies includes a complaint category that directly matches this, some types of complaints are identified that correspond to the types of incident within this category. Shefler and Achmon (2004) state that 63% of the complaints they examined related to issues of honesty and integrity, including cases relating to handling money dishonestly or using a misleading title. These cases also include complaints where confidential information was used without the permission of the client, which would have been coded under **Confidentiality** in the present study. Neukrug et al (2001) identify 3.93% of complaints relating to dishonesty in fee setting (such as in cases of insurance fraud) and less than 2% (exact percentage not given) relating to criminal convictions. In comparison, St Germaine (1997) identifies 5.92% of complaints relating to these categories highlighted by Neukrug et al (2001) with an additional 4.57% of complaints relating to deceptive or untrue representations of qualifications. Complaints relating to practising without a license or obtaining a license through fraud or deception are identified by St Germaine (1997) as representing 15.33% and by Neukrug et al (2001) as representing 8.34% of the complaints in their respective studies.

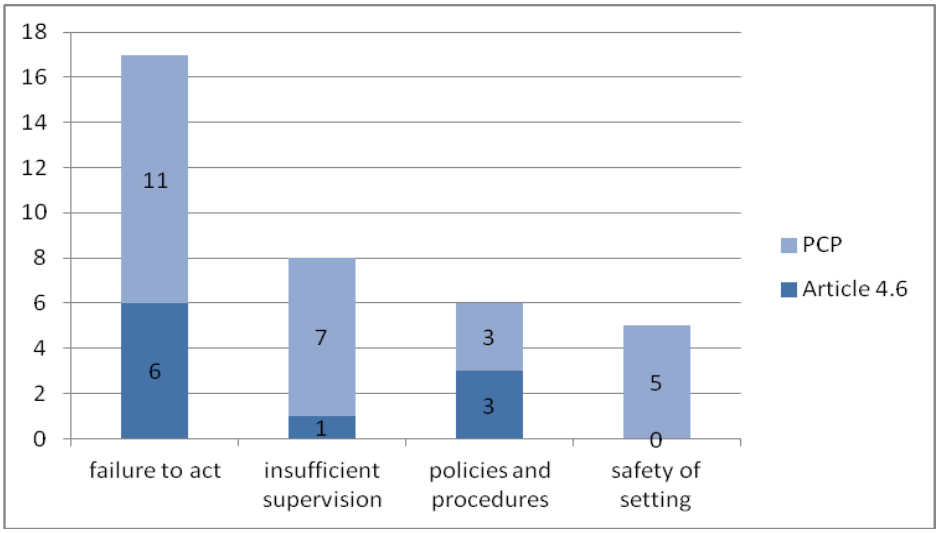
Category 5 – Negligence

This category represents incidents where the therapist has failed to act appropriately or professionally, or has acted without sufficient concern for their duty of care towards their client. There are four subcategories defined as follows:

1. *Failure to act* – The therapist fails to take appropriate action, for example failing to make a referral to another professional, failing to assess or diagnose risk of suicide or serious mental health issues. The therapist fails to work with relevant emotional/presenting issues as raised by the client.
2. *Insufficient supervision* – The therapist does not have a sufficient amount of supervision; a supervisor does not see their supervisee enough to provide sufficient supervision.
3. *Not adhering to the policies and procedures of employer* – The therapist fails to undertake aspects of their work as agreed in a contract of employment, for example, not completing relevant paperwork or not adhering to an organisation's risk procedures.
4. *Not protecting the safety of the counselling setting* - The counsellor allows excessive or unsafe intrusions into the counselling setting, such as answering phone calls in the room, allowing third parties into the room while a client is present, changing venues for counselling or meeting for sessions in public places.

Thirty-six incidents were coded under the **Negligence** category, which break down across the four subcategories as shown in Figure 26.

Figure 26: Negligence - breakdown by subcategory.



The **Negligence** category represents 10% of complaints incidents in this analysis. Negligence is mentioned as a type of complaint only by the BPS (2007a) which states that this represents 3.40% of its complaints, although no details are given about what is included in this. Negligence does not appear as a type of complaint in any other report or research, although Neukrug et al (2001) identify 1% of complaints as failure to report abuse, which would have been coded as negligence in the present study.

Limitations

The use of archived complaints documents in this research has resulted in limitations to these findings which need consideration. Conducting research from documents is of value, especially given that the material has been compiled free from the influence of the researcher (McLeod, 2001). However, analysing documents that have not been written or archived for research purposes creates its own difficulties. The analysis of BACP complaints is limited by a number of issues associated with using archived documents for research.

There were incomplete numbers of records due to the policy of destroying documents seven years after case closure. Similarly, within individual complaint records, there was incomplete information in many cases, such as for theoretical orientation of the MCA, which limited the analysis that could be conducted. Such difficulties are to be expected in documentary research (McCulloch, 2004), and require that results are interpreted with caution. Nonetheless, the archived BACP records afforded unique insights into UK complaints about therapists that would not have been achievable through other methods or by using other sources.

Interpretation of the data is also problematic, as is comparison with other published complaints research. The complexity of complaints processes, the development over time and changes to these processes, as well as the use of specific procedural terms present challenges for interpreting the data and presenting the results in a coherent and meaningful fashion. Comparison with the published research literature is difficult as it is not clear how much similarity exists between the different processes used by the various organisations or how these have been analysed as only minimal information is included in research articles.

Interpretation of the nature of alleged misconduct is particularly difficult. Complaints to BACP require complainants to state which elements of the Ethical Framework (or, in the past, of the relevant Codes of Ethics) are alleged to have been breached. While this facilitates the consideration of the complaint, analysing complaints against specific paragraphs of the Ethical Framework does not easily allow for comparison of the actions of therapists that have resulted in complaints and limits conclusions that can be drawn more generally about how practice can be improved or about the training needs of therapists. Within in this research, the decision to conduct a limited qualitative analysis of the complaints allegations to produce more meaningful findings relating to the nature of misconduct allegations attempts to address this difficulty. However, the results are not without their own limitations; Simons (1995) suggests that such classifications are "meaningless or arbitrary" (p40).

The difficulties in attempting to produce meaningful analysis of the types of complaints are manifold. Complaints letters have not been written for research purposes and present the

complainant's account of events. This account may be incomplete or inaccurate. Classification of the types of complaints from complaint letters is difficult, because it is not always clear what the complaint is about (Lloyd-Bostock & Mulcahy, 1994). In addition, the accounts that complainants present in letters are influenced by their perceptions of power and by a desire to be seen as reasonable (Lloyd-Bostock & Mulcahy, 1994; Nettleson & Harding, 1994). For the purposes of this research, only complaints that had been accepted as having a case to answer were included in this analysis, however, the accounts are uncorroborated. In addition, there is no way of knowing from this analysis whether there are particular issues in therapy that are complained about less than others or whether there are issues that are not complained about at all. There were no complaints categorised in this research where the complainant alleged that their therapist had fallen asleep in the therapy, for example, although there are cases of this in published client accounts (such as Hare, 2006). For these reasons, the findings cannot claim to identify patterns of what goes wrong in psychotherapy, but rather what people allege goes wrong in their therapy (or supervision, or training), reflecting what people feel is appropriate or possible to complain about (Gulland, 2009). Making comparisons about the nature of complaints in this research with those in the published research literature is problematic, given the lack of standardisation across studies.

Implications of these findings

The figures presented in this report regarding the rate of complaints received and upheld per year compared against total membership figures (0.172% received, 0.072% upheld) are lower than the comparable figures in the published literature, ranging between 0.69% (HPC, 2011) and 1.60% (Van Horne, 2004) for complaints received and 0.124% and 0.204% for upheld complaints (Van Horne, 2004). While there are limitations in comparing these figures as discussed earlier, a question emerges about why the BACP figures should be so much lower. One possible reason for lower rates of complaint might be BACP's requirement for career-long supervision, providing an effective safeguard to clients due to

the regular scrutiny to which therapists open their work. However, another possible factor might be the lack of statutory regulation of counselling and psychotherapy in the UK. It is possible without statutory regulation that some therapists who practice unethically are more likely to choose not to be members of a professional body, meaning that clients would not be able to complain about their conduct. Alternatively, the lower rates might be due to the number and range of professional bodies in the UK which could be confusing for potential complainants, making it difficult to come forward. Figures available from the HPC relating to newly-regulated practitioner psychologists lend some credence to this hypothesis. For the first nine months of statutory regulation, the rate of received complaints was 0.67%, equivalent to 0.89% for an entire year (HPC, 2010), falling to 0.69% in the first full year, both higher than the overall rate of complaint across all HPC professions at 0.35% (HPC, 2011). This might be interpreted as a spike in complaints which will stabilise over time; an argument that suggests that the move to statutory regulation of practitioner psychologists has made it easier for complainants to come forward, perhaps accounting for the higher figures than in the analysis of BACP complaints. However, until more time has elapsed and trends in these figures can be identified, it is not possible to be confident about the impact of statutory regulation on rates of complaint, or whether this is a significant factor in the lower rates of BACP complaints.

Findings relating to sanctions are important to consider but they are also problematic given that the ultimate sanction imposed by BACP, that of termination of membership, cannot be fully compared with sanctions found in the published literature that relate to being struck off, since ejection from BACP does not prohibit a therapist from continuing to practice. Nonetheless, some comparisons can be made. Figures cited earlier in this chapter showed that 49.5% of upheld cases resulted in sanctions to practitioners' membership or accreditation. This compares with numbers ranging from 45% (St Germaine, 1997), to 55% (Neukrug et al, 2001) of upheld complaints resulting in therapists having licenses revoked or suspended, and 57% of HPC upheld complaints (2011) resulting in registrants being struck off or suspended. Although the BACP figures might not be seen as differing greatly from these, they are slightly lower than the most recent numbers. It is possible that the self-

regulatory role of BACP accounts for this difference. Given that termination of BACP membership cannot prevent a therapist from continuing in practice, it is possible in some cases that developmental or educative sanctions are chosen to allow BACP to continue to have influence over a sanctioned practitioner's work and behaviour, arguably a more effective way of protecting the public in the absence of statutory regulation. Such action would not be appropriate in every case and it is clear from the figures presented here that if this is a factor in decisions about sanctions then it is being utilised in only a small proportion of cases. The BACP figures do, however, raise an interesting question about the options available to professional bodies to effectively regulate their members and protect the public.

The duration of BACP complaints was notably shorter than for complaints processes in the literature; the mean duration of PCP cases from receipt to final decision was approximately 32 weeks, for A4.6 cases this was approximately 22 weeks. The only data for comparison were available from the HPC (2011) where the mean duration was recorded as approximately 64 weeks. As with other areas of this research, the comparison must be made with caution as the HPC and BACP processes, while sharing similarities, are not identical. Nonetheless, there is considerable difference in these timescales which merits consideration. Time is an important factor in complaints processes since peoples' ability to accurately recall events is impaired with the passing of time (Ipsos MORI, 2010). The length of time it takes to resolve complaints is experienced as stressful by those complained about ('Chris', 2001) and complainants alike (Gulland, 2009). Arguably, the shorter timescales achieved by BACP provide a better service for complainants and members complained against than is possible for a large regulating body such as the HPC to provide. This supports arguments for a smaller regulating body dedicated to counselling and psychotherapy, rather than a large organisation responsible for regulating multiple professions, irrespective of whether through statutory or enhanced self-regulation. However, the timescales achieved by BACP, while shorter than those of the HPC, may still not be satisfactory for those involved in the process. Research into expectations of complaints processes in the health professions shows that members of the public view a period of three to six months as an acceptable duration

for the resolution of complaints, dependent on the seriousness of the grievance (Ipsos MORI, 2010).

Findings relating to MCAs show that male members are disproportionately represented among BACP complaints and that this is reflected in related research (HPC, 2010; Shefler & Achmon, 2004). However, it is not clear why this should be the case. Halter et al (2007) suggest that the reason male therapists are over-represented in research relating to sexual boundary violations is that the power differences inherent in therapeutic work are exacerbated by power imbalances due to gender. If this is the case, then it suggests a useful area for training in relation to power as well as gender, but again, this is an area that needs further research.

Insufficient information in the complaints data meant that the theoretical orientation of the member complained against could not be investigated. Anecdotal evidence in the literature suggests that specific areas of misconduct might be linked to theoretical orientation; stating that person centred counsellors are more likely to breach boundaries (Casemore, 2001), for example, or that psychodynamic counsellors' emphasis on working with transference can constitute an abuse of power (Bates, 2006). Exploration of possible links between theoretical orientation and misconduct would be useful in identifying specific areas of difficulty that arise in the practice of different approaches and which could be addressed in therapist training and supervision. It is also possible that theoretical orientation is simply not a factor in malpractice and that the areas of practice that become problematic are due issues other than modality, but without further research it is not possible to state this confidently.

Figures for the occupation or professional status of complainants in this study (44% lay people in PCP cases, 45% lay people in A4.6 cases) appear to compare favourably with figures cited in the literature. However, these figures suggest that lay people are under-represented as complainants, which raises important questions about why this might be. Given that the majority of complainants were counsellors, psychotherapists or in related professions, perhaps knowledge and understanding of what therapy is and what constitutes unacceptable practice is a factor in making a formal complaint. Alternatively, therapists might be expected to have greater knowledge of complaints procedures and who to contact

to raise a grievance while members of the public might struggle to navigate what can be a confusing system, particularly given the number of professional bodies and differing procedures. There might be some evidence to support this as a reason why lay people are less likely to make a formal complaint. The figures relating to complaints against practitioner psychologists show that 72% were brought by lay people, a figure considerably higher than in this research project or when compared with the HPC's figures across all their regulated professions (33.60%, 2011). This might indicate a spike in numbers where members of the public have been facilitated in coming forward to raise a complaint due to statutory regulation and being able to have one point of contact. As discussed earlier, until figures are available to determine trends in complaining it is difficult to be confident about the significance of recent figures.

The categorisation of complaints highlighted that **Boundaries and contracting** were issues that were most complained about, followed by **Misuse of power.** The impact of boundary management on therapy outcomes has received little research attention (Cooper, 2008) and issues of working with the therapist's power have also been neglected although growth in the area of alliance ruptures (such as Safran & Muran, 2000) perhaps explores some of the issues related to power in the therapeutic relationship. Given the finding that these areas appear to be causing difficulties in practice, it is surprising that more research has not been undertaken to investigate how therapists might manage these aspects of their work more effectively.

As discussed earlier, categorising complaints allegations is problematic for a variety of reasons and the process can be considered "meaningless or arbitrary" (Simons, 1995, p40). While this is a potential concern in relation to the complaints categorisation as a whole, it is worthy of discussion in relation to the complaint category labelled as **Sexual misconduct** in particular. This category includes not only allegations of sexual intercourse with current or former clients, but also sexual touch, sexualised therapist self-disclosure and sexualised dynamic. Categorisation of complaints in the related literature is minimal and limited in the definitions provided but, from what is described, it appears that where complaints have been classed as relating to sexual misconduct this relates only to incidences of sexual

intercourse and possibly sexual touch (Neukrug et al, 2001; St Germaine, 1997; Shefler & Achmon, 2004). The decision to include a broader definition within the BACP complaints research has implications for how these findings can be interpreted and how they might be used more widely. The decision to include sexualised dynamic and sexual therapist self-disclosure within the category of **Sexual misconduct** rather than be coded elsewhere means that this category appears to have a greater proportion of complaints than in much of the related literature. Taken out of context this could be unhelpful or misleading.

However, the wider definition is valuable in terms of highlighting areas of practice that therapists might find problematic. Research into therapists' experiences of sexual attraction within therapy demonstrates that such feelings are commonplace. Giovaziolas and Davis (2001) report that 77.9% of counselling psychologists in their study have been attracted to at least one client. Martin et al (2011) highlight that sexual feelings towards clients "commonly intrude" (p255) in therapy work and require appropriate management. However, feelings of fear, shame, embarrassment and vulnerability to acting unethically can affect therapists in exploring and working appropriately with sexual attraction in therapy (Rodgers, 2011). Given that such experiences appear to be widespread among therapists, it is important that the associated dangers that can arise are highlighted to support training and supervision of therapists in managing and working appropriately with erotic feelings in therapeutic work.

Analysis of the complaints categories also revealed that each complaint with incidents coded under **Sexual misconduct** contained incidents coded under other categories; as well as stating that the therapist had engaged in a sexual relationship, for example, complainants described that prior to this the therapist had run over time, made contact outside sessions, given gifts or breached other boundaries. This lends some support to the notion of the slippery slope as described in the literature (for example, Gutheil & Gabbard, 1993) or of a continuum of boundary crossings (Smith & Fitzpatrick, 1995; Gabbard & Peltz, 2001). Certainly, it further highlights the importance of further research into boundary difficulties in practice, whether they result in sexual boundary violations or not.

Conclusion

The analysis of BACP complaints aimed to produce a broad picture of information relating to numbers and rates of complaints, who is involved, what is complained about, outcomes and durations. The project succeeded in mapping a considerable amount of information that was previously unavailable. The research was limited by difficulties arising from examining documentary records, the complexity of the complaints processes, and by ethical concerns to protect those personally involved. In addition, interpretation of the data and comparison with published research proved problematic due to a lack of consistency across studies. Nonetheless, the project was successful in providing a detailed and substantial picture of complaints against therapists in the UK, the implications of which contribute to debates about the regulation of therapy as well as raising issues of potential trouble spots in practice.

PART 2 – INVESTIGATING WHY THERAPY CLIENTS DON'T COMPLAIN

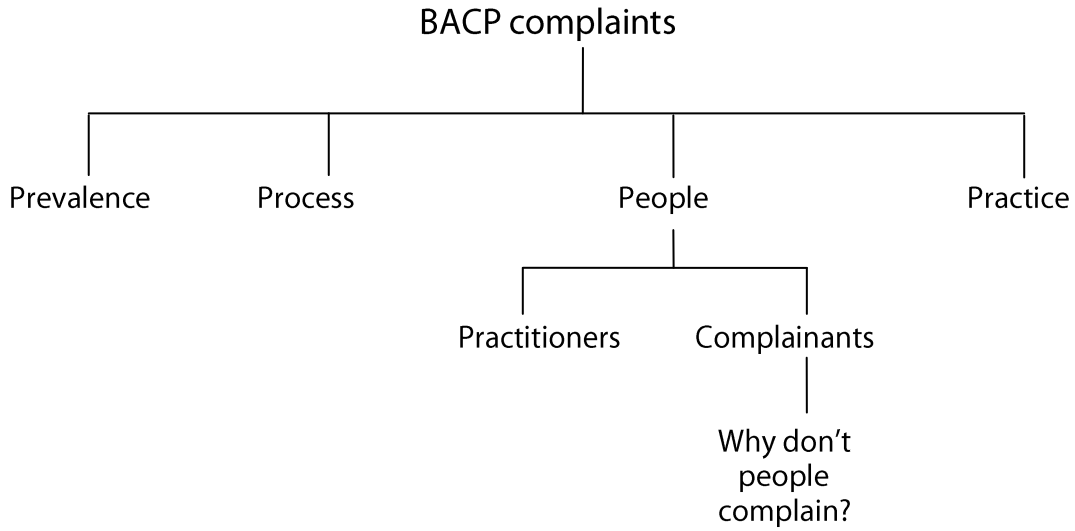
Chapter 5 – Methods

This chapter details how the projects within part 2 of this thesis build on part 1 using knowledge gained from the analysis of the BACP archive data. How the specific research questions shaped the choice of methodology is discussed. Next, the research design process is described, including an evaluation of difficulties encountered. Ethical considerations specific to this project are discussed. The chapter finishes with a detailed description of the methods used in the two stages of the project.

Research questions and methodology

Findings from part 1, the BACP complaints analysis, prompted further research questions within each of the four areas of prevalence, process, people and practice. Part 2 of the research was undertaken as a direct result of the finding that lay people are under-represented as client complainants, suggesting that there may be some people who do not complain about therapy that has been poor or which has harmed them. This research was part-funded by BACP. The relationship of the BACP analysis project to the research about not complaining demonstrates that the focus of investigation moved from a broad range of areas within the subject of complaints to a deeper investigation of one strand, representing a narrowing of the research focus into the area of client experience, as shown at Figure 27.

Figure 27: Narrowing of research focus.



The project aimed to explore clients' reasons for not bringing a formal complaint against a therapist. Specific aims of the project were as follows:

- What prevents people from complaining about poor or harmful experiences of therapy?
- What are the similarities and differences between lay people and practitioners in their reasons for not complaining?
- What are the factors that could facilitate people coming forward to report malpractice or abuse by a counsellor, should they so wish.

This is a mixed methods study in two stages combining both quantitative and qualitative methods and using conventional and online research methods. The methods of data collection were an online survey in stage 1 and individual interviews in stage 2. Methodological issues relating to developing questionnaires and conducting interviews are discussed.

Self-report questionnaires are used widely within research and have many advantages as research instruments as they are relatively easy to use, and many people are familiar with

completing surveys (McLeod, 1994). They are also considered valuable in researching sensitive topics as they can lessen the intrusion experienced by some participants who have experiences to share but who do not wish to be interviewed (Kellehear, 1997). However, it can be difficult to devise a new survey rather than make use of an existing and validated questionnaire (Bell, 2002). Effective survey design requires careful construction of the questions, choice of appropriate measurement scales, piloting, testing and validation (Oppenheim, 1992). Bell (2002) contends that it is all too easy for researchers to make errors at any of these stages – errors that can invalidate results and the conclusions that can be drawn from them. In spite of the difficulties associated with designing questionnaires, the researcher decided that a self-report survey offered a useful tool to begin to explore the range of reasons for not complaining.

Online research methods may appear to offer tempting advantages over traditional methods in terms of savings of time and cost, easier access to participants, and easier handling of data which do not require input by the researcher (Mann & Stewart, 2000). In addition, the greater anonymity afforded by online questionnaires (Harris, 1997) and the possibility that respondents would be more likely to answer sensitive questions in an online survey (Pealer et al., 2001) were considered to be potential benefits for this project, given the focus of the research. However, working in this different medium without sufficient thought and skill can lead to the failure of research projects (West & Hanley, 2006). The appropriateness of online methods and conventional methods at each stage of the project was considered in order to minimise the risk of such failure.

The second stage of the project involved exploring in depth people's experiences of not complaining and made use of individual face-to-face interviews. The aims of the research, particularly to explore possible differences in reasons for not complaining between different client groups, such as trainees and lay people could have been investigated with the use of focus groups. Such an approach has the advantage of reducing the inherent power imbalance between individual participants and researcher (Shaw & Gould, 2001). In addition, the interaction between participants encourages spontaneous responses and helps to uncover areas of consensus between participants (McLeod, 2001). While these were

positive reasons for considering making use of focus groups, this approach was rejected for practical reasons as such groups require that each group of participants meets together in the same place at the same time, an impractical requirement given the hard to reach nature of the participant group and the geographical distance between volunteers.

Online interviews, either synchronous or asynchronous, were considered and rejected for this project. Online interviewing may be advantageous in terms of convenience, flexibility and cost. In addition, online interviews might be preferred by people whose experience in a one-to-one, face-to-face counselling situation has been harmful. However, it has been suggested that people tend to be more open with others in cyberspace (Nguyen & Alexander, 1996; Wellman & Gulia, 1999) and may feel more able to discuss sensitive issues online rather than in face-to-face interviews (Murray & Sixsmith, 1998). These potential benefits for the research project of online interviewing were seen as key factors in *rejecting* these methods for this project. The absence of visual cues to aid the researcher's assessment of participants' emotional state, and the potential difficulties in building trust and rapport online (Orgad, 2005) were additional considerations in choosing face-to-face interviews for this phase of the project.

Research design

Setting out to reach people who had, by definition, not taken a particular form of action was significant in shaping the design of the project. In addition, ethical concerns relating to the fact that participants were likely to have experienced painful and possibly abusive, damaging experiences of therapy were considered throughout the design process. The effect of all these considerations upon the final design is discussed below.

Design issues

The project aimed to research the experiences of an invisible and hard-to-reach group. In order to be eligible for the research, potential participants needed to have had personal therapy of some kind, had a poor or harmful experience of this therapy and not made a complaint about this. So, the research was therefore trying to reach people who were invisible because they had *not* done something. In attempting to reach a group of people who are difficult to identify, it was necessary to publicise the research as widely as possible. Had significant funds been available this might have been achieved by taking out adverts in the press or popular magazines, but this was not possible with the resources available. The key factor in the choice of an online questionnaire for this project was the possibility it afforded of having a wide reach and therefore of accessing potential participants.

Another area for consideration when recruiting participants to the research was whether any criteria should be specified regarding what was meant by poor or harmful therapy. Leaving this open to interpretation by the potential participants meant that there was no way of knowing whether their grievance would be one that would be considered complaint-worthy by the relevant professional organisation. The research could have asked for details of what had happened that the client would have complained about for the researcher to evaluate the validity of the complaint. This option was rejected, however, as eliciting such information was regarded as unnecessarily intrusive, even were such an evaluation of the allegations considered practical or possible by the researcher. Given that the first step in deciding to make a complaint lies with the client who considers that they have a grievance, this must be self-defined. For this reason, no formal definition of poor or harmful therapy was given, allowing participants to choose whether they felt they had had an experience that might have warranted a complaint.

Ethical considerations

Ethical approval was given by the University of Leicester (Appendix 5) and the project was conducted in line with BACP's Ethical Guidelines for Researching Counselling and Psychotherapy (Bond 2004). In addition, the use of online methods was informed by the Association of Internet Researchers (AoIR) guidelines (Ess and the AoIR Ethics Working Committee, 2002) and the British Psychological Society's (BPS) guidelines for ethical practice in psychological research online (BPS, 2007b). As discussed above, it was considered unnecessary to ask participants to give details of what had happened in their therapy. The main body of the questionnaire was focused tightly around respondents' reasons for not making a formal complaint and did not explore their experiences of poor therapy, with a view to lessening the intrusion of the research instrument (Dickson-Swift et al, 2008). From an ethical perspective, exploring participants' experiences of poor therapy might additionally have caused further distress or trauma, and it was beyond the scope and role of the researcher to respond to that.

As with the online questionnaire, ethical considerations were foremost for the interview phase of the project. Individual research interviews have the potential to resemble the therapeutic encounter in a number of ways: they are confidential; conducted in a private room; one-to-one; and involve exploration and probing of experiences and feelings. Considerable thought was given both to practical elements and the nature of the researcher's approach in order to avoid recreating a dynamic that might prove distressing for the participant. Conducting one-to-one face-to-face interviews with people who have had painful, harmful or traumatic experiences of therapy raises issues regarding the safety of the participants. Meeting in private rooms with a researcher who is a therapist could feel like a replication of the therapy and could, therefore, be threatening. In addition, speaking about their reasons for not complaining might involve speaking about their therapy experiences and could be distressing.

Venues for the interview were chosen to be neutral and separate from therapy settings or services. This involved booking private rooms in public libraries, for example, making use of

teaching rooms in universities, or hiring small office space from commercial organisations. Some participants who were themselves therapists offered to be seen in the setting where they practised. While therapy settings were usually rejected as venues for interviews, this was agreed with these participants as it was clear that they had a different experience of the therapy space than those participants who were not therapists. Thought was also given to the layout of rooms during interviews in order to avoid evoking the therapy room as much as possible. The researcher always ensured that the chairs for the interview were arranged around the corner of a table, with a laptop and the papers for the interview available on the desk, aiming to foster a more business-like environment.

Similarly, the researcher's approach to the interviews was given considerable thought. Kvale (2007) highlights the tension between scientific and ethical responsibility when conducting qualitative interviews, and McLeod (1994) emphasises the challenge for interviewers in using skills learned as therapists without the research interview becoming counselling. As with the online questionnaire, the interviews aimed to have a clear focus on the reasons for not complaining. In addition, participants were informed explicitly that they would not be asked for details of what happened in the therapy. This focus was intended to limit the extent to which participants might revisit painful emotional experiences from the past in order to minimise the potential harm to respondents of participating in the research (Bond, 2004).

Participants were encouraged to take responsibility for their safety in the interviews by alerting the researcher if they felt distressed or wanted to stop. While the researcher is also a trained therapist, it was made clear to the participants that counselling would not be offered but, recognising that participants might find it difficult to stop the interview if they were distressed, the researcher was also able to draw on their skills as a therapist in order to monitor the participants' emotional state throughout the interviews.

Managing ethics – a reflexive statement

In two cases, dilemmas arose when trying to find a suitable venue to conduct the interviews. As I was unable to find an appropriate neutral location where I could borrow or hire a room, each of these participants initially suggested that I meet with them in their own home. I decided not to agree to this, in part to protect myself as a lone researcher, but also to protect the participants who, I thought, might become more vulnerable during the interview if conducted in a place where they felt more comfortable and safe. After explaining this to the participants, both then suggested that we meet in a café for the interview. My first reaction to this was that the lack of privacy made this unsuitable. How safe would it be for the participants to speak about potentially distressing experiences when surrounded by strangers? However, after exploring these issues with the participants in some more detail, and making them aware of my concerns for their safety, I did agree to conduct the interviews in these settings.

Conducting these interviews in public proved to have both advantages and disadvantages. The public setting and my concerns for the privacy and safety of the participants meant that I experienced these interviews as much more stressful than any of the others. I prepared myself for how I might respond if the participants became distressed. I carefully chose a table in the café that afforded some privacy. I took what steps I could to try to ensure safety, but as I had less control over these settings, I was more aware of how unpredictable events might be and this was a worry.

When I met each of the individual participants I discussed the issue of privacy and safety in public and stressed that we could stop at any time. As it turned out, both participants appeared to find the public setting helpful. For one thing, this was clearly different from the closed doors of their therapy experience. The hustle and bustle within the café and the voluble presence of other people seemed to allow them to feel safer than perhaps they might have done in a private room with me. The background noise meant that we could not be overheard by others, so it seemed that, paradoxically, the participants were afforded both privacy and the safety of not being alone with a stranger by being in a public place. A disadvantage of this was that the audio recordings of the interviews were much more difficult to hear.

The venue for one other interview was changed at the last minute when the participant decided that they would prefer to meet in the café at a large business complex rather than in the private room that had been booked for us. In that instance, I was more aware of the implications of conducting a research interview in public and was able to navigate this process more easily.

Finally, the need to protect participants' confidentiality was a concern when writing up the findings. While identifying information about the participants is relatively easy to omit from the text, the use of verbatim quotes from interviews to illustrate findings means that recognisable material relating to a participant might inadvertently be shared (McLeod, 1994). As a precaution against sharing any details that interviewees were not comfortable with, a draft of the completed report to BACP was sent to all participants who had indicated that they would be happy to receive details of the research. Each of these participants was told which participant number they had been allocated and any quotes from their own interview were highlighted in the text. The interviewer invited any comments, feedback, questions or concerns that the participants wished to raise in relation to this. A small number of participants responded to say that they felt the report and findings accurately represented their experience. No objections were raised by participants who read the draft report and no changes were made to the text.

Methods

The project comprised two stages: an online questionnaire to analyse the variety of reasons that people do not complain; and face-to-face interviews in order to explore in depth people's experiences of not complaining as well as their thoughts about what could have facilitated their making a complaint. The project used both qualitative and quantitative methods, and conventional and online research techniques.

Stage 1 – online questionnaire

The first stage of the project was a web-based questionnaire, using the Bristol Online Survey (BOS) package.

The questionnaire was developed to explore the following:

- Basic demographic details about respondents including their professional status (whether they are counsellors, trainees or do not work within psychological therapies) both now and at the time of their therapy experience.
- Information about their therapist and the therapy.
- Whether the respondent has ever brought a formal complaint against a therapist and the outcome of this.
- Reasons for not bringing a formal complaint. Respondents are asked to indicate the degree to which they agree or disagree with a range of statements, using a five-point scale. The selection of statements was developed by conducting a thematic analysis of published survivor accounts (Anonymous (a), 1991; Anonymous (b), 2005; 'Poppy', 2001; Richardson et al., 2008; Sands, 2000; Schepisi, 2006). An opportunity was given to respondents to comment on additional reasons that contributed to them not bringing a complaint.
- Any other information that respondents wish to share as part of the research.
- Whether the respondent would wish to volunteer to participate in a face-to-face interview as part of the research, and for contact details if they do.

The questionnaire did not explore what had happened in the participants' therapy that they would have considered complaining about. While this decision was arrived at to address ethical concerns, this clear focus also allowed the researcher to limit the length of the questionnaire to encourage participants to complete it fully (Crawford et al., 2001). To address issues of informed consent, potential respondents were informed about the scope of the project, the extent and limits of anonymity and the ways in which the research would be used on an information page at the start of the survey (Mann & Stewart, 2000). By clicking to continue, participants agreed to this. Participants were not asked for any identifying

information unless they volunteered to participate in the face-to-face interviews. Details about the security of this information and how confidentiality would be maintained was given on the relevant page of the survey.

The questionnaire was tested prior to full launch. This involved testing the online questionnaire with counselling colleagues to check technical aspects of the survey such as usability, accessibility and clarity of questions. After some amendments, the questionnaire was piloted with 10 volunteers who fulfilled the participant criteria and who had contacted BACP in response to a notice posted in *Therapy Today* by the Professional Conduct Department indicating that they would be willing to be involved with future research into complaints. The pilot volunteers were asked for feedback about their experiences of completing the questionnaire. This feedback also allowed the researcher to check that the length of time the questionnaire took to complete was within 10 minutes, as recommended to discourage drop-out (Crawford et al, 2001).

The full list of questions for the online survey is shown at Appendix 6 while Appendix 7 shows a screen shot of one of the online pages of the questionnaire.

The online survey was publicised widely, using a 'snowballing' approach (Barker et al., 2002) to reach as many people as possible who were invited to self-select as respondents. As discussed above, no prescribed definition of 'poor or harmful' therapy was given, allowing participants to choose whether they felt they had had an experience that might have warranted a complaint.

A variety of methods of publicising the research was used:

- Contact was made with online self-help forums and discussion boards for issues that people might bring to therapy such as depression or anxiety. People using these forums are likely to be both comfortable using online methods to explore personal experiences and would also have the forum for support.
- Contact was made with organisations that work with people with mental health issues to ask them to publicise the project to their members and contacts.

- Email cascading – the researcher emailed contacts from counselling and psychotherapy research forums to ask that details of the questionnaire were circulated to anyone who might be interested in responding. In addition, emails were sent to members of BACP, UKCP and BPS whose email addresses were publicly available and who had not indicated that they did not wish to receive unsolicited email.

Further details of organisations contacted and emails sent can be found in Appendix 8 and a copy of an example publicity email is found at Appendix 9.

The original project proposal sought agreement from BACP to write to people who had contacted the Professional Conduct Team but who had subsequently not made a complaint, with a view to informing them about the research. As responses to other recruitment methods were good it was decided that this would be unnecessarily intrusive and so was rejected.

While most online surveys are completed within 48-72 hours of receipt of email notification (Harris, 1997), suggesting that a lengthy period of the survey being available would not usually be of benefit, the snowballing approach to recruitment to this project meant that sufficient time would need to be allowed for potential participants to access the survey. For this reason, the questionnaire was available online for a total of six months. In addition, paper copies of the questionnaire were made available on request for those people who preferred not to complete the survey online. Responses from returned paper questionnaires were input to the online questionnaire by the researcher. While the BOS software is capable of some basic analysis, the data collected in the survey were exported into SPSS software for further statistical analysis.

Stage 2 – interviews

Volunteers for interviews were recruited via the online survey. The number of volunteers was far greater than originally anticipated and so a number of exclusion and inclusion criteria were developed to aid decisions about whom to prioritise for interview. These are shown in Table 9.

Table 9: Interview inclusion and exclusion criteria.

Exclusion criteria:	Inclusion/priority criteria
Ethical issues such as an existing/ongoing relationship with the main researcher	Priority given to people who indicated they were lay people at the time of therapy and at the time of completing the questionnaire
Questionnaire indicates experience was in supervision, training or group therapy	People who indicated they were lay people at the time of therapy and therapists/trainees at the time of the questionnaire
People who have made a formal complaint about therapy or in the process of making a formal complaint	Male volunteers
Therapy ended less than one year ago	Available on days that the researcher can travel. Geographical location – able to travel to and return from location in one day
People who were invited to interview but who either did not respond to contact or whose email contact was returned as 'undeliverable'	Order of questionnaire completion – those participants who completed the questionnaire earlier were considered before those who completed the questionnaire later.

Participants who volunteered for the project but who were not invited for interview were contacted to thank them for their interest in the research and to decline their offer, explaining that the response had been more positive than expected. In some cases it was not possible to contact volunteers, either because invalid email addresses had been entered into the questionnaire or because a postal address had been given without a name.

The interviews were conducted by the main researcher and usually lasted approximately 45 minutes. Interviews were conducted in neutral, non-counselling settings at convenient locations for the participants. The research funding meant that the main researcher was able to travel to various locations throughout the country to interview volunteers; geographical location did not exclude participants from the study.

An interviewee consent form (Appendix 10) was sent to volunteers prior to arranging interviews in order to give more information about the scope and procedure of the research. This was also discussed with each person prior to the start of the interview to allow for any questions or concerns to be addressed before the consent form was signed.

To minimise the potential harm to participants of speaking about painful emotional experiences (Bond, 2004), a semi-structured interview format was used (Holstein & Gubrium, 2003), which allowed the interviewer to explore specific areas but also to respond to what the interviewees said with supplementary questions based on what seemed relevant at the time. The interview questions were carefully focused around the aims of the project and did not actively explore the participants' experiences of their therapy. Areas explored in the interviews were:

- The reasons for not bringing a formal complaint about their therapy experience.
- What would have helped the participant to bring a formal complaint if they wished to do so.
- How they had experienced participating in the research interview.

The first four interviews were conducted as a pilot. This enabled the main researcher to develop the interview technique and to test whether the interview question areas were effective in eliciting responses that addressed the project aims. The interview was not altered as a result of this piloting and it was decided to include these interviews for analysis in the full project.

For convenience and speed, the interview recordings were transcribed by a research assistant, independent of the main researcher. While this is not ideal in qualitative research,

as it can mean the researcher becomes distanced from the audio recordings, this was mitigated by listening repeatedly to the recordings during analysis (Etherington, 2004).

Analysis was conducted by the main researcher using interpretative phenomenological analysis as a way of attempting to get to the heart of participants' experiences. Interpretative phenomenological analysis aims to explore each participant's experience from their own perspective, but recognises that this process must involve the researcher's own perspective and interpretation (Willig, 2001). The importance of reflexivity in this analysis has been discussed in depth in chapter 2.

Transcripts were coded with meaning units which were then grouped into categories and domains. These were checked and the original texts re-examined to clarify meaning and the emerging domains and categories were amended as a result of this. As the analysis neared completion, six research assistants were each issued with a summary of the domains and categories along with a randomly chosen interview transcript (each research assistant was given a different interview transcript). The research assistants were asked to conduct their own coding of the interview and to comment on the category descriptions. This feedback suggested that the emerging categories and domains were broadly robust, but also raised some elements for further consideration. In light of this feedback, final amendments were made to the analysis.

Chapter 6 - Questionnaire findings and discussion

This chapter presents findings from the analysis of responses to the online questionnaire. Details of the response to initial publicity for the project are given, followed by descriptive statistics compiled from the questionnaire. Analysis of the reasons for complaining is discussed and combined with comments from participants given to qualitative questions on the survey. The chapter goes on to discuss the limitations of the research and considers the implications of the findings.

Response to publicity

The online questionnaire was launched on 3 December 2008 and was live for a full six months. The questionnaire was publicised through online forums and by emails to therapists. The researcher received over 150 email responses to the publicity, the majority of which were from people who did not complete the questionnaire. A small number of emails were received from people who wished to complete the survey but who were experiencing technical difficulties in accessing or completing it. All technical difficulties were responded to individually so that people could complete the survey online or in hard copy format. A number of themes appeared repeatedly in the remaining emails and these are summarised below:

- Clients who have made formal complaints, sharing details of their experiences of this process.
- Clients sharing negative experiences of therapy.
- Therapists who have seen clients who have told them of concerning experiences with previous therapists and who feel unsure how to respond.

- Therapists who have heard concerning stories about other therapists 'through the grapevine' and who feel unsure what action to take; requests for research into why practitioners do not complain against other practitioners in these circumstances.
- Comments about the value of this research for practice and the public perception of the profession; therapists interested in the findings of the research but who do not have an experience to contribute; people offering to publicise the research on message boards and to forward the email to colleagues, clients and family.
- Therapists sharing poor experiences in supervision or training and their difficulties in complaining about this, asking for research into this area.
- Comments about receiving unsolicited email.
- Criticism of the research method – comments that email contact to therapists was pointless, that using a questionnaire was inappropriate, that the scale of the project was too small to be meaningful.
- Questions about funding of the research project and concerns about the independence of the project and the possible political agenda behind it.
- Criticism of the research project – comments stating concerns about the research topic, concerns that this would encourage clients to make complaints and would threaten the livelihood of therapists; comments that the research is unnecessary as there are so few incidences of malpractice.

The emails that criticised the choice of research topic were few in number (8 in total) but they were notable for the strength of feeling that they communicated. Their tone was angry and defensive, and they communicated a sense of anxiety and fear at the possibility of clients making complaints. Some examples of this from the emails:

> "Personally I would be furious if someone reported me, because they thought it was 'poor' & I would defend myself to the hilt to prove that it was in fact not my poor therapy service but in fact they were a 'poor client'!! What worried me was that if clients get wind of 'did you know you can complain' news... then some may just step forward to get their 5 minutes of fame, think they might be compensated by ruining a therapist or service in the process."

"I just wanted to register my aversion to the research you are undertaking. We live in a blame culture, where suing is on the increase and I would not wish to encourage this attitude in any way."

"...as for making a complaint about counselling someone perceives to be 'poor' or 'harmful' - both impossibly subjective and unmeasurable concepts - my god we'll all be struck off when that starts!!!"

Responses to the research – a reflexive statement

Receiving the emails, particularly those criticising the research, was a difficult and, at times, overwhelming experience. The anger and venom in some of the emails left me reeling. I felt hurt, vulnerable and under attack. I felt that I had made a mistake putting my head above the parapet and undertaking this research, opening myself up to this kind of criticism. I was shocked by the strength of feeling communicated and by the force of the attack that I experienced, particularly given that these amounted to only a small number of the emails I had received, many of which had been very positive and encouraging. I was left feeling angry and defensive, wanting to put my case across to those that had trashed my work, or so I felt. More than anything else I wanted to delete all the emails and forget about the responses that had shaken my confidence and left me feeling so vulnerable.

After considerable time and reflection, it became clearer that the responses in the emails were meaningful findings in this research and that my own emotional response might be useful in interpreting what was being communicated. Paying attention to the responses that I had not expected to receive, and which could easily have been overlooked, became an important part of the context of this research and is discussed both at the end of this chapter and in chapter 8.

All email responders were sent a reply to thank them for their time and interest in the research. Apologies were made to those people who were unhappy about having been contacted (unless it was clear that a reply would be unwelcome) with assurances that their details would not be retained.

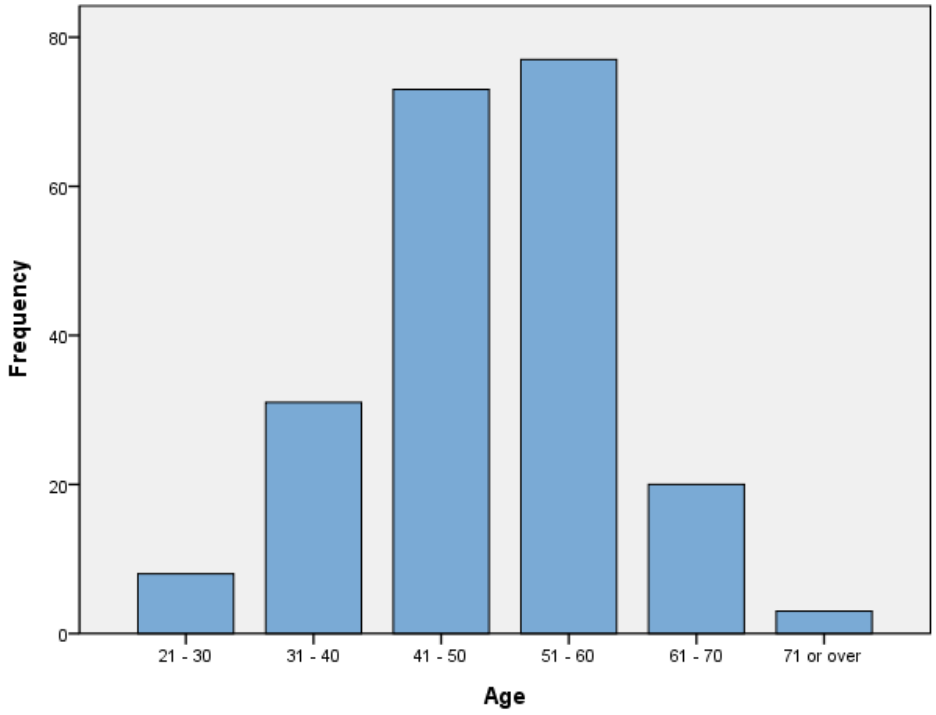
Demographic information

A total of 252 people responded to the questionnaire, of whom 212 completed the required elements of the survey fully and 40 gave incomplete responses. Three respondents completed paper copies of the questionnaire which were input by the researcher to the online survey and are included here. Results discussed exclude responses from the 40 incomplete responses.

A total of 205 of the survey respondents (97%) indicated that they currently resided within the UK, while the remaining seven respondents (3%) lived outside the UK. This question was included in the survey in order to limit the project to experiences of therapy within the UK, while recognising that an online questionnaire can be accessed worldwide. Each of the seven participants from outside the UK indicated elsewhere on the questionnaire that the therapy experience they were responding about was with a therapist in the UK and so these have been included for analysis.

The gender split of respondents was 179 female (84%) and 33 male (16%). Respondents indicated their age within a range as shown in Figure 28.

Figure 28: Respondent age range



Respondents were asked to indicate whether they were working as or training to be a practitioner within psychological therapies at the time of completing the questionnaire and also at the time of the poor or harmful therapy experience. This is shown at Table 10.

Table 10: Combined respondent professional status.

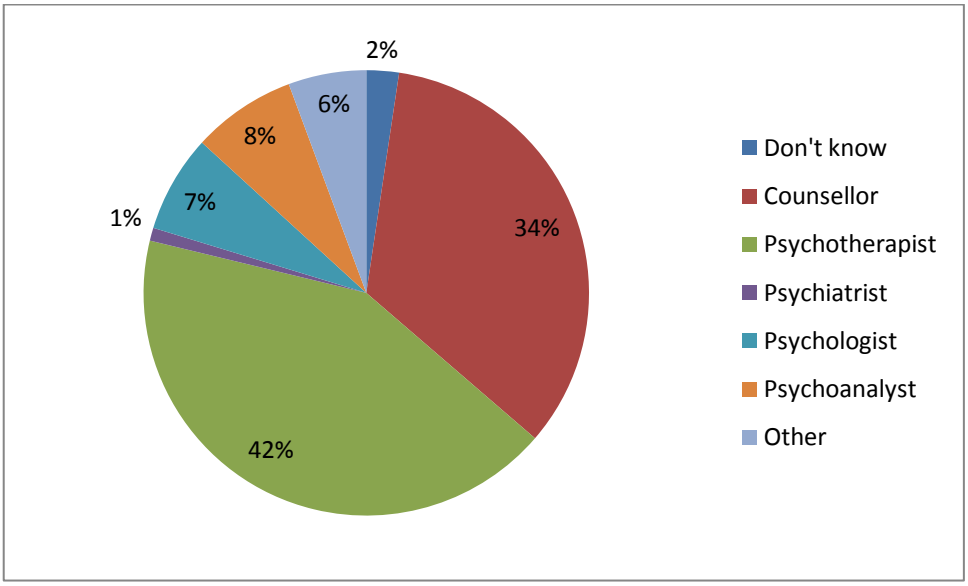
Descriptor	No. of respondents
Therapist × 2 (T×2) Participants who indicated that they were a therapist/trainee both at the time of the therapy and at the time of completing the questionnaire. In addition, this descriptor includes two participants who indicated that they were therapists at the time of the therapy and had subsequently retired and so were no longer working within therapy.	136
Lay person then, therapist now (LT) Participants who indicated that they were not working or training to work as therapists at the time of their therapy but who indicated that they were therapists or trainees at the time of completing the questionnaire.	43
Lay person × 2 (L×2) Participants who indicated that they were not working or training to work as a therapist either at the time of the therapy or at the time of completing the questionnaire.	33

At the time of completing the questionnaire, 156 (74%) of respondents were working within psychological therapies, 21 (10%) were training to work within psychological therapies and 35 (16%) did not work within psychological therapy. At the time of the therapy experience, 57 (27%) respondents were working within psychological therapies, 79 (37%) were training and 76 (36%) did not work within psychological therapies. The responses to these questions were combined to form a new variable for use in the analysis.

One hundred and thirty respondents indicated that their therapist was female (61%) and 82 indicated that their therapist was male (39%). As talking therapies are offered by different types of professionals, respondents were also asked to indicate the nature of the professional role of their therapist. The majority of respondents indicated that their therapist was a counsellor or psychotherapist, with 90 (42%) indicating psychotherapist, followed by 72 (34%) indicating counsellor. This was followed by 16 (8%) indicating psychoanalyst, 15 (7%) indicating psychologist (this category combines clinical psychologist, counselling psychologist and other titles given that included psychologist), 2 (1%) stating psychiatrist.

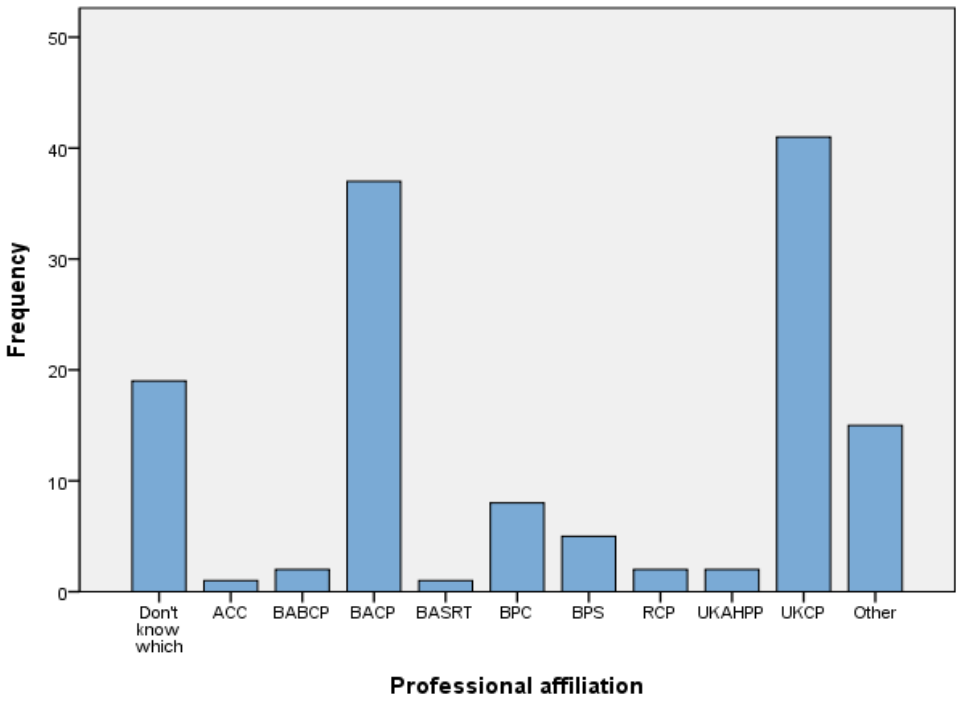
Twelve respondents (6%) indicated 'other' which included community psychiatric nurses or other titles that could not be included under other headings. Five respondents representing 2% did not know the professional title of their therapist. These responses are shown in the chart in Figure 29.

Figure 29: Professional role of therapist.



The questionnaire also asked respondents if they knew whether their therapist was a member of a professional body and to indicate which professional body this was. This information would be key if a client wished to bring a formal complaint against a therapist. One hundred and thirty-three (63%) respondents knew that their therapist was a member of a professional body, while 9 (4%) stated that their therapist was not a member of a professional body and 70 (33%) did not know. Of those who knew that their therapist was a member of a professional body, 19 (14%) did not know which professional body, but the remaining 114 (86%) were able to indicate the professional body from a given list, or indicate another organisation. This information is shown in the chart at Figure 30.

Figure 30: Therapist professional affiliation.



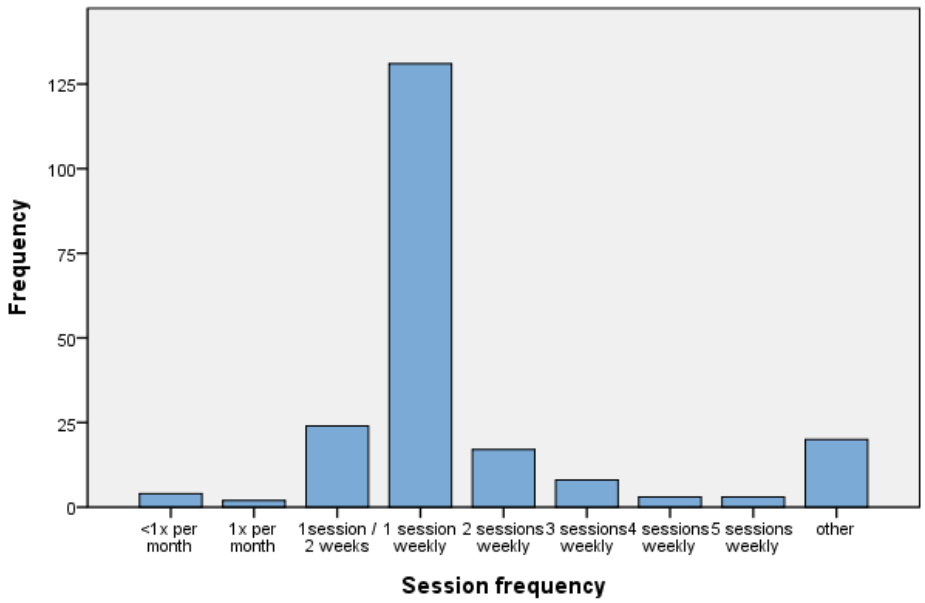
Legend:		
	ACC	Association of Christian Counsellors
	BABCP	British Association for Behavioural and Cognitive Psychotherapies
	BACP	British Association for Counselling and Psychotherapy
	BASRT	British Association for Sexual and Relationship Therapy
	BPC	British Psychoanalytic Council
	BPS	British Psychological Society
	RCP	Royal College of Psychiatrists
	UKAHPP	United Kingdom Association for Humanistic Psychology Practitioners
	UKCP	United Kingdom Council for Psychotherapy

When asked to indicate the setting for therapy, 148 participants (70%) stated that they saw their therapist in a private practice setting, with 30 (14%) participants receiving therapy in

NHS settings, 20 (10%) in voluntary organisations and 9 (4%) in university or college counselling services. Five participants (2%) indicated settings such as 'therapy clinic' which were classed as 'other'.

When asked for the frequency of their therapy, 135 participants (64%), indicated weekly sessions. Small numbers of participants indicated that their therapy took place four times a week (3 participants, 1%) or five times a week (3 participants, 1%). The 20 participants (9%) who indicated 'other' gave details of having had a one-off session with the therapist, session by arrangement or ad hoc contact of variable frequency. Full details of frequencies indicated are represented in Figure 31.

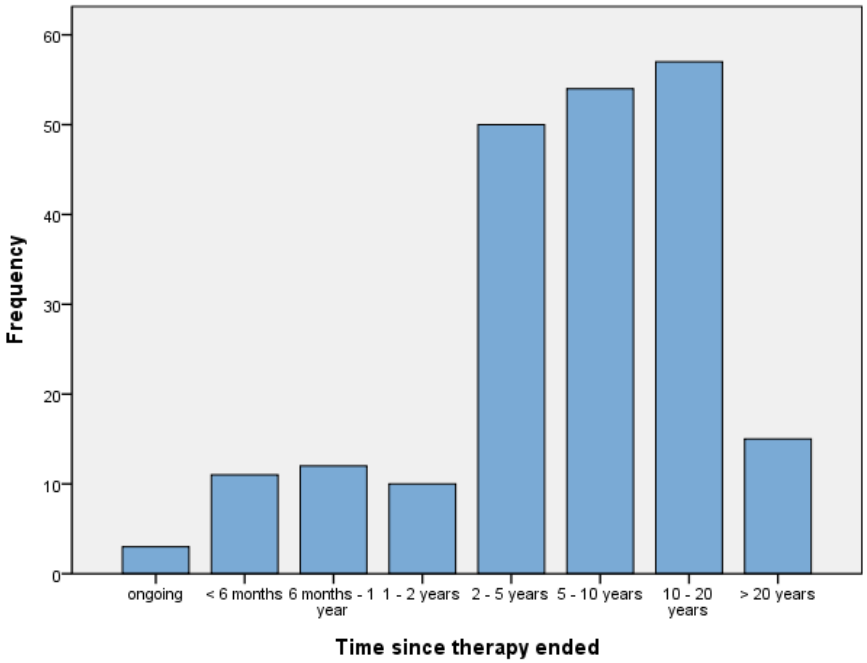
Figure 31: Frequency of therapy sessions.



The duration of the therapy was indicated as follows: 12 respondents (6%) attended only one session with the therapist; 37 (17%) between one session and two months; 40 (19%) between two and six months; 31 (15%) between six months and one year; 36 (17%) between one and two years; 41 (19%) between two and five years; 12 (6%) between five and ten years; and three (1%) over ten years.

When asked to indicate how long ago their therapy ended, 83 respondents (39%) indicated that the therapy ended within the last five years, with 54 (25%) indicating that the therapy ended between five and ten years ago, 57 (27%) indicating between ten and twenty years ago and 15 (7%) indicating that the therapy ended over 20 years ago. In three cases (1%) respondents indicated that the therapy was ongoing. Details of this, including a further breakdown of the duration for those clients whose therapy ended less than five years ago, are shown in the chart at Figure 32.

Figure 32: Time since therapy ended.



Respondents were asked if they had ever brought a formal complaint against a therapist. One hundred and ninety-two (91%) indicated that they had never done so, while 20 (9%) indicated that they had. Participants who had made a complaint were asked for details of the outcome. Three indicated that their complaints were not upheld by the professional body, one had a complaint in process at the time of completing the questionnaire and 11 had made complaints but did not indicate the outcome. Five respondents indicated that they had made a complaint which was upheld by the professional body concerned, and one of

these mentioned that the therapist joined a different professional body and continues to practise.

The final survey question asked respondents if they would be willing to volunteer to participate in a face-to-face interview to explore their reasons for not complaining. One hundred and ten people volunteered, representing 51.9% of the questionnaire respondents. Further details about the interviews and findings from this part of the study are presented in chapter 7.

Reasons for not complaining

Questions 14 and 15 of the survey each presented participants with 16 statements and asked them to rate on a five-point scale the degree to which they agreed that these were reasons for not complaining. Question 14 of the survey explored reasons relating to personal feelings (such as shame or confusion) that might affect whether someone brings a formal complaint, while question 15 examined external reasons (such as a lack of information about complaints processes or wanting mediation instead).

The reliability and internal consistency of the scale used for questions 14 and 15 was tested using Cronbach's alpha and the value was calculated as .891. Values above .7 are considered acceptable and above .8 are considered preferable (Pallant, 2010) indicating good internal consistency reliability for this scale with this sample.

Mean scores were calculated for individual responses. These are indicated in Table 11 for Q14, and Table 12 for Q15. Scores are out of five, with lower scores indicating disagreement with the statement and higher scores indicating agreement. The tables also include the standard deviation for each statement (showing the degree to which participants agreed or disagreed with each other), the number of participants who responded to each statement, and a chart showing the distribution of scores. While all the scores are potentially of interest, highest scoring and lowest scoring statements for each question are indicated in bold italics and discussed.

Table 11: Q14 statements, mean scores, standard deviation and distributions.

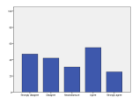
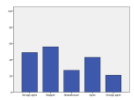
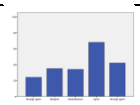
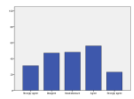
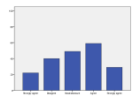
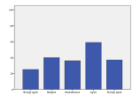
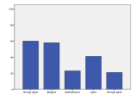
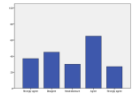
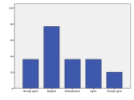
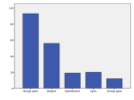
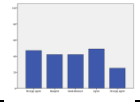
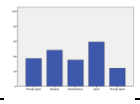
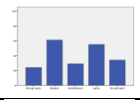
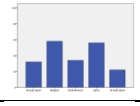
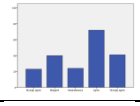
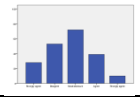
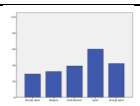
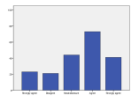
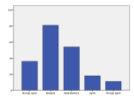
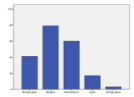
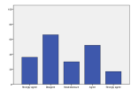
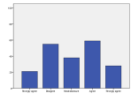
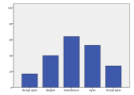
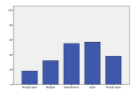
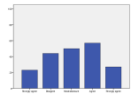
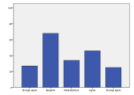
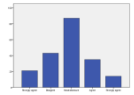
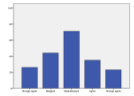
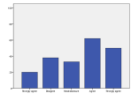
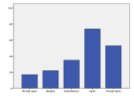
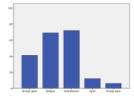
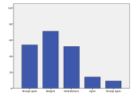
Q14 statements	Mean	SD	n	Distribution 1 - 5
a. I didn't trust my own view of what had happened	2.85	1.382	200	
b. I felt too ashamed	2.65	1.349	196	
c. I felt powerless to do anything	***3.34***	***1.304***	***203***	
d. I didn't want my therapist to get into trouble	2.97	1.250	205	
e. My therapist made me believe that what happened was OK	3.17	1.226	199	
f. I felt stupid for getting myself into this situation in the first place	3.22	1.312	197	
g. I didn't know that I could complain to anyone	2.53	1.369	203	
h. I would have felt disloyal to my therapist if I had complained	3.00	1.343	204	
i. I didn't realise that what had happened to me was wrong	2.64	1.235	205	
j. I felt ashamed for needing to see a therapist in the first place	***2.01***	***1.228***	***200***	
k. I didn't know how to make a complaint	2.82	1.351	205	
l. In spite of everything, my therapist had tried to help me and I would have felt ungrateful if I made a complaint	2.93	1.316	203	
m. I couldn't think clearly about what had happened to me and was not able to explain it to anyone	3.07	1.311	203	
n. I blamed myself for what happened	2.89	1.277	202	
o. I didn't have the confidence to complain	***3.34***	***1.316***	***200***	
p. My therapist was basically a good person who made a mistake and deserved another chance	2.75	1.073	202	

Table 12: Q15 statements, mean scores, standard deviation and distributions.

Q15 statements	Mean	SD	N	Distribution 1 - 5
a. I would have been judged by others	3.27	1.341	202	
b. I have no proof of what happened	3.44	1.245	202	
c. I wanted mediation instead of making a formal complaint	2.43	1.059	200	
d. I was not able to get the information I needed from the relevant organisation	2.31	0.943	200	
e. My therapist knew a lot of personal details about me and I was afraid that he/she would disclose them	2.74	1.258	201	
f. I would not have been believed	3.09	1.242	201	
g. I didn't want to make a formal complaint, I just wanted my therapist to say sorry	3.16	1.148	201	
h. There would have been no point complaining because the therapist would still get away with it	3.33	1.211	200	
i. I would have been blamed for what happened to me	3.10	1.222	201	
j. I was afraid that my therapist would say that I was mad if I complained	2.87	1.265	200	
k. My situation did not fit in with the complaints procedure	2.89	1.041	200	
l. The organisation would have covered up what happened	2.92	1.176	199	
m. I was too afraid of the consequences to me of complaining	3.41	1.307	203	
n. It would have been my word against the therapist's	***3.62***	***1.224***	***201***	
o. I missed the time limit for making a complaint	2.36	0.973	200	
p. Professional organisations don't take allegations of malpractice seriously	***2.26***	***1.073***	***200***	

The statement attracting the lowest mean score in Q14 was ***I felt ashamed for needing to see a therapist in the first place*** indicating that on average, participants felt that this was not a strong factor in not bringing a formal complaint. The two highest scoring statements in Q14 were ***I felt powerless to do anything*** and ***I didn't have the confidence to complain*** indicating, on average, higher levels of agreement with these as reasons for not complaining. In Q15, the lowest scoring statement was ***Professional organisations don't take allegations of malpractice seriously*** while the highest scoring statement was ***It would have been my word against the therapist's*** which has received the highest mean score across both questions.

Principal component analysis

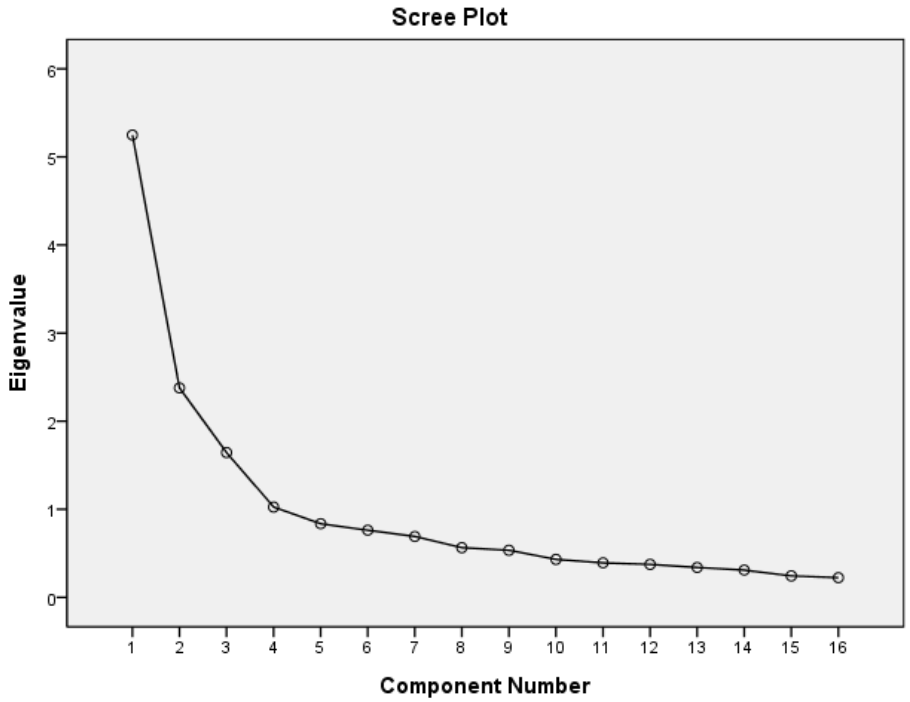
An exploratory factor analysis was conducted to explore the interrelationships between the statements in questions 14 and 15 and to reduce the number of variables for further analysis to a smaller number of underlying dimensions (Hinton et al, 2004; Pallant, 2010). Of the range of different methods of factor analysis, principal components analysis (PCA) was chosen as it seeks to explain the maximum amount of variance with the minimum number of underlying components or factors (Hinton et al, 2004). This section will describe results of PCA, first for Q14 and then for Q15.

Prior to performing PCA, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients of .3 and above. The Kaiser-Meyer-Olkin value was .828, exceeding the recommended value of .6 (Kaiser, 1970, 1974), and Bartlett's Test of Sphericity (Bartlett, 1954) reached statistical significance (p=.000), supporting the factorability of the correlation matrix.

A key aspect of conducting PCA is deciding how many components to choose and while there are a number of different tests that can aid this process, the decision ultimately depends on the researcher's judgment (Hinton et al, 2004; Bryman & Cramer, 2005). One method of choosing which components to exclude is *Kaiser's criterion* which selects all

factors with an eigenvalue greater than 1 (Bryman & Cramer, 2005). When the 16 statements in Q14 were subjected to PCA, four components with eigenvalues exceeding 1 were revealed, accounting for a total of 64.35% of the variance. A second test is to use Catell's scree test (1966), which argues that factors should be retained if they lie before the point where the values appear to level out. An inspection of the scree plot (Figure 33) shows that the values start to level out from the fourth component, which would support the retention of four factors.

Figure 33: Scree plot.



A third test is Horn's parallel analysis (Horn, 1965). This compares the PCA eigenvalues with those from a randomly generated data set of the same size, retaining components only where the eigenvalues exceed those generated in the test. When a parallel analysis was conducted it showed only three components with eigenvalues exceeding the corresponding criterion values for a randomly generated data matrix of the same size (16 variables ×212 respondents).

Parallel analysis is considered to be more accurate than both Kaiser's criterion and Catell's scree test (Pallant, 2010), which would suggest that only three components should be retained from the data reduction process. In addition, the fourth component revealed in the

PCA comprised only one variable, further supporting that it be discarded in favour of a three factor solution. However, examination of the correlation of the dependent variable within this factor was high (.742) suggesting that it should be retained as a separate component for further analysis (Hinton et al, 2004).

To aid in the interpretation of these four components, Oblimin rotation was performed. The rotated solution revealed 8 items loading strongly on component 1, 4 on component 2, 3 on component 3 and 1 on component 4. Table 13 shows the factor loadings for each variable (pattern coefficients and data coefficients), and details of the amount of variance in each item (communalities). The highest factor loadings and correlation for each item are shown in shaded boxes and are listed according to component grouping.

Table 13: Pattern and structure matrix for PCA with Oblimin rotation of 4-factor solution.

	Pattern coefficients				Structure coefficients				
Q 14 statements	C1	C2	C3	C4	C1	C2	C3	C4	Comm
a. I didn't trust my own view...	.384	.234	.224	-.306	.548	.355	.378	-.358	.488
b. I felt too ashamed	.805	.063	.007	.161	.807	.269	.261	.075	.680
c. I felt powerless to do anything	.661	-.289	.267	-.022	.673	-.096	.452	-.099	.596
e. My therapist made me believe...	.553	-.044	.002	-.457	.591	.103	.192	-.515	.558
f. I felt stupid for getting myself into...	.770	.054	-.170	.050	.724	.237	.076	-.026	.556
m. I couldn't think clearly about what had happened...	.559	.188	.223	-.071	.686	.351	.418	-.140	.553
n. I blamed myself for what happened	.789	.222	-.210	.109	.768	.406	.054	.032	.689
o. I didn't have the confidence to complain	.531	-.090	.323	-.036	.613	.074	.484	-.104	.479
d. I didn't want my therapist to get into trouble	.093	.756	-.071	-.083	.274	.775	.026	-.097	.618
h. I would have felt disloyal to my therapist if...	.105	.797	.077	-.052	.340	.831	.180	-.074	.715
l. In spite of everything, my therapist had tried to help...	-.013	.869	.041	-.034	.227	.869	.112	-.042	.758
p. My therapist was basically a good person who...	-.127	.817	.012	.227	.063	.783	.033	.232	.685
g. I didn't know that I could complain to anyone	-.110	.023	.911	.053	.179	.073	.876	.029	.782
i I didn't realise that what had happened...	.147	.329	.518	-.261	.423	.414	.603	-.300	.589
k. I didn't know how to make a complaint	-.025	-.027	.898	.152	.236	.042	.882	.119	.803
j. I felt ashamed for needing to see a therapist...	.382	.065	.227	.742	.392	.175	.324	.692	.748

The four-component solution explained a total of 64.35% of the variance, broken down as shown at Table 14.

Table 14: Components, variables and % variance.

		% variance	Cumulative %
Component 1: Lack of emotional resources	a. I didn't trust my own view of what had happened b. I felt too ashamed c. I felt powerless to do anything e. My therapist made me believe that what happened was OK f. I felt stupid for getting myself into this situation in the first place m. I couldn't think clearly about what had happened... n. I blamed myself for what happened o. I didn't have the confidence to complain	32.802	32.802
Component 2: Allegiance with therapist	d. I didn't want my therapist to get into trouble h. I would have felt disloyal to my therapist if I had complained l. In spite of everything, my therapist had tried to help me and I would have felt ungrateful if I made a complaint p. My therapist was basically a good person who made a mistake and deserved another chance	14.862	47.663
Component 3: Lack of information	g. I didn't know that I could complain to anyone i. I didn't realise that what had happened to me was wrong k. I didn't know how to make a complaint	10.277	57.940
Component 4: Shame linked to therapy	j. I felt ashamed for needing to see a therapist in the first place	6.409	64.349

Each component was named to reflect its constituent variables:

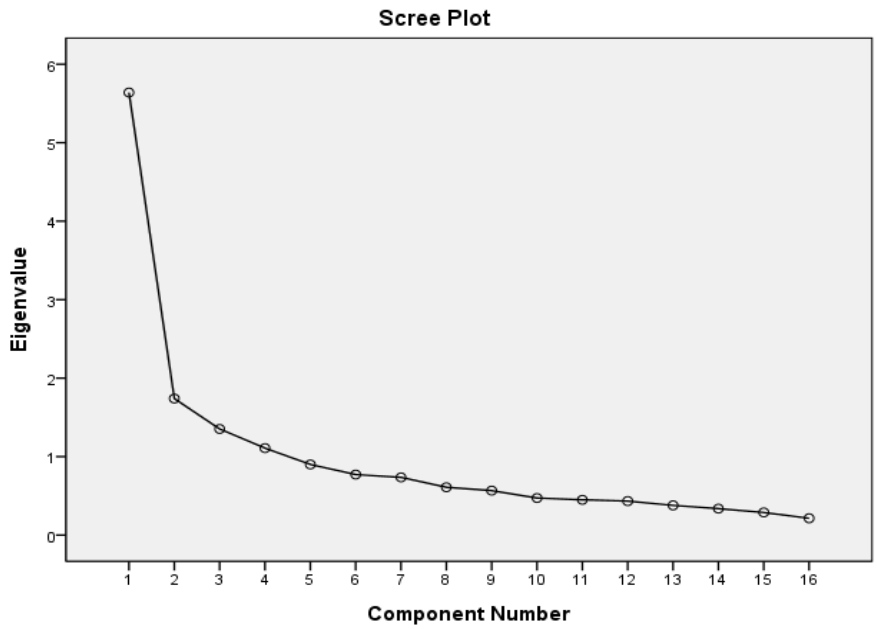
1. Lack of emotional resources
2. Allegiance with the therapist
3. Lack of information
4. Shame linked with therapy

The components were then used to compute new variables for further analysis.

The 16 statements in Q15 were also analysed using PCA. Prior to this, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients of .3 and above. The Kaiser-Meyer-Olkin value was .859, exceeding the recommended value of .6 (Kaiser, 1970, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) reached statistical significance (p=.000), supporting the factorability of the correlation matrix.

Prinicipal components analysis revealed the presence of four components with eigenvalues exceeding 1, accounting for a total of 61.05% of the variance. An inspection of the scree plot (Figure 34) showed the values levelling off after the second component, which would suggest retaining two factors (Catell, 1966).

Figure 34: Scree plot.



A parallel analysis was also conducted which showed three components with eigenvalues exceeding the corresponding criterion values for a randomly generated data matrix of the same size (16 variables × 212 respondents). In this instance, given the differing results to each test, and after examining the variable loadings on each component, a decision was made to retain three components for further analysis.

To aid in the interpretation of the components, Oblimin rotation was performed. The rotated solution revealed 10 items loading strongly on component 1, 4 on component 2, and 2 on component 3. Table 15 shows the factor loadings for each variable (pattern coefficients and data coefficients), and details of the amount of variance in each item (communalities). The highest factor loadings and correlation for each item are shown in shaded boxes and are listed according to component grouping.

Table 15: Pattern and structure matrix for PCA with Oblimin rotation of 3-factor solution.

	Pattern coefficients			Structure coefficients			
Q15 statements	C1	C2	C3	C1	C2	C3	Comm
a. I would have been judged by others	.695	-.220	.181	.663	-.028	.268	.516
b. I have no proof of what happened	.473	-.005	.344	.521	.137	.411	.387
e. My therapist knew a lot of personal details about me and I was afraid that...	.635	.012	-.040	.632	.176	.051	.402
f. I would not have been believed	.776	.143	.006	.815	.347	.124	.683
h. There would have been no point complaining because...	.649	.205	-.105	.688	.370	-.002	.523
i. I would have been blamed for what happened to me	.822	-.039	.003	.812	.176	.118	.661
j. I was afraid that my therapist would say that I was mad if I complained	.796	.017	-.216	.770	.214	-.102	.639
l. The organisation would have covered up what happened	.530	.428	-.224	.610	.555	-.126	.589
m. I was too afraid of the consequences to me of complaining	.739	-.081	.115	.734	.119	.215	.557
n. It would have been my word against the therapist's	.696	.115	.164	.749	.306	.269	.601
d. I was not able to get the information I needed from the relevant organisation	-.060	.774	.112	.159	.765	.144	.599
k. My situation did not fit in with the complaints procedure	.036	.480	.348	.211	.508	.378	.384
o. I missed the time limit for making a complaint	-.005	.703	.038	.185	.704	.075	.497
p. Professional organisations don't take allegations of malpractice seriously	.280	.649	-.250	.414	.709	-.176	.620
c. I wanted mediation instead of making a formal complaint	-.092	.267	.697	.077	.280	.698	.553
g. I didn't want to make a formal complaint, I just wanted my therapist to say sorry	.241	-.110	.656	.305	-.012	.684	.523

The three-component solution explained a total of 54.58% of the variance, broken down as shown at Table 16.

Table 16: Components, variables and % variance.

		% variance	Cumulative %
Component 1: Fears of negative consequences	a. I would have been judged by others b. I have no proof of what happened e. My therapist knew a lot of personal details about me and I was afraid that... f. I would not have been believed h. There would have been no point complaining because... i. I would have been blamed for what happened to me j. I was afraid that my therapist would say that I was mad if I complained l. The organisation would have covered up what happened m. I was too afraid of the consequences to me of complaining n. It would have been my word against the therapist's	35.247	35.247
Component 2: Procedural issues	d. I was not able to get the information I needed from the relevant organisation k. My situation did not fit in with the complaints procedure o. I missed the time limit for making a complaint p. Professional organisations don't take allegations of malpractice seriously	10.879	46.126
Component 3: Formality of process	c. I wanted mediation instead of making a formal complaint g. I didn't want to make a formal complaint, I just wanted my therapist to say sorry	8.453	54.579

Each of the components was given a new label as follows:

1. Fears of negative consequences
2. Procedural issues
3. Formality of process

These components were used to compute new variables for further analysis.

One-way analysis of variance

As detailed above, seven new variables were computed as a result of the principal component analysis of Q14 and Q15 and these were then used to conduct one-way between-groups analysis of variance (ANOVA) to explore the impact of participant combined professional status (as shown at Table 10) on each of these variables. These groups will be referred to as T×2 (therapist × 2), LT (lay person then, therapist now) and L×2 (lay person × 2) in these findings.

There was no statistically significant difference between the groups for the *Lack of emotional resources* and *Allegiance with therapist* variables from Q14, or for the *Fear of negative consequences* and *Procedural issues* variables from Q15. The remaining variables produced statistically significant differences at the $p<.05$ level and these are reported in detail below.

When the one-way ANOVA was conducted with the *Lack of information* variable and the combined professional groups, there was a statistically significant difference ($p=.000$) in scores for the three groups as shown in Table 17.

Table 17: Mean scores by group, *Lack of information* **variable.**

		N	mean	SD
Lack of information	T×2	130	2.38	1.01
	LT	41	3.37	1.03
	L×2	31	2.84	1.01

The effect size, calculated using eta squared, was .13, indicating a medium effect. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for the T×2 group was significantly different from the LT group. The L×2 group did not differ significantly from either of the other groups.

The lower mean score in the T×2 group indicates disagreement that lack of information was a factor in not bringing a formal complaint. The L×2 group might be expected to have scored most highly against this variable as they are likely to know less both about therapy and about the relevant complaints procedures, but their mean score also suggests that on average they were more neutral about lack of information as a reason for not complaining. The higher score in the LT group, significantly different from the score for the T×2 group, perhaps indicates that this group experienced having insufficient information in their status as lay people but that since training as therapists they are now more aware of complaints processes. This raises a question about whether those in the L×2 group are aware of how much information they do not have about therapy or about complaining.

The impact of participant combined professional status on the *Shame related to therapy* variable was explored using a one-way ANOVA and there was a statistically significant difference (p=.000) in scores for the three groups as shown at Table 18.

Table 18: Mean scores by group, *Shame related to therapy* **variable.**

		N	mean	SD
Shame related to therapy	T×2	128	1.67	.948
	LT	40	2.58	1.47
	L×2	32	2.66	1.41

The effect size, calculated using eta squared, was .14, indicating a large effect. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for the T×2 group was significantly different from both the LT and the L×2 groups. Mean scores for the L×2 group and the LT group did not differ significantly from each other.

This variable consists of one statement only from Q14, ***I felt ashamed for needing to see a therapist in the first place***. This statement received the lowest overall mean score of all the statements for Q14 and Q15, indicating that, on average, participants did not indicate that this was a reason in not bringing a complaint. The ANOVA analysis revealed that the mean score for the T×2 group was the lowest, indicating greater disagreement with the statement and a statistically significant difference from the other two groups' scores. This suggests that participants in the T×2 group experienced less shame in relation to accessing therapy than lay people who sought therapy. Although the mean scores for the LT and L×2 groups also indicate some measure of disagreement with the statement, it would appear that participants in these groups were more likely to experience some shame associated with seeing a therapist and for this to be a factor in not complaining.

The impact of participant combined professional status on the *Formality of process* variable was explored using a one-way ANOVA and there was a statistically significant difference (p=.003) in scores for the three groups as shown at Table 19.

Table 19: Mean scores by group, *Formality of process* **variable.**

		N	mean	SD
Formality of process	T×2	126	2.94	.90
	LT	39	2.65	.76
	L×2	33	2.38	.88

The effect size, calculated using eta squared, was .06, indicating a medium effect. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for the T×2 group was significantly different from the L×2 group. The LT group did not differ significantly from either of the other groups.

Statements within this variable asked participants about whether the formality of the complaints process was a factor in not bringing a complaint. Lower scores to these questions indicate disagreement that a less formal process was preferable. The highest scoring group for this variable was the T×2 group, indicating that participants within this group were more likely to prefer a less formal process. These scores differed significantly from those of the L×2 group, perhaps indicating that participants in this group were more in favour of a formal process.

Additional comments from participants

Questions 16 and 17 of the survey asked participants to give details of any additional reasons for not complaining that had not been covered in the questionnaire, and to add any other comments that they wished to make. Although the questionnaire deliberately avoided asking about what had happened in therapy, and this was made explicit to participants, more than half gave brief details of what had gone wrong, and a small number gave very

lengthy descriptions of the events of their therapy. While it is not appropriate to include details here of the events disclosed, a summary of the types of issues highlighted by participants is included:

- Bullying, punitive behaviour and comments from therapists in response to clients when wanting to end therapy.
- Therapists falling asleep in sessions.
- Therapists not understanding the client's problem.
- Seductive behaviour on the part of the therapist, sexual or flirtatious comments, giving personal gifts.
- Therapists instigating sexual relationships with clients.
- Ineffective therapists who didn't do anything wrong in particular but who were just not very good – a waste of time.
- Therapists talking about their own issues and difficulties.
- Therapists imposing a religious interpretation on clients' difficulties.
- Repeated time-keeping issues.

Some themes emerged in the responses to questions 16 and 17 relating to reasons for not complaining that were not covered elsewhere in the questionnaire. These themes cannot be generalised to all the participants within the survey, but they are described briefly here and discussed further in the limitations section of this chapter.

Twenty-four comments were made stating the client's fear of the possible consequences to a future career as a therapist if the poor therapy occurred while they were in training.

> "I was in training and there was a veiled threat of doing some sort of report, which would not go down well with my training organisation." (T×2, R148)
>
> "I was a trainee psychotherapist and did not want to make enemies or difficulties that may prove to be detrimental to my training path." (T×2, R198)

Seventeen comments were made stating that the experience of therapy had compounded the client's existing vulnerability such that they needed to prioritise recovery rather than complaining.

> "I suffered so enormously during the counselling and after that all of my life has been put on hold and I am not sure which parts will be recoverable." (T×2, R92)

Further comments by participants were examined and themes from these comments are given below:

- Comments about experiences of having brought a formal complaint against a therapist and how this has negatively affected their view of complaints procedures and professional organisations.
- Comments about lack of support available when going through a formal process.
- Comments about the difficulty of judging whether therapy is poor or harmful and that this is subjective.
- Comments about the questionnaire format – some people found that their experience did not fit the questions and that the format was too restrictive, others commented on how well it helped them to think about their experience and get to their reasons for not complaining.

Limitations

The use of an online questionnaire, while offering advantages for the project such as convenience of dissemination and possible ease of access to a difficult to reach group of potential participants, is not without its disadvantages. Sample bias, non-response bias due to the underrepresentation of some social groups online (Umbach, 2004), the reported possible unreliability of findings from online surveys (Sax et al, 2003), and difficulties presented by technological problems (Mann & Stewart, 2000) must all be considered in this project. The snowballing approach to recruitment (Barker et al, 2002) and self-selection of

participants (Coomber, 1997) are other important factors to consider when evaluating the sample of respondents.

The element of participant self-selection and the design decision to allow participants to assess whether their therapy experience had been poor or harmful, rather than attempting an evaluation of clients' experiences to determine whether or not they had a legitimate complaint to make, opens up this research to criticism regarding the validity of the respondents' issues with their therapy. It is not possible to assess from the information in the study whether any of the complaints would have been upheld had they been formally made to the relevant professional bodies. This decision remains an important aspect of the research design, however, given that any client who feels that they might have grounds for a complaint would have to make that assessment themselves before deciding whether to start the complaints process.

Online research methods are particularly useful when seeking to investigate experiences of hard-to-reach groups or sensitive issues (Coomber, 1997; Illingworth, 2001). The number of respondents to the questionnaire was good given that it was not possible to identify and target directly people who would be eligible to participate in the research. It is possible that the use of an online questionnaire might have favoured male respondents given that it has been documented that internet users have in the past been predominantly male (Mann & Stewart, 2000). However, there is increasing evidence that internet use is much more widespread across populations (Hewson et al, 2003), and that its broad reach can improve representativeness as more groups of people can access the research instrument (Litvin & Kar, 2001). The gender split of questionnaire respondents (15.6% male and 84.4% female) compares with 19% of complaints made by males and 81% by females in the BACP complaints. Given that research into complaints within the health professions suggests that women are more likely to complain than men (Pleasance et al, 2004), a greater proportion of male participants might have been expected to participate in a survey about not complaining. These findings might be due to sample bias or could suggest that reasons for not complaining are not influenced by the client's gender, but this would require further research.

The professional status of questionnaire respondents was a key area for the research given that one of the stated research aims was to explore the differences and similarities in reasons for not complaining between therapists and lay people. At the time of their therapy, 35.8 % of questionnaire respondents were lay people, 37.3 % trainees and 26.9% therapists. In the analysis of BACP complaints, 43% of complainants were classified as lay people, 18% were trainees and 38% were therapists or working within a related profession. While it had been hoped that the study would access more lay people, this response level is good considering that much of the recruitment to the research was conducted through therapist organisations and individual therapists. Email cascading among therapists proved to be more effective at eliciting responses than online contact with public message boards and forums. Active publicity in national media might have brought the research project to the attention of the wider public and may have resulted in a greater proportion of lay people completing the questionnaire, but this was not possible with the limited resources available to the researcher. It is possible, however, that therapists who themselves have experienced poor or harmful therapy are likely to be more motivated than lay people to respond to this research as they arguably have more to gain from seeking to improve the profession.

The online questionnaire was constructed with a view to limiting the degree to which it would encourage participants to revisit their therapy experience, and therefore did not ask for any information about what happened in the therapy. Arguably, the questionnaire failed in this respect, given the number of respondents who wrote in some depth on the questionnaire about their therapy experiences. While this might reflect a sense that people who have not complained feel silenced and feel a need for their experience to be heard and acknowledged, it raises concerns about the possible negative impact on participants of completing the questionnaire. The increased physical distance between researcher and participant that is characteristic of an online survey can be attractive to respondents, minimising power imbalances and fostering more openness in responses (Illingworth, 2001; Joinson & Paine, 2007). In this case, the disinhibiting effects of an online method might have undermined the intention to avoid harming participants. On the other hand, this might also demonstrate that people's reasons for not complaining are inextricably linked

with what happened to them in the therapy. This can be seen in comments made by participants relating to the harmful impact of the therapy and how this left them feeling too distressed to complain. Although the harmful impact of abusive therapy has been documented to some extent (Schoener, 2008), there is to date no research that examines the effects of non-abusive but harmful therapy, or that considers the impact of such effects on a client's ability to make a formal complaint should they so wish.

The effectiveness of the online questionnaire in exploring the reasons people do not bring a formal complaint about poor or harmful therapy needs to be considered. There was no existing survey instrument that could be used for this project, so a new questionnaire was developed. In addition, the survey was developed without any previous research into people's reasons for not complaining and therefore was based on accounts in the published literature. While its scope was exploratory, it is clear from participants' comments that many found the questionnaire did not effectively address their reasons for not complaining. Similarly, the principal components analysis reveals limitations in the use of statements for scoring. Arguably, the questionnaire has worked best as a pilot for developing an instrument to explore the reasons why people do not complain. Modifications could be made to the survey based on the factors revealed in the principal components analysis and incorporating statements relating to the additional reasons identified by participants. Oppenheim (1992) states that the development of surveys requires that questionnaires are tested and modified several times over. While this online survey was tested before launch with two different groups of participants, developing a robust measure of the reasons why people don't complain would require further development and repeated testing.

Implications of these findings

The email responses to the questionnaire warrant discussion, particularly those responses from therapists conveying opposition to the research topic. While these represented only a small proportion of responses, the strength of feeling communicated in them was striking. Comments centred around a worry that the research would encourage more people to make formal complaints, or to take legal action, and that this would put therapists' livelihoods at risk. The tone of these emails was both angry and defensive. This seems to relate to views stated in the literature that complaints are on the rise and that therapists are increasingly at risk of unfounded complaints (Kearns, 2011). Certainly, these emails seem to suggest that some therapists feel under threat or at risk in some way. Van Horne's view (2004), however, is that such concerns are borne primarily out of a lack of research into complaints meaning that therapists are unaware both of the relatively low risk of a complaint being raised against them, or about the complaints processes which consider them.

Findings relating to a lack of information about therapy and about complaints processes indicate that this was not an issue for participants from the T×2 group, as might be expected, but it was also not seen to be an issue for those from the L×2 group, which might be surprising. This is supported to some degree by research into expectations of the Fitness to Practise Complaints Process of the HPC (Ipsos MORI, 2010) which shows that members of the public were confident that they could access the information they needed about complaining. However, previous research into complaint behaviour within the health professions shows that one barrier to complaining can be the difficulty in finding the relevant information (Gulland, 2009), suggesting that although members of the public might feel confident that they will be able to access the relevant information, the reality might prove to be different, given the complexity of processes involved. This is supported, perhaps, by the significantly higher scores for this variable among the TL group. Participants who were lay people at the time of their therapy and who are therapists now, with some knowledge of both therapy and the processes available for redress, are perhaps in a better position to understand what information they lacked at the time of their therapy

than those in the L×2 group. If lack of information is a factor in not bringing a complaint this is concerning given that, as long ago as 1987, Vinson's research demonstrated that lack of information was the overriding factor in clients not bringing a complaint.

The finding relating to feelings of shame associated with seeking therapy showed significant differences between the L×2 group and the other two groups, indicating that lay people were more likely to agree that they experienced feelings of shame for seeking therapy. This has limited support in client literature (Sands, 2000). In the research literature, shame associated with abuse in therapy is identified (Benowitz, 1994; Kayberry, 2000; Vinson, 1987), but stigma associated with seeking therapy in the first place does not feature. The limitations of the questionnaire mean that the findings in this research are not sufficient to state with confidence that this is a major factor that inhibits members of the public in bringing complaints, and merits further research.

Findings relating to the formality of complaints processes showed significant differences between the T×2 and L×2 groups. Participants in the T×2 group were more likely to agree that they would prefer a less formal process, such as mediation. Mediation is seen by some as a more therapeutically relevant and relational approach to resolving clients' grievances with their therapists and offers a more helpful response than formal complaints procedures, which might explain why the T×2 group scored more highly here (Kearns, 2011; Totton, 2001). Research within the health professions suggests that complainants might not be happy with formal complaints processes (Gulland 2009; Mulcahy, 2003; Posnett et al, 2001). Mediation is a preferred option for many complainants and this seems to be linked to their experiences of processes proving to be more formal than they expected when they contacted the regulating body (Ipsos MORI, 2010). Perhaps the lower means scores for this variable given by the L×2 group, indicating that they were less likely to prefer mediation or less formal processes are linked to the findings about lack of information. If so, this raises questions about what members of the public understand is involved with formal complaints processes or their alternatives.

Two additional reasons for not complaining emerged that had not been included in the questionnaire statements. Comments were made by participants about the perceived risks

to clients who were trainees at the time of their therapy and were concerned about negative impact this might have on their future careers. This is supported in the literature relating to professionals who do not complain. Levenson (1986), Biaggio et al (1998) and Gabbard et al (2001) all highlight the negative consequences to career and livelihood that practitioners fear if they bring a complaint against a fellow professional. Similarly, Kayberry's research into abuse in supervision (2000) highlights supervisees' fears of negative consequences to their careers and how this inhibits them from bringing a complaint. How much greater might these fears be for a potential complainant who is not an established professional but a trainee, and a client rather than a peer?

Participants' comments relating to the lack of support available in bringing a complaint are echoed in the research literature relating to complaints within the health professions. Access to independent advice agencies that can give information and help provide support throughout the process of a complaint is important (Pleasance et al, 2004). More recent research highlights a range of support roles identified by complainants, ranging from someone to guide them through the complaints process and provide pastoral support, to someone who can actively fight their case for them (Ipsos MORI, 2010). There is insufficient evidence in this research to state categorically that a lack of support is a major factor in not bringing a formal complaint, but it warrants further investigation.

Conclusion

The online questionnaire set out to be exploratory in nature and to examine a range of reasons for not bringing a formal complaint. It succeeded in reaching a greater number of people than had been expected, given that the target group is difficult to identify and to reach. The questionnaire had considerable limitations, including the difficulty of exploring the complex constellations of emotional reasons associated with the experience of poor or harmful therapy that might contribute to not bringing a complaint. Nonetheless, the questionnaire was successful in providing new information about reasons for not

complaining. Findings revealed that there are differences between lay people and therapists in not complaining that relate to knowledge of therapy and complaints processes, and to a sense of shame associated with accessing therapy. In addition, emerging findings from the questionnaire informed the researcher's interviews and analysis during the interview stage of the project.

Chapter 7 – Interview findings and discussion

This chapter presents findings from the analysis of interviews with clients who did not bring a formal complaint about their therapy but who might have wished to. Some contextual information about the participants is presented, while the main bulk of the chapter presents the domains and categories that were identified in the analysis. A narrative, focussing on one participant's experience and presented in stanza form is offered to illustrate how the themes and categories relate to one another in the experience of not bringing a complaint. Finally, the chapter discusses the methodological limitations that influence interpretation of the findings, and considers the implications that can be drawn from them.

Interviewees

A total of 18 interviews were conducted with volunteers from the online survey. A brief extract from an interview is shown at Appendix 11 for information. Demographic information about interviewees collected both from the online survey and from a form issued at interview is presented at Appendix 12. These details are presented as written by participants.

Although interviews were focussed around volunteers' reasons for not complaining and participants were not asked about their experiences within the therapy, some people did speak about this. Participants described what happened to them as significant in their reasons for not complaining and so these have been briefly listed here. They are not described in detail or attributed to individual participants to protect confidentiality.

- Therapist disclosing details of their own personal life
- Therapist instigating and pursuing a social relationship
- Attempting to seduce the client
- Not believing that the client is gay and attributing their difficulties to this
- Gifts and romantic letters from the therapist
- Therapist falling asleep in sessions
- Bullying comments and behaviour
- Did not believe client's account of being raped, stated that this could not have happened
- Taking phone calls during sessions
- Ending the therapy without warning
- Not working in sufficient depth, not getting to the heart of the matter
- Siding with one partner in couple work
- Cold, unresponsive, insensitive demeanour

Interview analysis

The completed data analysis yielded subcategories and categories that were organised into four domains:

1. Being silenced within the therapy
2. Being silenced by the complaints procedures
3. Being silenced by the therapist
4. Reclaiming power

The component categories and subcategories have been ordered according to the number of categories and meaning units in each. The domains and categories are summarised at Table 20 below. This table also indicates the number of participants whose interview contained comments coded within this category (indicated by a number followed by 'P') and the total

number of meaning units coded within this category (indicated by a number followed by 'MU').

Table 20: Ordered domains and categories.

Domain 1 Silenced within the therapy	**Domain 2 Silenced by complaints procedures**	**Domain 3 Silenced by the therapist**	**Domain 4 Reclaiming power**
Emotional legacy of therapy (17P/119MU)	Complaints process a poor fit (17P/75MU)	Therapist's power (16P/48MU)	Research participation (17P/62MU)
Doubt and confusion (16P/91MU)	Futility of complaining (17P/71MU)	Client's distress not known (14P/52MU)	Resilience (14P/33MU)
Feeling responsible (16P/51MU)	Risk of being harmed (14P/64MU)		
Personal context (15P/60MU)	Lack of knowledge (14P/51MU)		
Debt of gratitude (9P/27MU)			

Each domain will be described in turn along with its component categories and subcategories. Subcategories are ordered within their parent categories according to the number of participants who spoke of these themes (indicated as above with a number and 'P'). Results were considered general if they fit for 15-18 cases, typical for 10-14 cases, variant for five to nine cases and rare for less than five cases. This is indicated with the number of participants as well as the number of meaning units coded within each subcategory (indicated with 'MU'). Rare and variant categories are defined, but are not discussed in detail in the text. Where quotations from interviewees are used to illustrate the findings, these are attributed to the relevant participant by 'P' followed by the interview number.

The domains have been summarised into an overarching theme or essence of 'being silenced' which is described after the categories and subcategories, along with a model to understand the experience of not complaining as described by participants in this study.

Domain 1 – Silenced within the therapy

Categories within this domain are linked by the theme of highlighting how what the client brought to therapy and their experience within the therapy contributed to them not complaining.

A summary of the categories and subcategories within this domain is shown at Table 21.

Table 21: Domain 1 - Silenced within the therapy.

Domain 1 Silenced within the therapy	
Emotional legacy of therapy (17P/119MU)	Sense of injustice (12P/Typical/31MU)
	Devastation (11P/Typical/22MU)
	Double dose (11P/Typical/22MU)
	Left hanging (6P/Variant/17MU)
	Shame (6P/Variant/10MU)
	Disillusioned with therapy (3P/Rare/4MU)
	Sense of waste (2P/Rare/2MU)
Doubt and confusion (16P/91MU)	Therapy process shrouded in mystery (15P/General/51MU)
	I knew no different (10P/Typical/26MU)
	Complaining didn't cross my mind (10P/Typical/14MU)
Feeling responsible (16P/51MU)	Protect other clients (11P/Typical/24MU)
	I did something wrong (10P/Typical/18MU)
	I should have known better (6P/Variant/9MU)
Personal context (15P/60MU)	Existing vulnerability (10P/Typical/18MU)
	Presenting issues (10P/Typical/16MU)
	Personal history (7P/Variant/16MU)
	Investing in the therapy (3P/Rare/6MU)
	Previously able to complain (3P/Rare/4MU)
Debt of gratitude (9P/27MU)	Wanting to preserve something good (7P/Variant/13MU)
	Made to feel grateful (2P/Rare/9MU)

Domain 1, category 1:

The **Emotional legacy of therapy** category refers to the emotional impact of the poor or harmful therapy that the participant experienced. This category contains seven subcategories:

- Sense of injustice
- Devastation
- Double dose
- Left hanging
- Shame
- Disillusioned with therapy
- Sense of waste

The **Sense of injustice** subcategory was classed as typical as 12 participants made comments which were classed within it, comprising 31 meaning units. This subcategory described participants' feelings of anger and frustration at the injustice of being harmed by a therapist that they felt had got away with harming them.

> "In a sense you see, for me, she got away with it … It feels that I let her get away with it, I let her off the hook." (P16)
>
> "I feel aggrieved that I've had such a rotten experience." (P4)

The **Devastation** subcategory (11 participants, typical, 22 meaning units) refers to participants' comments about feeling devastated, shattered and destroyed by their experience, to the extent that they cannot bring a complaint and instead have to focus their energy on healing, recovery and taking care of themselves.

> "I think the main reason would be self-preservation. My emotional state at the end of the counselling that I'd experienced, I was in such a place that I really needed to get myself back on an even keel and that was my priority, not complaining." (P4)

> "But I think probably the most overwhelming reason why I didn't complain was simply that business of being … of feeling very fragile at that point and feeling that all the energies I had had to be focussed on solving my problems." (P7)
>
> "And also I didn't feel … yeah, I didn't really feel that I could … yeah, I wanted to kind of forget about it as well." (P17)

Double dose refers to the subcategory (11 participants, typical, 22 meaning units) where participants describe how their therapy experience compounded the problems and difficulties they took to therapy in the first place. Some participants described how what went wrong in therapy directly paralleled the issues they were hoping to address, others talked about their symptoms being exacerbated by the therapy. In either case the participants described how this experience of a double dose made the possibility of complaining more difficult.

> "I mean you go to a counsellor because you're traumatised and then you're doubly traumatised and you feel that someone who has a lot of influence in a vulnerable situation has done something which you cannot combat." (P10)
>
> "I mean it did hook into one of the issues I'd taken to her anyway, which was around trust having been misplaced in someone who then completely blew it out of the water. So there was a sense in which, you know, there's a bit of history there, you know, is this going to repeat itself?" (P16)

The **Left hanging** subcategory (six participants, variant, 17 meaning units) refers to participants' descriptions of feeling that something has remained unresolved for them since their therapy experience.

> "It is a long time ago but it is still a touchy area for me." (P15)

The **Shame** subcategory (six participants, variant, ten meaning units) describes participants' accounts of feeling ashamed as a result of the therapy experience and how this contributed to their reasons for not complaining.

> "Ultimately I think it's shame … I think there was perhaps some element of shame, shame at being in counselling, I think there was shame at somehow it being my fault … It is definitely shame that stopped me." (P1)

The subcategory of **Disillusionment with therapy** (three participants, rare, four meaning units) refers to participants' comments that they would not feel able to go back into therapy with another therapist as a result of their experiences. The subcategory of **Sense of waste** (two participants, rare, two meaning units) contains participants' comments about feeling that they have invested money, time and resources on therapy that not only did not help but which harmed them.

Domain 1, category 2:

The **Doubt and confusion** category refers to the participant's difficulty making sense of their experience and working out what was happening to them and whether there was a problem with the therapy at all. This category contains three subcategories:

- Therapy process shrouded in mystery
- I knew no different
- Complaining didn't cross my mind

The subcategory of **Therapy process shrouded in mystery** is the study's only subcategory to be classified as general with 51 meaning units from 15 participants. This subcategory describes the participant's experience of the intangible, abstract nature of therapy as something that can be confusing and disorientating. As well as contributing to the participants' difficulties in working out whether or not something was going wrong, this

aspect of the nature of therapy also meant that participants felt that it would be very difficult to give a coherent, meaningful account of what had happened to them in writing as part of a complaint. This also links with the subcategory **Need for documentary evidence** below.

> "I was floundering around. The longer it went on the more I realised that something wasn't quite right, couldn't get my hands on what it was, I didn't know, kept trying to find whatever it was that was needed and in the end gave up." (P1)

> "I think it's extremely difficult if you've very little experience of the process to know the difference between something that's basically an issue for counselling and something that's actually an issue with the counselling. I think it's really hard to know the difference." (P3)

> "I suppose what I'm trying to say is how difficult it would be to actually make a complaint. Because, you know, short of doing an interview like you've done with me know, you know, if I were just to write a letter, I mean, God, where would I start, where would I begin, where would I end? And would it just sound quite feeble on paper?" (P7)

> "I hadn't done loads of talking and learning and finding out about it, so it was a bit as if I'd gone to a magician or something like that rather than, you know, if it's a medical think I'm the sort of person that … I read all the books about it and want to know exactly what they're doing … but I didn't feel like that about the counselling." (P14)

The category labelled **I knew no different** (10 participants, typical, 26 meaning units) refers to participants' descriptions of feeling confused by what was happening in their therapy, perhaps feeling frightened and uncomfortable by what was happening, but not knowing at the time that what was making them feel this way was not simply what they could expect in therapy. Participants did not know what to expect from therapy and described not being given any explanations or information about the process and so did not know when something that was happening was bad practice.

> "I mean I suppose I had an idea that something wasn't quite right but then it only came to light sort of in hindsight. […] So not realising, yeah, not understanding things like boundaries or what's appropriate, what's not appropriate, that sort of thing. And then still not knowing really whether that was right or not." (P15)

> "So if he's seen me once and then, you know, he's sent me to go and drink a bottle of diet pepsi to make myself better … I would have. … I would have just done what I was told because I didn't know any better." (P13)

> "I didn't know what counselling looked like, I'd not encountered it before, I didn't know anybody who had, so I had very little idea what to expect." (P1)

Complaining didn't cross my mind (10 participants, typical, 14 meaning units) is the subcategory that refers to participants' comments that they did not make a conscious decision not to complain, but rather that the idea of complaining did not occur to them.

> "It never occurred to me to even really voice the concerns that I had, let alone to be told that maybe it was the basis for a complaint." (P3)

> "But it didn't occur to me to complain because I got it free, I felt that they were the experts and I wasn't. It just didn't enter my head that I could complain." (P14)

Domain 1, category 3:

The **Feeling responsible** category refers to participants' comments that relate to feelings of guilt and responsibility. This category contains three subcategories:

- Protect other clients
- I did something wrong
- I should have known better

The **Protect other clients** subcategory was classed as typical with 11 participants making comments relating to this, coded as 24 meaning units. The comments within this subcategory describe participants feeling guilty about not having brought a formal complaint as this means that their therapist might harm other clients. Participants feel that they potentially have a duty to speak out and to try to protect others.

> "That does make me feel a bit guilty because that's rather a selfish response because what might she be subsequently doing to other people. That does worry me a bit to say the least." (P7)

> "In not reporting him I haven't stopped him from malpractice with anybody else, and that is something that I think about." (P1)

> "But then I kind of feel even worse now because I think, 'well, I don't know who else this might have happened to' or whether it's not OK, and then I feel more guilty about that than I do anything else because I have a responsibility to do something."(P9)

The **I did something wrong** subcategory (10 participants, typical, 18 meaning units) relates to comments by participants describing feelings of having contributed to what went wrong in the therapy and feeling as though the distress and difficulty they experienced is their fault.

> "I don't know, I guess maybe I blamed myself more at the time. That might have been why it didn't seem like something that's so obviously wrong with him." (P9)

> "At the time it was 'actually, this is me', this kind of feeling of 'this doesn't feel quite right, why doesn't it feel right? It must be me.'" (P1)

I should have known better (six participants, variant, nine meaning units) relates to participant comments that they feel that they could have prevented or stopped what went wrong in the therapy and that somehow they contributed to their experience by not acting sooner.

> "Well I felt that it was my fault for being so stupid in the first place, to kind of go along with what this person had said. So when you talk about it afterwards you kind of realise, 'why didn't I realise at the time?' So you feel you come across as gullible." (P17)

> "Maybe I should have seen it happening sooner and I should have done something about it, or I should have been more aware given that I had some counselling skills myself and I'd had therapy before, I should have known that it wasn't OK."(P9)

Domain 1, category 4:

The **Personal context** category refers to participants' comments about elements of their personal life that had an impact on their reasons for not complaining. This category contains five subcategories:

- Existing vulnerability
- Presenting issues
- Personal history
- Investing in the therapy
- Previously able to complain

The **Existing vulnerability** subcategory was classed as typical with 10 participants making comments relating to this, coded as 18 meaning units. The comments within this subcategory describe participants' emotional state as they entered therapy and their thoughts about the vulnerability that they arrived with.

> "I had come into it in not a particularly good state" (P1)
>
> "I think I was quite disorientated in general basically." (P3)
>
> "We were in a very fragile position." (P7)
>
> "And so, this is a case where two people have come to her at a very, very vulnerable time." (P10)

The subcategory of **Presenting issues** (10 participants, typical, 16 meaning units) is linked to the above subcategory and refers to participants' comments regarding their reasons for entering therapy and the difficulties that they hoped therapy would address. For reasons of preserving confidentiality, these will be summarised rather than quoted directly and attributed to individual participants. Issues that participants spoke of taking to therapy included:

- Depression and suicidal feelings
- Grief and loss, traumatic bereavement
- Relationship difficulties with partner – couple therapy
- Childhood abuse
- Personal development as part of counsellor training
- Residential psychiatric care, having been sectioned

Personal history (seven participants, variant, 16 meaning units) includes participants' comments regarding their history inasmuch as it relates to their understanding of why they did not bring a formal complaint about their therapy. These comments illustrate how participants have come to understand that something that happened in their therapy linked in to something from their past in an unhelpful way that made complaining more difficult.

> "So there was an element of that as well which I now realise is repeated behaviour patterns, that's how I've related to my mother." (P4)

The subcategory of **Investing in the therapy** (three participants, rare, six meaning units) refers to participants' comments about coming to therapy with a sense of hopefulness that it would help them and being committed to giving it a chance. The subcategory of **Previously able to complain** (three participants, rare, four meaning units) contains participants' comments regarding times when they have made formal complaints in the past, not necessarily about therapy, but in areas where they have been aware that they have tackled something difficult for them and contrast this with their decision not to complain about their therapy.

Domain 1, category 5:

The **Debt of gratitude** category refers to participants' comments about how grateful feelings in response to the therapy contributed to difficulties in bringing a complaint. This category contains two subcategories:

- Wanting to preserve something good
- Made to feel grateful

The **wanting to preserve something good** subcategory was classed as variant with seven participants making comments relating to this, coded as 13 meaning units. The comments within this subcategory describe participants' feelings of wishing to hold on to helpful aspects of their therapy and feeling that making a formal complaint would destroy this for them.

> "I'd been in long term therapy and I'd sort of thought that if I made a complaint about this, there's been good stuff and I'll lose the good stuff." (P12)

> "And also she did help me with certain things, so although it was bad in a lot of ways there was some good that came out of it, so I don't want to totally say this person is awful." (P17)

The subcategory of **Made to feel grateful** (two participants, rare, nine meaning units) refers to participants' comments about being made to feel that they could not complain because of a message that therapy is a precious and limited resource, they were not paying for it and a sense that they had no grounds for complaint because they were somehow lucky to receive any therapy at all.

Domain 2 – Silenced by complaints procedures

Categories within this domain are linked by the theme of highlighting how the client's expectations, fears and experience of complaints procedures contributed to them not bringing a formal complaint.

A summary of the categories and subcategories within this domain is shown at Table 22.

Table 22: Domain 2 – Silenced by complaints procedures.

Domain 2 Silenced by complaints procedures	
Complaints process a poor fit (17P/75MU)	Isolation (11P/38MU)
	Complaints process is too formal (9P/19MU)
	Unhelpful first contact (6P/12MU)
	Dual relationships (2P/6MU)
Futility of complaining (17P/71MU)	It takes time to heal (13P/32MU)
	The odds are stacked against me (9P/15MU)
	Need for documentary evidence (7P/10MU)
	Credibility issues (6P/13MU)
Risk of being harmed (14P/64MU)	I can't face it (11P/33MU)
	I will be blamed (8P/14MU)
	Exposing process (6P/12MU)
	Negative impact on career as therapist (4P/5MU)
Lack of knowledge (14P/51MU)	Don't know about complaints procedures (14P/30MU)
	Don't know about professional bodies (7P/14MU)
	Don't know what to look for in a therapist (4P/7MU)

Domain 2, category 1:

The **Complaints process a poor fit** category refers to participants' experience that existing complaints procedures did not offer them the route that they needed to address their concerns. This category contains four subcategories:

- Isolation
- Complaints process too formal
- Unhelpful first contact
- Dual relationships

The **Isolation** subcategory was classed as typical with 11 participants making comments relating to this, coded as 38 meaning units. The comments within this subcategory describe participants' sense of a lack of support available to them in making a formal complaint. These comments might speak directly of feeling alone and isolated or talk about the support that would have been helpful for them that they felt was not available. This support is described as someone who is knowledgeable about therapy and can help the client sort out in their mind whether what happened to them was wrong. The kind of support described is also for someone who can provide information about complaints procedures, someone who can act as an advocate for the client or as a mediator between the client and the therapist. While there were varying descriptions of the role of the supporter, a common theme within this subcategory was for there to be an independent contact – someone independent of the therapy and independent of the professional body (see also subcategory **Dual relationships** below).

> "I just needed there to be somebody who understood about counselling, somebody who wasn't as inexpert as I." (P1)

> "But I think the fact that somebody independent … if I complained and it was somebody independent and I could speak to that person independently and they would interview in a similar fashion to what you are doing now, where I could feel safe." (P8)

> "It's down to you as the client to make the step and there's no-one else around who'll help you out with it … If I could have exactly what I wanted it would have been someone independent to talk to about it and maybe sort of mediate almost to help me sort of clear my mind." (P12)

The **Complaints process is too formal** subcategory (nine participants, variant, 19 meaning units) contains comments that relate to participants feeling that the complaints process was too bureaucratic or too formal for their needs. This might be to do with how the possible outcome of the process for the therapist was seen; some participants spoke of feeling that they did not want their therapist to be 'struck off' as they felt this would be a disproportionate response. Some participants spoke of wanting an 'interim' process where their concerns could be addressed in a less formal manner than in the full-blown complaints process.

> "I've seen complaints policies from various organisations, different contexts, where the policy is that you must submit things in writing straight away, and I really think the best complaints policy involves speaking to somebody straight away – not writing it down – because writing it down involves entrenching your position right at the beginning." (P3)

> "I'm not into 'let's get people struck off' unless it's necessary." (P11)

> "It didn't feel like there was a halfway house … More sort of, it sounds a little odd, but a more formal informal process … A way that allows you to do things to start without either feeling you're attacking someone or being under attack, that there's actually more of a discussion." (P12)

> "And it might not have even meant me going ahead at the time, but it might have been a sort of 'OK this is now on record, think about it, if in six months you feel OK, you can come back.' … And almost hold it for a bit for me while I go away and sort of process it and decide what the next stage is that I feel I can address." (P16)

Unhelpful first contact (six participants, variant, 12 meaning units) contains participants' comments about incidents when they made contact with the appropriate professional body to explore the possibilities of bringing a formal complaint against their therapist, but had an unhelpful, off-putting experience in this contact.

> "I did ring [the professional body]. I explained my dilemma, I explained where I was. The advice I got was 'well you need to go back to her and thrash it out with her' which I felt was so inappropriate at the time. […] And so what I got from them wasn't helpful at all, it was almost throwing me back into the lion's den and telling me to take responsibility and deal with it myself. […] It was almost, 'yeah, we can hear you, go away', which I was really quite angry about, I felt that was very unhelpful." (P4)

Subcategory of **Dual relationships** (two participants, rare, six meaning units) refers to participant comments that relate specifically to difficulties in bringing a complaint because the professional body is not considered to be independent of the therapist, but to be acting on their behalf. Alternatively, comments in this subcategory might relate to additional existing relationships with the therapist or which the therapist has within the professional body that leave the client feeling that they cannot successfully raise a formal complaint.

Domain 2, category 2:

The **Futility of complaining** category refers to participants' comments that describe various ways in which they feel that making a formal complaint would not achieve anything for them. This category contains four subcategories:

- It takes time to heal
- The odds are stacked against me
- Need for documentary evidence
- Credibility issues

The **It takes time to heal** subcategory was classed as typical with 13 participants making comments relating to this, coded as 32 meaning units. The comments within this subcategory describe participants' experiences of needing considerable time to recover from the negative experience of their therapy, over a period of many years in many cases, and this meaning that sometimes when they were in a position to bring a complaint that a time limit

had been passed (although there was sometimes confusion about what the time limit might be). In other cases, the time it takes to heal creates difficulty in complaining as it raises doubts in the participant's mind about what happened and the validity of their experience.

> "But you know, how much of the rest have I distorted – was it this bad or was it this bad? So there's something about the passage of time." (P1)

> "And I think it's three years, isn't it, the time that you can complain? And I think it took me about that length of time to really step back from it, by which point there would have been no point somehow." (P12)

> " A number of years later, when you've resolved all of the other crap and you still find yourself thinking, 'OK, what's wrong with this picture?' … You know, when the dust has settled … I can't do anything about it now, it's way, way too late to do anything about taking it through a disciplinary process." (P18)

The subcategory labelled **The odds are stacked against me** (nine participants, variant, 15 meaning units) contains comments from the participants that reflect their feeling that bringing a formal complaint against their therapist would be a futile exercise as the process favours the therapist. Participants felt that it was unlikely that a complaint would achieve anything helpful and that this made the prospect of making a complaint a waste of time, energy and their resources.

> "I didn't consciously think, 'shall I complain? Shan't I?' and make a decision, I just thought 'there's no point really pursuing this."(P7)

> "You know, I didn't think that anything could be put right." (P10)

> "What would have been in it for me to go the disciplinary route? Validation that I was right? But I wasn't going to get that in the first place. And something done to stop it happening again? And that wasn't going to happen either. So what exactly is this for?" (P18)

The **Need for documentary evidence** subcategory (seven participants, variant, 10 meaning units) relates to participants' comments about their sense that their accounts of the therapy would need to be supported with facts and evidence such as specific dates and details of specific comments and incidents in the therapy. This is linked with the earlier subcategory

of **Therapy process shrouded in mystery** as participants described the intangible nature of therapy as contributing to this difficulty – the nature of therapy as dealing with internal experiences often meant that the nature of the difficulties cannot be easily documented. One participant spoke of their difficulty complaining in spite of having documentary evidence and artefacts from the therapy that might have supported a complaint. The subcategory is also linked to **Credibility issues** below as some participants felt that it was more likely that they would be believed if they had documentary evidence.

> "But I had evidence of letters he'd written, I'd got tapes, I'd got notes – handwritten notes, I'd got … well lot's of paper … you know, things that he'd written, lots of paper evidence and these tapes and music and things. … And I think I held onto it thinking 'well maybe I will', you know, but I never did." (P15)

> "Because I didn't keep notes going through, apart from sort of latterly, I wouldn't have the resources to fight it, I suppose." (P12)

> "I mean I kind of made some tentative enquiries at the time and they said, 'we do need some sort of idea of events and times' and I took that to mean they would need dates and … details, times, dates of events of things that happened, exactly what happened. But because … there wasn't so many actual things but I could remember it was more kind of the experience, I thought, 'what am I going to say?' and I couldn't … I just felt that I didn't have enough information to give anybody, you know, it wasn't concrete enough." (P9)

Credibility issues (six participants, variant, 13 meaning units) refers to participants' concerns that the therapist as the qualified professional was more likely to be believed than they were. This was sometimes exacerbated by the link to the **Need for documentary evidence** (see above) as participants felt that without concrete evidence the complaints process would come down to 'their (expert) word against mine' and that the client's word account would not be worth as much as the professional's.

> "Looking back at the time, there was a fear. A fear of not being believed … And when I'm the only one who knew, it's my word against her word." (P4)

> "This is not necessarily fact, it's 'he said, she said' and I'm certainly not making the comparison but it's like a physical attack on somebody, the only people that were witness to it were the alleged attacker and the

> alleged victim. And so then you've got to go down the route of 'who do I believe? And that's a terrible situation to be in." (P8)

Domain 2, category 3:

The **Risk of being harmed** category refers to participants' feelings that to bring a formal complaint would be too risky for them and could involve being harmed by the process. This category contains four subcategories:

- I can't face it
- I will be blamed
- Exposing process
- Negative impact on career as therapist

The **I can't face it** subcategory was classed as typical with 11 participants making comments relating to this, coded as 33 meaning units. The comments within this subcategory describe participants' feelings that to bring a formal complaint would require a great deal of strength to survive a process that might be experienced as traumatic in itself, particularly the element of having to revisit what happened in the therapy. There was a sense of feeling that they would have to take on a 'David and Goliath' type fight and that this felt like too much to tackle.

> "I wasn't strong enough and I didn't feel I could face it. I can remember thinking, 'gosh, I'll have to go over everything, what I experienced, how he made me feel, things he said again', and I couldn't bear the thought of that. And I remember thinking, 'my God, no wonder rape victims don't come forward.' You know, my situation was nothing compared with the violation of being raped and I thought, well, the thought of going all through this, what felt like mental rape in a way, was awful." (P6)

> "And I think at the moment I was still quite vulnerable at the time, I was in quite a vulnerable place myself and I don't think I was ready to have to kind of go over that again and again without having worked through it properly." (P9)

The **I will be blamed** subcategory (eight participants, variant, 14 meaning units) includes participants' comments about their fears of opening themselves up to blame, criticism and judgement if they brought a complaint. In addition, participants described their fears of being labelled and pathologised if they complained – having their reasons for complaining dismissed with an idea that they were not mentally or emotionally competent to understand what was happening in the therapy. Participants feared that to be blamed or judged in this way would feel damaging in itself.

> "And if you make a complaint how do you know they're not going to say, 'yes well, you would say that dear', or 'you don't really understand, that's probably your mental health issues talking', or 'are you sure you're completely rational?' … Yes definitely, there's definitely a feeling of that, that it could be used against you if you complained." (P14)

Exposing process (six participants, variant, 12 meaning units) refers to participants' fear of the complaints process regarding their anonymity and sense of having to reveal a lot about themselves as well as questions regarding how much personal information about themselves they would be required to share. There were additional concerns about confidentiality and anonymity for those participants who were therapists themselves.

> "It's not that confidential when you make a complaint." (P5)

> "I don't like the fact that the adjudications are printed every month. I understand the reasoning behind it … but for details of it from a client point of view, I think it's hard to see how you wouldn't … you know, particularly if you're in the field yourself, be able to really maintain your confidentiality." (P12)

The **Negative impact on career as therapist** subcategory was classed as rare with four participants and five meaning units. Those participants who were working as therapists or training to become therapists at the time of their therapy experience felt that complaining would be a risk because they might be judged as being unfit for practice themselves, labelled or pathologised.

> "And also the fact that yes I'm a therapist, but maybe if they find out that I'm emotionally unstable and all this is going on, I won't be able to practise as a therapist." (P4)

Domain 2, category 4:

The **Lack of knowledge** category refers to participants' comments about areas where they need clear and specific information to facilitate decisions about making a complaint or for taking up therapy in the first place. This category contains four subcategories:

- Don't know about complaints procedures
- Don't know about professional bodies
- Don't know what to look for in a therapist

The **Don't know about complaints procedures** subcategory was classed as typical with 14 participants making comments relating to this, coded as 30 meaning units. This subcategory relates to participants' comments about areas to do with complaints that they did not have information about. This included whether it was possible to make a complaint at all, under what circumstances, who to complain to, what the procedure of this would be, what time limits might be in place, what support has available, and what the possible outcomes might be.

> "To be given the opportunity to complain I think I would have had to have been given a very clear 'this is the time to do it and this is how to do it.' … It needs to be made really clear what to do if there is a problem." (P3)

> "I don't know how much of a factor it was, but I don't really know what the complaints procedure would have been … Therapists ought to … as a matter of course when they first meet prospective client, they almost ought to give them some information about a complaints procedure so that people are alerted to the fact that it is valid to make complaints and that this is how you do it if you feel you've got one." (P7)

> "I think the moment you walk in the door it should be very clear how to complain and who to complain to and that you can complain." (P14)

> "At the time I'd not idea what the disciplinary procedure was, let alone … I didn't even get that far, it wasn't the fact that I'd looked at it and thought … I didn't even get that far." (P18)

The **Don't know about professional bodies** subcategory (seven participants, variant, 14 meaning units) refers to participants' comments regarding their confusion or lack of knowledge about who is responsible for monitoring and regulating therapists. Some participants were aware that there are many professional bodies, while others were not aware of the existence any professional organisations at all. Some participants were not aware that therapists are not licensed or regulated by statute.

> "I had no idea about people having professional bodies or there being anything where people were accountable, it just never crossed my mind." (P2)

> "How do I know that [the therapist] is keeping up their supervision? How do I know that they haven't been struck off? How do I know whether they've still got a licence? How do I know anything? If they're operating from their home, how the hell do I know that they're actually bona fide?" (P8)

The **don't know what to look for in a therapist** subcategory (four participants, rare, seven meaning units) contains participants' comments about the difficulty they have knowing what questions to ask a new therapist before starting work with them regarding their theoretical orientation, training, supervision and so on.

Domain 3 – Silenced by the therapist

Categories within this domain are linked by the theme of highlighting specifically how the therapist's interaction with the client in the therapy and their feelings towards the therapist impacted on their decision not to complain.

A summary of the categories and subcategories within this domain is shown at Table 23.

Table 23: Domain 3 – Silenced by the therapist.

Domain 3 Silenced by the therapist	
Therapist's power (16P/48MU)	Client's comparative powerlessness (11P/25MU)
	The benefit of the doubt (9P/23MU)
Client's distress not known (14P/52MU)	What the therapist needs to know (9P/20MU)
	Therapist not listening to the client (7P/15MU)
	Lack of follow-up by referrers (4P/10MU)
	Not seeking client's views of therapy (3P/7MU)

Domain 3, category 1:

The **Therapist's power** category refers to comments by participants about how powerful the therapist was in their experience and the extent to which the relationship with the therapist influenced their decision not to complain. This category contains two subcategories:

- Client's comparative powerlessness
- The benefit of the doubt

The **Client's comparative powerlessness** subcategory was classed as typical with 11 participants making comments relating to this, coded as 25 meaning units. The comments within this subcategory describe participants' experiences of their therapist as powerful, knowledgeable and expert in a way which left them feeling powerless in comparison and unable, therefore, to stand up to them by making a complaint. This also has links with the earlier subcategory of **Credibility issues** (see above).

> "And this person's obviously very well qualified and so there's a bit of me thinking, 'oh perhaps I'm, you know, it's little old me, just got my [counselling] certificate, what do I know?'" (P16)
>
> "In that situation I am the client and I am the one with difficulties, and there is someone who is a professional, labelled a professional, so you've already for that sort of inequality." (P10)
>
> "I think they were unhelpful but I didn't feel I could complain, I just didn't feel … you know, they're bigger and more powerful than one is."(P14)

The benefit of the doubt (nine participants, variant, 23 meaning units) refers to comments made by participants regarding ways in which they were reluctant to bring a formal complaint because they saw their therapist as vulnerable or having unintentionally made errors in the therapy. Sometimes described by participants as letting the therapist 'get away

with it', this subcategory suggests a protective response towards the therapist at the expense of the client.

> "So I suppose on a different level there was a part of me wanting to still put her on a pedestal and let her off the hook." (P4)
>
> "And I found myself finding reasons for him having said it and I feel like I've been making excuses for him." (P5)
>
> "I suppose the other thing was, what would be the consequence of complaining? Would she get struck off? Would it ruin her career? Am I prepared to do that to another person who other people might find helpful?" (P7)
>
> "And also I think there's perhaps a sense of … a bit of loyalty." (P15)

Domain 3, category 2:

The **Client's distress not known** category refers to comments by participants about feeling unheard, that their therapist is not aware of the difficulties that the client experienced in the therapy, perhaps because the client's attempts to communicate this have been disregarded or because their views were not sought. This category contains four subcategories:

- What the therapist needs to know
- Therapist not listening to the client
- Lack of follow-up by referrers
- Not seeking client's views of therapy

The **What the therapist needs to know** subcategory was classed as variant with nine participants making comments relating to this, coded as 20 meaning units. This subcategory refers to comments that participants made about what they would like their therapist to know about their experience of therapy, that they feel the therapist does not realise.

> "I'd still quite like to face him. I'd really like to say to him, 'you were hopeless' … What would I want him to know? How wrong he was." (P6)
>
> "I'd like him to realise that he didn't do a very good job." (P13)

> "I don't think we have ever sat down where I've said, 'let me explain to you how this felt to me' and that's probably what I need to do. […] to say, 'the worst thing that you did to me was not recognising that actually you couldn't help me.'" (P1)

The **Therapist not listening to the client** subcategory (seven participants, variant, 15 meaning units) refers to comments made by participants about ways that they attempted to communicate their distress to the therapist at what was happening in the therapy, but this was not responded to.

> "Everything I said was kind of like, 'no, that's not how it is' so I kind of went away with that reinforced as well, the blame was kind of reinforced with me." (P9)

> "I also wrote to her. I think I wrote to her some months afterwards saying that I want her to explain herself and she wouldn't." (P10)

The **Lack of follow-up by referrers** subcategory (four participants, rare, 10 meaning units) contains comments from participants who were referred to therapy by a professional third party who subsequently never checked with the client how the therapy was going – participants indicated that this might have been helpful for them in order to start to speak about what was going wrong. **Not seeking client's view of therapy** (three participants, rare, seven meaning units) refers to participants' comments about never being actively asked by their therapist for feedback about the therapy process, and therefore feeling that they did not have the opportunity to raise their concerns.

Domain 4 – Reclaiming power

Categories within this domain are linked by the theme of highlighting positive aspects of the participant's experience that have helped them to speak up about what happened to them in therapy and which therefore have implications for how people who have experienced poor or harmful therapy might be helpfully responded to.

A summary of the categories and subcategories within this domain is shown at Table 24.

Table 24: Domain 4 - Reclaiming power.

Domain 4 Reclaiming power	
Research participation (17P/62MU)	Wanting to make a difference (14P/28MU)
	Positive research participation experience (10P/23MU)
	Considering making a complaint now (3P/6MU)
Resilience (14P/33MU)	Seeking alternative help (13P/22MU)
	Learning more about therapy (7P/11MU)

Domain 4, category 1:

The **Research participation** category refers to comments by participants about how they experienced participating in the research, and some reasons for volunteering. This category contains three subcategories:

- Wanting to make a difference
- Positive research participation experience
- Considering making a complaint now

The **Wanting to make a difference** subcategory was classed as typical with 14 participants making comments relating to this, coded as 28 meaning units. This subcategory refers to comments participants made about being motivated to volunteer for the research by a desire to contribute to bringing about change to complaints procedures in therapy, or to the practice of therapy, to help others.

> "What I would like to do is contribute to people's working practice now, so perhaps doing this I'm doing as much good as I can, bring as much good as I can out of the experience." (P3)
>
> "I just thought well maybe this is a way of complaining without complaining maybe … the opportunity to do something now that I wasn't able to for whatever reason before – or didn't feel about to do before – and that it might actually help to influence sort of any future kind of policy or something." (P9)
>
> "What makes it OK for me is the knowledge that you will do something with it, that it is more than just a conversation, that it does actually go somewhere. […] Even if all that happens is that you tuck it under people's noses who maybe do pay attention and we open up even the slightest … a millimetre forward in changing things." (P18)

The subcategory of **Considering making a complaint now** (three participants, rare, six meaning units) refers to comments made by participants that they were thinking about now brining a formal complaint against their therapist and that this had been in their mind since volunteering for the project or speaking about their experience in the interview.

Domain 4, category 2:

The **Resilience** category contains comments by participants that suggest their own resilience in the face of their poor experiences of therapy and action they were able to take that subsequently proved helpful to them. This category contains two subcategories:

- Seeking alternative help
- Learning more about therapy

The **Seeking alternative help** subcategory was classed as typical with 13 participants making comments relating to this, coded as 22 meaning units. This subcategory refers to comments participants made about seeking help from others after their poor therapy experience. While in some cases participants were helped by family or partners, each of the participants with comments in this subcategory also subsequently sought further help in therapy with another therapist, in spite of their earlier experience.

> "Well I started having therapy again, I think it must have been about … probably wasn't for about six months to a year actually thinking about it, it was probably quite a while afterwards." (P 9)
>
> "I think I then went to see another counsellor actually and spoke to them about it, but that was some time after." (P 15)

The **Learning more about therapy** subcategory (seven participants, variant, 11 meaning units) refers to participants' comments regarding how subsequently they learned more about therapy, either through reading and their own research or through taking up counsellor training. Participants talked about how this helped to make sense of their experiences and to clarify elements of it that previously had been confusing and unclear.

> "I think I would be less concerned had I not gone through counselling training in the interim which will have put a different complexion on it for sure." (P1)
>
> "I've also researched counselling quite a lot … so I'm much better informed now about how the process is designed to work." (P3)
>
> "It's much clearer now in hindsight and the more I know about counselling, and I actually trained to be a counsellor myself, so it's a lot clearer to me now." (P15)

Summary of domains and categories

The experience of being silenced and feeling unable to complain about poor or harmful therapy can be thought of as a spiral with distinct points (though this is not to suggest discrete stages). Each point on the tightening spiral can be seen as adding to the difficulty of the previous point so that the experience of being silenced becomes more constricting and more difficult to escape.

The spiral is illustrated at Figure 35 below and the points on the spiral are described at Table 25 below. This table also includes a narrative to illustrate each of these points. This is constructed from participant 18's interview account of their experiences and is presented in stanza form (Richardson, 2003).

Figure 35: Spiral of silence

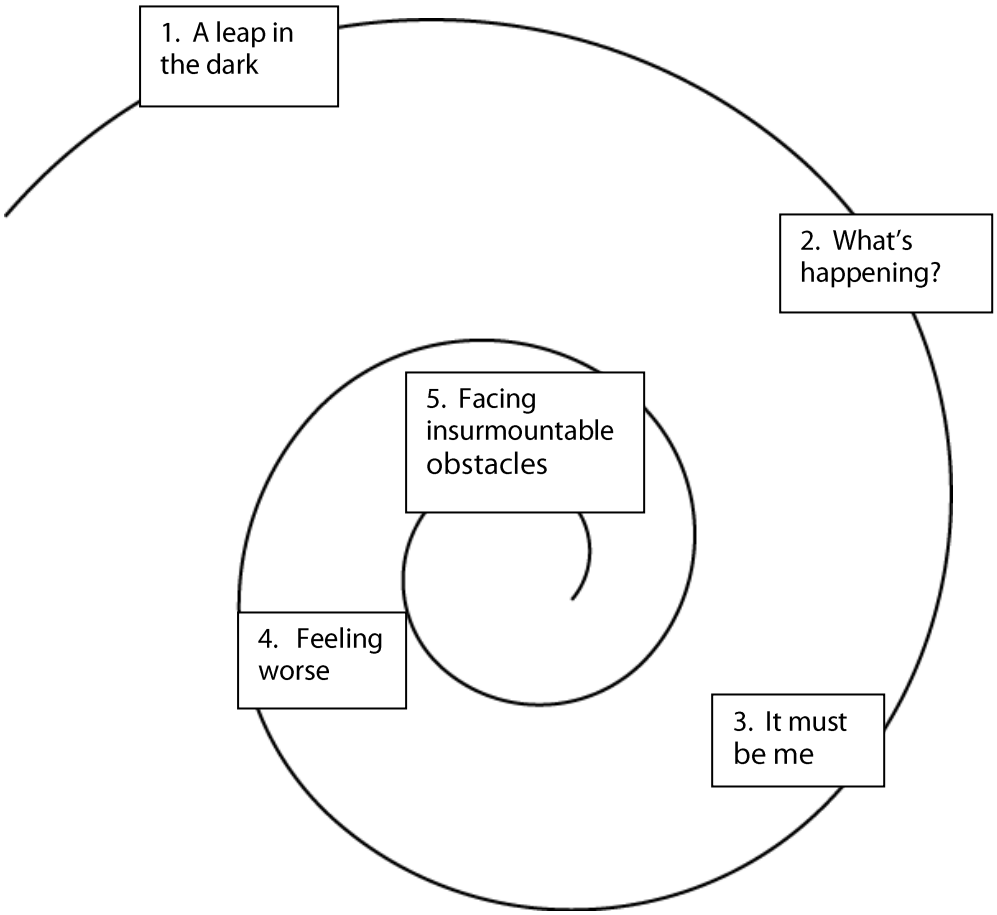


Table 25: Points on the spiral and participant narrative.

Point on the spiral	Participant 18's narrative in stanza form.
Point 1: A leap in the dark The client comes to therapy in a vulnerable and anxious state, bringing difficulties in the present as well as a history that might also add to their vulnerability. They are seeking help and are hopeful that the therapist they are seeing will be able to provide that help. The client might be very unclear about what to expect from counselling or, if they have some existing knowledge of therapy, they are likely to be unclear about what to expect with this therapist. There is a sense of the client putting themselves in the therapist's hands and trusting that they know what they are doing.	My childhood was what you might call colourful, black, blue and purple if you follow me, emotionally rather than physically, but enough to make things really difficult for me. I found a therapist who was recommended by someone else, by an old friend. Part of the therapeutic process is about putting your trust in someone else. It's a little bit like learning to swim, you can't do it from the edge of the pool, you have to jump in and get on with it. I still remember the first conversation I had with her, just about everything that we touched on I ended up in tears. I was at emotional rock bottom, I was suicidal.
Point 2: What is happening here? Something starts to go wrong in the therapy, but the client struggles to identify it and to make sense of it. This might be because they do not know what to expect from therapy. It might be because what is happening is intangible and difficult to trace to a particular event. There might be no physical or concrete occurrence, nothing that the client can put their finger on and so there is doubt and confusion about what is happening, whether something is going wrong or whether they are somehow misinterpreting something that is benign. It might not even occur to the client that they could possibly have a complaint to make.	We got on fine for quite some time and then things just went off the deep end. if it had been obvious, if it had been one specific event but actually it was all the more damaging because it wasn't. You can't point to it, you can't describe one specific event, it's 10,000 little, subtle remarks that could individually be understood totally differently. So if I did take it through disciplinary procedures, on the one hand I would have to try and explain to a bunch of people who weren't there what had gone on, which was nebulous to the point of … it would have been like trying to plait fog to explain it to someone else.

Point 3: It must be me The client is clearer that something has gone wrong in the therapy, but is very unclear about why or who is responsible for this. The client can assume that it is their fault. This might be reinforced by the therapist. In addition, the client's sense of the therapist as trustworthy, expert, and as a good person who wants to help can make it very difficult to see them as having responsibility in the difficulty.	When you're in the middle of an emotional maelstrom you're so busy dealing with all of the material that is coming up for you, it's very difficult. I mean, I was so far out of my depth I couldn't even see the shore any more… So it was very easy to slip in the ringer and tuck in the one that actually wasn't mine in the inbox for things to be dealt with.
Point 4: Feeling worse The experience of being harmed in therapy can leave the client feeling as though they are worse off than when they came to therapy. The difficulties encountered in the therapy are experienced as exacerbating existing difficulties, leaving the client devastated, drained and feeling too weak to do anything other than concentrate on their recovery. In addition they can feel guilty about not having complained as this feels as though they are not acting to protect other clients from the therapist. They are worse off than when they started and their energy has to go into survival and recovery.	And she left me so supremely sliced and diced that I didn't want to know about anything other than try to put my head back somewhere it was useable again. I do feel very guilty at times about… Because of my inaction, Because of what feels at times like my self-interest. She's still out there. And she's still got the potential to damage people. I was torn to bits. I got as far as, 'I don't even want to know, all I really want to do is crawl under the duvet or maybe drag it into the bottom of the wardrobe with me and switch the world off for 6 months to a year maybe'.

Point 5: Facing insurmountable obstacles The client feels that bringing a formal complaint against their therapist is just too much to face. They feel that the odds are stacked against them and there is no point to complaining. The process is complex, it can be difficult to get clear information about where to go or what to do. The client can feel that the therapist will be seen as more credible than them and that they will not be believed. In addition, they fear being harmed by the complaints process and being made to feel even worse – not listened to, blamed, pathologised, exposed.	A whole deck was stacked against me right from the start, at a time when I didn't even feel like finding the energy to pick up the chips and buy into the game. As I said, the deck is stacked from the start. The deck is stacked in her favour. You're the client … the one whose head is in a mess. So who are we going to believe? When a resourceful, articulate therapist is challenged by a client who doesn't even know the jargon? Yeah, right. So given that the whole deck is stacked against you from the start and all that's going to happen is you're going to lose either to a greater or lesser extent painfully what exactly is in it for you? Now I can read a marked deck before I even pick it up, and as you pointed out, you can't lose if you don't even play the game.

Meeting participants – a reflexive statement

Meeting the participants and conducting the interviews proved to be a challenging and moving experience. As I engaged with the interview recordings and transcripts through the process of analysis I struggled to find a way to make sense of the material in a way that would enable me to convey the most significant elements from the interviews. Reflecting on the impact that the participants had on me was instrumental in helping me to make decisions in the analysis about what seemed to be meaningful.

As I reached the end of my analysis of the interviews, I had an experience which highlighted the importance of reflecting on my own experience as a researcher and using this as part of the analysis. I was attending a training event at which I took part in an exercise that involved me role playing a research interviewer. At the end of the interview I briefly thanked the person role playing the interviewee. After the exercise finished the trainee commented on this and said that I seemed particularly eager to thank him for his participation.

I was immersed in the analysis of the interviews at this time and his comments struck a chord with me. I realised that I had felt it important to thank all the participants in my research. On the face of it this was ordinary, respectful behaviour and nothing unusual, but reflecting on this comment made me realise that it had *felt* more than ordinary politeness. It felt important to recognise not only the contribution that the participants had made to my research, but also to acknowledge the enormity of what had happened to them, especially since many of them had never spoken of these events before.

This made me wonder whether a need for their experience to be acknowledged was being communicated to me in the interviews and prompted me to revisit the transcripts and recordings to see if there was evidence of this in what participants had said or how they said it. This proved to be significant as I completed the analysis, and particularly as I attempted to draw the themes together and to identify a central theme.

When examined as a whole, the domains and categories point to a central theme or essence of the experience of not complaining as one of being silenced by a complex interaction of experiences and factors that leave the client feeling increasingly disempowered. This indicates a need for the poor therapy experience to be acknowledged, for the client's experience to be heard and this can be a factor in helping the client reclaim power and perhaps consider making a complaint if that feels appropriate. An acknowledgement of the harm done was lacking in the experience of these participants, but the opportunity to talk

within the research offered something of this. This is illustrated below with some final comments by participant 18.

Someone is actually
acknowledging the dirty little secret that is implicit in therapy.

That there are actually bad therapists out there,
not just ineffective,
but downright destructive ones.
They're out there, and you're the first person who's ever asked.

You're speaking for us.

You're giving us a voice.

That is worth more than you have any concept of.
Don't ever, ever underestimate the value that that has.

Limitations

The findings of this research relate to interviews with a particular group of participants meaning that claims about the applicability of the findings to a wider population are necessarily limited. The inclusion and exclusion criteria used by the researcher to decide who to invite to interview will inevitably have had an impact on the findings. For example, the decision to interview people whose therapy had ended at least one year previously is likely to have influenced the findings. Similarly, the research excluded interview volunteers who wished to discuss experiences in supervision, training or group therapy, which might have yielded different results.

Qualitative research is afforded greater validity and reliability when multiple data sources are used. Although findings from the online questionnaire lend some support to the interview findings, the lack of "adequate variety in kinds of evidence" (Morrow, 2005, p6) is a limitation within this research. Qualitative research is necessarily limited and localised, seeking to offer rich, meaningful insights into participants' experiences, but the relatively small numbers mean that generalisations from this group to a wider population of clients who have not complained cannot confidently be made. At the same time, the number of interviews was justifiable given the greater than expected number of volunteers, but it is large for a project of this type and duration. This meant that the analysis was a large task for one interviewer and took considerably longer than had been originally proposed.

The main researcher's involvement in the project both interviewing and conducting the analysis also required consideration. While immersion in the interview data and reflecting on the experience of conducting interviews is considered a strength in producing meaningful interpretations and findings (Etherington, 2004), this does open up the research to criticisms of researcher bias. It is hoped that the researcher's commitment to acknowledging their position throughout the research process and in this report, as well as the decision to involve six independent researchers in the final stages of the interview analysis as a way of checking the reliability of the findings will go some way to mitigating this (Elliott et al, 1999).

Implications of these findings

As with the online questionnaire, participants to this part of the project revealed aspects of what had happened within their therapy when discussing their reasons for not making a formal complaint. The aim of the project was never to seek to evaluate the events of therapy or to assess whether or not participants would have had a complaint that might have been upheld had they gone through that process – indeed the research actively sought to avoid making such judgements. Nonetheless, it is striking that the range of issues described by participants did not include examples that might be classed as intentionally abusive, but rather within the area of mistakes and poor practice (Palmer Barnes, 1998), or what Kearns (2011) might describe as "minor failures" (p11). It might be that this is linked to what participants described as difficulties relating to the intangible nature of therapy and how this affected their capacity to recognise what was going wrong. As well as posing a problem for clients in identifying whether they might have something to complain about, this is also an issue for organisations who investigate complaints – how can the intangible events of therapy be evaluated with a view to deciding whether an ethical breach has taken place when it is difficult even to define what is meant by exploitation or malpractice (Bond, 2010)?

Findings from the **Silenced within the therapy** domain point to the harmful effects that these negative therapy experiences had on the participants, compounding the original presenting difficulties. The negative impact of abuse in therapy, particularly sexual abuse, has been documented to some extent (Schoener, 2008; Halter et al, 2007; Somer & Nachmanil, 2005). Published client accounts also highlight the lasting impact of abuse in therapy (Jones, 2010; Anonymous (a), 1991). However, there has been no previous research that identifies the negative impact of mistakes, incompetence or poor practice that is not abusive. Results from the interview analysis show that for some clients, the effects of this are long-lasting, significant and damaging. The degree of harm to clients described in these accounts makes it difficult to see the poor practice represented here as simply "minor failures" (Kearns, 2011, p11). The contribution that this harm makes to clients' difficulties in bringing a formal complaint has not previously been identified in research.

Within the **Silenced within the therapy** domain, many of the findings are supported within existing literature. Kayberry's research (2000) highlighted feelings of shame and guilt as factors in not bringing a complaint. The finding that some participants did not realise that their experience was something that they might legitimately complain about is supported to some degree in research (Grunebaum, 1986; Claiborn et al, 1994) and in published client accounts (Anonymous (b), 2005; Jones, 2010). Similarly, the finding relating to the client's wish to preserve something good from their therapy relates to similar findings within the healthcare professions (Gulland, 2009).

An important new finding within this domain is within the **Personal context** category which highlights that clients' presenting issues, history and existing vulnerability contribute to a difficulty in bringing a complaint. Although Gulland (2009) finds that personal characteristics such as gender, age, ethnicity or disability present obstacles to complaining within the healthcare professions, no previous research identifies the impact of the experiential characteristics that prevent clients from complaining.

Findings in the **Silenced by complaints procedures** domain have substantial links with existing literature. The **Complaints process a poor fit** category is supported by findings in research within healthcare professions relating to people wanting less formal processes (Adler & Gulland, 2003). This is, however, contradicted in research which suggests that some people prefer a more formal process (Wallace & Mulcahy, 1999). An explanation for this contradiction might be offered by Pleasance et al (2004) who found that the likelihood of taking action is related both to the nature of the problem and the available processes. It might be that in this research, the nature of the difficulties that participants experienced in their therapy meant that a formal complaints process seemed a disproportionate response, in spite of the harm that they experienced, and hence contributed to a decision not to complain. Perhaps in cases of abuse in therapy, the formal response would be seen as a more appropriate for potential complainants.

Findings relating to the perceived **Futility of complaining** have some support in the literature. Gulland (2009) highlights that scepticism towards professional organisations can be an obstacle in complaining within healthcare professions, while Russell (1994) and

Kayberry (2001) suggest that this might be a factor within counselling and psychotherapy. Comments by participants relating to having an **Unhelpful first contact** with organisations link to similar findings by Vinson (1987). This is underscored by findings from Gulland (2009) and Cowan and Halliday (2003) that the relationship between the professional organisation and clients with grievances is extremely important and has the power to either encourage or discourage people from trusting complaints processes.

Participants' perceptions of the **Risk of being harmed** that bringing a complaint poses has some limited support in the literature. Published client accounts resonate with this finding (Anonymous (b), 2005; Jones, 2010; Schepisi, 2006) and in reports from client support groups such as Witness (Coe, 2008). Gulland (2009) highlights a general fear of retribution that inhibits people from complaining but does not present more detail about associated fears. The concern about the **negative impact on career as therapist** is supported by Kayberry (2000) and Vinson (1987) as well as building on findings from the online questionnaire.

The **lack of knowledge** category receives support in the literature. Vinson (1987) finds that lack of knowledge of complaints processes is the most significant factor in not complaining. Gulland (2009) and the Health Service Ombudsman (2005) find that this is also a factor within healthcare professions, and show that the necessary information about procedures and professional bodies can be difficult to obtain. Findings within the IpsosMORI report (2010) about experiences of the HPC fitness to practise hearings show that information about what to do if something went wrong was not made available to clients/patients up front, which links with experiences of participants in this research. Findings within the **Reclaiming power** domain also support the client's need for and information relating to complaints processes and of therapy itself. This empowering effect of this is also stated by Pope and Bouhoustos (1986) and Vinson (1987).

Findings relating to the **Client's distress not known** do not link directly to the literature, but may be supported indirectly through research that relates to therapists missing negative outcomes in therapy. Murdock et al (2010) found that in cases where clients terminated

therapy prematurely, therapists tended to attribute this to the client or to external difficulties rather than to aspects of their own contribution to the work with the client. Research by Boisvert and Faust (2006) shows that therapists underestimate the possibility that clients might worsen in therapy, while Thompson and Hill (1991) state that therapists have only minimal awareness of clients' negative reactions. Findings within the **Therapist not listening to the client** subcategory appear to contradict research suggesting that clients defer to their therapists by staying quiet about their negative reactions in relation to therapist intervention. Comments by interview participants suggested that they felt they tried hard to communicate their concerns about the work but that the therapist simply did not take this in.

Findings that highlight the impact of the **Therapist's power** on clients' decisions not to complain are supported in research relating to the healthcare professions which highlights the effect of the power imbalance between providers and patients and the inhibiting effect this can have (Gulland, 2009). The silencing effect of the power imbalance is also highlighted by research into client deference in therapy (Thompson & Hill, 1991; Regan & Hill, 1992; Hill et al, 1992; Rennie, 1994). Edwards et al (2004) argue that healthcare patients often give **The benefit of the doubt** in negative situations, taking a positive view that protects the professional. The nature of therapy requires the vulnerable client to put considerable trust in the knowledgeable, expert therapist, thereby putting considerable power in the hands of the therapist (Bond, 2010). The findings from this research demonstrate how that power dynamic, when mishandled, can not only contribute to a negative and harmful experience of therapy, but can inhibit clients from speaking up about their experiences.

A strength of this research is that it identifies a complex constellation of barriers to complaining that has not previously been recognised. Previous research into sensitive topics suggests that participants often feel able to speak about issues that they cannot elsewhere (Dyregrov, 2004; Grinyer, 2004; Liamputtong, 2007), that the research experience can be therapeutic (Cutliffe & Ramcharan, 2002; Hess, 2006), or empowering (Campbell, 2002; Rickard, 2003). Participants sometimes find that the opportunity to discuss their

experiences with the researcher helps them to make sense of what has happened in a new and helpful way (Baker et al, 2005; Grinyer, 2004) and can share that they have been waiting for someone who was interested in their story (Gair, 2002). These all reflect comments made by participants in this research that contributed to the analysis and, in particular, in the findings relating to the **Spiral of silence** and the essence of the experience, that participants had a need for their experience to be acknowledged. The **Spiral of silence** highlights how a number of factors combine and compound difficulty that clients experience in breaking silence about their experience. While there is some research that supports a notion of a wide range of possible obstacles to bringing a complaint (Gulland, 2009), there is no previous research that identifies the combined impact of such hurdles.

Conclusion

The interviews set out to explore in depth the reasons why these participants did not complain about poor therapy. The project was successful in capturing the complexity and richness of their experiences and in demonstrating how a number of factors combined which compounded their difficulties in coming forward. The findings also showed that participants in this part of the study experienced lasting harmful effects from therapy which appears to have been poor practice rather than abuse. Although qualitative findings such as these cannot be used to make generalizations to a wider population, the issues raised by these participants have implications for everyday practice as they highlight issues for clients relating to how their concerns about therapy can be missed by the therapist.

Chapter 8 – Thesis discussion and conclusion

A number of important issues emerge from the research in this thesis. In this chapter, the original contributions from the research to knowledge of complaints and complaining behaviour, counselling and psychotherapy theory and research methods are highlighted. The implications of the research findings are discussed as they relate to policy and practice, and recommendations are made based on this discussion. Finally, priorities for future research are identified.

Substantive contribution

The research in this thesis makes a key contribution to knowledge of complaints and complaining behaviour in counselling and psychotherapy. The analysis of BACP complaints successfully captures a detailed and substantial picture of complaints made in the UK over a 10-year period, to one of the largest professional bodies in counselling and psychotherapy. This is the first systematic research to examine therapy complaints in the UK in an area that has received minimal research attention internationally. The project to explore the reasons why people do not bring formal complaints is the first that focuses solely on clients' experiences of not complaining when something goes wrong in therapy. This research identifies a range of reasons for not complaining, as well as similarities and differences in reasons between different client groups.

BACP complaints analysis

The numbers of complaints are reported in some research studies and reports (St Germaine, 1997; Neukrug et al, 2001; Shefler & Achmon, 2004; Griffin, 2004; BPS, 2007a), however the rate of complaints compared with the number of members or registrants has been largely

ignored. The research in this thesis includes calculations of the rates of complaints received and upheld, contributing meaningful information to the knowledge of complaints in counselling and psychotherapy. The highest rates of BACP complaints per year in this research were calculated as 0.172% for complaints received and 0.072% for upheld complaints. The research demonstrates that these figures are lower than those in two related studies (Van Horne, 2004; HPC, 2011).

The number and nature of sanctions imposed in upheld cases is also given little attention in the relevant literature. The analysis of BACP complaints demonstrated that 49.5% of upheld cases resulted in sanctions to membership or the member's accreditation and this appears to be at a slightly lower rate than figures available in the literature relating to regulated or licensed professions (Neukrug et al, 2001; HPC, 2011).

The length of time from receipt of complaint to resolution is not considered in any of the counselling and psychotherapy complaints research studies or reports, even though this is an aspect of complaint experience of particular concern to complainants and those under investigation (Ipsos MORI, 2010). The findings in this thesis present information relating to duration of cases, and represent the first systematic research in counselling and psychotherapy that considers this in relation to complaints, and allows for comparison with complaints processes in related regulated health professions. The mean duration for Professional Conduct Procedure cases was approximately 32 weeks, while for the Article 4.6 cases the mean duration was approximately 22 weeks, showing that the BACP complaints cases were, on average, resolved in half the time of complaints made to the Health Professions Council (2011).

The identifying characteristics of therapists who are complained against have been neglected in complaints research, with only one study giving this attention (Shefler & Achmon, 2004), and limited information in the regulated health professions reports (HPC 2010), even though therapist factors in areas such as sexual boundary violations has received considerable attention (Schoener & Gonsiorek, 1988; Gabbard & Lester, 1995; Smith & Fitzpatrick, 1995; Hetherington 2000a; Norris et al, 2003; Halter et al, 2007; Levine, 2010). The BACP complaints analysis contributes new findings to knowledge relating to therapists

who are complained against, reaffirming that male therapists are disproportionately represented as members complained against, a finding supported in the related literature (Shefler & Achmon, 2004; HPC, 2010).

Similarly, characteristics of complainants have been largely ignored in counselling and psychotherapy complaints research with only cursory attention given in one brief report (BPS, 2007a) although this is an area considered in the HPC report (2011). The analysis of BACP complaints contributes new findings to knowledge of complaints, showing that lay people, who make up 44% of complainants against counsellors, are underrepresented as complainants. This appears to compare favourably with figures in the literature (BPS, 2007a; HPC, 2011).

The nature of what is complained about is considered in many of the counselling and psychotherapy complaints research studies (St Germaine, 1997; Neukrug et al, 2001; Shefler & Achmon, 2004; BPS, 2007a). These studies have limited usefulness as they use simplistic classifications of complaints that apply one label to each complaint. The categorisation in this research of complaints made to BACP represents the first comprehensive attempt to classify counselling and psychotherapy complaints in a way which captures the complexity of the allegations made in them. The findings show that *Boundaries and contracting* represented 39% of complaints to BACP followed by *Misuse of power* at 25%. The category of *Sexual misconduct* has been defined more broadly than in previous studies and represents 14% of these complaints. Although direct comparison with other studies is problematic, the most common areas for complaint have previously been found to be: sexual relationships with clients (St Germaine, 1997); inappropriate dual relationships (Neukrug et al, 2001); psychodiagnostics and evaluation (Shefler & Achmon, 2004); and competence (BPS, 2007a).

Why people don't complain

There is no prior systematic research that considers complaining behaviour by clients or their reasons for not complaining, although some research into clients' experience of abuse

in therapy does touch on issues relating to complaints (Pope & Bouhoustsos, 1986; Vinson, 1987; Claiborn et al, 1994; Kayberry, 2000), and there is research within the health professions that explores these issues (Gulland, 2009). Client accounts offer some insight into individuals' experiences (for example, Anonymous (a), 1991; 'Poppy', 2001; Adams in Richardson et al, 2008; Coe, 2008). The project in this thesis to explore the reasons why people do not complain provides an in-depth insight into client behaviour relating to complaints when therapy goes wrong.

The adversarial nature of formal complaints processes and the potential conflict between clients' and therapists' versions of events when the client does not have evidence of what happened are mentioned in client accounts as obstacles to complaining (Anonymous (a), 1991; Anonymous, (b), 2005; 'Poppy', 2001) and in one research study relating to abuse in supervision (Kayberry, 2000). The highest scoring reason for not complaining found in the online questionnaire was *It would have been my word against the therapist's*, suggesting that this is a concern for participants.

Lack of information about the nature of therapy or about complaints processes is identified in the literature as a factor in not complaining about therapy (Vinson, 1987; Sands, 2000) and, more broadly, within healthcare professions (Gulland, 2009). Similarly, feelings of shame associated with starting therapy are mentioned in only one client account as a barrier to bringing a complaint (Sands, 2000). The findings of the online questionnaire show that lack of knowledge about therapy and complaints processes is a greater obstacle for lay people in not complaining than for clients who are therapists or trainees, as are feelings of shame about having therapy in the first place.

Research within the health professions suggests that complainants might not be happy with formal complaints processes (Gulland, 2009; Mulcahy, 2003; Posnett et al, 2001), and that mediation is a preferred option for many (Ipsos MORI, 2010). There is no research within counselling and psychotherapy complaints that examines this, but only limited discussion regarding the suitability or not of a formal, adversarial process as opposed to an approach that seeks to resolve grievances through mediation (Kearns, 2011; Totton, 2001). Findings related to the questionnaire within this research suggest that therapists were more likely to

indicate that the formality of the complaints process was a factor in not complaining, and they were more in favour of a less formal approach to resolving complaints.

Literature relating to the factors that prevent therapists from complaining about peers highlights fears of negative consequences to their careers as an obstacle (Levenson, 1986; Biaggio et al, 1998; Gabbard et al, 2001). A similar concern is highlighted by Kayberry (2000) in relation to supervisees' concerns about bringing a complaint against their supervisor. A new finding in the research in this thesis was a reason highlighted by respondents to the online questionnaire that clients who were training as therapists felt inhibited from complaining because of fears of negative consequences to their future careers.

There is evidence in the literature of the harmful effects of abuse in therapy (Schoener, 2008; Halter et al, 2007; Somer & Nachmanil, 2005). However, the negative impact of mistakes, incompetence or poor practice that does not constitute abuse has not been identified in research. Results from the interviews exploring reasons for not complaining show that some clients experienced lasting harmful effects from therapy which appears to have been poor practice rather than abuse, contributing new information to knowledge about the harmful effects to clients of such practice.

There is no one research study within counselling and psychotherapy that identifies the range of reasons for not complaining although a number of different reasons are highlighted across a combination of studies and client accounts (Pope & Bouhoustsos, 1986; Vinson, 1987; Claiborn et al, 1994; Kayberry, 2000; Anonymous (a), 1991; 'Poppy', 2001; Adams in Richardson et al, 2008; Coe, 2008). Literature relating to complaints in healthcare professions similarly identifies a range of obstacles to complaining (Wallace & Mulcahy, 1999; Adler & Gulland, 2003; Pleasance et al, 2004; Gulland, 2009; Ipsos MORI, 2010). The unique contribution of the research in this thesis to this body of knowledge, however, is that it identifies not only a range of reasons why clients might not complain, but also how these factors combine in ways that compound clients' difficulties in coming forward.

Contribution to theory

The research projects in this thesis have produced findings that make an original contribution to counselling and psychotherapy theory relating to ethics and practice issues. This is the first systematic research that highlights the areas of everyday practice that can lead to complaints and the harm that can be caused to clients through the mismanagement of these areas.

The literature relating to abuse in therapy suggests that perpetrators are more likely to be male rather than female therapists (Schoener & Gonsiorek, 1988; Gabbard & Lester, 1995; Smith & Fitzpatrick, 1995; Hetherington, 2000a; Norris et al, 2003, Halter et al, 2007; Levine, 2010). This is reaffirmed in the finding from the analysis of BACP complaints that male therapists are overrepresented among those complained about. This finding contributes more to the theory, though, since this relates to complaints about all areas of practice, not only sexual boundary violations. If, as has been suggested, male therapists have to manage more complex dynamics in therapy due to the combination of the power imbalance inherent in therapy and power issues relating to gender (Halter et al, 2007), the BACP complaints analysis indicates that this causes difficulty not only in the area of sexual boundary violations but also across other areas of practice.

The therapist's power in therapy as it relates to ethics and practice has been discussed in the literature (Bond, 2010; Smith & Fitzpatrick, 1995; Valentine, 1996), but the extent to which this causes difficulty in practice is only indirectly captured in research. Studies that examine how alliance ruptures are caused and responded to might highlight issues relating to the therapists' responsibility and power (Safran & Muran, 2000) as does research relating to clients' deference in therapy (Regan & Hill, 1992; Hill et al, 1992; Rennie, 1994). The finding in the BACP complaints analysis that the *Misuse of power* represented the second largest area of complaints, however, indicates the extent to which this can cause difficulties for therapists in practice.

There is limited research relating to boundaries and contracting and their impact on therapy outcomes (Cooper, 2008). There is considerable literature relating to different aspects of boundaries in practice, however, such as the impact of the setting on managing boundaries (for example, Llewellin, 1994, Carroll, 1997; Zinovieff, 2004), or how constituent parts of the frame are worked with (such as Monger, 1998; Davies, 2000). The BACP complaints analysis demonstrates that the largest single category of complaints received relates to boundaries and contracting. This contributes to theory about boundaries and contracting as it indicates that this is a problematic area of practice.

The issue of sexual misconduct in counselling and psychotherapy is not a straightforward one. Definitions of what constitutes sexual misconduct in therapy can be problematic because of the ambiguity of some physical touch such as kissing and hugging (Bond, 2010, Hetherington, 2000a). The classification in the BACP complaints of a broad definition of sexual misconduct that includes sexualised dynamics and sexual self-disclosure contributes to theory and debate relating to this area of practice. Research evidence shows that it is commonplace for therapists to experience sexual feelings as part of their work (Pope & Tabachnik, 1993; Giovaziolas & Davis, 2001; Fisher, 2004; Martin et al, 2010). However, the BACP complaints research highlights that this can cause difficulties in practice, even in cases where therapists do not physically touch their clients or have sex with them.

The link between changes to boundaries and sexual misconduct has been discussed in the literature in terms of a slippery slope (Simon, 1991; Gutheil & Gabbard, 1993; Sarkar, 2004; Tjeltveit & Gottleib, 2010). This term has been criticised as it can suggest an inevitable slide into sexual boundary violations when other boundaries are crossed, and an alternative theory of a continuum of boundary management behaviour from the therapeutic and ethical to the abusive has been proposed (Gabbard & Peltz, 2001; Gottleib & Younggren, 2009). There is no systematic research that supports or refutes either of these positions. Findings within the BACP complaints categorisation, that each complaint with incidents coded under sexual misconduct also contained incidents coded under other categories, contribute further to theory relating to the possible relationship between boundary management and sexual misconduct. This does not prove or disprove the inevitability of the

slippery slope theory, but lends credence to the idea that non-sexual boundary crossings might be understood as warning signs by therapists and act as an indication to change their practice to prevent sexual boundary violations, as suggested by Martin et al (2010).

Contribution to method

The projects in this thesis make a contribution to research methods in counselling and psychotherapy. The analysis of BACP complaints successfully makes use of a documentary archive and rigorously examines those documents to produce a detailed analysis of complaints. The project to explore the reasons why people do not bring formal complaints makes innovative use of online research methods to investigate a sensitive issue with a hard to reach group.

Systematic research relating to counselling and psychotherapy complaints is sparse. Reports by organisations that consider ethical complaints offer tantalising glimpses of information, but their purpose is to illustrate the work of the relevant ethics committee rather than to provide an in-depth analysis of the complaints (APA, 1979-2010; ACA, 1989-2009; Griffin, 2004; BPS, 2007a). Research studies in the USA and Canada have surveyed boards responsible for licensing practitioners, allowing for large numbers of complaints to be included (Herlihy et al, 1987; Neukrug et al, 1992; St Germaine, 1997; Neukrug et al, 2001; Van Horne, 2004). While these studies have strengths and contribute useful insights to knowledge about complaints, they are limited by inconsistencies in responses from the licensing boards and have limited scope; none of these studies examine either complainant or therapist characteristics, for example. One further study examines archived complaints records (Shefler & Achmon, 2004) but this is not a systematic investigation and is available only as notes accompanying a conference presentation. In contrast, the complaints analysis in this thesis has systematically and comprehensively examined the BACP research archive, contributing original information to knowledge about complaints in counselling and psychotherapy, and providing a template for future complaints archive research.

Using archived documents for research requires the researcher to navigate large amounts of material (Steedman, 2001) and poses difficulties in developing a system for examining and using the documents (Velody, 1998). Access to the archives held by organisations is usually restricted and requires special permission (McCulloch, 2004). The analysis of BACP complaints demonstrates that access to complaints archives and the scope of analysis can be negotiated with the relevant organisation in such a way that the confidentiality of those involved in complaints can be protected appropriately while meaningful research can be conducted. This is a useful precedent that might encourage other counselling and psychotherapy organisations to consider similar research. In addition, this research marks an original contribution to method, having developed a data entry form that provides a framework for examining large complaints records, which could be of use for future research.

Reports or research studies into counselling complaints have either failed to consider the nature of what is complained about in detail (APA, 1979-2010; ACA, 1989-2009; Van Horne, 2004; Griffin, 2004), or produce limited, general classifications of complaints that relate to ethical codes and which ascribe each complaint to a single category (Herlihy et al, 1987; Neukrug et al, 1992; St Germaine, 1997; Neukrug et al, 2001; Shefler & Achmon, 2004; HPC, 2010, 2011). This is a missed opportunity, since the allegations made by complainants afford a singular insight into what goes wrong in therapy from which much might be learned that can improve practice. The analysis of BACP complaints and categorisation of complainants' letters makes an original contribution to method in this area. This research uses a method that analyses sensitive material in a way that protects the confidentiality of complainants and members complained against while producing meaningful results that can inform practice. In addition, the themes and categories identified in this research could provide a template for future complaints research.

Online research methods offer a number of potential benefits over traditional methods, but they have not always been used successfully in counselling and psychotherapy research (West & Hanley, 2006). Online methods are considered to be useful for investigating sensitive issues (Pealer et al, 2001) and in gaining access to hard to reach groups of people

(Coomber, 1997; Illingworth, 2001; Litvin & Kar, 2001). One strength of online methods is that the physical distance between researcher and participant helps to minimise power imbalances (Shaw & Gould, 2001) and fosters openness (Joinson & Paine, 2007). However, such distance also means that researchers are less able to assess any negative impact of the survey on participants, which can raise ethical difficulties relating to the scope and focus of questions (Orgad, 2005). The online survey developed as part of this thesis offers an original contribution to the use of online methods in counselling and psychotherapy research in that it successfully makes use of the advantages of the approach while also limiting the focus of the survey to protect participants from unnecessarily revisiting painful or harmful experiences.

Individual interviews are a frequently used method in counselling and psychotherapy research that allow for in-depth and meaningful data collection. A tension can arise, though, between the need to answer the research question and the ethical responsibility towards participants (Kvale, 2007). Researchers who are therapists and who make use of listening skills when interviewing face a challenge in responding empathically to participants while avoiding a therapeutic response and respecting the boundaries of the research interview (McLeod, 1994). The interviews conducted as part of the project to explore clients' reasons for not complaining make an original contribution to discussions about these tensions in qualitative interviewing. The research was successful in approaching one-to-one interviews in a manner which actively sought to avoid replicating aspects of therapy, and which achieved this by using different settings such as rented office space or public spaces, and by responding flexibly to participants' requests.

Limitations of the research

The research in this thesis represents an original contribution to knowledge and theory relating to complaints and complaining as well as to research methods in counselling and psychotherapy. Nonetheless, the findings and conclusions have limitations that require consideration.

The analysis of archived BACP complaints has limitations related to the use of documentary records that have not been compiled for research purposes, such as records missing owing to document destruction policies, and incomplete information in records (McCulloch, 2004). In addition the use of complaints letters for analysis is problematic since they have been written with a particular goal in sight, and to present the complainant in a particular light, they are uncorroborated and may be unclear (Lloyd-Bostock & Mulcahy, 1994; Nettleson & Harding, 1994; Gulland, 2009). The analysis of complaints letters to categorise allegations may, in itself, be flawed and the results arbitrary (Simons, 1995).

Interpretation of the complaints data and comparison with published complaints research poses many challenges. The BACP complaints processes are complex and have developed over time, making interpretation of the data and presentation of meaningful results difficult. It is possible to draw only limited conclusions from complaints data which relate only to the incidence of complaints to one UK organisation, rather than the prevalence of malpractice within counselling and psychotherapy. Comparison with the published research literature is problematic as it is difficult to ascertain what similarity there is between processes in different organisations when this detail is not included. Methodological differences also make comparisons difficult.

The online survey that was developed as part of the project to explore the reasons why clients might not complain about therapy requires consideration. There was no existing instrument that could be used for this survey, but the development of such research instruments requires repeated testing and modification (Oppenheim, 1992). Principal component analysis of the questionnaire revealed limitations in the use of statements for scoring which could have been modified in light of these findings. Arguably, the questionnaire was successful as a pilot survey. The snowballing approach to recruitment to the survey and self-selection of participants have an impact on the reliability of the findings (Barker et al, 2002; Comber, 1997). A decision was made as part of the design process to allow participants to the questionnaire and interviews to assess whether their therapy experience had been poor or harmful, rather than attempting to evaluate this as part of the research. This leaves the research open to criticism regarding the validity of the

respondents' issues with their therapy. With all of these issues in mind, findings from the survey are necessarily tentative and should be interpreted with caution.

The use of interviews as part of this research has implications for the findings. Qualitative research is localised, seeking rich, meaningful insights into participants' experiences, but it cannot confidently be used to make generalisations to a wider population (Kvale, 2007). Similarly, the researcher's involvement in the project both interviewing and conducting the analysis makes researcher bias a possibility. The researcher's engagement with reflexivity and commitment to acknowledging their position throughout the process, as well as the involvement of independent research assistants in the final stages of interview analysis, might mitigate this to some extent (Elliott et al, 1999) but cannot eliminate the influence of the researcher on the findings.

It is important to keep these key limitations in mind when considering the findings; however, the integrity of the research and the original contributions made by these research projects retain their importance.

Implications for policy and practice

The implications of findings in each research project have been presented separately in the relevant chapters and will now be discussed together, considering their relevance to three themes: regulatory issues; practice issues; and complaints and malpractice as a topic for further research.

Regulatory issues

This research has revealed that the rates of BACP complaints compare favourably with international studies relating to licensed therapists and with HPC-regulated health professions. Using numbers of complaints to draw conclusions about the incidence of malpractice is flawed and it is not possible to account confidently for the lower figures

achieved by BACP. The figures might lend support for career-long supervision. Alternatively, they might point to difficulties relating to the lack of statutory regulation of counselling and psychotherapy.

The current system of self-regulation in the UK means that clients who wish to complain are faced with a complex set of hurdles: is their therapist a member of a professional organisation to whom they can complain? If so, which organisation? What is the process for addressing complaints used by the organisation? What if the client is not happy with the outcome? Enhanced self-regulation, overseen by the Council for Healthcare Regulatory Excellence might go some way towards addressing this complexity. However, dealing with professional misconduct in therapy is necessarily a complex endeavour whether regulated by statute or not. Client experiences of complaints procedures show that access to clear information is a common difficulty (Ipsos MORI, 2010; Gulland, 2009). A robust process that protects therapy clients and promotes public confidence in the profession requires transparency and accessibility in order to be effective.

Recommendations

- Professional organisations should seek to be as transparent as possible about their complaints processes, making information widely accessible in a variety of formats, online as well as in print. Organisations should be aware that the complexity of complaints processes does not lend itself to clear explanations for lay people. Such material should give clear information, avoid jargon and legal language, explaining the process in as straightforward a manner as possible. It needs to be written for clients who do not have a detailed working knowledge of therapy or about therapy ethics.

- It is recommended that professional bodies within counselling and psychotherapy conduct regular analysis of their complaints, and present findings from their

analysis in publicly available reports. The annual HPC fitness to practise reports offer a useful model for this.

- Professional organisations should consider the nature of the response that is given to clients who contact them in distress or difficulty. Contact with the professional body might be the first time the client has spoken about their experience, and a purely procedural or administrative response can exacerbate the client's difficulties. Clients' need for expert and empathic support in understanding whether a complaint is appropriate and how to proceed is something that should be considered by professional bodies.

- A formal complaints process is not an appropriate fit for some clients. Professional organisations are recommended to consider alternative approaches to resolving grievances. An interim process would afford the client an opportunity to address their concerns about the therapist without taking their case to a full adjudication. This might involve the client logging their concern without naming their therapist so that they can take action at a later date if they should wish. Alternatively, a process like mediation would be more appropriate for some clients.

Improving practice

Although only a small minority of practitioners are subject to formal complaints, findings in this research have highlighted that boundaries and power dynamics in therapy are particularly problematic areas – issues which are relevant to the day-to-day practice of all therapists. Literature relating to an idea of a slippery slope of boundary crossings leading to sexual boundary violations in therapy suggests that attention to changes in boundaries is important for therapists to avoid sexual exploitation of their clients (Gutheil & Gabbard, 1993). This research supports a more complex understanding of boundaries, as proposed by Gottleib and Younggren (2009), one that recognises that attention to boundary changes is

necessary not only to avoid sexual boundary violations, but also to prevent harmful practice which does not have a sexual element. Martin et al (2011) showed that therapists who avoided sexual boundary violations were able to do so by recognising changes in their boundary practice with clients as danger signs that prompted them to reflect more deeply on their work and to make no further boundary crossings. The research in this thesis supports the notion that therapists should treat boundary changes in everyday practice as warning signs of potentially damaging practice that require rigorous self-reflection.

Similarly, findings in this research relating to the problematic nature of power dynamics in therapy suggest that this is an area that also requires careful attention in practice. Research showing that clients defer to their therapists (Regan & Hill, 1992) has already highlighted this as a problematic issue, but the complaints research in this thesis suggests that the misuse of power in therapy has implications not only in relation to therapist effectiveness but also in the avoidance of harm to clients. However, if clients struggle to convey their concerns about therapy, the responsibility for monitoring the impact of the work falls all the more heavily on the therapist, further supporting the requirement for rigorous self-reflection and attention to practice. Given that research shows that therapists underestimate the possibility of clients deteriorating (Boisvert & Faust, 2006) and overestimate their own effectiveness as practitioners (Walfish et al, in press), there is a question over whether therapists' capacity to monitor their practice is sufficient as a means of preventing malpractice of this kind, supporting the argument for formal means of eliciting feedback and routine measurement of client progress or deterioration. Castonguay et al (2010) point out that trainee therapists need to be informed that they could be responsible for harming a client at some point in their career, but the research in this thesis suggests that this is something that qualified therapists might need reminding of.

Recommendations

- Therapists should be aware of the difficulties that clients experience in voicing their grievances or concerns about therapist's practice. Therapists should consider

incorporating the use of routine client feedback measures in their work to facilitate evaluation of the effectiveness of their responses to clients. Therapists should take steps to actively elicit feedback from clients and be particularly alert to concerns clients might struggle to raise. Practitioners should consider using formal feedback forms and written contracts or more informal verbal reviews with the client.

- In addition to actively checking with clients throughout the therapy, findings in this research, that clients attempted to communicate their concerns but were dismissed by therapists, suggest further considerations for practitioners. This supports the use of ongoing supervision as a place to reflect on client work, and also underlines the discipline in therapeutic practice of the practitioner continually questioning their assumptions about how the therapy is progressing.

- Therapists should pay particular attention to their practice in relation to the boundaries of therapy and their capacity to work with the dynamics of power, as these results suggests that these are problematic areas of practice.

- Therapists should give clear information to clients about what to expect in therapy. Thought needs to be given about the amount, detail and form of this information, but it is suggested that both verbal and written information would be useful. Thought also needs to be given to the timing of this information and whether it needs to be followed up after the first session when the client can easily feel overwhelmed by anxiety at starting the therapy.

- The findings also suggest a need for the therapist to give clear information about what to do if the client is not happy with the therapy that they are receiving, or at least how the client can access this information if they wish. Again, this could be addressed verbally by the therapist and supported with written material. This is to suggest that complaints procedures should be accessible to clients rather than to advocate an approach of actively encouraging complaints.

Complaints and misconduct as a focus for research

The research conducted for this thesis proved to be a sensitive area as well as personally challenging for the researcher. Responses from therapists to the research topic included outrage, disgust and defensiveness. Such responses from individuals are, perhaps, partly echoed by professional organisations given that there has been no previous research into UK complaints in counselling and psychotherapy. Is research about therapy malpractice seen as airing the profession's dirty laundry in public? Research literature proposes a number of reasons to explain why individual therapists don't report cases of malpractice by colleagues: concerns to protect confidentiality; the emotional impact of this knowledge; beliefs that an adversarial approach is unnecessarily punitive and shaming; and fear of the repercussions of speaking up (Gabbard et al, 2001). Perhaps there are parallel concerns in relation to exploring complaints in research.

Reticence in conducting research into complaints, however, does not serve the profession well. As Seto (1995) states, this is an issue that "demands our individual and collective attention" (p82). Lack of meaningful information breeds anxiety among the different groups with a stake in psychotherapy, and fosters mistrust and criticism (Van Horne, 2004). Further research is desperately needed in order to address remaining unanswered questions. Research that identifies trends in complaint rates or that allows for comparisons between the numerous professional organisations would offer useful insights that can inform practice and regulatory policy. In order to make such a contribution, the research also needs to be disseminated to encourage debate and to demonstrate the willingness of psychotherapists collectively to address these issues (details of how the research in this thesis has been disseminated to date are given in Appendix 13). In spite of the individual and collective challenges that complaints research raises for therapists, the research in this thesis supports the view that this is an area of great value in terms of developing practice, protecting clients and raising the standing of the profession.

Research recommendations

- Meta-analysis of complaints across UK professional counselling and psychotherapy organisations and comparison with regulated health professions.

- Research into the relationship of theoretical orientation to practice difficulties around boundaries, contracting and power issues in therapeutic work, and to the incidence of complaints.

- Investigation into the effects of supervision in monitoring practice and upholding standards, as well as in cases where practitioners are complained against.

- Exploration of the dilemmas experienced by practitioners who become aware of fellow therapists' malpractice and how they respond to this.

- Research to explore the impact on practice of being the subject of a complaint.

- Examination of alliance ruptures and misconduct 'near misses' in therapeutic practice; how did therapists avoid irreparable breakdown and malpractice in these cases?

Conclusion

> "What makes it OK for me is the knowledge that you will do something with it, that it is more than just a conversation, that it does actually go somewhere. […] Even if all that happens is that you tuck it under people's noses who maybe do pay attention and we open up even the slightest … a millimetre forward in changing things." (Participant 18)

Conducting research into complaints involves a readiness on the part of the researcher to explore sensitive and challenging issues. More widely, it requires a degree of openness among therapists about harmful practice, and a willingness to acknowledge collective

responsibility for addressing this. It is not an easy topic for research or debate and raises difficult, sometimes painful, questions for practitioners and professional organisations alike. As the research participant quoted above illustrates, asking these questions offers the possibility of moving things forward.

Appendix 1: Ethical approval – BACP complaints analysis

University of Leicester

Institute of Lifelong Learning Research Ethics Review Approval Form
Name of student/researcher: Clare Symons
Course title:
Title of research: An Audit of complaints made to the British Association for Counselling & Psychotherapy (BACP)
Contact details: cms49@le.ac.uk **Vaughan College** **St Nicholas Circle** **Leicester** **LE1 4LB**
Status (please tick as appropriate): Undergraduate ☐ Postgraduate ✓ Researcher ☐ Staff ☐
Name of supervisor: *(For office use only)* Professor Sue Wheeler
Course director: *(For office use only)* n/a
I am pleased to confirm that I have read the research proposal and I consider the researcher has considered all the research ethics and has answered the relevant questions satisfactorily.
Professor John Benyon *Institute of Lifelong Learning* *Research Ethics Officer*
Date: 14 February 2008

FOR OFFICE USE ONLY

Decision sent to student ☐
Supervisor notified ☐
Filed ☐

Appendix 2: Agreement with BACP

Appendix 7

DEED OF COMPLIANCE (BACP)

THIS DEED is made the day of ....28th FEBRUARY 2007..... BETWEEN

(1) .....CLARE SYMONS..... ('the Contractee')
and
(2) British Association of Counselling and Psychotherapy (BACP) of BACP House, 15 St John's Business Park, Lutterworth, Leicestershire LE17 4HB

WHEREAS:

A. BACP, grateful for the Contractee's assistance in furtherance of its aims, and in particular in relation to work for BACP.

B. The Contractee appreciates that BACP must uphold certain standards, both legal and moral, in the furtherance of it's aims.

C. BACP and the Contractee have agreed that the Contractee shall abide by certain standards and rules of BACP laid down from time to time in order to maintain those standards.

IT IS AGREED AS FOLLOWS:

1. The Contractee shall at all times while performing contracted work for BACP and at all times thereafter:

   a. take all reasonable steps to ensure that all confidential information, whether in a readable form or otherwise, is kept confidential and is not disclosed to any person without the direct written direction of BACP or as is otherwise by Law

   b. take all reasonable steps to ensure that information held about any person is accurate in all respects and is not misleading

   c. shall, upon request from BACP, deliver up to BACP all confidential information obtained during the course of her/his work with BACP, whether original or copies, save where such information is held on any fixed medium within a computer, in which case the Contractee shall transfer all such information to a reasonable removable medium, erase all such data from the fixed medium using an effectual program that shall fully erase all of such data from such medium in such a way that such data are irrevocable using software techniques.

2. The Contractee shall, at all times while performing contracted work for BACP, comply with BACP data protection policies/procedures as notified to her/him from time to time and attend such training in relation to matters of conduct as BACP shall direct PROVIDED THAT the cost of such training shall always be borne by BACP.

EXECUTED AS A DEED and DELIVERED on the date first above written by:

(Print Full Name) .....CLARE SYMONS.....

Signature .....Clare Symons.....

Witness (Print Full Name) ANGELA MARY KAYE MACLEOD

Address ...16 ROSES DRIVE.....

.....NORTHAMPTON . NN3 9TE.....

Witness' signature.....

Appendix 3: Confidentiality agreement

I declare that I will treat any material sent to me or disclosed to me in the context of the Association's Complaints Procedure in the strictest confidence.

I will respect the confidentiality of evidential material and ensure its return to BACP when my role is complete within the Complaint's Procedures.

Signed Clare Symons

(*Name*)

Date 28.2.07

Appendix 4: BACP membership figures.

Individual members and organisational members by year

Year	Individual members	Organisational members	Total membership	Organisational members as % of total
1997	14344	837	15181	5.5
1998	15521	912	16333	5.5
1999	16154	959	17113	5.6
2000	16449	924	17373	5.3
2001	17137	960	18097	5.3
2002	18726	1082	19808	5.5
2003	20575	1093	21668	5.0
2004	21812	1137	22949	4.9
2005	23197	1157	24354	4.7
2006	25049	1153	26202	4.4
2007	26957	1155	28112	4.3

Gender split of members

It is not possible to obtain accurate figures from BACP regarding gender for each year as these details are only available for current members throughout the period of their membership.

Year	Female	Male	Unknown	Total	Male members % of total
1997	5193	1031	3	6227	16.6
1998	6168	1189	4	7361	16.2
1999	7196	1370	4	8570	16.0
2000	8158	1559	5	9722	16.0
2001	9710	1829	5	11544	15.8
2002	11765	2249	6	14020	16.0
2003	13956	2676	6	16638	16.1
2004	16251	3167	7	19425	16.3
2005	18330	3560	8	21898	16.3
2006	20360	3947	8	24315	16.2
2007	22966	4404	13	27383	16.1

Accredited members by year

Year	Accredited counsellor/ psychotherapist	Accredited supervisor	Total accredited members	Accredited members as % of total membership
1997	1491	74	1565	10.9
1998	1877	78	1955	12.7
1999	2333	94	2427	15.0
2000	2682	115	2797	17.0
2001	3232	156	3388	19.8
2002	4009	214	4223	22.6
2003	4669	233	4902	23.8
2004	5220	247	5467	25.1
2005	6026	258	6284	27.1
2006	6338	270	6608	26.4
2007	6848	297	7145	26.5

All figures courtesy of BACP.

Appendix 5: Ethical approval – why people don't complain.

University of Leicester

Institute of Lifelong Learning Research Ethics Review Approval Form
Name of student/researcher: Clare Symons
Course title: PhD Counselling & Psychotherapy
Title of research: Why don't people complain about experiences of poor or harmful counselling?
Contact details cms49@le.ac.uk Vaughan College St Nicholas Circle Leicester LE1 4LB
Status Member of staff and postgraduate student
Name of supervisor: *(For office use only)* Professor Sue Wheeler
Course director: *(For office use only)* Professor Sue Wheeler
I am pleased to confirm that I have read the research proposal and I consider the researcher has considered all the research ethics and has answered the relevant questions satisfactorily.
Professor John Benyon *Institute of Lifelong Learning* *Research Ethics Officer* 18/8/08
Date: 18 August 2008

FOR OFFICE USE ONLY

Decision sent to student ☑
Supervisor notified ☑
Filed ☑

Appendix 6: Questionnaire.

Why don't people complain about poor or harmful experiences of counselling?

About the research project

This research project aims to explore the reasons why some people who have experienced poor or harmful counselling do not make a formal complaint to a professional body. It is aimed at users of counselling or psychotherapy in the UK. The project comprises two parts: an online questionnaire to analyse the variety of reasons that people do not complain; and face-to-face interviews in order to explore in depth people's experiences of not complaining. It is hoped that the project will result in findings that can inform the development of ethical codes and complaints procedures for professional bodies in counselling and psychotherapy.

About the researcher

Clare Symons is a Lecturer in Psychodynamic Counselling at the University of Leicester and also works as a counsellor in private practice. She is an accredited member of the British Association for Counselling and Psychotherapy. This research project forms part of her research towards a PhD in Counselling and Psychotherapy.

About the questionnaire

The survey takes around 15 minutes to complete. When paper questionnaires are returned, answers are input to a computer database in order to facilitate analysis. All data collected will be held anonymously and securely.

At the end of the survey you will be asked if you are willing to be interviewed for the second stage of the research project. If you agree to this you will be asked for contact information. All personal details you submit will be held confidentially and will not be added to the computer database. For this reason, once your responses have been added to the database you will not be able to withdraw them.

By completing and returning this questionnaire you consent to your questionnaire responses being used in this research.

Researcher contact details: Clare Symons, University of Leicester, Vaughan College, St Nicholas Circle, LE1 4LB. Tel: 0116 242 2602
email: complaintsresearch@le.ac.uk

Throughout the survey the questions will refer to 'therapy' and 'therapist' rather than counselling, psychotherapy or any other form of psychological therapy.

About you

Please indicate where you live from one of the following options:

	United Kingdom and Northern Ireland		Other Americas
	Republic of Ireland		Asia
	Europe (excluding ROI and UK)		Africa
	United States		Australasia
	Canada		

Please indicate whether you are:

	Female		Male

Please indicate your age group from one of the following:

	Under 18 years		41 – 50
	18 – 20		51 – 60
	21 – 30		61 – 70
	31 - 40		71 or over

4. If you *currently* work within the field of psychological therapies, please indicate which of the following statements apply:

	I work as a counsellor/psychotherapist or as a professional in a related field in psychological therapy (please specify below)
	I am training to work within psychological therapy (please specify below)
	I do not work within psychological therapy

If you indicated that you work within or are training to work within psychological therapies, please specify the nature of the work:

……..

……..

Please indicate which of the following statements applied *at the time of the therapy*:

	I worked as a counsellor/psychotherapist or as a professional in a related field in psychological therapy (please specify below)
	I was training to work within psychological therapy (please specify below)
	I did not work within psychological therapy

If you indicated that you worked within or were training to work within psychological therapies, please specify the nature of the work:

……..

……..

About your therapist and the therapy

Please think about an experience of personal therapy that was poor or harmful to you. If you have had more than one such experience then please choose a time with **one** therapist for the purposes of this questionnaire.

6. Please indicate whether your therapist was

	Female		Male

Please indicate the type of professional role that your therapist had in the work with you:

	Don't know		Clinical psychologist
	Counsellor		Counselling psychologist
	Psychotherapist		Family therapist
	Psychiatrist		Psychoanalyst
	Other – please specify:		

8. Please indicate whether your therapist was a member of a professional body

	Yes (please specify below)
	No
	Don't know

If yes, please specify which:

	Don't know which
	Association of Christian Counsellors (ACC)
	Association of Child Psychotherapists (ACP)
	British Association for Behavioural and Cognitive Psychotherapies (BABCP)
	British Association for Counselling and Psychotherapy (BACP)
	British Association for the Person Centred Approach (BAPCA)
	British Association for Sexual and Relationship Therapy (BASRT)
	British Infertility Counselling Association (BICA)
	British Psychoanalytic Council (BPC)
	British Psychological Society (BPS)
	Counsellors and Psychotherapists in Primary Care (CPC)
	COSCA (Counselling and Psychotherapy in Scotland)
	Federation of Drug and Alcohol Professionals (FDAP)
	Irish Association for Counselling and Psychotherapy (IACP)
	Play Therapy UK (PTUK)
	Royal College of Psychiatrists (RCP)
	United Kingdom Association for Humanistic Psychology Practitioners (UKAHPP)
	United Kingdom Council for Psychotherapy (UKCP)
	Other – please specify:

What was the setting for therapy?

	NHS setting
	University or college counselling service
	Telephone counselling (if the therapy *usually* took place by phone)
	Therapist's private practice
	Online counselling (if the therapy *usually* took place online)
	Voluntary organisation
	Other – please specify:

How frequent were your therapy sessions?

	less than once per month		2 sessions per week
	once per month		3 sessions per week
	1 session every 2 weeks		4 sessions per week
	1 session per week		5 sessions per week
	Other – please specify:		

How long ago did the therapy end?

	The therapy is ongoing		between 2 years and 5 years ago
	less than 6 months ago		between 5 years and 10 years ago
	between 6 months and 1 year ago		between 10 years and 20 years ago
	between 1 year and 2 years ago		over 20 years ago

Approximately how long did the therapy last from the first session to the final? If the therapy is ongoing, please indicate the length of time from when you started to see the therapist.

	One session		between 1 year and 2 years
	between one session and 2 months		between 2 years and 5 years
	between 2 months and 6 months		between 5 years and 10 years
	between 6 months and 1 year		over 10 years

Reasons for not making a formal complaint

Have you ever made a formal complaint about a poor or harmful experience of therapy?

	Yes	No	

If yes, please give brief details of who you complained to and the outcome of your complaint:

……..

……..

……..

14. Below are listed a variety of personal feelings that might affect whether someone brings a complaint. With reference to your own experience, please indicate the degree to which each statement was a reason you did not bring a formal complaint.

	Strongly disagree	disagree	Neutral / unsure	agree	Strongly agree
a. I didn't trust my own view of what had happened					
b. I felt too ashamed					
c. I felt powerless to do anything					
d. I didn't want my therapist to get into trouble					
e. My therapist made me believe that what happened was OK					
f. I felt stupid for getting myself into this situation in the first place					
g. I didn't know that I could complain to anyone					
h. I would have felt disloyal to my therapist if I had complained					
i. I didn't realise that what had happened to me was wrong					
j. I felt ashamed for needing to see a therapist in the first place					
k. I didn't know how to make a complaint					
l. In spite of everything, my therapist had tried to help me and I would have felt ungrateful if I made a complaint					
m. I couldn't think clearly about what had happened to me and was not able to explain it to anyone					
n. I blamed myself for what happened					
o. I didn't have the confidence to complain					
p. My therapist was basically a good person who made a mistake and deserved another chance					

Below are listed a variety of external circumstances that might affect whether someone brings a complaint. With reference to your own experience, please indicate the degree to which each statement was a reason you did not bring a formal complaint.

	Strongly disagree	disagree	Neutral / unsure	agree	Strongly agree
I would have been judged by others					
b. I have no proof of what happened					
c. I wanted mediation instead of making a formal complaint					
d. I was not able to get the information I needed from the relevant organisation					
e. My therapist knew a lot of personal details about me and I was afraid that he/she would disclose them					
f. I would not have been believed					
g. I didn't want to make a formal complaint, I just wanted my therapist to say sorry					
h. There would have been no point complaining because the therapist would still get away with it					
i. I would have been blamed for what happened to me					
j. I was afraid that my therapist would say that I was mad if I complained					
k. My situation did not fit in with the complaints procedure					
l. The organisation would have covered up what happened					
m. I was too afraid of the consequences to me of complaining					
n. It would have been my word against the therapist's					
o. I missed the time limit for making a complaint					
p. Professional organisations don't take allegations of malpractice seriously					

If you have any other reasons for not making a formal complaint that are not mentioned in this questionnaire, please list these below:

……..

……..

……..

If you have any other remarks that you would like to add at this stage, please write them below:

……..

……..

……..

Thank you for answering the survey questions. Information follows about the second stage of the research project.

The second stage of the research project involves voluntary participation in face-to-face interviews. If you agree to be interviewed, the interview will be audio recorded and will last approximately 45 -- 60 minutes. It is planned that interviews will take place from January 2009 onwards, at a mutually convenient time and in a neutral, non-counselling setting. The main focus of the interview will be on your reasons for not pursuing a formal complaint rather than on what happened with your therapist. The researcher will not raise an official complaint against your therapist on your behalf, but can give you information about appropriate agencies that can offer help and support if this is how you wish to proceed.

Please indicate whether you are willing to participate in a face-to-face interview:

	Yes		No

If you have answered yes, please leave your name and email address or contact telephone number below. The researcher will contact you in order to give you further information and to answer any questions you may have about the interview stage of the research project. An interview will be arranged only if you are happy to proceed.

……..

……..

……..

Thank you
If you have any questions about the research, please do not hesitate to contact the researcher by email at complaintsresearch@le.ac.uk

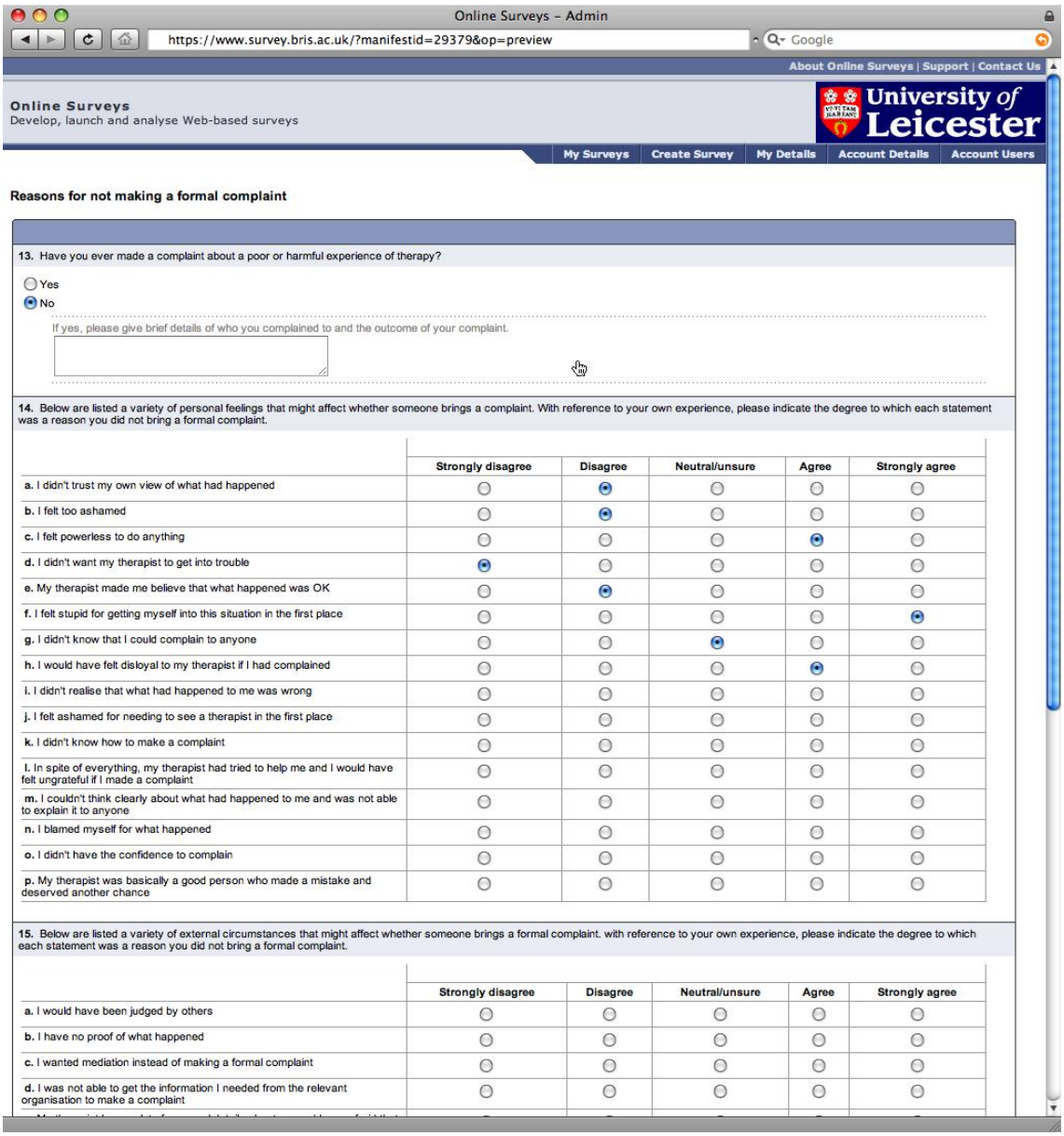
If you feel distressed in any way by participating in this research and would like some support to help you, please consider contacting one of the following organisations.

Citizens Advice Bureaux provide free, independent and confidential advice. Visit their web site at http://citizensadvice.org.uk to find your local office.

For emotional support in complete confidence, you can contact Samaritans. Their number is 08457 90 90 90 and is available 24 hours a day, seven days a week. If you prefer, you can email them at jo@samaritans.org.

Thank you again for taking the time to contribute to this research.

Appendix 7: Screenshot of online questionnaire.



Appendix 8: Email and web publicity.

Online forums and groups contacted:

www.mentalhealthforum.net

www.uncommonforum.com

www.talk-depression.org.uk

www.ukdepression.co.uk

www.ourdepressionboard.net

www.anxietyforum.net

www.anxiety-panic-attacks-phobias.co.uk

www.anxietyzone.com

www.anxietysupport.org.uk

www.social-anxiety.org.uk

www.aest.org.uk/support_forums

www.svox.org.uk

www.geocities.com/Hotsprings/1124/Support/tasfaq.html (therapy abuse support site)

www.time-to-change.org.uk

National Association for People Abused in Childhood

Witness

Email contact:

Main researcher's personal email directory – 50+

BACP Research conference 2008 delegate list email contacts – 90+

BACP members listed in the online directory – 8000+

UKCP registrants – 3400+

BPS Chartered Psychologists in online directory with 'counselling' as a speciality – 800+

Appendix 9: Example email text.

Dear psychotherapist,

Please forgive me for contacting you in this unsolicited way. I found your details on the 'find a therapist' section of the [professional organisation] web site and am writing to let you know about a research project that you may wish to be involved with. If you are not interested in the project, there is no need to respond - I will not store your email address and I will send no further emails.

This research, part-funded by the British Association for Counselling and Psychotherapy, aims to explore the reasons why someone who has experienced poor or harmful therapy might not make a formal complaint to a professional body. The project has been given ethical approval by the University of Leicester. I am hoping to reach as many potential participants as possible and with this in mind I am asking you to help in any of the following ways.

Please volunteer to take part in the project. If you have experienced poor or harmful therapy and have not made a formal complaint you may be interested in participating in the project yourself. If so, please complete the online questionnaire which can be accessed at http://www.survey.bris.ac.uk/leicester/whynocomplaint .
***Please forward this email to any relevant contacts*.** The project is open to anyone who has had a poor experience of counselling or psychotherapy and has not complained, and I am hoping to reach as wide a range of potential participants as possible. I would be grateful if you could forward this email to anyone you know who you feel might be interested in the research.
If you have any questions about the project, please do not hesitate to contact me either by replying to this email or by telephone on 0116 242 2602.
With thanks and best wishes,
Clare
Clare Symons
Lecturer in Psychodynamic Counselling
The University of Leicester
Vaughan College
St Nicholas Circle
Leicester
LE1 4LB
0116 242 2602

Appendix 10: Interview consent form.

Why don't people complain about experiences of poor or harmful counselling?

Interviewee Consent Form

You have already completed a questionnaire as part of this research project and have volunteered to participate as an interviewee. This document gives further details about the project and the nature of your involvement as a participant in order that you can be as informed as possible about taking part.

About the research project

This research project aims to explore the reasons why some people who have experienced poor or harmful counselling do not make a formal complaint to a professional body. It is aimed at users of psychological therapy in the UK. The project comprises two parts: an online questionnaire to analyse the variety of reasons that people do not complain; and face-to-face interviews in order to explore in depth people's experiences of not complaining. It is hoped that the project will result in findings that can inform the development of ethical codes and complaints procedures of professional bodies in counselling and psychotherapy.

About the researcher

Clare Symons is a Lecturer in Psychodynamic Counselling at the University of Leicester and also works as a counsellor in private practice. She is an accredited member of the British Association for Counselling and Psychotherapy. This research project forms part of her research towards a PhD in Counselling and Psychotherapy.

About the interviews

You are being asked to participate in an interview of approximately 45 - 60 minutes with the researcher. This interview will be audio recorded and transcribed by a research assistant in order to aid analysis of the themes raised in the interview. You will be asked to speak about your reasons for not raising a formal complaint against your therapist and your thoughts about what might have helped you to bring a complaint if you so wished.

Confidentiality

All information relating to you in this study will be held confidentially. This means that every effort will be made to protect your identity and information that you disclose. Only the researcher, research supervisors and research assistant will have access to the audio recording and transcript.

In exceptional circumstances, if the researcher has concerns about serious risk to you or to others she may have to consider passing on information to other appropriate parties. In these circumstances she would seek your consent to disclose the relevant information if at all possible, but if this is not possible and the danger is sufficiently acute, she may have to pass on the information directly.

It is intended that findings from the research will be written up for a formal report, a PhD thesis, conference papers and journal articles. It is likely that quotes from interviews will be used as part of these written materials. Identifying information will be disguised in order to ensure confidentiality. Copies of any such materials can be made available to you prior to publication for your feedback and comments – please ask the researcher about this. You may withdraw from the study at any point prior to publication of results and in this case all your interview data will be destroyed.

Information and support

The researcher recognises that this is a sensitive topic and it is possible that you may feel uncomfortable or distressed during the interview. While the researcher will make every effort to conduct the interview in a sensitive manner, she will not offer you counselling. Please let the researcher know if you wish to stop the interview at any time. If you feel you would like additional support after the interview, the researcher will be happy to think with you about where might access such support. In addition, the researcher will not pursue an official complaint against your therapist on your behalf, but can give you information about appropriate agencies that can offer help and support if this is how you wish to proceed.

If you have any complaint about the research project or your treatment as a participant you should, if possible, first raise your concerns with the researcher. If this proves unsatisfactory, then you should contact the research supervisor Professor Sue Wheeler (0116 252 5918). If you are still unhappy then the matter will be referred to the relevant University Faculty Board and an investigation will follow.

I (Name)…… …… have read and understood the details above and agree to take part in the research study.

Signed ……..
Address: ……
……
Telephone:……Email: ……
Date:……

Researcher contact details: Clare Symons, University of Leicester, Vaughan College, St Nicholas Circle, LE1 4LB. Tel: 0116 251 7368 email: *complaintsresearch@le.ac.uk*

Appendix 11: Extract from interview transcript.

Interview 12

Q So if it's OK to start then, I just wonder if you can tell me a little bit about how it is you came not to complain about the experience you're thinking about.

A Gosh, there were so many reasons. I won't describe these but it was a number of things that happened over the course of time and I think my first feeling was to try and sort it out with the therapist and try and repair the relationship, and so initially complaining didn't enter my head, it was to put things right. As things progressed it was clear that that wasn't happening. There were a number of things....well I suppose all the way through my real hope was to try and put things right, so in a sense I didn't actually want to go down the complaint route, I didn't want to sort of....because I'd been in long term therapy, I'd been with her for 5 years, part group, part one to one, and I'd sort of thought if I make a complaint about this, there's been good stuff and I'll lose the good stuff, so there was real....those sorts of personal reasons. Also, my head was in such a muddle, you know, I tried sort of writing down the things I wished to complain about and it just looked so jumbled. It's not like a medical thing, you know, you're going to have your right leg chopped off and they chop off the left one....

Q Yes, it's not tangible.

A No. And because it was several things it was....I mean there were certain tangible things but it took a while to settle really to kind of work out what they were. So actually framing the complaint was difficult. But I think above all I was really frightened because it felt....I mean I'm a therapist myself so I know on the other side how I would feel if it happened to me, it would be awful, but it's interesting, as the client it sort of felt like all the power was on her side. I felt like if I made a complaint she had written material, things that I'd done over time, and I wasn't clear what sort of material she would be able to bring out in her defence and whether I would end up feeling under attack. And then the other thing was that all of the adjudications are printed in the BACP journal and I was in therapy as part of my MSc training so I mean I wasn't sort of secret about the fact that I was there, a lot of people knew the name of my therapist and I didn't see that if the adjudication was printed out that it would be confidential, I felt there would be plenty of people who could easily identify me because, you know, either because I'd spoken about how I was in therapy with her because I'd spoken to people along the way about my problems, so it really felt quite threatening. And I phoned the BACP for some advice but they weren't exactly helpful. So I sort of really sort of

Appendix 12: Interviewee demographic information.

Interviewee no.	Gender	Age group	Ethnic/cultural background	Sexual orientation	Social Class	Disability	Status now	Status at time of therapy
1 - Pilot	F	51-60	White British	Heterosexual	Middle	No	Therapist	Lay person
2 - Pilot	F	51-60	WC	Lesbian but open minded	Now middle, from working	No	Therapist	Lay person
3 – Pilot	F	21-30	White British	Mostly heterosexual	Working class?	No	Lay person	Lay person
4 – Pilot	F	51-60	White British	Heterosexual	Middle	No	Therapist	Therapist
5	F	41-50	White British	Heterosexual	Middle class	No	Lay person	Lay person
6	F	51-60	British	Heterosexual	Middle	No	Therapist	Therapist
7	F	41-50	White British	Heterosexual	Middle?	No	Lay person	Lay person
8	F	41-50	Cypriot	Heterosexual	Middle	No	Lay person	Lay person
9	F	31-40	White British	Bisexual	-	No	Therapist	Trainee
10	F	51-60	Chinese	Heterosexual	Mobile from working class	No	Lay person	Lay person
11	F	51-60	White British	Bisexual	Middle class	No	Therapist	Trainee
12	F	51-60	White English	Heterosexual	Middle	No	Therapist	Therapist
13	F	31-40	White British	Heterosexual	Middle class	No	Lay Person	Lay Person
14	F	51-60	British White	Heterosexual	Middle class	No	Lay Person	Lay Person
15	F	31-40	White British	Heterosexual	-	No	Trainee	Therapist
16	F	51-60	White British	Heterosexual	Middle	Yes	Therapist	Therapist
17	F	31-40	White British/French	Heterosexual	Middle	No	Lay Person	Lay Person
18	M	41-50	White European	Gay	-	Yes	Lay Person	Lay Person

Appendix 13: Dissemination of research findings

Articles in peer reviewed journals

Khele, S., Symons, C., & Wheeler, S. (2008). An analysis of complaints to the British Association for Counselling and Psychotherapy, 1996-2006. *Counselling and Psychotherapy Research*, 8: 2: 124-132.

Symons, C., Khele, S., Rogers, J., Turner, S., & Wheeler, S. (2011) Allegations of serious Professional misconduct: an analysis of the British Association for Counselling and Psychotherapy's article 4.6 cases, 1998-2007. *Counselling and Psychotherapy Research*, 11: 4: 257-265.

Other reports

June 2008 - An audit of complaints made to the British Association for Counselling and Psychotherapy, 1996-2007: A report to BACP.

September 2009 – Why people don't complain: A report to BACP.

Research conferences

June 2007, 13th Annual BACP Research Conference, York
Paper presentation with S. Khele and S. Wheeler - *An audit of BACP complaints.*

May 2008, 14th Annual BACP Research Conference, Cardiff
Paper presentation - Allegations of serious professional misconduct. An analysis of BACP's Article 4.6 cases.

June 2008, Society for Psychotherapy Research 39th Annual Meeting, Barcelona
Paper presentation - An audit of complaints made to the British Association for Counselling and Psychotherapy.

May 2009, 15th Annual BACP Research Conference, Portsmouth
Poster presentation - Why don't people complain? Investigating clients' reasons for not bringing a formal complaint.
Paper presentation - What do people complain about? An analysis of complaints made to BACP.

May 2010, 16th Annual BACP Research Conference, London
Poster presentation - Acknowledging the dirty little secret: Client accounts of why they don't complain about poor or harmful therapy.

May 2011, 17th Annual BACP Research Conference, Liverpool
Paper presentation - Under-informed vs over-identified: differences between lay people and therapists who have not complained about poor or harmful therapy experiences.

Other presentations

September 2008, Presentation to BACP Board of Governors – *Results and recommendations of BACP complaints analysis.*

November 2008, Presentation to BACP staff members – Results and recommendations of BACP complaints analysis.

October 2009, BACP National Conference, Newcastle
Paper presentation by invitation - Safeguarding clients, improving practice: what practitioners can learn from research into complaints and malpractice.

February 2010, Presentation to BACP Professional and Ethical Practice Committee (PEPC) – *Results and recommendations of why people don't complain project.*

November 2010 & March 2011, BACP Making Connections events, Cardiff & Norwich.
Paper presentation by invitation - Complaints, malpractice and ethical dilemmas: what research can contribute to everyday practice.

May 2012, University of Chester Counselling Society.
Presentation by invitation - Asking ourselves difficult questions: What complaints research can contribute to everyday practice.

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