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Questioning the Victim Status of Complainants in Professional Ethics Investigations

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ABSTRACT *The power differential between practitioner and client is examined by reviewing empirical studies, professional practice frameworks and related legal and procedural questions, in the context of complaints about health professionals. Professional regulatory bodies – including ethics committees, association boards, and government licensing authorities – oversee the ethical behaviour of professionals, specifically monitoring their use of power. Complaints which these regulatory bodies address are generally framed in terms of the way that power is used poorly or harmfully by a practitioner. Alleged ethical breaches are usually evaluated from a specific epistemological premise – the existence of a power incline between practitioner and client. We explore some alternative perspectives regarding the power that clients hold, in the process exposing assumptions about the question of harm done. Linear views of causality and responsibility are questioned, and it is suggested that a more complex understanding would better serve investigatory processes. This discussion does not delve into the psycho-dynamics underlying the complaints process, but rather addresses the operation of regulatory bodies in terms of perceptions of power differences in the professional relationship. Copyright © 2016 John Wiley & Sons, Ltd.*

Key words: professional codes of ethics; regulation; regulatory bodies; sanctions; boundaries; victims; power differential; harm; administrative law; persecutors; grievance procedures; punishment; responsibility

INTRODUCTION

Clients of psychotherapy come for help, insight and healing. Often they have been victims of abuse in one form or another. Professional codes of ethics exist to protect clients from any further abuse, and ensure that practitioners act with skill and benevolence. Within the complex dynamics of psychotherapy there may arise situations in which the client believes they have been harmed, often in ways similar to their previous trauma.

When complaints occur there is often a complex and difficult process of parsing out the degree to which a practitioner has indeed acted harmfully – whether by omission or commission – and the extent to which the client may in fact be viewing the situation

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through a distorted lens. Any suggestion that the client is presenting an erroneous view can appear to be discounting their experience, thus compounding their trauma. Additionally, intimating that clients have some responsibility in the interaction can be interpreted as blaming the victim.

Complaints are investigated using an essentially adversarial process; this poses a problem as without the ability to question the client's view of events, no real justice is possible. However, such questioning runs counter to basic principles of psychotherapy (e.g., respect for the client's reality) and may be viewed dimly by authorities in an investigation process.

Assumptions regarding the relative disparity of power between client and therapist are virtually unquestioned in the ethical framing of psychotherapy as discussed in the literature. The naming of any power that the client may have can appear to diminish the responsibility of the therapist – which is not the intent of this paper. However, we attempt to open up the subject for discussion and debate by addressing some of the problems that may arise in the identification of the client as victim in investigatory procedures.

THE POWER DIFFERENTIAL: A SKEWED VIEW

One of the fundamental assumptions in professional ethics is that there is a power differential between practitioner and client. Professionals by their training, expert knowledge, experience, and position, hold a great deal of bestowed power both from society and clients (Savan, 1989). The intent of ethical codes is to see that power is used well, and to guard against it being used harmfully (Barstow, 2008). The central issue at stake in an ethics complaint or malpractice suit is that the professional did not use their power properly and the client was harmed in some way as a result. Despite these principles being widely accepted, there are voices which challenge certain of the underlying assumptions about power differentials (Zur, 2013a). At the same time, any such critiques need to be treated with caution, being alert to where they may be used to discount damaging victim experiences, or rationalize destructive abuses of power.

There are dangers at either end of the spectrum of attitudes towards the power differential. On the one hand, any argument which diminishes the responsibility of the professional can potentially reduce appropriate accountability for misuses of power. The problem with raising the suggestion that a client may have some responsibility is that historically this has been used to discount the abuse experienced by clients and to protect professionals in relation to damaging behaviour; hence any such discussion can appear to play into "victim blaming" (Sykes, 1992).

On the other hand, if the client's victim status is overplayed the result can be to strip them of agency and result in a paternalistic position which also diminishes any responsibility at all on their part. Some writers (e.g., Anderson, 1992) portray clients using the metaphor of infants, emphasizing their inability to make autonomous decisions in the therapy context. This produces an arguably flawed ethic, and would likely be contested by the clients themselves.

Due to the way that ethics complaint hearings generally utilize an adversarial mode of investigation (Menkel-Meadow, 1996), the presentation of a grievance takes place in a setting which tends to emphasize the vulnerable or victim status of clients and underscore the power of the professional (Rutter, 1989). Such assumptions are not generally open to questioning by the accused professional, though they tend to underlie both investigation and decision making processes in relation to a complaint (Williams, 2000). Even to question some of these assumptions can be seen as tantamount to siding with exploitative practitioners, creating loopholes whereby

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they can escape the weight of their responsibility. Yet, without a real debate there is a danger of value propositions regarding victimhood being ossified into unquestionable beliefs.

There is widespread agreement that professionals carry a range of types of power (Pope & Vasques, 2007; Younggren & Gottlieb, 2004), though some argue that it is not so much the role itself as the actions of therapists which build a power base in the relationship (Howard, Nance, & Myers, 1987). The literature however rarely discusses the client's power (Zur, 2013b). While it is important to identify issues at stake in the use and misuse of power by professionals, it is also relevant to deconstruct the dynamics of power usage by those who are identified in the "disempowered", or lesser-powered position. By understanding the choices and responsibility of the client, a deeper analysis can be arrived at regarding the problems that lead to complaints (Zur, 2013a). To be able to fully explore ethical issues and the nature of ethical transgressions, it is important to move beyond an either-or stance, and examine the ways that client-practitioner power exists along a continuum (Lazarus, 1994).

Following Zur (2013b), we can examine some of the ways that clients hold power. There is very little written about this – the primary focus is generally on the power that practitioners hold. French and Raven (1959) offer a well-accepted typology of social (interpersonal) power positing five bases of power: reward power, coercive power, legitimate power, expert power, and referent power (Podsakoff & Schriesheim, 1985). This will be used here a lens through which to identify some facets of the client side of the equation.

Clients may have their own *expert power* in areas which the practitioner may know little or nothing; they may have *positional power* if they have some kind of social or role based authority (such as a judge or police officer); they potentially have *coercive power* in terms of the capacity to intimidate, stalk, or vexatiously litigate; *reward power* comes firstly through the bestowal (or withdrawal) of "the job" (of therapy provider) to the treating professional – though there are other ways clients can reward on a relational level for instance by approval, or conversely they may punish by venting; *referent power* describes personal charisma, which some clients may possess and use in the context of the therapy relationship to try to get what they want; *manipulative power* refers to certain ploys that clients can use to get their way – from engaging the professional in order to procure a court or insurance report, to the kind of deceit that social workers and drug and alcohol staff experience with addicts whose intentions and behaviours are contrary to their presentation.

Outlining these sources of client power in no way obviates the duties of the practitioner. Barstow & Feldman (2013) characterize clients as being 100% responsible for their actions, and practitioners being 150% responsible. The point of this exploration is that power involves dynamics, relationship, and complexity. Following Giddens (2003), there is always both an agency and a structural component to any power dynamic. This means that there are choices being exercised by both parties which should be accounted for, as well as wider contexts including the nature of the role transaction, the governing institution and broader influences such as the particular profession, its history and values. Where there is power, there is also the potential for misuse; to focus only on the power of therapists is naive and unhelpful in discussions on the nature of ethical practice (Zur, 2008), but where and how clients should be held accountable for their power is an open question raised in this paper.

The deliberations of disciplinary bodies however tend to focus on one side – the power exercised by the professional in the context of their role. Whilst investigations need to draw pragmatic boundaries around scope and complexity, focusing too narrowly can undermine the robustness

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of findings and produce overly simplistic conclusions. The therapist may indeed be 150% responsible, but that does not mean the client has zero responsibility. However, if a therapist were to raise this proposition in their defense, they would probably be seen as demonstrating a complete lack of ethical awareness. It is thus important that the conduct of an investigation by a regulatory body takes into account bilateral notions of duty, wherein patients are also understood to have responsibilities in the therapeutic relationship (Younggren Fisher, Foote & Hjelt, 2011).

THE POWER OF COMPLAINT

The domain of psychotherapy is being examined in this paper in order to explore issues relating to power in the professional relationship, though much of this is also relevant to other healthcare and helping professions.

Therapy uncovers trauma, with the intent to bring about healing. However, part of the mind-set connected with trauma often involves an ongoing identification with the experience of the victim role, resulting in a type of concrete thinking which pre-emptively identifies aggressors and boundary violators (Saperstein, 2006); this constitutes part of an interactive system (Berne, 1964) which may get co-opted in an ethics investigation process. Put another way, analyses based on linear notions of causality attribute aggression to the behaviour of individuals – and specifically the professional who is on trial; but systemically, aggression can be understood to be "in the system", and this perspective suggests a very different type of interpretation and response which utilizes multiple causality and other ways of understanding the distribution of responsibility (Robine, Yontef, & Spagnuolo-Lobb, 2001). Taking a stepped-back view enables recognition of the multiplicity of forms that aggression can take, including for instance the combativeness that is often involved in a complaint process (Sandler, 2004).

In most professional jurisdictions around the world, complaints by clients are addressed using a quasi-legal framework which has parallels to the operation of the formal court system and borrows some of its language, but which does not necessarily follow the principles of natural justice (Pettifor & Sinclair, 1991). Lesser infractions may be dealt with in less formal ways, but grievances are generally heard in an adversarial context which includes initial charges, an investigation, a prosecution process or hearing, a judgement, and consequent punishment or sentence (Menkel-Meadow, 1996). Whilst hearings may take place in a variety of settings including administrative courts, ethics committees of professional associations, licensing boards, professional review committees aligned with institutions or employers or health care tribunals, all such hearing processes are generally based on principles of administrative law (Bricklin, Bennett, & Carroll, 2003).

Administrative law is used to regulate business and public processes and operates under a different set of operational principles than civil or criminal law; for instance, there is no presumption of innocence (Gonsiorek, 1997). The benchmark for evidence is not "beyond reasonable doubt"; the requirements of proof are less, usually requiring only a 'preponderance of the evidence' (O'Connor, 2001). This is aimed at balancing the power of the professional, and strengthening the capacity of the client to challenge it, essentially holding that the rights of an accused professional are less important than the need to protect the rights of the client (Williams, 2001).

In fact, a shift in the power dynamic occurs when an investigation is initiated. The client puts forward a complaint and the practitioner becomes a defendant: the weight of doubt is placed on

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the professional who must prove their innocence (Schoenfeld, Hatch, & Gonzalez, 2001). Because the practitioner is seen to hold the additional knowledge, status and responsibility for the fiduciary relationship, they are considered also responsible for demonstrating that they properly used the power that accompanies their position – hence a "guilty until proven innocent" orientation (Schoenfeld et al., 2001). This flies in the face of the traditions of natural justice, and also changes the power dynamic radically: at the word of a client, a professional career can be entirely jeopardized, with only minimal rules of evidence in play (Adams, 2001). Consequently, the power of the client is significantly increased in this process and the result can be a finding against the practitioner, even if there is no verified evidence other than the client's word. Despite this altered power dynamic, the status of the client in such investigations is the "aggrieved party", which provides them with the identity of vulnerability and the status of being a victim (Williams, 2000).

Whilst this vulnerability is generally very real, at least in a subjective sense, there is also the fact of the vulnerability of the practitioner in the investigatory situation. Ethics complaints or malpractice suits often take several years to get to court, during which time the professional has been isolated, alienated and investigated; the emotional impact on the practitioner is usually devastating (Neukrug & Milliken, 2011; Saunders, Barros-Bailey, Rudman, Dew, & Garcia, 2007). In the face of this, professionals often make errors of judgement throughout the process, from the provision of evidence, to accounting for their actions before a panel; such errors can jeopardize a case, show them in their worst light, and negatively impact on jury or judge's decisions (Belk, 2013).

The issue fundamentally at stake is the question of the misuse of the practitioner's power at some point in the professional relationship. In order to examine this, an institution takes over the relationship, so that the professional is no longer in the power-up position. This may be necessary in order to give sufficient weight to the complainant, but one of the questions being raised here is the way that power is used by the investigating body itself. Is such power exercised in a way which empowers, or disempowers both parties in the process? For in championing the client in their lesser-power role, the institutional process may overlook the facets of the dynamic where the client exercises power. For instance when there are times when a social worker may attempt to help someone in the "underdog" role, only to find that there is a great deal more complexity involved with the interlocking dynamics of power; at times the "vulnerable client" may turn their hostility onto the worker, often resulting in distress and ultimately burnout (Enosh, Tzafrir, & Gur, 2013; Savaya, Gardner, & Stange, 2011).

UNETHICAL USE OF POWER BY CLIENTS AND PEERS

In exploring this topic, it must be stated that under no circumstances does questioning of the nature of the power dynamic in a therapeutic relationship exonerate the therapist from their responsibilities. Nor does it in any way discount the harm which is done by a therapist acting either unskilfully or with insufficient care, especially in cases where a client is used for the sexual needs of the therapist. There is some danger that by questioning the way power shifts in the professional relationship, an argument may be created which could be misused to discount client experiences of exploitation, or abet the avoidance of full responsibility on the part of the practitioner. With this caution in mind, we will now explore some ways in which clients may misuse their power.

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There are examples of clients who do indeed use the power of the complaint in unethical ways, whereby a therapist is falsely accused for some kind of gain (Wright, 1985b). Williams describes this as being "Victimised by Victims" (2000). Ironically, it has been proposed that therapy itself tends to sell a victim story to clients as a way of defining their experience (Dineen, 1996); this can produce a polarity of hidden aggression which may at times play itself out through a complaint process.

Pope & Vetter (1991) conducted a survey of psychologists, asking them whether they had treated a patient who had been sexually intimate with a prior therapist; 50% of psychologists reported that they had encountered at least one instance of this. But 4% also reported clients who had falsely accused their previous therapists of sexual assault. Whilst this is clearly a minority, any level of miscarriage of justice is of concern, and needs to be understood and responded to by regulatory bodies who have a responsibility to see the destructive effects of this minimized. This study is now 25 years old, so its current relevancy could be questioned. Remarkably perhaps, the study has never been replicated. But we do know that despite improvements in professional knowledge about the topic of therapist-client sex and significantly increased regulation, the incidence (6–9%) does not appear to have significantly changed over four decades (Schoener, 2013).

It may be argued that any system of justice is not perfect, and that there will always be some people who will abuse it; the cost of supporting those on the lesser side of a power differential is that occasionally a person in the power-up role may suffer to an unwarranted degree. This does not however preclude discussion about the phenomena of false accusations, or consideration of the context in which they may arise. Malingering and fraud play a role in some complaints (Rogers, 1997), especially those arising in the context of a system which awards monetary compensation (Williams, 2000). In fact sometimes insurance companies will settle out of court even if there is insufficient evidence, just to head off further costs (Wright, 1985a); the complaint does not actually have to be proved in such cases.

A major difficulty in cases where there has been a false allegation is that the accused essentially has to prove a negative – that it didn't happen. A fair investigation would attempt at least to engage in a thorough fact finding process, identifying if the alleged action occurred, and if so, its significance. Investigations are not always thorough enough; sometimes due to limited resources only written submissions are considered (Adams, 2001) and there are certain subjects such as practitioner-patient sex complaints which tend to be highly emotionally charged and lend themselves to prejudgment of either accusations or denials. It is hard for persons' hearing such cases to maintain an unbiased and careful evaluation of each situation; there are strong tendencies to want to either protect colleagues, or the patients (Pope, 1990). For this reason sexual harassment type cases are not always conducted using sufficient thoroughness, with terrible consequences for the professional if there is a false finding (Burr, 2011). The practitioners reputation, license and livelihood are at stake, yet the process of investigation and adjudication is often conducted by professional peers, not trained in the law in any way, who may in fact have conflicts of interest in terms of other relationships with the accused (Adams, 2001; Annas, 1991).

Although it is difficult to establish the proportion of false allegation, case examples point towards the role of psychopathology in such incidences; specifically, there are a disproportionate number of litigants who fall in the Borderline Personality Disorder class (Gutheil, 1989; Raffle, 2013). People with Borderline characteristics can make use of complaints processes to 'act out lifelong issues involving their good and bad internalized parental images' (Williams, 2013, p. 1).

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Obviously the person bringing the grievance is not on trial, nor in most instances can they be psychologically tested. But it would be appropriate for regulatory bodies in the health care industry to be on guard against court processes being used as a part of a pattern of manipulation (Zur, 2008); such patterns can be recognizable in the distorted ways of viewing the world characteristically displayed by this personality type (Forward, 1997). Clearly this is a very difficult question, but it therefore requires critical debate; in light of these issues it may be that the adversarial framework used by most grievance procedures needs to be reviewed, and alternatives seriously considered (Gunther, 2015).

Another source of false allegations can be the result of the influence exerted by subsequent therapists. There have been instances where a client "memory" of abuse from a therapist was implanted as a result of a suggestion or line of leading questioning by another therapist (Williams, 2000). Comments therapists make in a disapproving tone about the treatment provided by the previous therapist can be taken out of context by patients, who can come to see the previous treatment they received as being unethical. In such circumstances the patient can become a kind of battleground for differing theoretical persuasions (Williams, 1997); ethics investigations can become an unwitting instrument for this to play out, and clients may exercise their power of complaint in a way which is a channel for aggression rather than simply self-protection.

Ethical codes can also be manipulated by professionals who are competitors or by angry family members for the purpose of revenge (Shapiro, Walker, Manosevitz, Peterson, & Williams, 2008). An instance of the former is the case of the psychologist who was accused by a colleague of holding an "unethical point of view" regarding a marital therapy case; this actually came before the APA as a full complaint (Adams, 2001). Revenge can be a factor in the filing of grievances against professionals, especially in child custody cases where the losing party takes their frustration out on the associated practitioner. The lack of filing fees and ease of registering a complaint with a board means that an action can be easily instigated, causing many problems to the professional; the object may not be related to financial gain, but rather seeking vengeance (Williams, 2000). In a study by Montgomery, Cupit, & Wimberley (1999) the second highest source of complaints against psychologists were child custody cases, and they represented the third highest basis for malpractice suits.

Whilst psychologists do make mistakes, these type of complaints are more likely to result from stresses which a parent may be experiencing in relation to a custody issue, and which ends up being displaced onto the professional concerned. This suggests the need for some kind of counterbalancing mechanism in regulatory processes, giving due weight to the consideration of complaints, but not allowing the process to become an avenue for inappropriate venting or secondary blaming. Whilst regulatory authorities would always claim probity in such matters, there are legitimate critiques which have been raised about the way the power of the regulatory system can be co-opted for inappropriate purposes by clients (Adams, 2001).

All complaints need to be taken seriously, and there are instances where practitioners act in ways which create significant and identifiable harm. There are degrees of magnitude though; when lesser therapeutic mistakes are labelled "abusive" in a manner which suggests they are highly damaging, the complex and difficult shifts which occur in a therapeutic relationship can get inappropriately reduced to a set of summary charges (Samuels, 2014). It is a well-known phenomenon that intensive therapy will often contain phases of idealization, and then a so-called "negative transference". Whilst the negative phase can contain useful material for the therapy (and valid "grains of truth" in terms of a critique of the therapist), if a complaint emerges from this

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stage of the work, it may be coloured with a high degree of reactiveness in which small actions of the therapist – even ones requested by the client – can come to be seen as some type of violation (Levenson, Butler, & Powers 2008). Though investigating bodies have the brief to discern what is overreaction, and whether in fact professional misconduct has occurred, it appears that there are instances where findings are made in ways that unduly and uncritically echo into the complainant's sense of rage and betrayal (Welch, 2000).

For instance, the case of the therapist who faced changes in insurance coverage which resulted in their client being unable to afford continuing treatment; the client felt "abandoned", even though the therapist had taken proper steps to refer them on. The investigating board impugned that the therapist had a need to create an overly close relationship with the client, and that therefore the client's distress was their responsibility (Williams, 2013). In another complaint, a 2 year investigation ensued after a client charged that a group leader was fingering his tie in a way she felt to be sexually suggestive (Adams, 2001). In cases such as these, the adversarial approach taken by the investigative authority can become aligned with – and arguably hijacked by – disproportionate client reactions. The investigative body takes the client complaints seriously – which they must do in the first place – but then the weight of power can be arraigned against the practitioner in ways which do not appear to be balanced, or even reflect common sense at times. It has been suggested that in some cases, it is the practitioner who becomes the victim of unfair processes (Williams, 2000).

Risk management is predicated on the notion that practitioners can make decisions which help them control their exposure to complaints and lawsuits of this type, but the factors described here may be relatively independent of practitioner actions, such that risk management practices may not in fact provide sufficient protection (Bennett, Bryant, VandenBos, & Greenwood, 1990; Goisman & Gutheil, 1992). The focus on managing risks in relation to clients misses the fact that some of the risk derives from the way that investigatory bodies deal with complaints – a larger structural issue.

The description of patients as "consumers" or "customers" represents a shift in the way that relationships within the health profession are conceptualised; health care becomes a commodity, and the relationship is seen in consumer-merchant terms (Rabinovich-Einy, 2011). Within this frame the consumer is the ultimate arbiter – the employer of the professional – and this represents a change in the way the power dynamic operates when a complaint arises; issues are reduced to a baseline question – was the customer getting what they paid for (Woody, 2009). Psychiatric hospitals started using the term "mental health consumers" in attempts recognise individual rights of patients; the goal was to empower them, for instance by the establishment of client advisory boards (Morrison, 1978). APA bylaws were changed specifically to fall in line with principles of consumer rights (Hare-Mustin & Hall, 1981). Thus grievances are conceived of in terms of consumer protection, which may bias hearings in favour of the "customer" operating on the idea that "consumers of services have a right to recompense should that service not reach the standard which they expect to find" (Bell-Boule, 1999, p. 200). A contemporary example of the reversal of power roles in the consumer model is evidenced by the burgeoning of "practitioner reviews" on sites such as Yelp, where a dissatisfied client can leave a negative review which then remains on the internet in perpetuity, creating an ongoing impact which may effect damage to a therapist's reputation (Kolmes, 2009).

The professional relationship has a fiduciary basis involving trust and expectation that the practitioner will exercise their authority and power in the best interests of the client in exchange

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for a fee (Salevao, 2005). The trouble with the contemporary emphasis on the framing of the client as consumer, is that the focus of the relationship narrows into a commercial transaction, which becomes the basis for evaluation, with regulatory bodies taking on the role of "consumer protection" (Woody, 2009). The role of the consumer is not questioned in this context; in the commodified world we live in, a financially based relationship is simply seen in terms of the equation of exchange, and not as the potential for a dual relationship which may impinge on the therapy. However, if therapy services are provided and a client neglects to pay, it becomes clear that there is a form of power exerted by clients in their "employer" role.

Whilst some professions may position the client as a "passive recipient of a procedure instigated and implemented by an active practitioner who applies their 'skills' and 'professional expertise' to the problem" (Samuels, 2014, p. 7), this is arguably not the case with therapy or social work. In these professions, the relationship is the main ingredient (Duncan & Miller, 2000); it is not predictable or controllable in the way a "product" or "operation" might be, and problems which arise may to some degree be co-created. In fact, in the case of therapy, the practitioner may not always intend to meet the clients presenting need, which can be seen as covering more fundamental needs of which they have less awareness. Thus the simplistic model of consumer rights does not provide a fair or relevant measuring stick when a complaint arises.

Part of the problem here is the evaluation of therapists' professional behaviour using frameworks which may not syntonic with actual models being followed by the therapists themselves; this is the case for instance where a humanistic model of therapy may draw different boundary distinctions than a strict psychoanalytical orientation. There is no one "correct" model of therapy, and different schools suggest different approaches to treatment. Samuels (2014) suggests this represents a meta-power struggle between competing views on the nature of the professional relationship, with a particular model (client-passive) sometimes being superimposed on therapists, and then used as an evaluatory tool in hearings conducted by regulatory bodies.

Therapy, social work, and a variety of other helping professions require a level of "therapeutic alliance", which underpins all technical and skill based interventions (Duncan & Miller, 2000). When this goes wrong, the larger question is whether it gets dealt with as a relational fracture, or as an offence against a code. To take a case in point: when therapists take on clients with a history of childhood trauma, they can find themselves in a kind of rescuer role. However, this can take a dark turn whereby the therapist subsequently finds themselves in the position of (unwittingly) repeating the original injury in a variety of ways, with the result that the client re-experiences the original trauma (Gabbard, Shengold, & Grotstein, 1992). To use the language of Karpman (2007), we see here a cycle where the therapist who starts in the role of rescuer, turns into a persecutor; but in the transactional nature of such systems, clients who start as victims also then take a turn in the role of persecutor. Whilst it is the right of clients to bring a grievance, it is also important to understand the systemic patterns which may be present, and the ways in which the complaints process can in some ways become subsumed in these transactions. From this point of view, grievance processes would be better structured so as to step away from such dysfunctional and conflictual dynamics as far as possible, and orient themselves instead towards healing and a better quality of resolution between complainant and professional.

The adversarial system by which ethics complaints are heard generally constructs a story of the complainant as innocent, powerless and dependent (Mitchell, 1999). Whilst there are elements of this which are true, in the end it may not be respectful to accept or promote this view as it does not address some of the complexities of professional relationship, nor the shifts of powers that occur

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in a complaints process. The challenge is to engage in a more complex analysis of the power dynamics, and move away from unquestioned assumptions in regards to the power differential (Zur, 2008).

The model of identification of guilt and consequent punishment may not best serve either a client in the notifier position, or the practitioner who may have erred in some way (Holmes-Bonney, 2010). An alternative goal must is to find healing, learning, and a capacity to resolve relational fractures (Freiberg, 2011).

THE SUBJECTIVITY OF HARM

Accusations that harm has been effected by a professional can be problematic when the alleged violation is highly subjective, as when the perceptions and reactions of a client are afforded an almost objective status by a regulatory hearing. Boundaries, apart from physical ones, are after all perceptual affairs. This does not diminish the importance of a complainant's subjective experience, but it does point to the need for caution when making serious judgments about a professional during a hearing process. When boundaries are reified, a "boundary violation" can be an actual charge which constitutes the subject of investigation. This is problematic as it lends an objective status to something which is entirely relational and intersubjective (Kirsher, 2013). Mental or emotional injuries are hard to define, and causation is a complex question which cannot always be clearly established (Deardorff, Cross, & Hupprich, 1984).

Phillips (2003, p. 317) pointed out that "in some situations, a boundary violation can be defined as virtually anything the patient experiences as intrusive or harmful no matter how innocent or 'therapeutic' the intent of the professional". Phillips evidenced a range of cases in which actions which were later characterised as "boundary violations" were originally instigated by the client, sometimes through relentless demands; excluding here anything which would be sexually related – the patient requested something, then later sued the therapist for providing what was requested.

Certainly, it behoves therapists to act with caution, care, and professionalism. But there are also limits to what can reasonably be foreseen, and the very nature of therapy requires that boundaries – "the conjunction of safety and spontaneity" (Gabbard & Lester, 1995, p. 41) are flexible. After analysing a number of problematic cases, Williams (2013) questioned whether a therapist who is perhaps naive and does not successfully manage the complexity of a sensitive client's rage, should be subject to an extended inquisition-like process where they may be portrayed as acting abusively towards a hapless client.

Malpractice cases require proof of "demonstrable harm"; there are instances where the mere presence of a negative state of mind subsequent to the therapy is claimed as harm. However, proof of causality is fraught when it comes to subjective states, and the claim "I feel that I have been harmed" is impossible to contest (Adams, 2001). At its worst this can lead to trials where an accusation based on a feeling becomes a "fact", without the need for substantive evidence. In a court of law this category error would not pass the rules of evidence, but in the much lower requirement for evidence that is used in professional grievances cases, this type of accusation can become the basis for an adverse finding. In more prosaic language, this can be the equivalent of "pointing the bone".

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CONCLUSION

Professionals are held to account for the standards of their behaviour, the quality of their service, and the harmful effects of lapses of responsibility, carelessness, or outright exploitation. Oversight of these requirements by regulatory bodies is important, providing mechanisms to police flagrant abuses of power which do occur. However, without a more nuanced approach to this function, regulatory bodies run the risk of making findings based on overly simplistic frameworks which do not adequately engage the complexities of the therapy process. This can result in poor decision-making about grievance charges, inappropriate punishment of practitioners, and the creation of a climate of fear in the professional domain. The resultant "solution" of defensive risk management may yield certain benefits in terms of carefulness and caution, but also contributes to a reduction of openness and trust in the practice of the helping and healing professions. An alternative would involve a willingness to understand the operation of power in the professional relationship as interactive, complex, and best addressed through dialogue rather than inquisitional and adversarial mechanisms (Gunther, 2015).

The question of harm also requires a more penetrating analysis, balancing the need for protection of clients with an understanding of relationship as involving interacting dynamics. The framing of clients in a passive mode is unhelpful and inappropriate to the practice of therapy, perhaps more relevant to a medical model. It is suggested that attempts of regulatory bodies to measure and allocate the quantum of responsibility not appropriate and do not assist in resolving grievances. More effective may be to use institutional power to facilitate dialogue and mediation, incorporating perhaps adaptions of restorative justice, with the aim of bringing about learning, healing and reconciliation, rather than administering punishment.

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